



Making Medicaid Work for Children in Child Welfare: Examples from the Field

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The **Center for Health Care Strategies** (CHCS) is a nonprofit health policy resource center dedicated to improving health care access and quality. We work with state and federal agencies, health plans, providers, and consumer groups to develop innovative programs that better serve low-income Americans, especially those with complex and high-cost health care needs.

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“Safety and permanency are necessary but not sufficient to ensure well-being.”

*Bryan Samuels, Commissioner, Administration for Children and Families
U.S. Department of Health and Human Services*

Medicaid Strategies Important to the Child Welfare Population

Background

Nearly all children involved with the child welfare system are eligible for Medicaid, which is the primary source of funding for both physical and behavioral health care for this population. The extent to which the Medicaid benefit structure and service delivery system are customized for children in child welfare has a critical bearing on whether states can meet the mandated child welfare goals of safety, permanency, and especially, social and emotional well-being.

It is well documented that children in child welfare have significant health care needs, including physical, dental, and behavioral health needs. Nationally, their expenditures in Medicaid are driven more by behavioral health care use than by physical health care use, suggesting the critical importance of effective Medicaid delivery systems for both physical and behavioral health care.¹

Some states have undertaken collaborative efforts across child welfare, Medicaid, and behavioral health systems to “make Medicaid work” more effectively for children involved with child welfare and their families and caregivers. Their experiences can inform other states about effective Medicaid strategies and how to approach the necessary systemic changes.

The Annie E. Casey Foundation commissioned the Center for Health Care Strategies to explore strategies used in selected states to improve Medicaid for children in child welfare. The project involved reviewing state child welfare, Medicaid, and behavioral health system background materials and developing an interview protocol to collect information about a range of strategies affecting the Medicaid program. Four states that have made progress were selected, and key individuals were identified in each state to interview by phone. Five or more individuals were interviewed in each state, at minimum including representatives from the child welfare, Medicaid, and behavioral health systems. Information from each state was synthesized to develop case studies that detail their strategies and accomplishments. Information across states was also analyzed to derive general observations and lessons learned. This document discusses the Medicaid strategies that emerged as most important for effectively serving children in child welfare and then presents case studies highlighting the experiences of Arizona, Massachusetts, Michigan, and New Jersey. The document concludes with a discussion of cross-state observations and lessons learned.

Most Important Medicaid Strategies

The protocol used to guide the interviews with key informants in the four states studied explored Medicaid strategies in eight areas including: (1) Medicaid financing; (2) enrollment, eligibility, and access; (3) screening and early intervention; (4) covered services; (5) individualized service planning; (6) psychotropic medications; (7) Medicaid providers; and (8) performance and outcome measurement. Each of these areas is discussed briefly below, highlighting the strategies assessed to be most significant for meeting the needs of the child welfare population.

Medicaid Financing

- Medicaid Match** – A strategy for some of the states is to use child welfare general revenue as Medicaid match to expand home- and community-based services. State dollars used for Medicaid services draw federal match dollars at a 50 percent or higher match rate, so use of child welfare general revenue for children in foster care, most of whom are Medicaid-eligible, and for Medicaid-eligible services makes more sense than spending 100 percent state-only dollars. In Arizona, for example, the child welfare system contributed funds to the Medicaid behavioral health system as Medicaid match, allowing the state to draw down additional federal Medicaid dollars to generate more resources for services. In Michigan, the child welfare system moved funds to the behavioral health system to provide Medicaid match. With the additional federal Medicaid dollars that are captured, increased resources are available to provide services to children in child welfare with serious emotional disturbances under the state’s Medicaid 1915(c) Home and Community-Based Services Waiver.

For behavioral health services in New Jersey, the state identified services previously supported solely with state dollars that could be incorporated into the state Medicaid plan, allowing the state to capture federal funding for these services. In the first year of its system reform, New Jersey financed its Medicaid match by combining existing state dollars being spent on children with serious emotional disturbances through child welfare

Key Medicaid Strategies for the Child Welfare Population

Medicaid Financing

- Use of child welfare general revenue as Medicaid match to expand home- and community-based services
- Risk-adjusted rates and incentive payments to guard against under-service and encourage evidence-informed practices

Eligibility, Enrollment, and Access

- Presumptive Medicaid eligibility for children in child welfare
- Coverage of children in foster care beyond age 18
- Co-location and Medicaid financing of health and behavioral health liaisons in child welfare offices to assist with eligibility, screening, access, linkage, consultation, and crisis intervention

Screening and Early Intervention

- Timeframes for physical, behavioral, and dental health screens through EPSDT for children entering care
- Use of standardized screening tools

Covered Services

- Robust Medicaid benefit covering home- and community-based services including such services as family peer support, mobile crisis response and stabilization services, therapeutic foster care, and intensive in-home services
- Coverage of evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy

Individualized Service Planning and Intensive Care Coordination

- Coverage of Wraparound practice model to support individualized care planning
- Coverage of intensive care coordination at low care coordinator to child ratios (e.g., 1:8-10) for children with complex needs

Psychotropic Medication

- Monitoring of psychotropic medication utilization and consultation to prescribers and child welfare workers

Medicaid Providers

- Inclusion of skilled child welfare providers and specialists in Medicaid networks
- Practice guidelines and protocols for Medicaid providers
- Ongoing training on the unique needs of the child welfare population and effective practices

Performance and Outcome Measurement

- Performance expectations specific to the child welfare population for Medicaid managed care entities and providers and monitoring of quality of implementation
- Tracking of performance, service utilization, expenditures, and outcomes specific to child welfare population
- Cross-agency data sharing agreements and use of data to identify areas needing improvement and to show results

and behavioral health (including funds previously expended on residential care) with new funds authorized in the state budget to build its statewide system of care.

- **Risk Adjusted Rates and Incentive Payments** – An important financing strategy for the child welfare population is to use risk-adjusted rates and incentive payments to provide sufficient resources to serve this high-need group and guard against under-service. In Arizona, a single Medicaid health plan was created to provide all medically necessary physical health and dental services to children in foster care. This plan is financed through a risk-adjusted capitation rate. Similarly, the behavioral health capitation rates paid to the state’s regional behavioral health authorities are risk-adjusted for the child welfare population and are, on average, 29 percent higher than for non-child welfare involved children.

In Michigan, child welfare and behavioral health collaborated to develop a strategy for serving children in child welfare with behavioral health challenges who do not meet the criteria for the level of care provided through the 1915 (c) Medicaid Home and Community-Based Services Waiver. Incentive payments are provided to the community mental health services agencies to make it more feasible for them to serve these children through the Medicaid behavioral health managed care system. These incentive payments are over and above the capitation rates for Medicaid children and are targeted to children with serious mental health conditions in foster care or those involved with child protective services.

Eligibility, Enrollment, and Access

- **Presumptive Eligibility** – In all four states, all or nearly all children in child welfare are eligible for Medicaid. In both Massachusetts and Michigan, there is presumptive eligibility for children in child welfare. Making children who enter foster care presumptively eligible for Medicaid can help to ensure more immediate access to health and behavioral health screens and services.
- **Coverage Beyond Age 18** – Medicaid coverage for children in foster care beyond age 18 is a strategy currently used in some states; in 2014, coverage to age 26 will be required under health reform. This coverage is essential for youth and young adults aging out of the foster care system and making the transition to adulthood and independent living. Currently, Massachusetts provides coverage up to age 25 for youth aging out of the foster care system, and in 2008, Michigan increased eligibility for Medicaid to age 21 for youth in foster care if their case closed at the age of 18 or later.
- **Co-Location and Liaisons** – Co-location of health and behavioral health staff and liaisons in child welfare offices has proven to be an effective strategy for assisting with eligibility determination, enrollment, and access to care. To facilitate enrollment and access to physical health services, the child welfare system in Michigan has health liaison officers placed within county child welfare offices. These liaisons are experts in working with the Medicaid health plans and their staff, as well as with child welfare staff and foster families. When a child enters care, the liaison officer facilitates enrollment in a health plan and ensures that health care services continue without disruption if the child transitions to a new foster home or another placement.

For behavioral health services, children’s mental health clinicians placed within Michigan’s child welfare agencies work directly with child welfare staff to identify children who are eligible for services under the 1915 (c) Medicaid Home and Community-Based Services Waiver for children with serious emotional disturbances. The services provided by these “access staff” are covered under Medicaid as assessment services. Beyond determining eligibility, the clinicians provide consultation,

assistance in accessing behavioral health services, as well as assistance to child welfare staff regarding children with behavioral health concerns.

In New Jersey, Child Health Units are co-located in each of the 47 child welfare offices across the state. Staffed by nurses, the units work collaboratively with case workers, foster parents, and other caregivers to ensure timely access to medical and dental care for children, particularly those who require specialty care.

Screening and Early Intervention

- **Timeframes for Screens** – Timeframes for physical, behavioral, and dental health screens help to ensure that children entering the child welfare system are assessed quickly for physical and behavioral health concerns and are linked with needed services to intervene as early as possible. In Arizona, an urgent response strategy was jointly developed by child welfare, behavioral health, and Medicaid whereby every child entering foster care receives a behavioral health assessment within 72 hours of entering care. This strategy creates a “fast track” to link a child in foster care with behavioral health services. Massachusetts requires medical screening for children entering state custody within seven days and a comprehensive examination within 30 days, and Michigan requires a full medical examination by a physician within 30 days of a child entering foster care, which includes a behavioral health component.

In New Jersey, children entering foster care are required to have a physical health examination within 30 days of placement, which is paid for by Medicaid. Through a partnership between Medicaid and child welfare, enhanced rates were negotiated for this comprehensive medical examination. Mental health screening is also required for children in out-of-home placement and also must be completed within the first 30 days.

The Child Health Units in New Jersey also fulfill a screening function by visiting each child placed out-of-home within two weeks of entering care and thereafter at regular intervals, often with the child welfare worker, to assess health care needs, provide developmentally appropriate anticipatory guidance, and review the child’s health care plan with the caregiver. Child Health Unit nurses and case workers are responsible for ensuring that children receive ongoing screening and that children who are identified with suspected mental health needs receive mental health assessments and follow-up care. Similarly, the health liaison officers in Michigan fulfill a screening and assessment function so that physical and behavioral health needs are identified as soon as possible after children enter care.

- **Standardized Screening Tools** – The use of standardized screening tools provides a mechanism for ensuring that children in child welfare are assessed with valid instruments that are sufficiently sensitive to identify their physical and behavioral health needs. All Medicaid enrollees in Massachusetts are required to have a behavioral health screen based on screening protocols and using one of a set of standardized tools. Primary care practitioners receive training on using the tools and linking children with services when behavioral health needs are identified. In Michigan, standard screening and assessment tools are required for younger children on Medicaid and are recommended for older children for their screens under the Early Periodic Screening, Diagnosis, and Treatment (EPSDT) benefit. For children in foster care, a validated, normed screening instrument must be used at each scheduled EPDST well-child visit. There are child health forms specific to child welfare that document that the required medical, behavioral health, and dental screenings have been completed. New Jersey employs a version of the Child and Adolescent Needs and Strengths (CANS) assessment to evaluate children with suspected behavioral health treatment needs.

Covered Services

- **Coverage of a Broad Range of Home- and Community-Based Services** – A robust Medicaid benefit covering a broad range of home- and community-based services and supports, in particular behavioral health services, is essential for children in child welfare to enable them to be served in home and community settings rather than in hospitals and residential treatment centers. The states in our sample all have a rich benefit package that covers a wide array of services and supports (in addition to traditional treatment services such as individual, group, and family therapy; medication review and administration; and evaluation). Covered services include intensive in-home services; Wraparound facilitation or treatment planning; intensive care management; mobile crisis response and stabilization; therapeutic foster care; respite care; family peer support; family training; substance use treatment; therapeutic mentoring; behavioral assistance; and transportation. This has been accomplished in states by adding services to the state Medicaid plan and/or revising service definitions and by using the Rehabilitation Services Option and Targeted Case Management. In addition, some states have used Medicaid waivers to expand coverage.

Several services are especially important for children and families involved with child welfare. Through intensive in-home services, teams of providers come into the home and community to provide treatment, in-home behavioral support, and education for caregivers on how to manage their child's challenging behaviors. Family peer support offers family partners who have lived experience to mentor, support, and advocate for other families as they progress through the service delivery process. Coverage of family peer support greatly increases the ability to engage families and provides services through a more family-centered approach; it is a significant support to families involved with child welfare, to child welfare staff, and to health care providers.

Mobile crisis response services provide crisis teams that can respond to crises at foster homes, family homes, shelters, group homes, and other settings and divert children from hospitalization. Some can remain involved with families for a period of time (ranging from one week in Massachusetts to as much as nine weeks in New Jersey) for stabilization purposes rather than risking out-of-home placements.

In New Jersey, three new services will be added to the Medicaid benefit package as a result of a recently approved Comprehensive Medicaid Waiver – youth support and development, services for youth in transition to adulthood, and non-medical transportation that is a part of a child and family's individualized service plan.

In some states, Medicaid benefits are supplemented by state funds that are used to finance services or supports that are not Medicaid-billable. For example, New Jersey provides flexible funds to pay for services and supports that are part of the individualized service plan but are not covered by Medicaid, such as tutors or housing assistance.

- **Coverage of Evidence-Based Practices** – Specific strategies are needed to cover evidence-based interventions, particularly behavioral health interventions, relevant to the child welfare population such as Trauma-Focused Cognitive Behavioral Therapy. In Arizona, a separate Medicaid billing code was created for Multisystemic Therapy, and other evidence-based practices are covered using existing codes for assessment, case management, therapy, and others. Billing code matrices were developed to help providers determine how to bill for practices such as Functional Family Therapy, Multidimensional Treatment Foster Care, and Cognitive Behavioral Therapy.

Michigan covers evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy and Parent Management Training-Oregon Model. Evidence-based practices are covered under Medicaid when delivered by a certified clinician and are covered under billable service codes such as home-based therapy or individual or family therapy. New Jersey covers some specific evidence-based practices (including Multisystemic Therapy and Functional Family Therapy), and the state has supported training in various evidence-based treatments including Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy, Parent-Child Interaction Therapy, and Brief Strategic Family Therapy.

- **Coverage of Intensive Care Coordination** – Coverage of intensive care coordination at low care coordinator to child ratios (e.g., 1:8-10) is critical for children in child welfare in recognition of their complex needs and multi-system involvement. High-need case management in Arizona was added to the Medicaid benefit and is primarily billed as case management, though some components can be billed under codes for living skills training, family support, and therapy. Community Service Agencies (i.e., care management entities) in Massachusetts provide intensive care coordination financed by Targeted Case Management using a Wraparound practice model, and Targeted Case Management is considered a critical service in Michigan as well. New Jersey also uses Targeted Case Management to help finance intensive care coordination provided through its Care Management Organizations, which also use a high quality Wraparound approach.

Individualized Service Planning

- **Coverage of Wraparound Practice Approach** – Coverage of the Wraparound practice model to support individualized care planning is essential for children and families involved with child welfare based on their complex needs and the multiple agencies and caregivers typically involved in their care. Child and family teams are the lynchpin of the Wraparound practice approach, with a team that is specific to each child and family and includes the family (defined as foster, kinship, birth families, and other involved caregivers) and all other involved providers as well as natural supports that may be identified by the family and youth. The team develops an individualized, customized plan for services based on the youth's and family's strengths and needs, ensures that services are provided and coordinated, monitors progress, and revises the plan as needed. This approach has been successful in avoiding "deep-end" placements.

In Arizona, the Wraparound process for service planning and delivery is mandated for all children on Medicaid who receive behavioral health services, including those in child welfare. Wraparound facilitation is covered by Medicaid using billing codes including case management and family support. These teams are empowered to determine medical necessity and the service plans they develop are considered to be authorized services for Medicaid. A Wraparound approach to planning and delivering services is also the foundation of Massachusetts' practice model for its Children's Behavioral Health Initiative. Community Service Agencies located in each of the child welfare service areas provide intensive care coordination financed by Targeted Case Management using "high-fidelity Wraparound" as described by the National Wraparound Initiative.²

Wraparound is covered in Michigan's state Medicaid plan so that any child in need can receive this service. The service is provided most frequently to children who are involved in multiple systems and are at risk for out-of-home placement. Similarly, the practice model for the children's behavioral health system in New Jersey is the Wraparound approach. For children involved with child welfare and juvenile justice, the plans must address safety and permanency issues.

Psychotropic Medication

- **Monitoring and Consultation on Psychotropic Medications** – In recognition of the over-prescription and inappropriate prescription of psychotropic medications to children in child welfare, recently highlighted in a U.S. Government Accountability Office (GAO) study, states are strengthening their monitoring of psychotropic medication utilization and consultation to prescribers and child welfare workers. In Arizona, a replica of the GAO study was conducted, and similar concerns were identified – children in child welfare were prescribed psychotropic drugs at a higher rate, polypharmacy was an issue, and many were prescribed higher doses than the maximum levels cited in guidelines, with the potential for serious, adverse side effects. As a result, Medicaid, behavioral health, child welfare, the Medicaid health plan, and the Regional Behavioral Health Authorities are collaborating to determine best practices and update relevant practice protocols.

In Massachusetts, the state, in partnership with Massachusetts Behavioral Health Partnership (MBHP), a behavioral health managed care organization, has implemented consultation to primary care practitioners on the appropriate use of psychotropic medications, and MBHP has undertaken quality initiatives to address the issue of children with long term use of these medications. In addition, data from the Medicaid pharmacy system are analyzed for the child welfare population to identify outliers, both children and prescribers, so that a system to address these cases can be implemented. The medical director of the child welfare agency will play a major role in following up on identified situations warranting intervention.

The child welfare system in Michigan hired a child and adolescent psychiatrist as a medical consultant at the state level to focus on child welfare issues, including the prescription of psychotropic medications. An updated policy on these medications requiring a standardized written consent form was implemented in 2012, along with guidelines for psychotropic medications that apply to all Medicaid-enrolled children accompanied by an oversight process. The guidelines include “triggering” criteria that indicate the need for review, and through a partnership with Medicaid, these criteria are cross-matched with the medications prescribed for children in child welfare to identify red flags and outliers. The medical consultant follows up with the prescribing physicians when indicated. A manual on psychotropic medications is being widely disseminated to providers in Michigan, and a YouTube tutorial is being developed as well.

New Jersey is part of a six-state national quality collaborative coordinated by the Center for Health Care Strategies to reduce the inappropriate use of psychotropic medications in the foster care population. The state created a team comprised of Medicaid, child welfare, and behavioral health to explore next steps to monitor the use of these medications.

Medicaid Providers

- **Inclusion of Skilled Child Welfare Providers and Specialists in the Medicaid Network** – Medicaid providers knowledgeable about the child welfare population and trained in effective practices are fundamental to providing effective care. Providers are needed with expertise that is relevant to children in child welfare such as sexual abuse, attachment disorders, and trauma. A specialty provider initiative in Arizona was undertaken to develop expertise in these areas and to ensure that the Medicaid behavioral health provider networks include providers with these skills. Since the child welfare system had existing contracts with providers with these specialties, it was ultimately mandated that the regional authorities include these specialists in their provider networks. All of these providers were required to become certified as Medicaid providers. The state conducted annual

surveys as part of a “sufficiency process” to determine whether these specialty providers were, in fact, included in the networks.

