



Strategies for Maximizing Medicaid for Children and Families in Child Welfare

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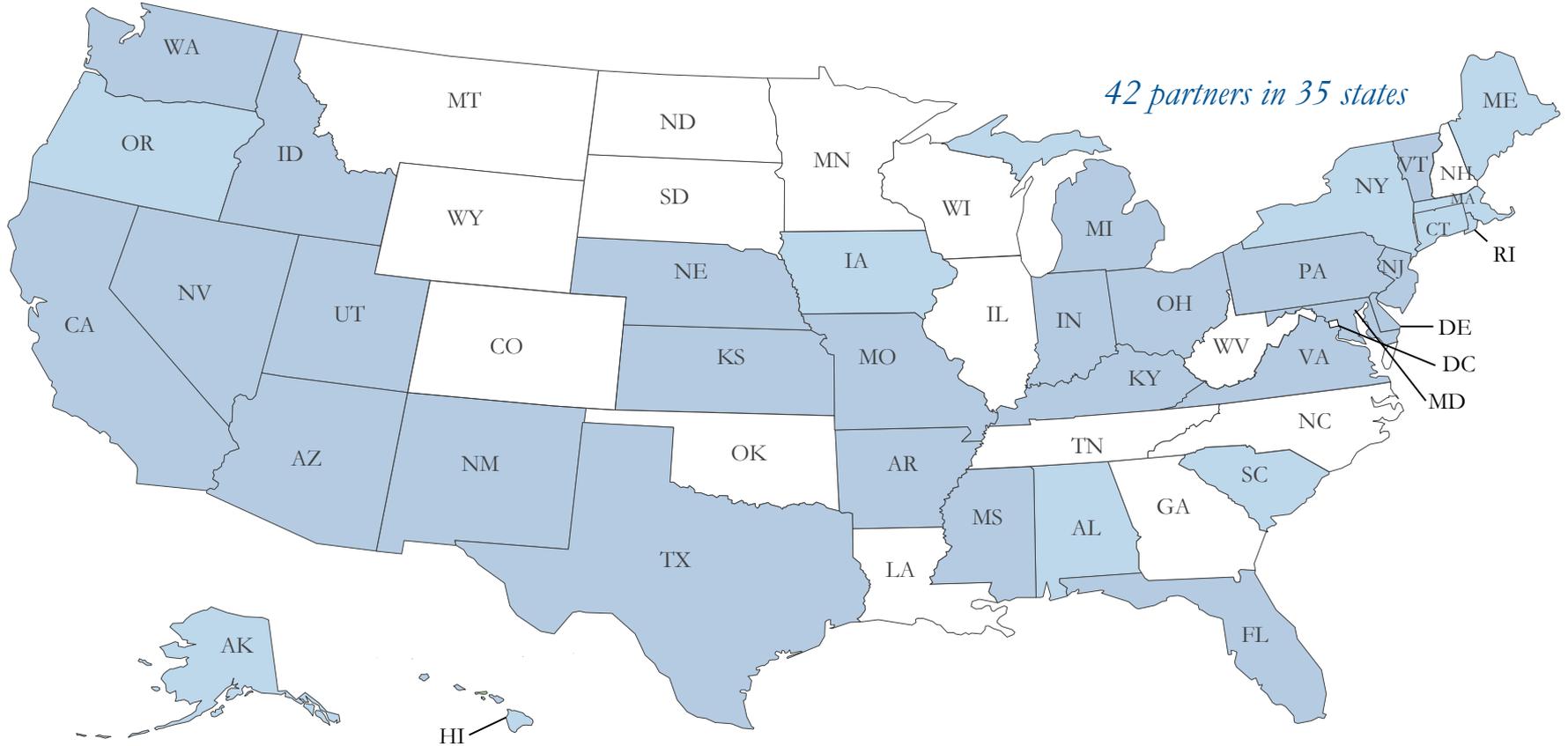
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Health Status of Children in Foster Care