Provider networks in Massachusetts are required to include expertise in trauma-informed care. A certificate program was implemented at a college in Boston for advanced study in trauma-informed care for the child welfare population. In Michigan, the provider networks of the community mental health services agencies include a variety of specialists to meet the needs of children in child welfare and other populations. When providers with a particular type of expertise are not available, the agencies may seek out a specialty provider that is “out of network.”

- **Practice Protocols for Child Welfare Population** – Practice guidelines and protocols for Medicaid providers are used as a strategy to highlight the unique needs of the child welfare population and to outline best practices for responding. Practice protocols were developed in Arizona to guide behavioral health service delivery to children in child welfare that outline procedures for coordinated service planning and delivery. Behavioral health and child welfare collaborated in Massachusetts to develop guidelines for behavioral health agencies and providers on how to work with the child welfare system.
- **Ongoing Training** – Training is needed to ensure that the providers serving the child welfare population have the necessary knowledge and skills on an ongoing basis. In Arizona, behavioral health providers receive training in areas relevant to the child welfare population through modules including “a day in the life of a child in child welfare,” clinical needs of the child welfare population, how to work with the child welfare agency and the courts, and others. In Michigan, community mental health services agencies receive training on the unique needs of children in child welfare, in many cases with child welfare staff, foster parents, and others with this expertise serving as trainers. In addition, the mental health agencies provide training to child welfare staff on behavioral health services. Extensive training is also provided statewide on evidence-based practices that are essential for the child welfare population, most notably on Trauma-Focused Cognitive Behavioral Therapy.

New Jersey has two structures that provide ongoing training on the unique needs of the child welfare population – a Child Welfare Training Academy and a Behavioral Health Research and Training Institute. Both offer vehicles for preparing child welfare, health, and behavioral health providers to work with this high-need population.

Performance and Outcome Measurement

- **Tracking Child Welfare-Related Performance, Utilization, Outcomes, and Expenditures** – A critical strategy to make Medicaid work for children in child welfare is to incorporate and monitor performance expectations specific to the child welfare population and to track service utilization, outcomes, and expenditures for this population. Collecting this information from managed care entities and providers allows Medicaid, child welfare, and behavioral health to make data-based decisions and implement strategies to improve quality and outcomes.

Arizona established performance standards for physical health services under Medicaid, and the Medicaid health plan for children in foster care is routinely monitored. Under the Medicaid Managed Care Waiver in Michigan, a reporting system provides encounter data that track service utilization, and there is a marker to identify children in child welfare. For children served under the 1915 (c) Medicaid Home and Community-Based Services Waiver, data are collected relative to a set of indicators, and a functional assessment is built into the system using scores on the Child and

Adolescent Functional Assessment Scale. Specific data are produced on outcomes for the child welfare population.

For youth receiving intensive care coordination and mobile crisis services in Massachusetts, detailed reports are produced on various indicators. Data are collected to track indicators specific to the child welfare population, for example, using Medicaid claims and behavioral health data to identify children in child welfare and provide information on this subset of children. An indicator that has been tracked reflects the number of child welfare-involved children in psychiatric hospitals awaiting placement, which has been reduced significantly.

In New Jersey, outcomes-based contracts are used with providers that require information on a number of key indicators, some particularly relevant to the child welfare population such as stability of children and families, well-being, and permanency. Regular data reports are also produced on specific benchmarks for children in child welfare, including benchmarks on physical health and behavioral health services. For example, data are collected on how many children receive pre-placement medical assessments, comprehensive medical examinations, examinations in compliance with EPSDT guidelines, semi-annual dental checks, and immunizations. For behavioral health services, reports are generated on mental health assessments for children with suspected mental health needs and the extent to which they receive timely and appropriate follow-up and treatment.

- **Cross-Agency Data Sharing** – Cross-agency data sharing is a strategy that allows Medicaid, child welfare, behavioral health, and other system partners to communicate and to monitor progress and impact across agencies. In Arizona, the data system from the Medicaid health plan for foster care children and the child welfare system data system interface to share data seamlessly to improve service delivery for children in child welfare.

State Case Studies

ARIZONA

QUICK LOOK: Making Medicaid Work for Arizona's Child Welfare Population

- Medicaid is the platform for a single behavioral health delivery system (behavioral health carve-out) with attention to the needs of children in child welfare
- Enrollment of children in foster care in a single health plan for medical and dental care
- Risk-adjusted rates
- Using child welfare funds to draw down additional federal Medicaid match to expand behavioral health resources
- Practice guidelines and protocols for Medicaid providers related to the child welfare population
- Co-location of behavioral health staff in child welfare offices
- Broad medical and behavioral health benefit, including support services like respite and family peer support
- Urgent response required by Medicaid behavioral health plans when child enters care; screens within 72 hours
- Coverage of the Wraparound approach to service planning and delivery
- Attention to appropriate use of psychotropic medications
- Specialty providers knowledgeable about the child welfare population
- Provider training on needs specific to child welfare population
- Tracking service utilization of the child welfare population

Overview of Arizona's Child-Serving Systems

The child welfare system in Arizona, which is state administered, is housed within the Department of Economic Security (DES). Within this department, the Division of Children, Youth, and Families (DCYF) is responsible for child welfare services, including child protective services, foster care, and adoption, that are provided in five geographic regions.

The Arizona Health Care Cost Containment System (written as AHCCCS and pronounced "access") is the state's Medicaid program, which operates within a managed care environment through an 1115 Research and Demonstration waiver. AHCCCS oversees contracted health plans to deliver health care to individuals and families who qualify for Medicaid and other medical assistance programs.

Arizona has a population of 6.4 million, with Hispanics and Latinos comprising nearly 30 percent, and has the largest number of speakers of Native American languages in the 48 contiguous states. As its population grows, Arizona's child welfare system serves a growing number of children in foster care, today numbering 14,000. Nearly 1.5 million people in the state are enrolled in Medicaid (24 percent of the state's population), with children comprising close to half of the Medicaid population.

Arizona's approach to providing physical and dental health services to children in foster care is unique in that children in care are enrolled into a single Medicaid health plan¹ – the Comprehensive Medical and Dental Program (CMDP) – created specifically for this population. CMDP was established in 1970 by state law and is administered by DCYF. Medicaid contracts with DCYF for CMDP through an Intergovernmental Agreement to serve as the health plan for children in foster care.

¹ Although Medicaid enrollees are required by federal law to have a choice of health plans, in Arizona a waiver of choice for the child welfare population allows these children to be enrolled in one single plan (CMDP) for their physical health services.

Behavioral health care is provided to children in foster through the behavioral health managed care system overseen by the Department of Health Services, Division of Behavioral Health Services (DBHS). The state Medicaid agency contracts with DBHS through an Intergovernmental Agreement to manage the behavioral health system under Medicaid. The division, in turn, contracts with four Regional Behavioral Health Authorities (RBHAs) covering six geographic regions throughout the state and with three Tribal Behavioral Health Authorities. These entities manage behavioral health service delivery for both children and adults in their respective areas.

Background and Collaboration

Arizona state agencies have worked collaboratively to meet the physical and behavioral health needs of children in the child welfare system. CMDP, the medical and dental health plan for children in foster care, was integrated into the state's Medicaid program in the mid-1980s.

"We pulled together an interagency group of child welfare and behavioral health providers and agency staff to have a frank conversation about how children experience removal from their homes. We talked about the experience from the child's point of view."

In addition, the state has worked extensively to design strategies for improving behavioral health services for this population. Stemming from the recognition of unmet needs, the trauma involved in placement in foster care, and the unique mental health needs of this population, the state created a task force in 2000 to examine mental health services for children in child welfare. Utilizing case reviews and other methods, the task force identified systemic problems that

impeded behavioral health service delivery for this population.

A class action lawsuit, referred to as Jason K. or JK, was instrumental in moving this collaboration to a new level. Originally filed in 1991, the JK lawsuit alleged that Arizona had failed to provide the mental health treatment mandated by Medicaid's EPSDT provision. The class of plaintiffs included all Medicaid eligible persons under the age of 21 who were identified as needing behavioral health services. The lawsuit resulted in what has been described as an historic settlement agreement in 2001, committing the state to a complete redesign of its Medicaid children's behavioral health system. Children in state custody due to abuse and neglect were specifically mentioned as part of the class, laying the groundwork for a special focus on this population in crafting the new system. As such, the child welfare system had a significant influence in shaping the settlement agreement.

Through the settlement, a set of principles emerged based on the system of care approach, which calls for individualized services that are: tailored to the needs of each child and family, accessible, coordinated, based on best practices, and provided in the most appropriate setting. Eventually, all child-serving agencies signed onto these principles to meet the behavioral health needs of children in Medicaid. The adoption of the principles led to the development and financing of a Medicaid benefit that today includes a broad array of home- and community-based services and supports, as well as the development of specific goals and protocols for serving the child welfare population that were jointly developed by behavioral health and child welfare.

AZ Medicaid Behavioral Health System Principles

- Collaboration with the child and family
- Functional outcomes
- Collaboration with others
- Accessible services
- Best practices
- Most appropriate setting
- Timeliness
- Services tailored to the needs of the child and family
- Stability
- Respect for the child and family's unique cultural heritage
- Independence
- Connection to natural supports

These child welfare-specific goals include:

- Immediate delivery of behavioral health care through “urgent behavioral health response;”
- Contracts with behavioral health providers that require an understanding of the unique needs of children in child welfare;
- Assessments that better meet child welfare system needs through a strengths-based, individualized, holistic approach that includes assessments of risk, trauma, substance use, etc.; and
- Specialty services available for post-traumatic stress; sexually inappropriate behaviors; loss, attachment, and bonding; family functioning, parenting skills, and family preservation; youth in transition to adulthood; adoption support, etc.

“Although Medicaid controlled the package of services, they looked to behavioral health as the experts to identify what services were needed and significantly expanded the array of covered services.”

The partnership among the Medicaid, behavioral health, and child welfare agencies was critical in implementing reforms to address these needs. Leaders in the Medicaid agency were strong proponents of community-based services rather than residential care for children, and as a result, were receptive to recommended changes. The high level of cooperation resulted in coverage for a broad array of services and supports that became effective only five months after the JK settlement.

Building these relationships across agencies took a great deal of work. Following the JK settlement agreement, state agency directors signed a Memorandum of Understanding that has been the foundation for their partnership. A children’s executive committee met for a number of years, bringing together agency leaders to chart a common direction, design the system, coordinate, and resolve problems. While the committee is not as active as in the past, the relationships among the agencies continue. As in many states, turnover in leadership presents a particular challenge to maintaining cross-agency relationships, and continual efforts to nurture partnerships are essential. Local children’s coordinating councils were created to provide cross-agency leadership in rolling out a new practice approach using child and family teams and to coordinate services across the Medicaid, behavioral health, and child welfare systems.

“Lots of the interaction between agencies is relationship driven, and much is based on trust that each agency will do its fair share.”

The federal Centers for Medicare & Medicaid Services (CMS) was supportive of the proposed strategies, allowing the state to move forward in implementing changes to its Medicaid program.

Medicaid Financing and Service Delivery

In Arizona, nearly 94 percent of children in child welfare are eligible for Medicaid. In addition, children in foster care are eligible for transitional coverage upon leaving care, which provides an additional 60 days to enroll in another Medicaid health plan or a private health plan. As the major source of health care financing for this population, the state has implemented strategies to provide high quality, cost-effective physical and behavioral health care to these children.

In 1982, Arizona became the final state to implement a Medicaid program. At the outset, the program was created with a Medicaid Section 1115 Waiver as a demonstration project and has operated under a managed care model from its inception. The waiver gave the state a great deal of flexibility, and as the Medicaid system has evolved, this flexibility has provided a vehicle for tailoring the structure and services to better meet the needs of children involved with the child welfare system along with their families and caregivers.

Physical Health

As the designated health plan for children in foster care, CMDP is responsible for ensuring – in partnership with foster care providers – that children receive appropriate and high-quality health care services. This entity receives a risk-adjusted capitation rate for children in child welfare, which it uses to pay for all medically necessary physical health and dental services for this group. Arizona’s Medicaid program also offers reinsurance as a stop-loss mechanism for its contractors, which is characterized as a risk-sharing strategy. (Reinsurance reimburses health plans for cumulative claims that exceed established thresholds during a year.)

“Having a health plan dedicated exclusively to children in foster care allows us to pay attention to their special health care needs and to be fully integrated with the child welfare system.”

Each child in foster care is assigned to a primary care provider (PCP) that is selected by the foster caregiver to serve as the child’s medical home. Foster parents often know which provider they prefer based on past experience and/or to keep all their foster children with the same practitioner. The role of the PCP includes coordinating health care services and arranging for specialty health care providers when needed. PCPs are paid on a fee-for-service basis by the health plan.

The CMDP and child welfare data systems interface so that data can be shared seamlessly, for example, to easily identify the services that a child has received. It is noteworthy that on almost every pediatric health care measure, the plan ranks number one among all of the Medicaid health plans in the state.

Behavioral Health

Arizona’s child welfare system previously provided behavioral health services to its population through a separate funding stream and provider network, rather than through the state-run behavioral health system, resulting in inefficiencies and fragmented care. Collaborative efforts across Medicaid, child welfare, and behavioral health, particularly following the JK settlement agreement, have resulted in substantial improvements in the delivery and financing of behavioral health care for children in child welfare.

Funding for behavioral health services goes from the Medicaid agency to the DBHS, which operates a managed behavioral health system for children and adults. Services are delivered through contracts with the RBHAs, that then contract with providers. Today, approximately 65 percent of children in child welfare in Arizona are actively engaged in the RBHAs and receiving some type of behavioral health care. One region of the state is currently taking corrective action to increase the penetration rate for this population, since its penetration rate has been approximately 50 percent as compared with 70-80 percent for other regions in the state.

RBHAs receive a pre-paid capitation rate for Medicaid enrollees. Annual actuarial reports are produced to examine utilization and utilization trends, which drive adjustments in capitation rates. The costs over the previous three years are used to justify rates for the next fiscal year. Although RBHAs are at risk, there is a “loss-profit corridor” whereby RBHAs are reimbursed by DBHS for losses in excess of 3 percent. Capitation rates vary across the state’s regions based on variation in service expenditures and utilization.

Approximately 15 percent of the Medicaid children enrolled in RBHAs for behavioral health services are involved with child welfare, even though children in foster care represent only about 3 percent of overall Medicaid child enrollment. The system partners acknowledged that the child welfare population has significantly greater treatment needs as compared with other Medicaid-eligible children, and as a result, incorporated provisions specific to child welfare into the Medicaid behavioral health system, including:

- **Capitation rates are risk-adjusted for the child welfare population.** The capitation rates for children in foster care were developed with the assistance of actuaries and are, on average, 29 percent higher than the rates for non-child welfare involved children. With these additional resources, the RBHAs are better able to provide the appropriate intensity and types of specialized services needed by this high-risk group.
- **The child welfare system contributed funds to the Medicaid behavioral health system as Medicaid match,** allowing the state to draw down additional federal Medicaid dollars and generating more resources for services. Fragmentation was reduced by consolidating most behavioral health resources in the Medicaid managed care system.
- **Several practice protocols have been developed for this population,** to guide behavioral health service delivery for children and families involved with child welfare, for example:
 - Procedures for a uniform and coordinated service planning process; and
 - Procedures for service delivery when a child remains with his or her own family; is removed to protective foster care; is returned to the family of origin from foster care; achieves permanency through adoption/guardianship; or is preparing for independent living.

“Child welfare wanted certain guarantees from the Medicaid behavioral health system to feel confident that their children would be served well. The protocols help to demonstrate a good faith effort.”

Screening and Early Intervention

One of the most important strategies for serving children in child welfare is urgent response, a rapid approach for screening and early intervention. A protocol for urgent response was jointly developed by Arizona’s child welfare, behavioral health, and Medicaid agencies, requiring that every child entering foster care receive an assessment of behavioral health needs within 24 hours of entering care. Due to fiscal constraints, this time window was later extended to 72 hours. Stakeholders indicated that the

“One impetus for urgent behavioral response was a 2002 newspaper story about a five-year-old girl swept up in the foster care system and placed in a shelter on a weekend with no support or response to this traumatic event in her life.”

extension in timeframe still allows them to meet the needs of the child and may even provide a more accurate picture of the child’s needs. Providers now have a bit more leeway in conducting the urgent response and in maintaining qualified staff for this purpose. Higher capitation rates for the child welfare population have also allowed the RBHAs to create units with sufficient staff levels for the screening services.

Urgent response creates a “fast track” to link a child in foster care to behavioral health services. If there is an indication of need, the child is referred to a provider for ongoing services; the urgent response clinician identifies an appropriate provider and coordinates the care. If an immediate referral for ongoing services is not needed, a follow-up contact occurs approximately two weeks after the urgent response visit, and again at four weeks, to check in with the child and caregiver and assess whether needs have changed. Initially, fewer than 30 percent of child welfare-involved children were enrolled in RBHAs. After implementation of the urgent response, enrollment in the RBHAs grew to nearly 65 percent; and today, more than 90 percent of children removed from their homes receive an urgent response screening.

“The urgent behavioral response offers a lifeline to substitute caregivers in foster homes and shelters because they have a contact in the behavioral health system to call who will respond immediately.”

Any critical physical health care needs identified during the urgent response screens are brought to the attention of the child welfare worker. A comprehensive medical screening consistent with EPSDT

requirements must then occur within 30 days of entering foster care, and all subsequent EPSDT visits must include developmental and behavioral health screens.

The state's behavioral health system co-locates behavioral health professionals in child welfare offices to conduct assessments and provide crisis services – all of which are Medicaid reimbursable. Child welfare staff have found this extremely helpful.

Covered Services

Arizona's Medicaid billing system was created to anticipate many combinations of services, levels of care, and service settings. Following the JK settlement, the state Medicaid agency added billing codes for the broad array of children's behavioral health services and supports deemed necessary for Medicaid children, including those in child welfare.

"The highly comprehensive physical and behavioral health benefit provided through Medicaid is richer than most policies in the commercial world."

Arizona's Medicaid program covers a robust package of behavioral health services and supports for children, most of which are heavily utilized by the child welfare population. Despite variations in the availability of some services across the state – for example, in some rural areas – many children and families have access to services and supports that go well beyond traditional behavioral health treatment. These services support foster homes, kinship homes, and other child welfare placements, and allow children to be served in the community, avoiding congregate care placements.

The range of supportive services covered by Arizona Medicaid includes:

- In-home services
- Respite care
- Life skills training
- Family and peer support
- Therapeutic foster care
- Case management
- Supported housing
- Supported employment
- Mobile crisis intervention
- Crisis stabilization
- Respite
- Transportation

Flexible funds and traditional health services (such as Native American traditional health and acupuncture) are intended to supplement the Medicaid service package and are financed with grant funds.

"The service array has enabled a large reduction in residential beds in the state, and the provider community is better equipped to manage children in child welfare in community-based services than ever before."

Medicaid also covers evidence-based practices through both new and existing billing codes. A specific Medicaid billing code was created for Multisystemic Therapy, while other evidence-based practices are covered using existing billing codes for assessment, case management, therapy, and others. Billing code matrices help providers

determine how to bill for evidence-based practices such as Functional Family Therapy, Multidimensional Treatment Foster Care, and Cognitive Behavioral Therapy. Some of the additional evidence-based practices that can be found in various regions of the state include early childhood mental health consultation, Incredible Years, Brief Strategic Family Therapy, Trauma-Focused Cognitive-Behavioral Therapy, and Motivational Interviewing.

Therapeutic foster care is a particularly significant service that was added to Medicaid. The first licensed therapeutic foster homes were implemented in 2003 and were an important vehicle for discharging children from residential treatment by providing the support needed to bring them back to the

community to live in a family setting. Within two years, the number of children in out-of-state placements was reduced from approximately 100 to 20. Therapeutic foster care was seen as highly cost-effective— at only a fraction of the cost of residential treatment. The state’s child welfare system works with both the behavioral health and Medicaid agencies in several aspects of the therapeutic foster care program. Only foster homes licensed by child welfare are used for therapeutic foster care. A curriculum for treatment parents was developed jointly by child welfare and behavioral health. Treatment parents work with the child and the child’s birth family, particularly when there are potential reunification plans. Through a cost sharing arrangement, Medicaid pays for the therapeutic portion of the service, while child welfare covers the costs of room and board. However, when a child stabilizes, the rate paid to treatment parents drops to that of regular foster homes, creating a challenge for treatment parents, which may result in a placement change.

Another intervention recently added to the children’s behavioral health system is referred to as “high-need case management” and is primarily billed as case management under Medicaid. Some of the components of high-need case management can be billed under the codes for living skills training, family support, and even therapy if the case manager has appropriate credentials. Although this service is not limited to children in child welfare, many child welfare-involved children qualify based on their serious and complex needs. The service is provided by a case manager (with a caseload ranging from 8 to a maximum of 20) who facilitates the development of an individualized service plan; arranges and coordinates services; monitors progress; and supports the child and family.

Individualized Service Planning

In Arizona, the Wraparound process for service planning and delivery is mandated for all children in Medicaid who receive behavioral health services, including those in child welfare. Child and family teams are the lynchpin of the Wraparound approach, with a team specific to each child and family developing an individualized, customized plan for services and supports; monitoring progress; and revising the plan as needed.

Child and family teams are typically small for children with less serious and complex problems. However, for high-need children, the teams are comprised of the Wraparound facilitator (usually the high-need case manager), foster family, birth family (as appropriate), youth, child welfare worker, behavioral health provider, other involved providers, and others as needed. Facilitation of the Wraparound process is covered by Medicaid, using case management and/or family support billing codes; the time of some of the other providers may also be covered under Medicaid.

Initially, child and family teams were implemented for children in or at high risk for out-of-home placements, such as residential treatment, many of whom were in child welfare. “Family” was deliberately defined as including foster families, kinship families, birth families, and other caregivers, to be responsive to the various contexts for this population. A practice protocol for child and family teams was developed at the outset with cross-system input for the functioning of these teams and mandating that every involved system be included in the planning.

Child and family teams are empowered to determine medical necessity, and the service plans they develop are considered to be “authorized” services for Medicaid. Only a few designated services – inpatient hospitalization, residential treatment, group home care, and prescriptions for psychotropic medications – require prior authorization outside of the teams. RBHA professionals can approve these services, but denials can only be rendered by a behavioral health medical professional. These four services must meet medical necessity criteria and are subject to utilization review and periodic reauthorization. Emergency placements are retrospectively approved.

The RBHAs have provided extensive training to providers on how to use the child and family team process. The approach has been so well received that the adult system has adopted it, referring to it as “adult clinical teams.”

The agency partners are currently working on developing a youth “assent” process, which is a youth empowerment effort designed to engage youth in their own care in an age-appropriate way. The purpose is to provide youth with information and to ensure that they are actively involved in decision making. This process is well aligned with the concept of child and family teams and holds promise for further strengthening youth involvement. A workgroup of youth members developed a practice protocol for youth involvement that went into effect in July 2012.

Psychotropic Medication

As in other states, Arizona is grappling with the appropriate use of psychotropic medications among children in child welfare and whether children are receiving other needed services and supports in addition to or as an alternative to medication. In 2011, the behavioral health and child welfare agencies, and the children’s medical directors of the RBHAs began a collaborative process to explore these issues.

Medicaid data were pulled for both physical and behavioral health service use, and a replica of the U.S. Government Accountability Office (GAO) study on this subject was conducted. The results were similar to those found in other states: children in child welfare were prescribed psychotropic drugs at a higher rate; many had regimens that included multiple medications; and many were prescribed higher doses than the maximum levels cited in guidelines, with the potential for serious, adverse side effects. Medicaid, behavioral health, child welfare, the Medicaid health plan, and the RBHAs are now working together to determine best practices, update relevant practice protocols, and determine other necessary action steps.

Medicaid Providers

The Medicaid health plan for physical health (CMDP) utilizes a network of providers who are willing to see children in child welfare and to accept Medicaid rates. CMDP’s provider relations department reaches out to these providers to cultivate relationships through meetings, newsletters, and engagement strategies. These methods also serve as vehicles for disseminating information and training to increase provider capacity for serving the child welfare population.

When behavioral health services for children in child welfare were moved to the Medicaid behavioral health system, the child welfare agency was concerned that RBHAs did not have the expertise to treat their children; so two strategies were implemented to address this concern.

“Initially, there was a huge learning curve for behavioral health providers to serve children in child welfare, but this has been overcome.”

1. **A specialty provider initiative** was developed to cultivate expertise in six areas of specialization, including: sexual abuse, early childhood, and eating disorders. Since the child welfare system had existing contracts with specialists in these areas, it was ultimately mandated that these providers become certified as Medicaid providers and that RBHAs include them in their provider networks. The state conducted annual surveys as part of a “sufficiency process” to determine whether these specialty providers were, in fact, included in the RBHA networks. Subsequently, it was mandated that the RBHAs also include developmental pediatricians in their provider networks.

2. **Training modules were developed for behavioral health providers** in areas relevant to the child welfare population. Modules have included: “a day in the life of a child in child welfare,” clinical needs of the child welfare population, and how to work with the child welfare agency and the courts, among others. In addition, statewide training has been conducted to develop the knowledge and skills among providers to offer the expanded array of services and supports; web modules were developed for some training components. Throughout the training, emphasis has been on developing skills to meet the unique needs of children involved with child welfare.

The state has also undertaken efforts to develop the expertise to provide trauma-informed care. As part of the behavioral health network development plan, an annual survey is conducted to determine which providers have had training to qualify as specialty providers in trauma-informed services.

Performance and Outcome Measurement

For physical health, Arizona’s Medicaid program has established performance standards, and data are routinely collected by the CMDP. Results have shown that CMDP exceeded the statewide average on all 20 Medicaid performance standards. CMDP had the highest rates statewide for access to primary care providers for all age groups combined, adolescent well care visits, and annual dental visits, and exceeded the statewide average for all immunization measures.

For behavioral health, Arizona adopted a small set of outcome indicators in 2005 to be used across all agencies. Child and family teams are required to report on these outcomes twice a year, and based on outcomes reports from thousands of teams, the state found that, in every age band, outcomes were better for children with child and family teams as compared with those without teams. These indicators include: acceptable emotional regulation, avoiding delinquency, achieving success in school, increased stability, living with a family, and decreasing safety risks. The indicators were revised in 2010 to align with national reporting requirements and now include substance abstinence, stable housing, employment, education, arrest-free, and participation in self-help groups.

Behavioral health performance indicators for children in child welfare are not currently reported separately, though the state is considering this option. It was noted that monitoring penetration rates and service utilization for children in child welfare in the behavioral health system is useful in assessing whether this group is being well served. For example, it was determined that in one county, the penetration rate for children in child welfare was significantly lower than in the rest of the state, and a corrective action plan was implemented to improve the response to this population.

Next Steps for Arizona

Arizona has recently experienced significant changes – most notably, turnover among high-level leaders, resulting in shifts in policy directions and priorities. Interviewees stressed the importance of effective communication with new leaders that includes providing information about the strategies in place to improve the Medicaid system for the child welfare population, a historical perspective on the implementation of these strategies, and data showing that they work. Recommitting to the children’s executive committee is a desired next step to establish strong partnerships among the new leaders and to reinvigorate and continue the progress that has been achieved.

Improved communication between primary care and behavioral health providers was cited as an area needing attention. Training and support for primary care practitioners in identifying behavioral health problems and seeking appropriate care was also mentioned as a potential next step.

In the largest county in Arizona, an integrated model that combines financing for physical and behavioral health is being implemented for adults with serious mental illness. One behavioral health entity will manage all primary and specialty care for this group; youth of transition age (ages 18-21) are included. Although a similar model has not yet been proposed for children, there is speculation that it may be applied to children in the future. The state is also exploring how health home models under the Affordable Care Act may be applicable to behavioral health services.

Advice to Other States

Based on their experience, interviewees suggested strategies that they consider essential in making Medicaid responsive to the needs of children involved with the child welfare system. An overarching recommendation is to ensure that the expertise of all partners is included in strategizing and problem solving about both physical and behavioral health services for the child welfare population. Interviewees felt that it is essential to include

“Ensure that you have a shared vision about how the system should work from an operational perspective, not a grandiose theory.”

individuals who are knowledgeable about the journey of children in child welfare, such as the impact of maltreatment, out-of-home placements, and the need to treat the entire family and caregivers and not just the Medicaid-enrolled child. The need for a shared vision and commitment among child welfare, behavioral health, Medicaid, and other system partners to meeting the needs of children in child welfare was emphasized. Other recommendations include the following:

Physical Health Services

- Establish one Medicaid health plan exclusively responsible for the child welfare population, rather than scattering the population across multiple plans;
- Ensure timely and thorough EPSDT exams through the primary care provider in the child’s medical home, including the required developmental and behavioral screens;
- Incorporate into Medicaid an electronic data system that interfaces with the child welfare data system to facilitate enrollment in Medicaid, the provision of timely physical and behavioral health services, communication among providers, and other critical functions; and
- Establish a process and accountability mechanisms for communication between primary care providers and behavioral health providers.

Behavioral Health Services

- Incorporate a rapid response system (using a statewide protocol) to identify urgent behavioral health needs among all children entering the child welfare system;
- Cover a wide array of services and supports for children in Medicaid, with particular attention to services that are important for children in child welfare;
- Implement risk-adjusted capitation rates for children in child welfare so that behavioral health providers have sufficient resources to provide the higher level of services needed by this population and their caregivers;
- Require specialty providers to be included in provider networks to ensure capacity for addressing needs related to trauma, adoption, sexual abuse, attachment disorders, and others;
- Incorporate a child and family team process for service planning and delivery;
- Develop statewide practice protocols for how behavioral health services should be delivered to children in child welfare; and
- Co-locate behavioral health providers in child welfare offices to serve as a primary conduit to the behavioral health system.

Monitoring of Physical and Behavioral Health Care Services

- Establish a meaningful and robust quality improvement process to monitor health care service delivery;
- Track service utilization and outcomes for children in child welfare and publish results to provide information for quality improvement;
- Implement strategic communication strategies using data to demonstrate improved results, cost savings, and impact on children in foster care to use with policy makers such as agency executives, legislators, and other key stakeholders.

Focus on Sustainability

- Institutionalize strategies for serving the child welfare population in policy, contracts, and other vehicles to ensure continuity;
- Recognize that policies and practice protocols must be supported by ongoing training, monitoring, and quality improvement strategies;
- Start with small victories, such as focusing on 100 children who are in out-of-state treatment facilities, and determine how to ensure access to home- and community-based behavioral health services when they are brought home; and
- Keep the focus on specific, concrete strategies to achieve agreed-upon goals among all system partners.

“It’s essential to maintain strong leadership, high priority, and passion for supporting the highly vulnerable children in child welfare through whatever political or administration changes may occur.”

Conclusion

The experience of stakeholders in Arizona underscores the importance of focusing not only on aligning Medicaid and behavioral health systems to the unique needs of children in the child welfare system, but also on the quality of the implementation of these strategies. Specific provisions for this population may be well thought out and supported by policies, procedures, protocols, financing, and other vehicles, however, these strategies must also be implemented with fidelity to the intention and monitored to identify areas for improvement. Clear, formal expectations, supported by training, are needed to ensure that providers throughout the system are prepared for successful implementation. Further, performance indicators and routine monitoring are essential for providing reliable information to track performance, assess progress, identify problems, and improve implementation. Finally, a focus on sustainability is key.

ILLUSTRATING THE IMPORTANCE OF ARIZONA’S EFFORTS: Maria and Josie*

Maria was removed from her home in the middle of the night at age five, placed in an emergency shelter and then in foster care. She began wetting the bed, refusing to talk, and crying often. Her foster mother could not find a Medicaid provider available or with the experience to see Maria. The child welfare system ultimately paid for a therapist, but the process took several weeks to put in place. Shortly thereafter, Maria was reunited with her family and was no longer able to see the therapist through the child welfare system. Although Maria remained eligible for Medicaid based on family income, her therapist was not a Medicaid provider. Maria began to regress in her behavior, aggravating tension within the family.

Contrast Maria’s experience with that of Josie, who also was removed from home at a young age. The Medicaid behavioral health system through its urgent response team ensured that Josie received a behavioral health screen within 72 hours of being removed and linked her to a Medicaid provider trained in trauma-informed care. When Josie was reunited with her family, she continued to see her therapist, and her family received peer support services and respite.

**Note. These are not actual case vignettes; they are representative to illustrate the differences for children as a result of state efforts to strengthen Medicaid for children in child welfare.*

MASSACHUSETTS

QUICK LOOK: Making Medicaid Work for Massachusetts' Child Welfare Population

- Mandated behavioral health screening as part of EPSDT screens
- Coverage of broad array of home- and community-based services
- Use of Targeted Case Management to support an intensive care coordination approach using high quality Wraparound
- Coverage of family peer support
- Coverage of mobile crisis intervention model that allows longer-term involvement of crisis team with the child and caregivers
- Coverage of youth in foster care to age 25
- Presumptive Medicaid eligibility for children in foster care

Overview of Massachusetts' Child-Serving Systems

The child welfare system in Massachusetts is administered by the state Department of Children and Families (DCF), which is charged with protecting children from abuse and neglect and strengthening families. DCF has four regional offices and 20 area offices across the Commonwealth; a central office in Boston provides support to the field offices. Of the 40,000 children served by the department, approximately 85 percent remain in their homes, and about 8,000 are in foster care.

Massachusetts is the third most densely populated state in the country, with a population of 6.7 million, and two-thirds of its population living in two metropolitan areas – Greater Boston and Springfield. Massachusetts has about 8,000 children in foster care, and serves over 1.3 million individuals through the Medicaid and Children's Health Insurance Programs, with nearly half being children.

The state's Office of Medicaid is part of the Executive Office of Health and Human Services (EOHHS). This office oversees MassHealth, which is the public health insurance program for low-income residents and is comprised of both Medicaid and the Children's Health Insurance Program. MassHealth, which serves more than 1.3 million members, includes four fully capitated managed care organizations (MCOs) providing physical and behavioral health care, and one Primary Care Case Management (PCCM) program that partners with a capitated behavioral health carve-out (Massachusetts Behavioral Health Partnership – MBHP) for mental health and substance use disorder services. MBHP serves over 20,000 children involved with DCF and the Department of Youth Services, the state's juvenile justice agency.

The Department of Mental Health (DMH) serves as the state mental health authority. DMH is organized into three geographic areas, each of which is managed by an area director and is divided into local service sites that provide fee-for-service case management services and oversee behavioral health services for adults, children, and adolescents in partnership with the state Medicaid agency. Similar to child welfare, the central office in Boston supports the regional and local sites.

Background and Collaboration

DCF has worked collaboratively with MassHealth, MBHP, and DMH to ensure that children involved with the child welfare system receive appropriate health and especially, behavioral health services. The various Medicaid provisions that benefit the child welfare population emerged from complementary reforms in these three systems that have evolved over the past decade and a half. Child welfare was shifting its practice model, increasingly emphasizing home- and community-based services and services "at the front door," i.e. for families first coming to the attention of child protective services, to reduce out-of-home

"The group had honest conversations about the needs of children and what they could do to address the needs."

placements. A Medicaid Section 1115 Research and Demonstration Waiver, first implemented in 1997, allowed the state to develop alternatives to psychiatric hospitalization and supports for families with many risk factors, including families with children at risk for abuse and neglect. During the past decade, Massachusetts' behavioral health system had already implemented pilot programs based on the system of care approach. For example, the Massachusetts Mental Health Services Program for Youth (MHSPY) involved transferring funds from child-serving agencies to Medicaid to implement population-based, case-rate financed behavioral health services for children with serious behavioral health problems using a Wraparound approach and intensive care coordination. A system of care steering committee was also created at the state level that included representatives from all child-serving agencies at the deputy commissioner level.

Even as these reforms evolved and converged, a class action lawsuit was filed in federal court against the state's Medicaid program. The lawsuit, referred to as "Rosie D." after the lead plaintiff in the case, alleged that the state had failed to provide appropriate services under Medicaid's EPSDT mandate, and that as a result, Medicaid-eligible children with behavioral health problems were placed in hospitals and residential treatment centers unnecessarily. The court ruled in 2007 that the state's Medicaid program was out-of-compliance with EPSDT, and required that the Medicaid program be restructured to provide an array of community-based services and supports, including screening, intensive home-based services, intensive care coordination, family peer support, crisis management, and in-home therapeutic supports.

Following the court order, Medicaid, behavioral health, child welfare, juvenile justice, and other agencies worked collaboratively to design and implement a new system. The effort was named the Children's Behavioral Health Initiative (CBHI) and was led by EOHHS. To reflect the importance of the cross-agency partnership, an interagency leadership team was established that oversees activities related to the CBHI. Although strategies related to Rosie D. were designed to meet the needs of all Medicaid children with serious behavioral health disorders, a significant proportion of these children are involved with the child welfare system. As a result, the child welfare agency was a "major player" in the process and brought attention to the unique needs of its children and to effective approaches for addressing them.

"The Medicaid agency has been very receptive and open to thinking about ways that Medicaid dollars could be used to meet the needs of the child welfare population more effectively, and has been a willing participant in the work."

Throughout the reform process, child welfare and Medicaid have had a strong partnership. The child welfare agency meets with Medicaid regularly to address problems, craft creative solutions, and implement enhancements. Similarly, the behavioral health system has a Medicaid liaison who is the "go-to" person for handling the interface.

The state-level, interagency CBHI Executive Committee continues to meet monthly to address emerging problems and to design and implement new initiatives such as a joint procurement for some services. System of care committees at the local level were created to convene child-serving agencies as a vehicle for collaboration and for addressing important service delivery issues. Child welfare, Medicaid, and behavioral health are important members of these interagency entities. Although the effectiveness of the local committees varies across the state, primarily based on local leadership, interviewees described a "culture of collaboration and cross-pollination" at both the state and local levels.