- Foster children are more likely than other children in Medicaid to experience emotional and psychological disorders and have more chronic medical problems
- 60 % experience a chronic medical condition
- One-quarter suffer from three or more chronic health conditions
- 20-60% have a developmental disability or delay
- 35 % have significant oral health problems
- 70 % exhibit moderate to severe mental health problems
- 40 to 60 % are diagnosed with at least one psychiatric disorder
- Most common physical health issues for children include skin conditions, vision and hearing problems, dental caries, asthma, anemia and malnutrition



Children in Foster Care: Health Care Needs

- Children in foster care represent 3 % of children in Medicaid but 15 % of children in Medicaid using behavioral health services
- Children in foster care represent 13 % of those in Medicaid receiving psychotropic medications
- Children in foster care are four times more likely to receive psychotropic medications than children in Medicaid overall
- Children in foster care are more likely to use restrictive/expensive service types including residential/treatment group care, inpatient psychiatric care and emergency room visits.



Children in Foster Care: Medicaid Coverage

- Virtually all children in foster care are categorically eligible for Medicaid, which covers a specific set of benefits under EPSDT
- Health care for foster children should include: an initial screening, comprehensive medical and dental assessment, developmental and mental health evaluation, and ongoing primary care and monitoring of health status.
- Each of these domains is covered under Medicaid, but some specific services or aspects of care may not be reimbursable under Medicaid (e.g., tutors, room and board costs for therapeutic foster care, services to parents or family members).
- Other services including intensive care coordination, peer support, intensive in-home services are reimbursable under Medicaid through waivers or State Plan Amendments but not automatically included in a state's Medicaid program.
- **Result = gaps in coverage**



Strategies for Maximizing Medicaid for Children and Families in Children Welfare: Key Themes

- Understanding the unique needs of children and families involved in child welfare
- Recognizing importance of relationships and collaboration
- Creating multiple strategies
- Creating a robust Medicaid benefit to cover a range of home and community-based services
- Adopting an individualized approach to services using the wraparound process
- Creating financing vehicles to maximize resources and flexibility
- Understanding the mandates, goals and cultures of partner agencies
- Ensuring solid implementation and monitoring of new strategies
- Implementing sustainability strategies for each provision



Medicaid Financing: Medicaid Match

State dollars used for Medicaid services draw federal match dollars at a 50 % or higher match rate so using child welfare general revenue for children in foster care (most of whom are Medicaid-eligible) and for Medicaid-eligible services is an effective strategy as opposed to using 100 % state-only dollars.

Example: in **Arizona**, the child welfare system contributes 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.



Medicaid Financing: Risk Adjusted Rates

Use risk-adjusted rates.

Example: 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 risk-adjusted capitation rate (Under capitation, whole networks of hospitals and physicians band together to receive single fixed monthly payments for enrolled health plan members. Payment is made on a per member basis. Under risk-adjusted capitation rate, that payment is adjusted to reflect cost of health care for children in foster care).



Medicaid Financing: Incentive Payments

Use incentive payments to provide adequate resources to serve children in child welfare and protect against under-service.

Example: In **Michigan**, incentive payments are provided to the community mental health services agencies to make it more feasible for them to serve children in foster care 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 health conditions in foster care or those involved in child protective services.



Eligibility, Enrollment and Access: Presumptive Eligibility

Children in child welfare should be *presumptively eligible* for Medicaid. 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.

Example: In **Massachusetts**, there is presumptive eligibility for children in child welfare. 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), especially when reunification is the goal.



Eligibility, Enrollment and Access: Co-locations and liaisons

Examples: 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. 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.

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, especially those who require specialty care.



Eligibility, Enrollment and Access: Co-locations and liaisons – Embedding Nurses

Examples: Utah's Department of Health's Fostering Healthy Children Program provides a nurse case manager to oversee all children in care. This program is funded using Medicaid case management dollars and embeds a nurse manager in the child welfare agency at a rate of 1 nurse per 100 children.