The remedial plan for Rosie D. included the requirement that the Commonwealth seek approval from CMS for its reforms. The ensuing negotiations have focused primarily on expanding the array of services that is covered under the state's Medicaid plan. The state prepared many materials to support the proposed changes, and numerous meetings and phone calls were used to explain the service expansion

and to provide CMS with information about the potential impact of these services on both outcomes and cost. With the exception of crisis stabilization units (where room and board costs were challenged by CMS as being neither clinical nor medically necessary), the proposed “remedy services” were approved by CMS. These included: intensive care coordination utilizing a high-quality Wraparound approach, family peer support and training, in-home therapy, therapeutic mentoring, in-home behavioral services, and mobile crisis intervention. A fundamental challenge identified by interviewees is that CMS considers Medicaid to be an insurer responsible for covering medically necessary services, rather than a human services agency with a mandate to protect children or provide support services to children and families, like the child welfare or behavioral health systems. However, Massachusetts paid particular attention in their Medicaid service descriptions to the medical necessity of supportive services, such as family peer support, in garnering CMS approval.

“Throughout the negotiations, the primary concern of CMS was that the covered services would be clinical and medically necessary.”

Medicaid Financing and Service Delivery

The primary financing mechanism in Massachusetts’ Medicaid program for both physical and behavioral health services is the Medicaid 1115 Waiver, in place since 1997. In addition, the Medicaid Rehabilitation Services Option has allowed the state to provide Medicaid reimbursement for a range of services and supports that allow individuals with disabilities to live independently in their homes and communities, including children with serious behavioral health challenges. Coverage of Targeted Case Management has been used by the state to help specific groups of enrollees (such as children with behavioral health disorders) access medical, behavioral health, social, educational, and other services. All of the behavioral health remedy services for Rosie D. are financed through state plan amendments under Targeted Case Management and the Medicaid Rehabilitation Services Option.

Physical Health

Massachusetts has a Medicaid managed care system to provide both health and behavioral health services. Physical health services are provided by four MCOs under contract with Medicaid and one PCCM program. PCCM is a system of managed care used by state Medicaid agencies in which a primary care provider is responsible for approving, coordinating, and monitoring an individual’s care for a monthly case management fee, in addition to fee-for-service reimbursement for treatment. Children in child welfare receive a medical passport that is used for identification, linking to primary care providers, ensuring regular visits, and preventing redundancy.

To maximize flexibility and continuity of care, the child welfare agency wanted to retain the ability to choose the MCO for children in foster care. Accordingly, the procurement of physical health care is the responsibility of the child welfare worker, and the choice of health plan and primary care provider can be made on an individual basis. Despite this option, most children in child welfare are enrolled in the PCCM program, which reportedly has a more robust provider network to serve high-risk children and families with bio-psychosocial challenges. As a result, most children in child welfare, as discussed below, receive behavioral health services through MBHP, the behavioral health carve-out associated with the PCCM program.

Contractually, the MCOs and PCCM program are mandated to establish relationships and work closely with state agencies. In addition, EOHHS developed protocols with input from MassHealth, DCF, and DHS to guide how Medicaid and its health plans will work with child welfare. Interviewees noted that efforts are still needed to ensure that these are routinely followed in the field.

Contracts with MCOs are financed through a capitation payment that includes reimbursement for both service delivery and administrative costs. In turn, MCOs contract with provider networks and negotiate rates for each covered service. Providers are paid on a fee-for-service basis. Prior authorization is required for some services, but most service requests are approved, particularly for children in child welfare. Authorization is not needed for emergency or outpatient services. The PCCM program is not capitated for physical health services; rather, primary care providers receive enhanced reimbursement. However, the behavioral health carve-out, through which PCCM-enrolled members receive their behavioral health care, is fully capitated.

Capitation rates are adjusted based on experience. Although there are no special, risk adjusted rates for children in child welfare, the previous costs of serving this population are factored into the capitation rates, which are adjusted annually.

Behavioral Health

The four MCOs and the PCCM program cover the same Medicaid benefit, including the home- and community-based services added to the Medicaid state plan as a result of Rosie D. The Medicaid benefit includes 12 outpatient visits for behavioral health services without prior authorization. In addition, the state worked with all of the MCOs to ensure that common utilization management parameters would be used for the new home- and community-based services under Rosie D. and that the integrity of care plans developed by child and family teams would not be threatened by restrictive prior authorization criteria.

Most children in child welfare receive their behavioral health services through MBHP, which receives capitation payments from Medicaid, as well as administrative payments to provide network management and support services to the PCCM program. To build the infrastructure for the CBHI, MBHP and the four MCOs procured a network of care management entities, called Community Service Agencies (CSAs), to serve children with serious behavioral health challenges. There are currently 32 CSAs – one in each of the 29 child welfare service areas, and three specialty CSAs – that serve any child meeting the criteria for intensive care coordination. The CSAs utilize the Wraparound practice model, intensive care coordination, and family peer support provided by family partners. The specialty CSAs, with particular expertise in serving children and families from African American and Latino backgrounds, as well as children with hearing impairments and their families, were added to the network to bring their organizations' expertise into the CSA provider community. All CSAs are required to serve any eligible child and family seeking services.

Child welfare helped to develop the criteria for the CSAs, and the managed care companies procured the CSAs based on these criteria. Most of the agencies that became CSAs were already providers of behavioral health services in Medicaid provider networks. Many also had previous contracts to provide services to the child welfare population and, therefore, had relevant experience and skills.

Locating the CSAs in each child welfare service area makes it possible for the CSAs to develop strong partnerships with the child welfare agency and its leaders at the local level. These relationships have raised sensitivity among behavioral health providers to the unique needs of children in child welfare.

Unlike many care management entities, the CSAs currently do not receive case rates or other types of bundled payments. All services provided by CSAs are covered by Medicaid and billed individually on a fee-for-service basis, although the state is interested in exploring a case rate approach. Children in child

“The nuances of being involved with child welfare are many – relationships, custody, permanency, trauma, and changes in status. It is important that the CSAs be attuned to these needs to provide effective care.”

welfare are eligible to receive CSA services if they meet medical necessity criteria. The state created manuals for its various child-serving agencies to detail “how the CSA works for your kids.” These manuals were developed by CBHI staff in partnership with each of the child-serving agencies.

Eligibility, Enrollment, and Access

The vast majority of children in child welfare are eligible for Medicaid; only a few have private third party liability. There is presumptive eligibility for children in foster care and coverage up to age 25 for youth aging out of the foster care system to ensure that they receive needed medical and behavioral health support as they make the transition to adulthood. Medicaid eligibility is established when children are in the care or custody of DCF, have an adoption or guardianship subsidy agreement, are not in placement and have no or inadequate health care coverage, or are returning home on a trial basis. If parents are not Medicaid eligible, the child welfare system often uses its own resources to provide services to family members (such as substance use services), particularly when reunification is the goal. When children in child welfare are enrolled in the PCCM program, they are automatically enrolled in the behavioral health carve-out, MBHP.

Screening and Early Intervention

DCF has a rigorous approach to ensure that children in child welfare have annual physical and dental exams. Children entering state custody must have a medical screening within seven days and a comprehensive examination within 30 days.

Prior to Rosie D., the screening provided during well-child visits under the EPSDT mandate for children in Medicaid focused primarily on physical health, and behavioral health screening was only sporadically included, if at all. Even when screening occurred, referral for behavioral health services did not routinely follow. The premise of the Rosie D. lawsuit was that children were not being screened for behavioral health issues, and as a result, were treated in expensive, high-end placements rather than in the least restrictive setting. The remedy required that behavioral health be a component of EPSDT screens and that the screens be consistent and standardized. The state was required to implement screening procedures for primary care physicians with a behavioral health component using standardized tools. Medicaid billing codes were modified to ensure reimbursement for the screening.

“The screening process was not proactive to identify behavioral health problems early and intervene before they became more serious. Now, behavioral health screening is routine for children in child welfare, using reliable instruments.”

All Medicaid enrollees under age 21 are now required to have a behavioral health screen. Screening protocols were developed, and rather than mandating one screening tool, a core set of options was approved by Medicaid for use during well-child visits. These tools include:

- Ages and Stages Questionnaires: Social-Emotional;
- Brief Infant-Toddler Social & Emotional Assessment;
- Modified Checklist for Autism in Toddlers;
- Parents' Evaluation of Developmental Status;
- Pediatric Symptom Checklist;
- Pediatric Symptom Checklist – Youth Report;
- Strengths & Difficulties Questionnaires; and
- Patient Health Questionnaire 9 – Depression Screener.

Currently, approximately 70 percent of children enrolled in Medicaid are screened for behavioral health issues during well-child visits.

Many stakeholders were involved in developing the screening protocols. Child welfare and Medicaid worked together to achieve consistency in procedures and tools to the extent possible. The work was done with strong support from leaders in the pediatric community, and experts in screening were enlisted as advisors. Once the protocols were completed, primary care practitioners received training on how to use the various tools and how to refer children with identified behavioral health needs for services. Thirteen such sessions were held around the state. In addition, a screening toolkit was developed, as well as online training materials, telephonic and on-site consultation, and a community of practice around assessment. A small group of developmental pediatricians was hired by the MCOS and MBHP to develop the training and the toolkit, and they serve as faculty for the training. These activities were funded with MCO and MBHP administrative dollars.

Additionally, child psychiatrists are on staff and available to provide consultation to DCF on behavioral health issues, including case-specific consultation provided during designated office hours. The Massachusetts Child Psychiatric Access Project (MCPAP), an initiative of MBHP and Medicaid, also provides pediatricians with free, real-time telephonic access to child psychiatry consultation. MCPAP has regional sites across the state with teams of psychiatrists and social workers that are available to any pediatrician.

These changes have resulted in significantly enhanced screening for behavioral health problems in the child welfare population. Ongoing work is focused on enhancing screening to explore the child's history of trauma, a critical area for children in child welfare.

Improvements were also implemented for comprehensive behavioral health assessments for children identified with behavioral health conditions. The child welfare agency had already adopted the Child and Adolescent Needs and Strengths (CANS) for the population requiring residential services, and this tool has now been adopted for use by behavioral health providers. The CANS is now part of an initial behavioral health assessment for Medicaid enrollees under age 21 with identified behavioral health concerns, and providers must update it every 90 days as part of a treatment plan review. The CANS is also used by the CBHI to determine if a child meets the criteria for serious emotional disturbance, to aid in decision support for care planning, and to track progress and needs over time.

Overseen by EOHHS, Massachusetts' versions of the CANS were developed by an interagency committee that included Medicaid, behavioral health and child welfare. Two forms comprise the Massachusetts CANS (Mass CANS) – CANS Birth through Four and CANS Five through Twenty. The goals were to ensure comprehensive assessments; provide a common language for communication about child and family needs; increase awareness of strengths; and increase awareness of culture as a factor in assessment and treatment. A trauma module for the CANS has been developed, and the state is considering adding this as a requirement.

Covered Services

Rosie D. resulted in Medicaid coverage for a significantly expanded array of services and supports, enabling children with serious behavioral health problems to be served within their homes and communities rather than in hospital or residential treatment settings. Referred to as the “remedy services,” these newly covered services under the state's Medicaid plan have resulted in marked improvements in care for all Medicaid-enrolled children, including the child welfare population, which received particular consideration throughout the planning process for expanding services.

Previous pilots in Massachusetts yielded valuable information about the services and supports that would be critical to include in the expanded array. The state implemented new home- and community-based services, including in-home therapy, family support and training, mobile crisis services, and therapeutic mentoring, among others, and required that they be planned and delivered through an individualized, Wraparound approach.

In-home therapy is particularly critical for the child welfare population, as traditional outpatient therapy is largely ineffective for this group. Through this service, a therapist and bachelor's level staff person provide treatment in a patient's home (birth, foster, kinship), which includes behavioral support and education for families or caregivers on how to manage their child's challenging behaviors.

"This says to families that we're here to help you, bring out your strengths, and help your children. However, it is also made clear that the interests of the child are paramount and that if abuse or neglect is observed, it will be reported to the child welfare worker."

Under the category of family support and training, family partners who have lived experience can mentor, support, and advocate for other families as they progress through the service delivery process.

"Medicaid has brought this (peer support) service in a big way. Parents who have been there can work with other families to be advocates for them in the system."

Medicaid coverage of family peer support has greatly increased the ability to engage families and provide services using a more family-centered approach. The service has been very well received, with many parents requesting this type of support. Interviewees underscored the relevance and importance of family partners, both for families involved with child welfare and as a support to child welfare staff and providers.

Another addition to the array was mobile crisis intervention, which is now the way emergency services are provided to all Medicaid-eligible children in Massachusetts. Crisis teams go to foster homes, family homes, shelters, group homes, and other settings to respond to the crisis and divert children from hospitalization. Initially available for 72 hours, mobile crisis teams may now remain involved for seven days to see the child and family through the crisis rather than risking an out-of-home placement. Continuing efforts are underway to ensure that foster families and others know this service is available and to call the local crisis team rather than the police or an ambulance for behavioral health crises. Child welfare workers and caregivers have found the mobile response and stabilization service to be enormously beneficial as it helps to avoid traumatic experiences with police, ambulances, and hospital emergency rooms, as well as placement disruptions.

If a child needs a residential treatment or group home placement, the team follows the child into the setting and continues working with the family, providing for greater continuity. If a child begins services while in a group home or residential treatment center, the residential provider must continue to provide services after the child returns to the community by working with the home and school and providing respite when needed to ensure stabilization prior to withdrawing. Medicaid reimburses only the clinical services delivered in a residential treatment setting for Medicaid-eligible children. The child welfare and behavioral health systems have made significant progress in creating a joint procurement for residential services to create a more seamless continuum of care.

Formerly, if a family had a family partner financed by Medicaid, that service would be discontinued if their child entered a residential treatment center through the child welfare system. The state is now shifting the payer for family support and training so that child welfare will cover the cost of the family partner while the child is in a residential treatment setting.

Massachusetts is one of five states that received a grant from the federal Administration for Children and Families to provide trauma-informed treatment to the child welfare population. The child welfare agency has worked closely with Medicaid to develop strategies for enhancing provider skills in trauma-informed treatment approaches.

Individualized Service Planning

An individualized approach to planning and delivering services is the foundation of the state's practice model for the CBHI. The CSAs provide intensive care coordination (ICC), financed through Targeted Case Management, using "high-fidelity Wraparound" as described by the National Wraparound Initiative. This particular practice approach was adopted to best meet the needs of children with serious and complex behavioral health problems who are involved with multiple agencies and providers. An individualized child and family team creates a plan of care for the child, with support from all involved agencies, and formal and natural supports. An estimated 30 percent of the children receiving ICC are involved with the child welfare system, and their child welfare workers are central players on the team.

The central tenet of ICC is putting the family at the center of the planning process. Families are defined as foster, kinship, birth families, and other involved caregivers. A care coordinator works with the youth and family to create this team. The team completes a risk management and safety plan; conducts a comprehensive home-based assessment of the youth's and family's strengths and needs; identifies goals; develops an individual care plan that guides the family and team in achieving goals; and ensures that the services and supports identified on the individual care plan are in place and coordinated. This approach

"There is now someone whose sole responsibility is to convene and facilitate the service planning process, break down barriers, and engage all involved agencies to participate and develop a single plan of care."

has been successful in meeting the needs of children and families involved in child welfare and in avoiding "deep-end" placements for treatment such as hospital and residential care. Children must meet medical necessity criteria to be eligible for ICC, and prior approval is required. However, access is rarely a problem – over 99 percent of requested service authorizations for remedy services are reportedly approved by the MCOs and MBHP.

Before ICC was implemented, child welfare had been using family team meetings to plan and provide services. In addition, Medicaid has supported a number of pilot initiatives across the state that embraced the concept of an individualized, Wraparound approach. In the development of the remedy services for Rosie D., it was determined that the Wraparound process should be a Medicaid-covered service under the state plan. As a result, there is now a dedicated, Medicaid-financed care coordinator to facilitate individualized planning and to ensure coordination across agencies.

One of the most important "value-added" provisions according to child welfare is when a child is in a 24-hour setting and presents a combination of clinical, custody, and disposition issues. A care manager is now assigned to each child in custody who is admitted to a 24-hour setting, and planning occurs in the setting with the close involvement of the child welfare worker and family. Joint treatment planning can then occur, and discharge and transfers can be expedited.

Medicaid Providers

With the advent of the CBHI, the state mandated that all of the MCOs have the same core network of providers for the remedy services. This requirement is particularly helpful for children in child welfare. If a child changes to a different placement, there is an opportunity for the child and family to remain with the same providers. If a child moves to a different region where that is not possible, at minimum they can receive comparable services.

Efforts have been made to prepare behavioral health providers for working with the child welfare population and to help the various child-serving agencies learn how to access and navigate the new behavioral health system. Protocols, developed by CBHI staff in collaboration with DCF staff, provide guidelines to behavioral health agencies and providers, including one on how to work with child welfare.

Efforts have also been directed at developing skills among Medicaid behavioral health providers that are especially relevant to child welfare. In particular, the MCOs and MBHP are required to establish provider networks that include expertise in trauma-informed care. A certificate program was implemented by Simmons College in Boston for advanced study in trauma-informed care for the child welfare population.

Although there are no requirements to include other areas of expertise in provider networks, the MCOs and MBHP are obligated to work with child welfare workers to find an agency or therapist with specialized skills when necessary (e.g., sexual abuse) and to contract for these services out of network if necessary. Massachusetts is resource rich in terms of behavioral health professionals, and many of the MCO and MBHP provider networks include highly skilled clinicians who are trained in such evidence-based practices as Trauma-Focused Cognitive Behavior Therapy and Multisystemic Therapy.

Psychotropic Medication

MassHealth (Medicaid) has implemented efforts to address the use of multiple psychotropic medications among children, with a particular focus on: children prescribed more than four medications, those receiving two or more in the same class, and children under five receiving psychotropic drugs. These efforts were spurred by the 2006 death of a four-year-old girl on multiple psychotropic medications, as well as a report from the state's inspector general on overprescribing of these medications. A work group examined this issue specifically for children in child welfare.

Although it is considered a work in progress, several procedures have already been implemented to address issues related to the prescription of psychotropic medications. Data from the Medicaid pharmacy system is being analyzed for the child welfare population to identify outliers – both children and prescribers – so that a system to address these cases can be implemented. The medical director of the child welfare agency will play a major role in following up on situations warranting intervention. In addition, at the direction of Medicaid, MBHP has implemented the MCPAP program that provides consultation services to primary care practitioners at no cost. This program enables primary care practitioners to call and speak directly to a child psychiatrist regarding behavioral health symptoms, diagnoses, and medications. The service is available to any primary care practitioner, regardless of whether the child is covered by Medicaid or other insurance.

Although many providers are on board with changes in medication prescription, particularly for children in child welfare, additional work is needed to shift the thinking and practices among other physicians in the state.

Performance and Outcome Measurement

The Rosie D. remedy requires that data be collected on the outcomes of behavioral health services, and regular reports are generated on specific indicators. For all remedy services, the state produces detailed reports on access to services including waiting lists, utilization of services, and average hours of various services provided per month. For youth enrolled in ICC, data include patterns of use for other remedy services, referral source, length of time from request to first service, discharge reason, length of stay, caseloads, and staffing levels. For mobile crisis services, the state tracks the location of the intervention

(e.g., home, community, provider location, school), the disposition, the length of the intervention, and compliance with the access standard, which is within one hour of the call seeking services. To track the success of mobile crisis in connecting youth to follow-up services, the state monitors their utilization of any other behavioral health services pre- and post-encounter. The state is also working on methods for analyzing CANS data to measure changes in the functioning and status of youth, and findings will be included in public reports in the near future.

Some data are collected to track indicators specific to the child welfare population. For example, Medicaid claims data and data from MBHP both identify children in child welfare and can provide information for this subset of children on Medicaid. One indicator that has been tracked reflects the number of child welfare-involved children in psychiatric hospitals awaiting placement, which has been reduced significantly. Decreases in hospital readmissions and more consistent follow-up have also been found.

Two years of case reviews have been conducted by the Rosie D. court monitor for children served through ICC and in-home therapy, with the experience of 124 children per year examined using the Community Service Review. Findings indicate that the individualized approach used by the CSAs and the broad array of services and supports are achieving positive results; two-thirds of the youth made favorable progress. The effectiveness of this approach in engaging and serving children and families involved with child welfare is an important lesson learned.

“The reviews have found that the system of care approach and Wraparound process have provided an effective method of serving children with serious behavioral health problems and a powerful way of engaging families involved with the child welfare system.”

Next Steps for Massachusetts

Interviewees noted a number of potential next steps that will further Massachusetts’ progress in making Medicaid work for children in child welfare:

- **Incorporate more evidence-based practices.** Although the state offers a rich Medicaid benefit, cost sharing among Medicaid and other agencies is needed for EBPs like Multisystemic Therapy or Multidimensional Treatment Foster Care, which provide cost-effective alternatives to residential treatment.
- **Develop appropriate substance use treatment for youth,** as well as treatment for youth with co-occurring substance use and mental health disorders.
- **Enhance training and workforce development.** Efforts are underway to create a Center of Excellence that would support the work of the CBHL.
- **Provide training for front-line child welfare staff.** Much training has been provided for supervisors and leaders, but less for front line staff, creating some challenges in implementing the new approaches and processes.
- **Increase the number of transitional care units for children in hospitals** who no longer require treatment in that setting but who are awaiting a more permanent placement. In some cases, it is difficult for child welfare workers to identify placements, arrange pre-placement visits in foster homes, and complete other necessary preparations as quickly as they would like. These services would allow foster parents to have an opportunity to shadow workers in the facility and/or receive training on how to handle the child’s behavior prior to discharge. A blend of Medicaid and child welfare funds has been used to support some of these strategies, however financing for transitional settings and for implementing some of these strategies to support transitions more broadly would be helpful.

“Shared training leads to shared values, a shared sense of best practices, and shared skill building.”

In addition to these improvements, Massachusetts is exploring a state plan amendment for children with serious emotional disturbances that would use the CSAs as health homes for children under the ACA. Many of the services specified under the ACA for health homes are already being delivered by the CSAs.

Advice to Other States

- “Don’t wait for a lawsuit,” but rather be proactive in assessing system needs and taking action. Massachusetts is currently facing another class action suit (Connor B.) that accuses the child welfare system of failing to provide adequate permanency and safety services for children in foster care. Energy and resources are being spent on years of discovery and depositions – resources that could be devoted to improving the system.
- Develop a mechanism for blended funding across state child-serving systems to increase flexibility in how services are delivered.
- Incorporate a robust behavioral health benefit in Medicaid that includes a range of home- and community-based services and supports that are individualized and flexible.
- Adopt the Wraparound process as the model for service delivery, as it is a very powerful approach in engaging families and caregivers in services, partnering with professionals, and providing individualized, coordinated care.
- Enhance expertise in provider networks in areas relevant to child welfare, such as attachment disorder, sexual abuse, and trauma-informed care.
- Provide information and training to managed care vendors so that they are fully attuned to the unique needs of the child welfare population.
- Breakdown silos between child welfare, Medicaid, and behavioral health systems by increasing each system’s knowledge of the others’ functions, mandates, and operations. Explore the creation of a children’s cabinet that sends a clear message that the agencies are unified, competition is reduced, and the stage is set for effective collaboration.

Conclusion

Collaboration has been the key to making Medicaid work for children in Massachusetts’ child welfare system. Partnerships, buy-in, and commitment are needed at three levels – among high-level executives, middle managers with content expertise, and front-line staff who truly implement policies as they work with children and families. Progress in the state has been based on an understanding by Medicaid of the needs of the child welfare population, and by an understanding on the part of the child welfare and behavioral health agencies of what Medicaid can and cannot do in response to these needs. Despite progress, system improvements are still needed; however, the structures and intentions to continue work and solve problems remain strong.

“Over the years, the spirit of collaboration that has been developed among Medicaid, child welfare, behavioral health, and other systems has been outstanding. There is a willingness to work together as a team, meet regularly, and solve problems.”

ILLUSTRATING THE IMPORTANCE OF MASSACHUSETTS' EFFORTS: Brian and Sean*

Brian was removed from home at age 10 for suspected sexual abuse by his stepfather. Brian's foster mother took him to her family pediatrician, who was a Medicaid provider, but the pediatrician found no significant physical health issues. When Brian entered middle school, he began acting out in sexually inappropriate ways. His child welfare worker arranged for him to see a therapist, but Brian was sullen in therapy sessions and increasingly defiant with his foster parents. At age 13, Brian was accused of molesting a younger classmate and became involved with the juvenile justice system. The court recommended that Brian be placed in a residential treatment center specializing in serving youth with sexually aggressive behaviors.

Contrast Brian's experience with that of Sean, who also was removed from home at age 10 for suspected sexual abuse by a relative. Sean's pediatrician conducted the comprehensive screen mandated by the Medicaid system, which included a behavioral health screen using a standardized tool. The screen identified the need for a more comprehensive mental health assessment, which led to Sean's receiving intensive home-based services and therapeutic mentoring. The Medicaid system's ability to screen for mental health problems and intervene early prevented a likely deterioration in Sean's emotional well-being and behavior and the need for more restrictive placements.

**Note. These are not actual case vignettes; they are representative to illustrate the differences for children as a result of state efforts to strengthen Medicaid for children in child welfare.*

MICHIGAN

QUICK LOOK: Making Medicaid Work for Michigan's Child Welfare Population

- Home and Community-Based Services Waiver
- Incentive payments to providers
- Use of child welfare general revenue as Medicaid match to expand resources
- Presumptive eligibility for children entering care
- Health liaisons and mental health specialists in local child welfare offices
- Timeframes for physical, behavioral and dental health screens through EPSDT for children entering care and use of Pediatric Symptoms Checklist and Ages and Stages Questionnaire
- Broad coverage of home- and community-based services, including evidence-based practices
- Coverage of family and youth peer partners with lived experience
- Coverage of Wraparound approach to service planning
- Red flags and consultation to prescribers for psychotropic medications
- Performance monitoring unique to child welfare population and use of data to show results

Overview of Michigan's Child-Serving Systems

Michigan's child welfare system is administered by the state Department of Human Services (DHS). At any given time, approximately 14,000 children in the state are in foster care. Michigan's Medicaid program is administered by the Department of Community Health (DCH), one of the largest public agencies in Michigan, which also administers public mental health and substance use services. Children's mental health services are directed by the Division of Mental Health Services to Children and Families. DHS and DCH have worked together to improve services for vulnerable children and their families, implementing a number of effective strategies to make Medicaid more functional for children in the child welfare system.

Michigan is the eighth most populous state in the nation, with a population of 9.9 million. The state provides Medicaid coverage for more than 1.7 million residents, nearly half of whom are children. There are nearly 14,000 children in foster care in Michigan.

Background and Collaboration

Michigan's efforts have concentrated on improving the behavioral health services provided through Medicaid for children involved with child welfare. The child welfare system has long recognized that behavioral health problems pose a significant impediment to permanency, safety, and the well-being of children in care. There is a strong history of collaboration between the child welfare and behavioral health systems in the state, and these agencies have strategized jointly about how best to provide effective behavioral health services to this group of children.

"Foster parents were afraid to adopt and birth parents were afraid to reunite based on behavioral health challenges."

Although a partnership was established previously, it was a lawsuit against the child welfare system and a subsequent consent decree that provided the impetus for child welfare and behavioral health to take their collaboration further and implement strategies for improving behavioral health care. The class action lawsuit, filed in federal court in 2006, alleged that

the state was failing to move children into stable, permanent homes and was not providing adequate medical, dental, and mental health services. The consent decree resulted in efforts to improve the state's child welfare system, with a particular focus on behavioral health services, which were deemed critical to permanency plans and the ultimate well-being of children in that system.

A key result of the collaboration was the use of a Medicaid Section 1915(c) Home and Community-Based Services (HCBS) Waiver. This waiver allows states to provide long-term care services in home- and community-based settings rather than in institutions. The services provided under this waiver were designed to provide intensive services to children with serious emotional disturbances, including those involved with the child welfare system.

A core interagency operational team, which includes directors from behavioral health, child welfare, and Medicaid, among others, meets every other week to oversee implementation of this partnership. In addition, a policy leadership team that includes higher-level directors from both DHS and DCH meets monthly.

“The agencies are willing to accommodate each other. They recognize that it will save money down the line if we can intervene quickly with intensive home- and community-based services.”

Michigan stakeholders indicated that a successful partnership needs both types of structures – operational and policy level – in tandem to create meaningful change. The leadership team sets policy and ultimately makes decisions; the core team “does the work.” Both groups focus on ways to streamline funding and improve access to services. The relationships forged through

these structures have resulted in interagency agreements, the application of the HCBS Waiver to the child welfare population, the creation of incentive payments to providers to serve the child welfare population, and additional match to draw down Medicaid funds.

Medicaid Financing and Service Delivery

Physical Health

In 2010, Michigan’s Medicaid agency transitioned children in foster care from fee-for-service to managed care under a Medicaid Section 1915(b) Managed Care Waiver, which now covers almost all of the state’s children in foster care. The child welfare system was extensively involved in planning for this change to ensure that the new system would incorporate provisions to meet the unique health care needs of these children.

Physical health care is provided by the Medicaid health plans, and each child entering child welfare custody is assigned to a health plan and a primary care practitioner to provide a medical home. If a child entering care is already enrolled in a health plan, the child remains in that health plan unless the plan does not provide services in the community where the child is placed in foster care. As the shift to managed care was implemented, numerous meetings occurred between child welfare and the Medicaid health plans to ensure that the plans had a sound understanding of the needs of this population and how the change would likely affect services for this group. These health plans also are responsible for a basic mental health benefit of 20 outpatient visits. The intent is that the needs of children with mild to moderate mental health problems can be met in this way. Children in need of mental health services beyond these outpatient visits are referred to the Medicaid behavioral health managed care system described below, which is managed by specialty behavioral health organizations.

Behavioral Health

The Medicaid and behavioral health systems are both located within DCH, and its Division of Mental Health Services to Children and Families provides policy and program direction for public mental health services provided to children with emotional disturbances and developmental disabilities and their families. Prepaid Inpatient Health Plans, the HCBS Waiver, and incentive payments are approaches used to provide behavioral health services to children and tailor services to the unique needs of children in child welfare.

Prepaid Inpatient Health Plans – To provide behavioral health services under Medicaid, DCH contracts with Prepaid Inpatient Health Plans (PIHPs), and there are currently 18 PIHPs in the state. The PIHPs are comprised of either a single Community Mental Health Services Program (CMHSP) or an affiliated group of CMHSPs in more rural areas, with one serving as the lead. The CMHSPs deliver behavioral health services throughout the state’s 83 counties. The PIHPs are financed through Medicaid on a capitated basis per Medicaid-eligible enrollee. When the managed care waiver is renewed next, the number of PIHPs will likely be consolidated to 10 in an attempt to reduce complexity and bring more uniformity to the system.

Home and Community-Based Services Waiver – The 1915(c) Medicaid waiver for children with serious emotional disturbances (SEDs), referred to as the “SED waiver,” was first approved by CMS in 2006. The waiver is used to serve children in local communities, with counties providing general fund match in order to request utilization of a “waiver slot.” The SED waiver has also been a primary vehicle for serving children in child welfare with serious behavioral health problems. To implement the waiver for this population, the child welfare system moved funds to behavioral health to provide Medicaid match. With the additional federal Medicaid dollars that are captured, increased resources are available to provide intensive home- and community-based services to children in child welfare who have serious behavioral health challenges. The waiver sits outside of the behavioral health managed care capitation so that the resources are protected for these high-need children.

To be eligible for services under the SED waiver, a child must meet the criteria indicating a risk for psychiatric hospitalization without intensive services in the community, and must show substantial impairment on the Child and Adolescent Functional Assessment Scale (CAFAS).

“Historically, the child welfare system purchased behavioral health assessments and treatment with its own resources. As a result, the use of behavioral health services through the Medicaid managed care system was spotty. The SED waiver has turned this around.”

The services and supports under the SED waiver are delivered within the framework and philosophy of a system of care, calling for a broad array of home- and community-based services and supports that are individualized, evidence informed, family driven, youth guided, and culturally and linguistically competent. Joint letters from child welfare and behavioral health were issued establishing systems of care as the desired service delivery approach. Services under the SED waiver are being systematically phased in, beginning with eight large urban counties (which are home to the majority of the child welfare population) and proceeding to include mid-size counties. Smaller counties will be phased in last. To date, more than 36 counties have received technical assistance to begin SED waiver services for children in child welfare, and most are currently providing these services.

The rates for the SED waiver were initially based on a survey of CMHSPs that are delivering services, with an effort to align rates with actual costs. Beginning in 2011, the CMHSPs are also reimbursed for the costs of administering the SED waiver.

Incentive Payments – The SED waiver has served as a way to build trust between child welfare and behavioral health, and to demonstrate that the children’s mental health and Medicaid systems can succeed in serving the child welfare population by providing evidence-based practices, tracking and monitoring outcomes, and achieving positive results. Based on this experience, child welfare worked collaboratively with behavioral health to serve children who do not meet the criteria for the level of care provided in a psychiatric hospital setting (i.e., waiver criteria). The result is a second phase of response to the needs of the child welfare population with the creation of incentive payments to make it more feasible for the CMHSPs to serve these children through the Medicaid behavioral health managed care system.

These incentive payments are over and above the capitation rates for Medicaid children and are targeted to children with serious mental health conditions in foster care or those involved with child protective services. Payments are based on “risk categories” and are provided at two levels. If the CMHSP is providing an eligible child with Wraparound or home-based services (outside of the SED waiver), the incentive payment is higher. If a child is not receiving Wraparound or home-based services but is receiving two or more different mental health services in a month, the CMHSP qualifies for a lower incentive payment. The CMHSPs do not receive incentive payments for children receiving services through the SED waiver.

This strategy was implemented in July 2012, and although data are not yet available, there has been positive feedback from the field. Whereas previously the CMHSPs indicated that they could not afford to adequately serve the child welfare population within their capitation rates, the incentive payments have provided a mechanism and a motivation to improve access for this population.

“The CMHPs have received an injection of funding that enables them to serve these high-risk children in child welfare, and the child welfare system is pleased that their children can now access behavioral health services using Medicaid dollars.”

Incentive payments are monthly case rate payments for eligible children, paid quarterly. Encounter data are examined, and if the recipient identification matches a child in foster care or child protective services and is in one of the categories described above, then the incentive payment is applied for that child. The payments for the first few months were intentionally higher than those being paid on an ongoing basis, in order to provide resources for the CMHSPs to build capacity to meet the unique needs of the child welfare population. The agencies needed to hire more therapists, in addition to starting new programs and recruiting staff with the specialized skills to serve children involved with child welfare. Incentive payments allow the CMHSPs to provide a broader array of services and supports for children, foster parents, and birth parents.

“By using child welfare general fund dollars as Medicaid match in the behavioral health system, we get much more for our money.”

Consequently, the child welfare system is now reducing the purchase of behavioral health services with its own resources. Since the children qualify for the Medicaid entitlement, they can be served through the Medicaid managed care behavioral health system. Child welfare provides its general fund dollars as match that is then enhanced by drawing down federal Medicaid funds.

Approval from CMS is needed for waivers and any changes to the state Medicaid plan. Michigan has been successful in negotiating for these vehicles and breaking through any barriers to getting this accomplished.

Eligibility, Enrollment and Access

In Michigan, children in child welfare have presumptive eligibility for Medicaid. In 2008, eligibility for Medicaid was increased to age 21 for youth whose foster care case closed at the age of 18 or later. In 2012, the state implemented the Young Adult Voluntary Foster Care Program, allowing youth to re-enter foster care and receive a daily stipend and Medicaid coverage, if they meet certain requirements.

To facilitate enrollment and access to physical health services, the child welfare system places health liaison officers within county-based DHS offices. These liaisons are experts in working with the Medicaid health plans and their staff, as well with child welfare staff and foster families. Their role is to ensure that children in child welfare receive the health services they need. When a child enters care, the liaison

officer facilitates enrollment in a health plan, and if the child transitions to a new placement, the liaison officer ensures that health care services continue without disruption.

For behavioral health, federal mental health block grant funds are used to support the initial placement of children’s mental health clinicians within child welfare agencies. These clinicians work directly with child welfare staff to identify children who are eligible for services under the SED waiver. The services provided by these “access staff” are essentially screening and assessment and, therefore, are covered under Medicaid on an ongoing basis.

“It is extremely helpful to have mental health staff available on site with the expertise to assess children, determine eligibility for services, and consult with child welfare workers.”

Beyond determining eligibility, the clinicians provide consultation, assistance in accessing behavioral health services, and assistance to child welfare staff regarding children in foster care and those involved with child protective services. The presence of the access staff has also cemented relationships at the front line between the child welfare and Medicaid behavioral health systems. All of the initial eight sites for the SED waiver were offered funding for these access positions. Access positions have been added to most of the new sites, some of which had been using existing funds or Medicaid to finance these staff.

Screening and Early Intervention

As Medicaid transitioned to managed care, a subcommittee was formed to specifically address behavioral health care. A particular area of focus was how health plans would screen children in child welfare for behavioral health problems.

Medicaid health plan providers must complete a full medical examination by a physician – which includes a behavioral health component – within 30 days of a child entering foster care. The use of standard screening and assessment tools for behavioral health are required for younger children in Medicaid and recommended for older children for their screens under the EPSDT program. For children in foster care, a validated, normed screening instrument must be used at each scheduled EPSDT well-child visit, and providers must document that medical, behavioral health, and dental screenings have been completed.