In **New Jersey**, each Child Health Unit is staffed with a clinical nurse coordinator, health care case managers and administrative support staff. Every child in foster care is assigned a health care case manager with a ratio of 1 nurse to 50 children. The Child Health Unit is responsible for ensuring that appropriate physical and mental health services are provided to each child in foster care in its jurisdiction and for coordinating the collection and dissemination of relevant health records. Nurses participate in family team meetings and home visits in collaboration with child welfare cases. It is funded through a state federal Medicaid administrative match.



Screening and Early Intervention: Timeframes for screens

Examples: In **Arizona**, 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.

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.



Screening and Early Intervention: Standardized Screening Tools

Examples: 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 assessment instrument must be used at each scheduled EPSDT 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.



Covered Services: Ensuring Access to Critical Services

- Intensive in-home services (teams of providers come into the home and community to provide treatment, in home behavioral support, and education to caregivers on how to manage their child's challenging behaviors);
- Wraparound facilitation or treatment planning;
- Intensive care management;
- Mobile crisis response and stabilization (provide crisis teams that can respond to crises at foster homes, family homes, shelters, group homes, and other settings and divert children from hospitalization.
- Therapeutic foster care;
- Respite care;
- Family peer support (provides family partners who have lived experience to mentor, support, and advocate for other families as they progress through the service delivery process);
- Family training;
- Substance use treatment;
- Therapeutic monitoring;
- Behavioral assistance;
- Transportation



Covering a Broad-Range of Home and Community-Based Services: Strategies

These services can be covered by:

- adding services to the state Medicaid plan
- revising service definitions
- using the Rehabilitation Services Option
- using Targeted Case Management
- using Medicaid waivers to expand coverage



Covering a Broad Range of Home and Community-Based Services

Example: In **New Jersey**, three new services were added to the Medicaid benefit package via 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 the 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.

In New Jersey, flexible funds pay for services and supports that are part of the individualized service plan but that are not covered by Medicaid (e.g., tutors or housing assistance).



Covered Services: Evidence-Based Practices

Example: 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 determine how to bill for practices including Functional Family Therapy, Multidimensional Treatment Foster Care and Cognitive Behavioral Therapy.

Michigan covers evidence-based practices including Trauma-Focused 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.



Trauma-Informed Treatments

Diagnosis/Concern	Evidence-Based Interventions (Examples)	Age
Actionable Trauma Symptoms → <i>Posttraumatic Stress Disorder</i>	<ul style="list-style-type: none"> • Child-Parent Psychotherapy (CPP) • Parent-Child Interaction Therapy (PCIT) • Combined Parent-Child Cognitive Behavioral Therapy for Families at Risk for Child Physical Abuse (CPC-CBT) • Trauma-Focused Cognitive Behavioral Therapy (TF-CBT) • Alternatives for Families/Abuse Focused Cognitive Behavioral Therapy (AF-CBT) • Cognitive Behavioral Intervention for Trauma in Schools (CBITS) • Trauma Affect Regulation: Guide for Education and Therapy (TARGET-A) • Structured Psychotherapy for Adolescents Responding to Chronic Stress (SPARCS) • Prolonged Exposure (PE) Therapy for Youth 18-25 	0-6 2-17 3-17 4-55 5-17 6-12 10-55 13-21 18-25



Covered Services: Intensive Care Coordination

Examples: 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.

In **Massachusetts**, community service agencies provide intensive care coordination financed by Targeted Case Management using a Wraparound practice model.



Covered Services: Individualized Service Planning

Examples: 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. Wraparound facilitation is covered by Medicaid using billing codes including case management and family support.

A wraparound approach to planning and delivering services is also critical to **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."



Medicaid Providers: Inclusion of skilled child welfare providers and specialists in the Medicaid network

Examples: A specialty provider initiative in **Arizona** was undertaken to develop expertise in key 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 mandated that the regional authorities include these specialties in their provider networks. All of these providers were required to become certified as Medicaid providers.