Medicaid and behavioral health are exploring the use of validated screening tools particularly for behavioral health issues among children in foster care as part of their well-child visits to primary care practitioners. A recently-finalized policy recommends that providers use the Pediatric Symptoms Checklist for older children in foster care, and Ages and Stages for younger children. The state’s Medicaid policy will specify these tools as examples of validated behavioral health screening instruments, and will establish procedures for appropriate assessment and treatment of behavioral health problems. Following the adoption of this policy, meetings will be convened for Medicaid health plans and CMHSPs to provide information and training on referral practices and relationships.

In the Detroit area, a pilot is underway that involves screening children in child welfare in primary care settings, with the addition of a trained mental health clinician in those settings to serve as liaisons, provide training to the primary care practitioners, ensure that assessments are completed, make referrals, and follow up with parents.

Covered Services

A broad array of home- and community-based services and supports is covered in the state Medicaid plan. In addition to traditional treatment services (e.g., individual, group, and

“It’s essential that the Medicaid state plan cover a broad range of services and supports so that they’re adequately financed and sustainable. It’s impossible to meet the needs of children in child welfare without this.”

family therapy; medication review and administration; and evaluations), the rich Medicaid benefit includes home-based services, Wraparound, respite, crisis response and stabilization services, Targeted Case Management, treatment planning, family training, family support partners, substance use treatment, and others. Covered services also include evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy, and Parent Management Training-Oregon Model.

Several services are particularly important for the child welfare population. The intensive in-home services that are covered under the state Medicaid plan play an important role in keeping children in the community and preventing placement disruptions, as well as Wraparound which is also covered under the state Medicaid plan and is a required service for all children served in the SED waiver. Family peer

“Mobile crisis services have provided an effective way to respond to crises and save placements by de-escalating situations rather than having to remove children in the middle of the night.”

support, provided by individuals with lived experience, is a critical service for children in child welfare and their foster, kinship, and birth families. Youth peer support is also a covered service, and the state is working to implement this service. Mobile crisis teams are another key service available 24 hours a day in some communities.

Children eligible for the SED waiver can receive additional mental health specialty services and supports that are not in the state plan but covered under the waiver, such as community living services and supports, therapeutic foster care, and family training. They may also receive other services that are not included in the SED waiver, including therapeutic overnight camps, transitional services, and expressive therapeutic activities (e.g., music, art, and recreational therapy).

Child welfare workers, foster parents, kinship care providers, and others have provided positive feedback indicating improved access to behavioral health services and supports, and as a result, less reliance on residential treatment, more stability for children in their foster homes, and increased movement to permanency.

Individualized Service Planning

The SED waiver has demonstrated the importance of the Wraparound approach to service planning and delivery and how this approach is successful in coordinating services and supports for a child and foster family. Wraparound is covered in the state’s Medicaid plan so that any child in need can receive this service, but it is provided most frequently to children who are involved in multiple systems and are at risk for out-of-home placement. The Wraparound approach is considered especially relevant for children in child welfare, given their complex needs and the consequent involvement of multiple agencies and caregivers.

The Wraparound process used in Michigan revolves around a child and family team coordinated by a Wraparound facilitator that develops an individualized, tailored service plan to address the unique needs of each child and family. The teams typically include the family (e.g., birth family, foster family, kinship family, or other caregivers), youth (as appropriate), involved providers (e.g., child welfare worker, behavioral health clinician), and informal supports identified by the family. The team, which is unique to each child and family, uses a systematic process to identify both the strengths and needs of the child and family across multiple life domains, strategies for meeting needs, and desired outcomes. The resulting individualized service plan details the services and supports to be provided and includes a crisis and safety plan. As service delivery proceeds, the team monitors progress and revises the service plan as indicated. Extensive Wraparound training and technical assistance is provided to communities to implement the process with fidelity. DCH has a full-time Wraparound training coordinator who organizes and oversees a training program and monitors the fidelity of Wraparound. DCH also contracts with Michigan State

University to evaluate Wraparound and the SED waiver. Both of these contracts are funded with federal mental health block grant dollars.

For children in child welfare, the Wraparound approach offers the opportunity to provide intensive services and supports in all of the areas of need identified through the child and family team process. In doing so, the stability of placements has increased, disruptions in the lives of children have decreased, and the likelihood of achieving permanency goals has improved.

“There have been many testimonials from foster parents who have said that things turned around for them, and they felt so supported by the Wraparound process and the services that were brought to bear.”

Using non-Medicaid dollars, the child welfare system also employs a practice model that uses family team meetings for all children when they enter care or change placements. This model includes providers and support persons identified by the family, and a process of engagement, assessment, teaming, and mentoring similar to a Wraparound approach. An individualized plan is created for each child and family through this process. The child welfare worker documents the treatment plan, ensures that services are provided, and monitors progress, similar to the role of the Wraparound facilitator or care coordinator. Use of similar values-based practice approaches creates greater synergy between the child welfare system and the CMHSPs and helps to ensure that all children, not only those with serious behavioral health challenges, receive individualized care.

Medicaid Providers

CMHSPs have their own provider networks to deliver Medicaid services that include a variety of specialists to meet the needs of children in child welfare and other populations. When providers with a particular type of expertise are not available, the agencies may seek out specialty providers that are out of network. Agencies in rural areas with more limited networks may seek out specialty providers more frequently.

The child welfare system also has a network of fair market contracts with private providers that can be used to purchase services for children in child welfare outside of the Medicaid behavioral health system. Often, these providers are used when the child needs more than the 20 mental health outpatient visits allowed by the health plans, but does not meet the criteria for serious emotional disturbances to qualify for the services provided through the CMHSPs. However, these providers are being used less frequently, and Medicaid providers more extensively, as confidence has grown that the CMHSPs can effectively meet the needs of children in child welfare.

“Bringing the SED waiver to so many communities to serve the child population has provided an excellent vehicle for the CMHSPs to learn more about these children and their needs.”

CMHSPs receive training on the unique needs of children in child welfare – often from child welfare staff, foster parents, and others with this expertise. The SED waiver and incentive payment vehicles have provided opportunities for such training in an increasing number of communities. Training is provided through the state

Wraparound coordinator funded by DCH and through locally organized efforts. Training on mental health services and the SED waiver are also provided to child welfare staff by the CMHSPs. In addition, DCH and DHS hold monthly calls with communities providing services for children in child welfare under the SED waiver, as well as quarterly face-to-face meetings. As a result of the waiver and incentive payments, the child welfare and behavioral health agencies have increased their knowledge about each other’s systems, and collaboration between child welfare and behavioral health providers has grown tremendously. Training on serving children involved with child welfare is also provided at the state’s annual system of care conference.

Extensive training is provided on evidence-based practices that are covered by Medicaid and essential for the child welfare population. These evidence-based practices are covered by Medicaid when delivered by a certified clinician, using billable service codes such as home-based therapy or individual or family therapy. The state began training clinicians in Trauma-Focused Cognitive Behavioral Therapy in 2008, with the goal that all communities would have clinicians trained in this approach. In addition, a curriculum was developed by the National Child Traumatic Stress Network (“Caring for Children Who Have Experienced Trauma: A Workshop for Resource Parents”) to provide information and training related to trauma for foster parents and adoptive parents. The curriculum was adapted by Michigan for use with birth parents to help them understand how to support their children more effectively. The training for clinicians in Trauma-Focused Cognitive Behavioral Therapy and the resource parent training on trauma are both financed with federal mental health block grant funds.

Training in Parent Management Training – Oregon Model has been provided through a partnership between DCH, an affiliate of the Oregon Social Learning Center, and a contract with a CMHSP to oversee a statewide system to train clinicians and ensure fidelity to the model. Clinicians with this expertise are available statewide through the CMHSPs. DCH also hired a coordinator to organize statewide training in the Wraparound approach, ensuring that the model is implemented with fidelity. Michigan also offers a statewide training curriculum on family peer support, and training for peer support providers is delivered through a contract with the state’s family organization –the Association for Children’s Mental Health, a chapter of the National Federation of Families for Children’s Mental Health.

Psychotropic Medication

Michigan has taken a number of steps to address the prescription of psychotropic medications for the child welfare population. A child and adolescent psychiatrist was hired by the child welfare system as a medical consultant at the state level to focus on child welfare issues, including the prescription of psychotropic medications. In 2012, DHS updated its policy to require a standardized written consent form for all prescriptions of psychotropic medication to children in child welfare. In 2012, the state also developed guidelines for psychotropic medications that apply to all Medicaid-enrolled children, as well as an oversight process.

The guidelines for prescribing psychotropic medications include the following ‘triggers’ that indicate the need for review: a child on four or more medications, a child on two medications in the same class, or a child under five receiving medications. The medical consultant uses these criteria to cross-match the medications prescribed for children in child welfare with the guidelines through a partnership with Medicaid, looking for red flags and outliers. When indicated, the medical consultant follows up with prescribing physicians to review the case and provide consultation. In addition to addressing concerns about medications for individual children, the goal is to identify prescribing trends and to set policy to address any identified issues. The medical consultant also provides training on psychotropic medications to a number of audiences, including foster parents.

Child welfare meets at least monthly with the pharmacy claims division of DCH to review claims for psychotropic medications prescribed to the foster care population. Claims for children in foster care are compared with claims data for the general Medicaid population. The state is in the process of approving an interagency agreement to fund a data specialist at DCH who will be devoted to child welfare work. All informed consent approvals will be routed to this individual, and those falling outside of the prescribing guidelines will be referred to the DHS medical consultant.

A manual describing psychotropic medications and their side effects was purchased by DHS and is being widely disseminated to all CMHSPs, hospitals, residential treatment providers, juvenile justice facilities, and others. Child welfare is also working with the DHS communications department to develop a YouTube tutorial that will be delivered by the medical consultant and disseminated with the manual. This training is supported by child welfare general fund dollars. Interviewees indicated, however, that additional training is needed around medications for primary care physicians, child welfare staff, and foster parents, among others.

Performance and Outcome Measurement

Under the managed care waiver, a reporting system provides encounter data that tracks service utilization, and includes a marker to identify children in child welfare. For behavioral health, the CAFAS is used to determine eligibility for services through the Medicaid behavioral health system, as well as to monitor progress. The CAFAS was converted into an electronic system to make it easier for the CMHSPs to collect and report the data.

For children served under the separate SED waiver, data are collected relative to a set of indicators, and a functional assessment is built into the system using CAFAS scores. Preliminary data suggest significant success in serving children involved with child welfare. For example, results demonstrate success in keeping children in the community, reducing the use of residential treatment, and significantly improving functioning based on changes in CAFAS scores. CAFAS data are also available for children receiving services through the incentive payment part of the system and will be part of the evaluation for this initiative.

“Evaluation results have been extremely helpful in demonstrating to the leadership team and other stakeholders that the investment in home- and community-based services produces positive outcomes, providing a strong foundation for moving to the next phase of broader implementation.”

Almost all of the children served under the SED waiver have histories of stays in residential treatment, psychiatric hospitals, or emergency shelters. Data show that at six months, upwards of 97 percent of children enrolled in the SED waiver were able to be maintained in the community with home- and community-based services and supports. As compared with the previous system of child welfare providing services through contracts without the ability to demonstrate outcomes, the system now shows policy makers and the legislature what they are spending and the results they are achieving, particularly in comparison to residential treatment and hospital care.

Next Steps for Michigan

Looking to the future, interviewees indicated areas that require further attention. First, better strategies are needed to serve children who have more moderate needs and do not meet the criteria for having a serious emotional disturbance. Often, the 20-visit mental health outpatient benefit provided through the Medicaid health plans is not sufficient to meet the needs of these children, but they are not at a severity level that would make them eligible for Medicaid services through the CMHSPs.

Eliminating any remaining duplication between the child welfare and Medicaid behavioral health systems is another potential area for improvement. According to interviewees, continuing strategies are needed to hold the CMHSPs accountable for providing services to the child welfare population and for child welfare workers to decrease their use of separate contract providers. Increased trust of CMHSPs among child welfare workers is needed before they will completely give up the option to use their own providers. Although trust is gradually increasing, specific additional strategies to address this need consideration.

Another identified gap is the difficulty in obtaining Medicaid services for parents. If children are in foster care, their parents lose their Medicaid coverage if they do not qualify on their own, leaving them ineligible for Medicaid-covered services even if the child welfare system is working toward reunification. As a result, their treatment needs often go unmet, stifling a full recovery for the family.

In addition, efforts are needed to incorporate a greater focus on behavioral health in appointments for physical health care. Interviewees indicated that a more holistic approach would be ideal, but that primary care practitioners often do not feel that this is within their purview or area of expertise.

As implementation of the ACA proceeds, the state has given some preliminary thought to whether PIHPs may qualify as health homes, but no decisions have yet been made.

Advice to Other States

- Cover a broad array of services and supports under the state Medicaid plan to ensure that they are adequately financed and sustainable.
- Create an administrative structure at the state level, with both a core operational team and a policy leadership team across child welfare, Medicaid, behavioral health, and other key agencies.
- Demonstrate with data that the Medicaid behavioral health system can deliver the services needed by the child welfare population and achieve good outcomes.
- Incorporate behavioral health staff at the front line to help child welfare staff assess the need for behavioral health intervention, determine appropriate services, and link with providers.
- Incorporate child welfare liaison staff with expertise in Medicaid to facilitate enrollment when a child enters foster care, ensure that children are linked with primary care providers, and provide feedback to policy makers about needed improvements in access to physical health and behavioral health services.
- Ensure that the partnership includes state and local stakeholders, both of which are needed to implement strategies to improve services, particularly in a county-run system.
- Include evidence-based practices that are relevant for the child welfare population in the array of covered services and supports.
- Monitor Medicaid claims data against the foster care population and measure service utilization and outcomes for this group of children.

“They are ‘our’ kids, and we must take steps together to make sure they’re being served. We’re thankful for what child welfare, behavioral health, and Medicaid have already accomplished and for the willingness to continue working collaboratively.”

Conclusion

Michigan’s efforts to make Medicaid work better for children in the child welfare system have paid off, particularly in increasing access to a broad array of home- and community-based services. These high-need children are the most expensive to serve, and they consume the bulk of time and financial resources of the child welfare, Medicaid, and behavioral health systems. If they cannot access home- and community-based behavioral health services, they frequently change placements and require more costly residential care. Interviewees reported that the key to success is to share the responsibility for serving these children and to be open to working together to meet their needs.

ILLUSTRATING THE IMPORTANCE OF MICHIGAN'S EFFORTS: Jacob and Jeremy*

At 12, Jacob was removed from his father's home due to neglect and was placed with an aunt in another town. Jacob began using drugs and skipping school. His aunt talked to her child welfare case worker about getting Jacob substance abuse counseling and also thought that a male adult mentor would be good for him. However, traditional Medicaid did not cover substance abuse services or therapeutic mentors, and the child welfare system's budget had been cut, making access to these services through child welfare also difficult. Jacob became increasingly angry and aggressive toward his aunt, and after threatening her with a knife, was held at the juvenile detention center. While there, Jacob attempted suicide. He was hospitalized in an adolescent psychiatric unit for a week, placed on psychotropic medications, and discharged to a residential treatment center after his aunt refused to take him back without community-based services. Jacob remained in the residential facility for nine months, and was then discharged to a foster home. The one-year cost of his detention, hospitalization, medications and residential stay totaled \$67,900, \$48,000 of which was paid for by Medicaid.

Contrast Jacob's story with that of Jeremy, also removed from home at age 12 and placed with a relative, and having a similar history of substance use, skipping school, anger, aggression, and alternating threats to kill his grandmother or himself. Jeremy, however, was enrolled in a Medicaid waiver program allowing access to substance abuse treatment, therapeutic mentoring, and a Wraparound process that provided him with a care coordinator and his grandmother with a family partner to provide peer support. Most importantly, they were both involved in a structured, strengths-based Wraparound process to find community-based approaches and solutions to the problems Jeremy was experiencing. The waiver services Jeremy and his grandmother received over the course of a year – therapeutic mentoring, substance abuse counseling, and Trauma-Focused Cognitive Behavioral Therapy for Jeremy, and family peer support for his grandmother; as well as care coordination, and use of a small amount of flexible funds for a boxing gym membership paid for by child welfare, totaled \$21,740 in costs to Medicaid. Jeremy remains in the community with his grandmother.

**Note. These are not actual case vignettes; they are representative to illustrate the differences for children as a result of state efforts to strengthen Medicaid for children in child welfare.*

NEW JERSEY

QUICK LOOK: Making Medicaid Work for New Jersey's Child Welfare Population

- 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
- Tracking and review of psychotropic medications through data sharing between child welfare and Medicaid

Overview of New Jersey's Child-Serving Systems

New Jersey's child welfare services are administered by the Department of Children and Families (DCF) through its Division of Child Protection and Permanency. Children's behavioral health services are also administered by DCF, with its Division of Children's System of Care taking the lead.

The state's Medicaid program is housed within the Department of Human Services (DHS), Division of Medical Assistance and Health Services. DCF and DHS have been collaborating for over a decade to improve the delivery of physical health care for children in child welfare and to build a children's behavioral health system, which operates essentially as a child population behavioral health carve-out. Although Medicaid dollars for children's behavioral health services are managed by DCF and are in the DCF budget, the state Medicaid agency acts as the single payer administratively for all children enrolled in the child behavioral health system, for Medicaid- and non-Medicaid-eligible children alike.

New Jersey is the 11th most populous state in the United States with a population estimated at nearly 9 million in 2012. Approximately 1.2 million individuals are enrolled in Medicaid and the Children's Health Insurance Program, close to half of whom are children. There are approximately 7,800 children in foster care in the state.

Background and Collaboration

Strategies for meeting the health and behavioral health care needs of children in child welfare have their roots in several converging factors in the state. One catalyst for change was a lawsuit brought in 1999 on behalf of children in foster care by Children's Rights, a nonprofit agency. The class action lawsuit was aimed at ensuring improved outcomes for children in out-of-home placement by improving the state's child welfare system. The lawsuit resulted in a settlement agreement in 2003 (which was later modified

"The settlement agreement is not an end and further represents only part of what must be a larger plan to deliver on the promise of safety, well-being, and permanency for New Jersey's children."

in 2006) that mandated sweeping reforms in the child welfare system. In 2007, a new cabinet-level department was created (DCF) that raised child welfare issues to the top level of state government, and an executive team was created to implement the needed reforms. The reforms have involved adopting a new case practice model to

incorporate best practices for serving the child welfare population, rigorous training for staff and supervisors, and an emphasis on outcomes informed by the use of a Statewide Automated Child Welfare Information System (SACWIS).

Improvements in physical and behavioral health care were a significant focus of the child welfare reforms. Collaboration among the Medicaid, child welfare, and behavioral health agencies was instrumental in achieving the goals of these reforms.

Physical health services were addressed first. Around 2004, with Medicaid's support, the child welfare agency sought to enroll children in foster care into the Health Maintenance Organizations (HMOs) under contract with Medicaid, rather than keeping them in a fee-for-service Medicaid system. Coordination of care was improved by assigning a care manager in the health plan to be responsible for linking and working with the child's care provider.

Following the creation of DCF in 2006, child welfare sought to bring the health care case management of children in foster care to a new level and partnered with the University of Medicine and Dentistry of New Jersey's School of Nursing to develop and implement child health units within child welfare to improve care coordination for children.

"High-quality health care services have been significant in improving outcomes for children in child welfare, as well as reducing caseloads and improving overall practice."

Efforts to implement systems of care for children's behavioral health took a big leap forward in 2000 with the development of a plan for a statewide system of care. The plan involved a sequential rollout in each county or in groups of smaller counties comprising a service area. Implementation was a five- to six-year process, with the

first three counties rolled out in 2001 and the last three counties in 2006.

There was a great deal of high-level and political support for this initiative (first referred to as the Children's System of Care Initiative), including from the governor's office. It created much excitement in the state, particularly among families, who were instrumental in developing and generating support for the initiative. Family advocacy is credited as a critical factor in the adoption of the system of care approach throughout the state, and this approach is now firmly established in state policy and has spanned multiple administrations.

"The child welfare lawsuit and settlement really didn't focus on behavioral health, but there was a parallel process to develop systems of care and we're all connected now."

The parallel process in the behavioral health system ultimately connected with the child welfare reforms. Ongoing collaboration and a strong working relationship are the basis for the success that has been achieved.

"Strong working relationships among child welfare, behavioral health, and Medicaid allow us to be more flexible (than a rigid policy document) and allow us to respond to a changing environment."

Medicaid has been a strong partner in the statewide implementation of systems of care. The agency serves as the single payer for the child behavioral health delivery system, utilizing funds pooled across mental health, child welfare, and Medicaid to draw down additional federal Medicaid match.

Although there is no formal structure at the state level, ongoing meetings among partners are used to discuss issues, solve problems, and create new policies where indicated. At the county level, Children's

Interagency Coordinating Councils provide a structure for collaboration, joint planning, and problem solving.

Medicaid Financing and Service Delivery

All children in foster care who are receiving New Jersey Medicaid are enrolled in one of the four HMOs that are under contract with Medicaid. These plans are funded with a capitation rate, and they, in turn, pay negotiated rates to a network of providers who provide comprehensive physical and dental health services to children in child welfare.

For behavioral health services, New Jersey identified services previously supported solely with state dollars that could be incorporated into the state Medicaid plan. The state then covered these services under the Rehabilitation Services Option (Rehab Option), allowing them to capture federal funding for these services. New Jersey used the “freed” state dollars as seed money to build the infrastructure for new community-based services across the state. In the first year of its system of care reform, New Jersey financed its Medicaid match by combining \$167 million in existing state general fund dollars being spent on children with serious emotional disturbances through child welfare and behavioral health (including \$117 million that was previously spent on residential care) with \$39 million in new funds authorized for children with serious emotional disorders in the 2001 governor’s budget. Currently, a combination of child welfare, behavioral health, and Medicaid funds support behavioral health services, including those provided to children in child welfare.

“Our system of care was built by blending funds across systems to maximize federal Medicaid funding. This was the key to redirecting existing funds to develop community-based services and reducing residential treatment.”

In October 2012, after about a year of negotiations, CMS approved New Jersey’s application for a Medicaid Section 1115 Demonstration Waiver, referred to as the “Comprehensive Medicaid Waiver.” This waiver will redesign the state’s Medicaid program to provide greater flexibility and improve care coordination, financing, and the ability to provide services in home- and community-based settings. The Comprehensive Waiver will combine the existing Medicaid and Children’s Health Insurance Program (CHIP) and the state’s four previous Medicaid Section 1915(c) Home and Community-Based Waivers, and will require that approximately 98 percent of Medicaid beneficiaries enroll in managed care. When implemented fully, all children, including those with developmental disabilities and substance use disorders, will receive their behavioral health services through the children’s behavioral health system (child behavioral health carve out).

“We were very persuasive with CMS and convinced them that without this flexibility there is an ‘institutional bias’ and that children would be placed in costly residential settings.”

The Comprehensive Waiver preserves the integrity of the child behavioral health carve-out. It also will allow the state to consider a child at risk for institutional-level care as a “family of one,” waiving parental/guardian income that would otherwise render the child ineligible for Medicaid, enabling access to home and community services for these children. By using Medicaid dollars to serve these children in home- and community-based settings, rather than in institutional-level care, Medicaid is expected to save money.

Through the Comprehensive Waiver, three new behavioral health services will be added to the benefit package: youth support and development (a service somewhat similar to mentoring), services for youth in transition to adulthood (ages 16 – 21), and non-medical transportation that is part of a child and family’s individualized service plan. Similar to the approach used to build the system of care, previous state-only

funding for home- and community-based services will be utilized as Medicaid match so that federal Medicaid dollars can be drawn down to expand service delivery. This strategy makes sense for expanding services for populations of children, such as those in foster care, who tend to be Medicaid-eligible and for financing services that can be covered by Medicaid, rather than relying only on state general revenue funds.

Physical Health

Each child enrolled in one of the Medicaid-contracted HMOs has a primary care practitioner (PCP), typically a pediatrician. Selection of a health plan and PCP is based on the child's need and caregiver's preferences. To the extent possible, if a child is already enrolled in an HMO and has an existing relationship with a PCP, continuity of care is encouraged by keeping the child with the same plan and provider.

Physical health services have been improved dramatically through investments in a child health unit (CHU)-based model of care coordination in partnership with the University of Medicine and Dentistry of New Jersey's School of Nursing. CHUs are co-located in each of the 47 child welfare offices across the state, where they work collaboratively with case workers, foster parents, and other caregivers to ensure children's health care needs are being met. CHUs partner with HMO care managers to ensure timely

"Nurses on the ground coordinate with health workers using a basic health care road map to make sure that health care takes place."

access to care for children and youth, particularly for children requiring specialty care. CHU staffing includes baccalaureate prepared nurses and staff assistants. The CHUs are staffed to ensure that there is one nurse for every 50 children in out-of-home placement. Regional nurse administrators supervise the local units for each region.

Every child entering foster care is assigned to a nurse who serves as a health care case manager and resource person. The nurses work in the trenches with child welfare caseworkers, helping to address key aspects of well-being for children in out-of-home placement by ensuring children receive timely well-child visits, immunizations, and dental care and ensuring each child has an updated health plan that is reviewed with the caregiver and youth as appropriate. Nurses visit children in out-of-home placement within two weeks of entering care and thereafter at regular intervals. These visits are often conducted with the child welfare caseworker, and are used to assess health care needs, provide developmentally-appropriate anticipatory guidance, and review the child's health care plan with the caregiver. Since the health units were established, outcomes have significantly improved, with 100 percent of children entering foster care receiving a pre-placement assessment, 87 percent receiving a comprehensive medical exam within the first 30 days, 82 percent receiving dental services, and 96 percent having up-to-date immunizations.

Behavioral Health

The children's behavioral health system in New Jersey is essentially a Medicaid carve-out that has been customized for children. It serves all children and adolescents with serious behavioral health challenges statewide and their families. New Jersey

"The system is not a child welfare, mental health, Medicaid, or juvenile justice initiative, but one that crosses systems."

has created a single, integrated system of behavioral health care across child-serving systems, which has drawn on multiple financing streams, including Medicaid, behavioral health general revenue, and child welfare dollars to create a single payer system. The goal is to serve youth with emotional and/or behavioral health needs and their families by providing a broad array of home- and community-based

services that are guided by system of care values including strengths-based, individualized, efficacious and culturally competent services and partnerships with families and youth.

DCF provides children and families with a virtual single point of contact that registers, tracks, and coordinates behavioral health care for children by contracting with a commercial managed behavioral health care organization called PerformCare. This organization functions as an administrative services organization, which New Jersey calls a Contracted Systems Administrator (CSA). PerformCare manages referrals, data, financing, and other system-level functions.

At the local level, nonprofit care management organizations (CMOs) under contract with DCF provide intensive care management using a Wraparound model for youth with complex needs. DCF also contracts with locally-based nonprofit Family Support Organizations (FSOs) that provide peer support to families involved with the CMOs as well as advocacy, policy and advisory activities, community education, and warm lines. FSOs are funded through a combination of state general revenue and Medicaid administrative case management dollars. These organizations also house Youth Partnership initiatives that provide opportunities for youth to offer peer support, participate in social marketing and strategic communications activities, and assume leadership roles in systems of care. CMOs in partnership with FSOs function as a more customized approach to coordinating care for children with the most serious behavioral health challenges, many of whom are involved with the child welfare system.

The CMOs serve as sole-focus care management agencies primarily funded by Medicaid, and Medicaid funds for this purpose are managed by and sit within the budget of DCF. Approximately 10 percent of the funding for CMOs comes from state-only administrative dollars. Services and supports for children served by the system of care who are not Medicaid eligible are currently financed with state funds. However, as noted, this will change to a large degree as the Comprehensive Waiver is implemented and Medicaid can be billed for their services based on the premise that the costs of institutional care will be avoided by providing home- and community-based services within the system of care. It is estimated that about 35 percent of children in CMOs are involved with child welfare, though this varies by county. The average 35 percent representation is much larger than the approximate 3 percent representation of child welfare-involved children in the overall Medicaid child population.

At the county level, each CMO has a relationship with the child welfare office in its respective area. Typically, the child welfare office designates a lead person with behavioral health expertise who

“Relationships between the CMOs and area child welfare offices are continually improving. It’s helpful to have a child welfare person who is the ‘go to’ person for behavioral health and works directly with the CMO.”

connects with the area CMO. This person fulfills a liaison role including coordination and problem solving functions. Coordination is also supported by regular meetings between child welfare area directors and CMO executive directors, in addition to the coordination activities between the nurses in the CHUs and the CMOs.

The children’s behavioral health system also provides a newer generation model of 24-hour mobile response and stabilization services (MRSS) for *all* youth with behavioral health needs. This model provides both 72-hour crisis intervention and ongoing eight-week stabilization services, enabling a team to work with the child, family/caregiver, teacher, and others in the home and community to link the child to appropriate services. In each of the last five years, this service has prevented placement disruption (i.e., has kept the child in his/her living situation) for 96 percent of children served. MRSS

is a particularly important service for children in child welfare who often change placements due to behavioral health crises.

Eligibility, Enrollment, and Access

New Jersey does not have presumptive eligibility for Medicaid for children in foster care. DCF handles eligibility determination and works to enroll children expeditiously in Medicaid. Children who are not eligible for federal Medicaid due to financial or citizenship status are enrolled in a parallel state-funded (non-FFP) Medicaid program. Children may be eligible for Medicaid up to age 21.

Currently, Medicaid-eligible children who need basic behavioral health services (e.g., brief outpatient services) may access these services through community mental health centers and other providers who participate in HMO networks. Some children also may access basic services through providers contracted by the child welfare system. Children who need more intensive behavioral health services are referred to PerformCare (i.e., to the behavioral health carve out). To facilitate access, child welfare has a separate phone number for PerformCare that connects with a team that specializes in the child welfare population and is trained extensively in the unique needs of this group. The state is currently in the process of consolidating behavioral health services so that all children will access behavioral health care through the behavioral health carve-out.

In addition to PerformCare's specialized child welfare team, access is enhanced by each CMO employing a clinical consultant who is available to provide behavioral health consultation to nurses and other child welfare workers in each county's child welfare office. In addition to case-specific consultation, an

"The clinical consultant is the 'go-to' person on mental health issues and is a great resource to child welfare staff."

ancillary benefit of the clinical consultants is that they are well positioned to serve as liaisons. Their close connection with child welfare allows them to improve communication, identify problems, and address issues collaboratively with their child welfare partners.

Screening and Early Intervention

Children entering foster care are required to have a physical health exam within 30 days of placement, which is paid for by Medicaid at an enhanced rate negotiated by Medicaid and child welfare. Mental health screening is also required for children in out-of-home placement and must be completed within the first 30 days of placement. CHU nurses and case workers are responsible for ensuring that children receive ongoing screening and that those who are identified with a suspected mental health need receive an assessment and follow-up care.

Regular screenings during well-child visits, mandated by Medicaid's EPSDT benefit, are performed by the child's PCP within the assigned HMO. A behavioral health component is required as a part of the screens, and although no specific tool is required, PCPs must specify the tools they use for this purpose.

The state behavioral health system of care utilizes common assessment tools to evaluate children with suspected behavioral health treatment needs. The tools used in New Jersey are a version of the CANS. The CANS is also used by CMOs for service planning and outcome measurement.

Covered Services

The state's behavioral health carve-out for children has a broad benefit package that includes a range of traditional clinical services as well as nontraditional services and supports. To achieve this breadth, the state expanded the services covered by Medicaid under the Rehabilitation Services Option to include: assessment, mobile response and stabilization services, therapeutic group home care, treatment

homes/therapeutic foster care, intensive care management, Wraparound process, intensive in-community services, and behavioral assistance. Family peer support provided through the FSOs is financed through Medicaid administrative dollars. Intensive in-community services are psychotherapy services provided in the child's home and/or community. Under a plan developed with the intensive in-community therapist, a behavioral assistant can work with the child and family to modify specific behaviors.

Through the new Comprehensive Services Waiver, youth support and development, services for youth in transition to adulthood (ages 16 – 21), and non-medical transportation that is part of a child's individualized service plan will be covered as well. Some specific evidence-based practices are covered under Medicaid, including Multisystemic Therapy and Functional Family Therapy, each of which is available in key areas of the state. DCF has financed training for clinicians in various evidence-based treatment including Cognitive Behavioral Therapy, Trauma-Focused Cognitive Behavioral Therapy, Parent Child Interaction Therapy, Brief Strategic Family Therapy and others. The most commonly selected training by counties has been Trauma-Focused Cognitive Behavioral Therapy. As noted, Medicaid also covers intensive care coordination using high quality Wraparound through the CMOs, a model that has a growing evidence base; the state helps to finance this model using Targeted Case Management.

This array of home- and community-based services has allowed the state to decrease the length of stay in residential treatment centers by 25 percent, reduce expenditures for psychiatric hospitalization, and nearly eliminate out-of-state treatment placements. Of youth accessing mobile response and stabilization services, 96 percent are able to remain in their homes rather than being placed in inpatient or other out-of-home treatment settings. The number of youth in custody who are in juvenile detention settings awaiting placement has also been reduced significantly. In addition, New Jersey has the 47th lowest youth suicide rate in the country, suggesting that increased access to behavioral health screens and earlier intervention may be having an impact.

Services and supports that are part of the individualized service plan, but are not covered by Medicaid are financed with state-only dollars (e.g., tutoring, camp, dance classes, karate lessons). Therapeutic mentoring and transportation were previously the most utilized services funded with state-only dollars. However, they are now covered under Medicaid, allowing the state to further maximize available funds by increasing the federal contribution.

Specialized services needed by the child welfare population, such as treatment related to sexual abuse and attachment issues, are also available. Contracts with providers from both the behavioral health and child welfare systems include language that requires particular services and specifies standards and outcomes.

Birth parents are also able to access needed behavioral health services, including treatment for substance use. Child welfare conducts needs assessments, and covers the costs of services if a parent is not covered by Medicaid or private insurance.

Individualized Service Planning

New Jersey's children's behavioral health system utilizes the Wraparound approach to developing, implementing, and coordinating individualized service plans. CMOs use child and family teams created for each family to develop these plans, which are required to be strength-based and culturally relevant. They also must address safety and permanency issues for children referred to CMOs who are involved with the child welfare and juvenile justice systems. CMOs are required to hold a child and family team meeting within 30 days of the initiation of services. Many CMOs use tools developed by the National Wraparound Initiative to ensure fidelity to the model.

CMOs employ care managers who serve as Wraparound facilitators, carry small caseloads, and receive close supervision and support from clinical supervisors. New Jersey's CMOs have formed a professional association, which certifies Wraparound care coordinators.

Care managers and child and family teams are assisted by FSO family support coordinators who provide peer support for families involved with CMOs. Family peer support is financed through Medicaid administrative claims. Community resource development specialists located at CMOs also support the individualized service delivery approach by identifying and developing community supports and natural helpers to augment treatment services.

For children also served by the child welfare system, birth parents, foster parents (referred to as 'resource parents' in New Jersey), and kinship families are included in a family team meeting that shares many similarities with the Wraparound child and family team approach and is instrumental in guiding the planning process for the family. Nurses from the child welfare health units attend the initial team meetings when indicated and may participate in subsequent meetings as needed. Efforts are underway across the state to join these meetings into one when a child is being served by both systems rather than having parallel processes in the child welfare and behavioral health systems.

"We're in the process of marrying the two systems, and there are pilots in the state to demonstrate this. Ultimately, we want to cut down and have only one service plan for a child and family."

Medicaid Providers

Each of the four Medicaid managed care plans (HMOs) has a provider network that includes a broad array of specialty health providers. For example, if a child in the child welfare system needs a pediatric cardiologist, the HMO must procure providers to deliver that specialty care.

Developing providers skilled in trauma-informed care is a work-in-progress in the state. There are specific requirements for trauma-informed services in residential treatment programs for children with histories of trauma, including evidence-based practices. Current efforts are exploring how to build trauma-informed services within both the child welfare and behavioral health systems.

There are several vehicles in the state for training Medicaid providers on the unique needs of the child welfare population. The New Jersey chapter of the American Academy of Pediatrics conducts outreach to physician practices on child abuse and neglect prevention and provides education about the child welfare system and how to recognize suspected abuse and neglect. DCF supports a Child Welfare Training Academy that focuses primarily on providing training to child welfare professionals, but in recent years, training has also been made available to providers and others in the community who might benefit. In addition to training related to the specific roles of child welfare staff, specialized training in such topics as child sexual abuse, working with lesbian and gay youth, working with gang-involved youth, and others may be relevant to the provider community and help them to develop the specialized skills needed to work with children in child welfare.

The behavioral health system provides training and technical assistance through the University of Medicine and Dentistry of New Jersey's Behavioral Health Research and Training Institute. This structure is financed through a contract with the university, and allows considerable flexibility in using funds to meet the training and technical assistance needs of behavioral health providers. Some of the training offered by the Institute is specific to children in child welfare and their needs, and a particular emphasis of the training is on child and family team practice. The Behavioral Health Research and Training Institute and the Child Welfare Training Academy have not been well connected in the past, but efforts are underway to better coordinate their work.

Psychotropic Medication

DCF developed a psychotropic medication policy several years ago in collaboration with many stakeholders that took part in a psychotropic medication advisory council. This policy has helped to monitor the use of psychotropic medications for children receiving services from DCF.

More recently, New Jersey became a part of a six-state national quality collaborative, coordinated by the Center for Health Care Strategies, to reduce the inappropriate use of psychotropic medications in the foster care population. The state created a team comprised of Medicaid, child welfare, and behavioral health to explore potential next steps to advance its efforts to monitor the use of psychotropic medications.

Performance and Outcome Measurement

The Office of Performance Management and Accountability (PMA) in DCF is instrumental in performance and outcome measurement for both the children's behavioral health and child welfare systems. PMA assesses service delivery, along with the needs, strengths, and experiences of families involved with DCF.