Provider networks in **Massachusetts** are required to include expertise in trauma-informed care.

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. When providers with a particular expertise are not available, the agencies may seek out a specialty provider that is out-of-network.



Medicaid Providers: Practice Protocols for Child Welfare

Examples: 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.



Medicaid Providers: Ongoing Training

Examples: In **Arizona**, behavioral health providers receive training in areas relevant to the child welfare population through modules.

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. The mental health agencies also provide training to child welfare staff on behavioral health services and extensive training is provided state-wide on evidence-based practices.

In **New Jersey**, ongoing training on the unique needs of the child welfare population is provided through 1) a Child Welfare Training Academy and 2) a Behavioral Health Research and Training Institute. Both offer vehicles for preparing child welfare, health and behavioral health providers.



Performance and Outcome Measurement: Tracking Child Welfare-Related Performance, Utilization, Outcomes and Expenditures

Examples: **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) 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.



Performance and Outcome Measurement: Cross-Agency Data Sharing

Example: In **Arizona**, the data system from the Medicaid health plan to foster care children and the child welfare system data system interface to share data seamlessly to improve service delivery for children in child welfare.



Other Opportunities: Interagency Collaboration for Better Care Coordination

Example: Tennessee's Department of Child Services (DCS) collaborates with TennCare, the state Medicaid agency through an interagency agreement to coordinate the enrollment and ongoing provision of health services for all children in state custody.

DCS notifies TennCare Select, the State's Medicaid managed care company serving children in foster care, and the child is assigned immediate eligibility and a primary care practitioner (PCP) who serves as their medical home.

The PCP is responsible for providing basic primary care as well as coordinating all physical and behavioral health services for these children.



Other Opportunities: Hiring Child Welfare Medical Directors

Example: The **Baltimore** City Department of Social Services has a full-time medical director who is responsible for ensuring that children in foster care receive health care services through the Making all Children Healthy (MATCH) program. MATCH was created in 2009 as a result of a class action lawsuit.

The Medical Director works with the Baltimore City Department of Social Services and the Baltimore Mental Health Systems.

The Medical Director oversees teams of nurse case managers, medical professionals, and mental health specialists who provide coordinated care to children. Services include a comprehensive health assessment within five days of entering the system, medical case management for children with complex medical and behavioral health needs and coordinated routine exams.



Other Opportunities: Creating Foster Care Health Clinics

Examples: In **Worcester, MA**, the Foster Children Evaluation Services program within the University of Massachusetts Department of Pediatrics conducts health care evaluations upon entry into the foster care system, in collaboration with the Worcester Department of Children and Families.

Starlight Pediatrics (**Rochester, NY**) is the oldest centralized medical home for children in care in the nation. Services include universal health, mental and developmental screening, comprehensive health assessments, primary care, coordination of specialty referrals with child welfare, onsite mental health evaluations, health care management, and education to caregivers. A health summary is provided to child welfare after each child's health visit. Services are covered by Medicaid and managed care but these funds do not cover care management which is paid for by county dollars.



Other Opportunities: Establishing and Designating Special Child Welfare Managed Care Organizations

Examples: **Texas** was the first state to adopt a standalone MCO for children in foster care. Texas' STAR Health program provides health, behavioral health and dental care, and an electronic health passport, 24 hour nursing phone consultation and care management.

In **Illinois**, All children in out of home care receive health insurance through HealthWorks, a state sponsored PPO Medicaid health plan. Children are immediately eligible for insurance on entry into foster care. Child welfare nurse specialists who are registered nurses are assigned to each DCFS region to provide health care consultation. DCFS and the Department of Human Services run HealthWorks collaboratively. HealthWorks provides a designated medical home and specialized case management. The foster parent can choose any credentialed HealthWorks provider. These providers complete training and receive an enhanced reimbursement rate, including a monthly management fee, for each child they treat in foster care.



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