DCF also assesses performance and outcomes for both behavioral health and child welfare through contract monitoring. Outcomes-based contracts are used that require information about a number of key outcome indicators, some particularly relevant to the child welfare population such as stability of children and families, well-being, and permanency.

The class action settlement requires regular reports with data on specific benchmarks, including physical and behavioral health services data. For example, data are collected on how many children receive pre-placement medical assessments, comprehensive medical exams, exams in compliance with EPSDT guidelines, semi-annual dental checks, and immunizations. For behavioral health services, reports are generated on mental health assessments for children with suspected mental health needs and the extent to which they receive timely and appropriate follow-up and treatment.

SafeMeasures is a continuous quality improvement system that is used to meet reporting needs, as well as to produce data dashboards accessible to child welfare workers in the field. Information from SafeMeasures feeds into New Jersey Spirit, which is the child welfare data system. The CANS is used to derive outcome data for children receiving behavioral health services through the CMOs.

Next Steps for New Jersey

The state will continue to promote trauma-informed care by increasing the knowledge and skills of child welfare, health, and behavioral health providers, and exploring evidence-based practices. Its efforts to ensure safe and appropriate use of psychotropic medications among children will also continue.

The new Comprehensive Medicaid Waiver will impact services for children in child welfare, particularly for those with dual diagnoses of substance use disorders and pervasive developmental disabilities. Planning is underway to implement the reforms made possible by the waiver.

DCF developed a strategic plan for 2012 – 2014 that provides a framework for the next steps to improve the quality and outcomes of service delivery. The strategic priorities include:

- **Seamless System of Care** – To provide ease of access to care for children, youth and families;
- **Performance Management and Accountability** – To ensure the integrity and quality of DCF's system of care;

- **Partnerships** – To collaborate with stakeholders and community partners to improve outcomes for New Jersey children, youth and families;
- **Communication** – To enhance the effectiveness of communication with employees, partners, the media, and the general public; and
- **Organizational Development** – To continually examine and prepare the organization structurally, in alignment with the mission and strategic plan.

Another priority is to better engage biological families in services. Since many children are ultimately reunified with their families, the state seeks to better position parents to understand their child's health needs and help them to develop the skills needed when the child returns home.

"We are strong proponents of the behavioral health and child welfare systems sitting structurally in the same department. That has allowed us to work together closely to connect these systems. Medicaid dollars also sit in the department and the executive management team can determine how Medicaid is used for our populations."

Planning for implementation of the ACA is in the early stages, and the implications for Medicaid, behavioral health, and child welfare are being explored.

Advice to Other States

- Consider an organizational structure that places behavioral health and child welfare within the same department. In New Jersey, this has been a highly effective approach to connecting those systems.
- Shift the management of Medicaid behavioral health dollars from the Medicaid agency to behavioral health. This allows for financing strategies to be designed to specifically meet the behavioral health needs of children enrolled in Medicaid, including the child welfare population.
- Create child health units in child welfare. All indications are that the model has led to improved access to health, dental, and behavioral health care for children in child welfare.
- Emphasize family involvement in both policy and services. New Jersey has adopted a family-centered approach to services, created Family Support Organizations in each locality that are funded by Medicaid administrative dollars, provided family peer support services through the FSOs, and included families on policy and advisory groups.
- Invest in staff training and development to move the system to a strength-based, individualized, family-centered practice model, to reduce inappropriate placements, and to provide home- and community-based services.
- Emphasize cross-agency collaboration. This has played an essential role in New Jersey in bringing the voices of all of the partner systems to the table to think through challenges and design strategies and plans.

"We're doing a full court press on providing comprehensive medical, dental, and mental health services to children in child welfare. It has been a success story for our state."

ILLUSTRATING THE IMPORTANCE OF NEW JERSEY'S EFFORTS: Natalie and Angela*

Natalie was placed in foster care for neglect at age nine. She suffered from asthma and, to her new foster mother, seemed very anxious. Her foster mother took her to her family pediatrician, and he changed her asthma medication and prescribed anti-anxiety medication. After Natalie was with them for close to a year and doing fairly well, her foster family moved away from the state, and Natalie was placed with another family. She also had a new child welfare case worker. Somehow, Natalie's case file with the notes about her health issues and medications did not make the transition with her. Her new foster mother took her to a new pediatrician, who continued asthma medication and put her on an anti-depressant, noting that she seemed remarkably withdrawn. Natalie began to gain weight on the new medication, which, in turn, aggravated her asthma. She also began to stay in her room for long periods of time. Her foster mother called the pediatrician, who increased the dosage on her anti-depressant. On a weekend not long after, Natalie had a severe asthma attack and her foster parent took her to the emergency room. The emergency room staff treated her asthma and also observed that Natalie seemed to be making no sense, her speech was incoherent and her thoughts racing. They placed her on an anti-psychotic medication. Around this time, Natalie's foster family had a child of their own and told the state that they could no longer care for Natalie.

Contrast Natalie's experience with that of Angela, also removed from home around age nine and placed with a foster family. Angela, who had asthma and attention deficit hyperactivity disorder, also experienced several foster care placements in the three years she was in foster care. However, the pediatricians she saw all participated in the Medicaid HMO networks and had participated in trainings provided by the child welfare system. Her child welfare workers, who were charged with providing consent for psychotropic medications, had access to medical expertise through the health units in the local child welfare offices. In addition, Angela had an electronic health record, noting her health issues and medications, which the health unit periodically ran against the Medicaid claims data system to ensure that there were no additional medications being prescribed about which the child welfare workers were not informed. In particular, the system would flag certain medications, such as anti-psychotics, for review by a consulting child psychiatrist. As a result, there was much better oversight and management of the medications that Angela received to ensure she received only what was appropriate. Her mental health status did not deteriorate, and she ultimately was adopted by her foster family.

**Note. These are not actual case vignettes; they are representative to illustrate the differences for children as a result of state efforts to strengthen Medicaid for children in child welfare.*

Lessons Learned

Cross-State Lessons

Lessons learned from the experiences of these four states provide valuable guidance to other states in their efforts to ‘make Medicaid work’ for children in child welfare. These lessons fall within several broad categories – including, understanding the unique needs of the child welfare population, covering a broad range of services and supports, and creating financial incentives to provide high quality care – each of which is highlighted below.

Understand the Unique Needs of Children and Families Involved with Child Welfare

All of the states began their work with the premise that children in child welfare have unique needs that require customized responses in delivering both physical and behavioral health care. These children comprise a vulnerable and high-risk population with a high prevalence of physical, behavioral, and developmental problems. Their Medicaid service use, particularly of behavioral health care and psychotropic medications, mirrors or exceeds that of children on Supplemental Security Income (SSI). Their histories include trauma from abuse and neglect, separation from their homes and families, and often multiple out-of-home placements entailing changes in schools, caregivers, friends, and routines. Historically, many of the needs of these children have not been met, the services that they receive have been expensive, and outcomes have been poor.

In addition to the child welfare system, multiple child-serving systems touch the lives of these children – Medicaid, behavioral health, primary health care, substance use, education, early childhood, juvenile justice, systems serving transition-age youth, and others. Interviewees stressed that all of these systems must be attuned to the needs, nuances, and journeys of children in child welfare and must participate in designing and implementing strategies to respond. All of these states recognized the critical importance of behavioral health care especially for children in child welfare and have devoted much of their efforts to improving the financing and quality of Medicaid behavioral health services and supports.

“One of the most effective things we’ve done was to create a matrix showing the unique needs of children in child welfare and developing a protocol to guide Medicaid providers to respond to each one.”

Recognize the Importance of Relationships and Collaboration

Uniformly, interviewees emphasized that cross-agency relationships are critical and that strategies must be grounded in an acknowledgement of shared responsibility for children in child welfare along with receptiveness to working together to meet their needs. Although partnerships between child welfare and Medicaid are fundamentally key, the efforts described here nearly always involve the behavioral health agency and, in many cases, other child-serving agencies as well. In addition, the states profiled indicated that while collaboration at the state level is essential, collaborative relationships at the local level among system leaders and front line staff are also critical for policies and procedures to be implemented.

“It’s all about relationships!”

The states have built a variety of interagency structures as vehicles for joint strategy development and problem solving. These include high-level policy structures such as a policy leadership team in Michigan and the Children’s Behavioral Health Initiative Executive Committee in Massachusetts. Interagency operational-level structures have also been created, such as the core leadership team in Michigan, as well as local structures, such as the local coordinating councils in Arizona and the interagency children’s system of care councils in New Jersey.

Create Multiple Strategies

In these four states, strategies typically were not designed and implemented as a complete package. Rather, some were developed as needs were identified and were implemented sequentially over a period of years. Others were implemented as part of a larger system redesign that involved significant systemic changes, such as the Children’s Behavioral Health Initiative in Massachusetts, the system reforms in Arizona and Michigan (each of which resulted from class action lawsuits involving Medicaid), and the children’s system of care initiative in New Jersey. It is important to note that, while a class action lawsuit can provide a powerful impetus for change, the impetus can also result from reviewing practice and outcomes for children in child welfare and proactively developing strategies for improving services and supports. In New Jersey, child welfare reforms and a children’s system of care initiative were implemented through cross-system collaboration.

“It’s hard to identify the most effective strategy. It’s a combination – one can’t work without the others.”

In addition, these states used multiple strategies, rather than relying on just a few approaches. In fact, each of the states had at least some strategies in all of the areas explored such as screening, service coverage, individualized care, and financing approaches.

Incorporate a Robust Medicaid Benefit

All of the states expanded Medicaid coverage to include a broad array of services and supports, moving beyond traditional services to significantly enrich the Medicaid benefit. Intensive in-home services, intensive care management, Wraparound service planning, family and youth peer support, mobile crisis services, respite care, family training, therapeutic mentoring, therapeutic foster care, supported housing, and supported education and employment are among the services that were added to their state Medicaid plans or are provided under a Medicaid Home and Community-Based Services Waiver.

In addition, the states cover many specific evidence-based practices, either under their own service codes or under existing codes. Examples that are particularly important for the child welfare population include: Trauma-Focused Cognitive Behavioral Therapy, Parent Management Training-Oregon Model, Multisystemic Therapy, and Multidimensional Treatment Foster Care. Providers with expertise in areas essential for children in child welfare are required to be included in Medicaid provider networks, such as clinicians with skills in the areas of trauma, adoption, sexual abuse, and attachment disorders. A

“It’s essential that the Medicaid state plan cover a broad range of services and supports so that they’re adequately financed and sustainable. It’s impossible to meet the needs of children in child welfare without this.”

specialty providers’ initiative in Arizona mandates the inclusion of these providers, and in Michigan, training is provided statewide to ensure that skilled clinicians are available to provide trauma-informed services in each service area. In New Jersey, a university-based institute provides training related to child and family team practice.

Adopt an Individualized Approach to Services Using the Wraparound Process

An individualized approach is the cornerstone of planning and delivering behavioral health services under Medicaid in all of these states, who each use high-fidelity Wraparound as defined by the National Wraparound Initiative. A child and family team facilitated by a care coordinator is created for each child and family and includes the family and youth, child welfare worker, behavioral health provider, other involved services providers, and other support persons identified by the family. This team creates and implements a comprehensive, individualized service plan that guides service delivery. In two of the states, Massachusetts and New Jersey, the Wraparound approach is combined with intensive care

coordination at low ratios (e.g., one care coordinator for eight to ten children and families), billable through Targeted Case Management, to ensure the appropriate intensity of care management for children in child welfare with serious and complex issues. Wraparound is the practice approach used both by New Jersey's and Massachusetts' care management entities that serve high-need children.

In the states studied, services included in the child and family team's plan of care are considered authorized for purposes of Medicaid. For example, in Arizona, the teams are empowered to determine medical necessity, and the service plans they develop are automatically authorized. Only a few designated services, typically those that are restrictive and expensive, may require prior authorization outside of the teams, such as residential treatment. Interviewees stressed that the Wraparound process is powerful for children and families in child welfare and plays a critical role in coordinating care.

"Foster parents have said that things turned around for them, and they felt so supported by the Wraparound process and the services that were brought to bear."

Create Financing Vehicles to Maximize Resources and Flexibility

These states have taken advantage of various Medicaid options and provisions to implement their strategies; some of these options were already in place in the state's Medicaid system but not sufficiently customized for children in child welfare. The Medicaid 1115 Research and Demonstration Project Waiver has provided flexibility for both Massachusetts and Arizona. A Medicaid 1915(c) Home and Community-Based Services Waiver in Michigan has been used as a primary vehicle for serving children in child welfare who have serious emotional disturbances. In some cases, the child welfare agency has transferred funds to provide Medicaid match, enabling the state to draw down additional federal Medicaid dollars, thereby maximizing the resources available for services. The Medicaid Rehabilitation Services Option has been used to support home- and community-based services, including evidence-informed practices, as in New Jersey. Targeted Case Management has provided a vehicle for intensive care coordination for children with intensive needs, as in New Jersey and Massachusetts. In Arizona, Medicaid contracts with a single health plan that provides all physical and dental health services to the child welfare population.

"The providers have received an injection of funding that enables them to serve these high-risk children in child welfare, and the child welfare system is pleased that their children can now access behavioral health services using Medicaid dollars."

The states have also implemented incentive payments and risk-adjusted rates to ensure adequate resources to serve children with high needs in the child welfare population. For example, Michigan implemented incentive payments to its community mental health service providers for children in foster care that are over and above standard Medicaid capitation rates, in order to provide both a mechanism and motivation to meet their needs. In Arizona, risk adjusted rates provide significantly higher capitation rates for children in child welfare.

Understand the Mandates, Goals, and Cultures of Partner Agencies

Collaboration is difficult without a basis of understanding among partner agencies, including how they view their missions and goals and the cultures in which they function. Child welfare, Medicaid, and behavioral health agencies come to the table with their respective roles and mandates in mind, and thus, a broad shift in thinking is often needed to accomplish real change. Partners also need to understand the constraints and pressures that are experienced by each, such as increasing caseloads for

"It is a constant dance for everyone to be comfortable with community-based alternatives to residential treatment and to increase utilization of these services."

child welfare workers or deficits in Medicaid. As one interviewee noted, “Child welfare, Medicaid, and behavioral health should learn more about the functions, mandates, and operation of each system and establish a vehicle for bringing the systems together in conversations regarding what is needed to make them work together in a more collaborative and cost-effective way.”

Ensure Solid Implementation and Monitoring of New Strategies

In reflecting on their experiences, interviewees underscored the importance of focusing not only on designing policies, plans, strategies, and practice protocols, but also on the quality of the implementation of these strategies. There is often a difference between policies designed at the state level and how they are implemented in the field. Accordingly, it is critical to have specific, measurable criteria, such as expectations of the number of children to be served, the number of care managers hired, size of caseloads, and training required, as well as close monitoring of expectations. Monitoring is essential to track performance, assess progress, identify problems, and improve implementation.

“Clear, formal expectations, supported by training, are needed to ensure that providers throughout the system are prepared for successful implementation; and routine monitoring should be used to make sure strategies are implemented with ‘fidelity’ to the intention.”

Interviewees also stressed the importance of tracking service utilization and outcomes for the child welfare population. Examples include monitoring penetration rates for the child welfare population in the Medicaid system, the types of services they are receiving, use of psychotropic medication, expenditures, and outcomes. Less than positive results provide valuable information for quality improvement, while positive results can be instrumental in demonstrating to policy makers improvements in services, cost savings, and the impact of home- and community-based services for children in child welfare. In Michigan, data have shown that the Medicaid behavioral health system, for example, can, in fact, deliver the services needed by the child welfare population and achieve good outcomes.

Implement Sustainability Strategies for Each Provision

“Without the buy-in and commitment of high-level leaders, the whole building will fall down.”

A caution expressed by many interviewees is the potential difficulty in sustaining the strategies put into place to make Medicaid more responsive to the needs of children in general, and children in child welfare in particular. This challenge was attributed primarily to changes in executive leadership that result in changing priorities, new directions, and lack of commitment to the work started under previous administrations. Since newly appointed leaders were not a part of the initial efforts, they may not have the information needed to continue to allocate staff and resources or may have different priorities. New leaders may not be familiar with the needs of the child welfare population and with the approaches implemented. It was emphasized that for each approach adopted, consideration should be given at the outset as to how it will be formalized so that the both the strategies and the commitment to the needs of children in child welfare will be maintained over the long term.

A two-pronged approach was recommended. First, strategies should be “institutionalized” in policy, contracts, financing, regulations, and other vehicles to ensure continuity. Changes must be systemic and incorporated into the system, rather than pilots or actions without mechanisms to keep them in place over time. A capacity for ongoing orientation and training related to policy, system, and practice changes is needed both for quality control and to build a broad base of support. In addition, intentional strategies are needed to provide new decision makers with information and data to garner their support.

Fiscal crises and budget cuts also have an impact on care for children in child welfare and for the services and supports that are financed by Medicaid. In some cases, there is an influx of children entering foster care, which is attributed to stressors related to the economy. With funding cuts and increased demand, some children and families may find it more difficult to obtain services, caseloads may increase, and financing strategies that have been implemented may be in jeopardy. It was noted, however, that fiscal crises can also present opportunities for child welfare, Medicaid, and other child-serving agencies to invest resources more wisely in cost-effective approaches. National mandates and opportunities, such as those associated with the Affordable Care Act, the Fostering Connections to Success and Improving Adoptions Act, and the Child and Family Services Implementation and Innovation Act, provide a platform for child welfare and Medicaid systems to work together to improve the quality and cost of physical and behavioral health care for children in child welfare.

Moving Forward

All of these states recognize that they are “works in progress.” What distinguishes them is that they have created long-standing collaborative approaches among the child welfare, Medicaid, and behavioral health systems, maintaining respect for the mandates and pressures facing each system and developing common ground. Each of these states has made a commitment to continue this work to refine their strategies and undertake efforts to tackle the needed next steps they identified.

“They are *our* kids, and we must take steps together to make sure they’re being served. We’re thankful for what child welfare, behavioral health, and Medicaid have already accomplished and for the willingness to continue working collaboratively.”

As states move more fully into implementation of health reform, the experiences and lessons from these four states may help to inform such innovations as health homes, patient-centered medical homes, the use of home- and community-based options like the 1915(i) provision, benefit designs, managed care requirements, and other key features to ensure that the needs of children in child welfare are appropriately addressed.

¹ S. Pires, K. Grimes, K. Allen, T. Gilmer, and R. Mahadevan. Spring 2013 (forthcoming). *Faces of Medicaid: Examining Children’s Behavioral Health Services Use and Expenditures*. Center for Health Care Strategies.

² For more information, visit the National Wraparound Initiative website at: <http://www.nwi.pdx.edu/>

Additional Child Welfare Resources

The Center for Health Care Strategies' (CHCS) Child Health Quality portfolio includes a substantial focus on improving access to and quality of health care for children in child welfare. CHCS works with Medicaid, child welfare, and behavioral health stakeholders on such issues as: (1) addressing psychotropic medication use among children in foster care, (2) improving Medicaid managed care for children in child welfare, and (3) addressing the behavioral health needs of children in child welfare. Visit www.chcs.org for more information on CHCS' child welfare-related initiatives and resources.

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