



*Webinar Series:
Medicaid services &
plans to address
vulnerable children's
health care needs*

Medicaid 301: Medicaid Funded Services for Children and Families with Complex Health and Social Needs

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casey family programs

November 7, 2019

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Before we Begin

- Lines have been muted to reduce disruptions
- Webinar will be recorded & posted at:
<https://www.casey.org/medicaid-webinar-series/>
- Pose questions throughout the session:
 - On the Zoom Platform: Select “Questions and Answers” dialogue button, type in your question, and hit send.
 - If attending by phone, email KMresources@casey.org.
- We will do our best to answer questions - either immediately, or in the Q&A portion at the end. If we don't cover your question, we will provide answers in a follow-up document sent to all registrants.
- Polling: Simply select your answer from the list in the pop-up window on your screen, and select “submit.”

Today's Presenters

Christine Calpin, Managing Director, Public Policy, Casey Family Programs, ccalpin@casey.org

Pamela Winkler Tew, Program Officer, Center for Health Care Strategies, ptew@chcs.org

Sheila Pires, CHCS Senior Consultant and Senior Partner, Human Service Collaborative, sapires@aol.com

Setting the Stage

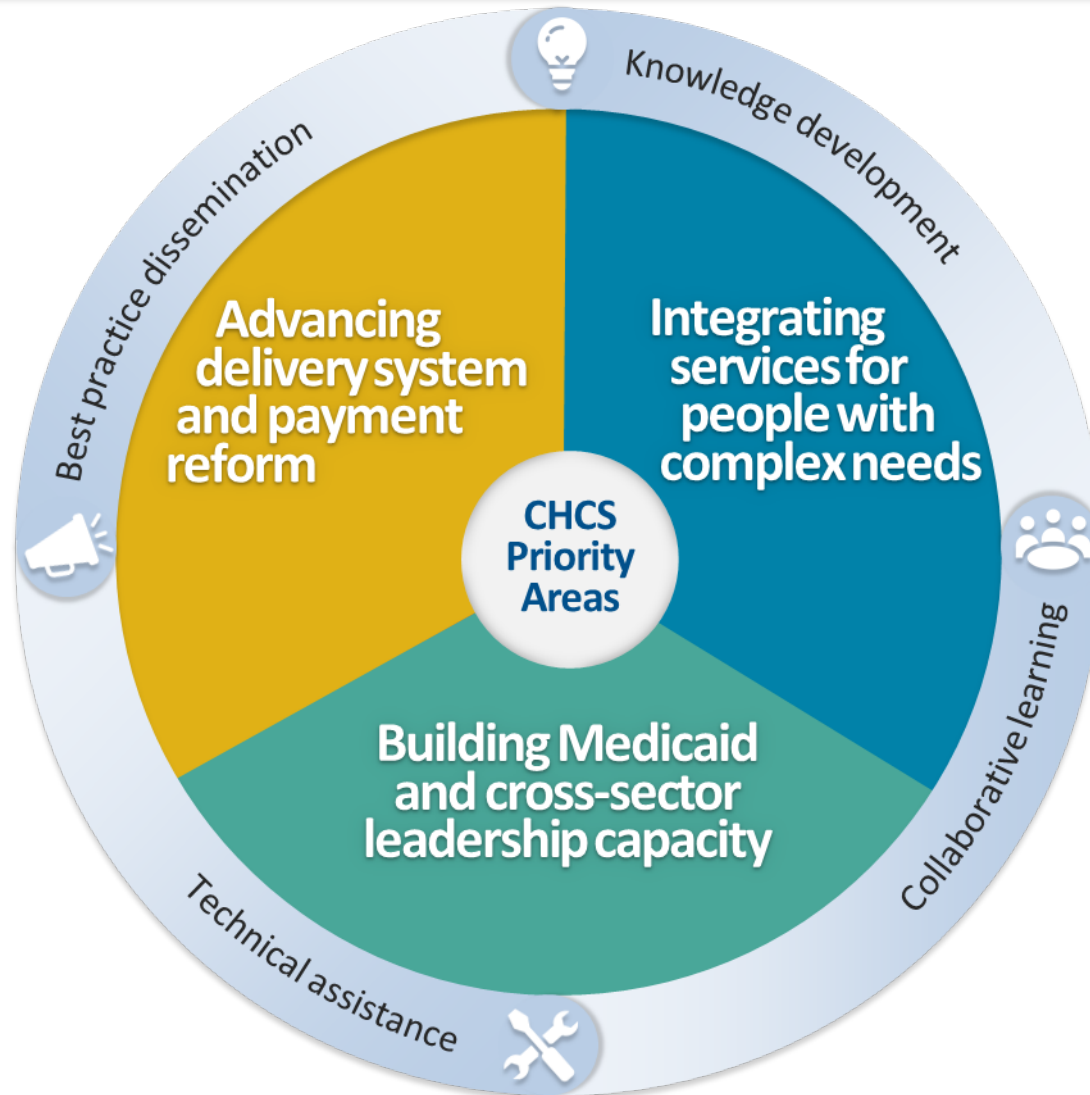
1. Current landscape, in light of Family First
2. The importance of partnering with Medicaid

Agenda



- Overview of Children in Foster Care in Medicaid
- Specific Medicaid Benefits
- Medicaid Strategies and State Examples
- Q&A

About the Center for Health Care Strategies



Medicaid Webinar Series

- **Medicaid 101:** This session looks at Medicaid Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) services and provides participants with a greater understanding of who and what is covered, addressing children's dental, complex behavioral health and mental health care needs, availability of waivers, and what it takes to amend state plans.
- **Medicaid 201:** This session looks at how Medicaid and child welfare relate through the lens of the Family First Prevention Services Act and provides participants with a better understanding of the avenues available for working with their Medicaid partners to create a service array that meets the needs of children, youth and families.
- <https://www.casey.org/medicaid-webinar-series/>

Goals of Presentation

- Understand why it is critical for child welfare agencies to work with their Medicaid partners
- Develop an understanding of how Medicaid can support services that are particularly applicable to child welfare
- Have a clear picture of the array of services supported by state Medicaid agencies across the country
- Develop an understanding of strategies used by states to address quality and cost concerns shared by Medicaid and child welfare

Why Medicaid is Essential to the Well-Being of Children in Foster Care

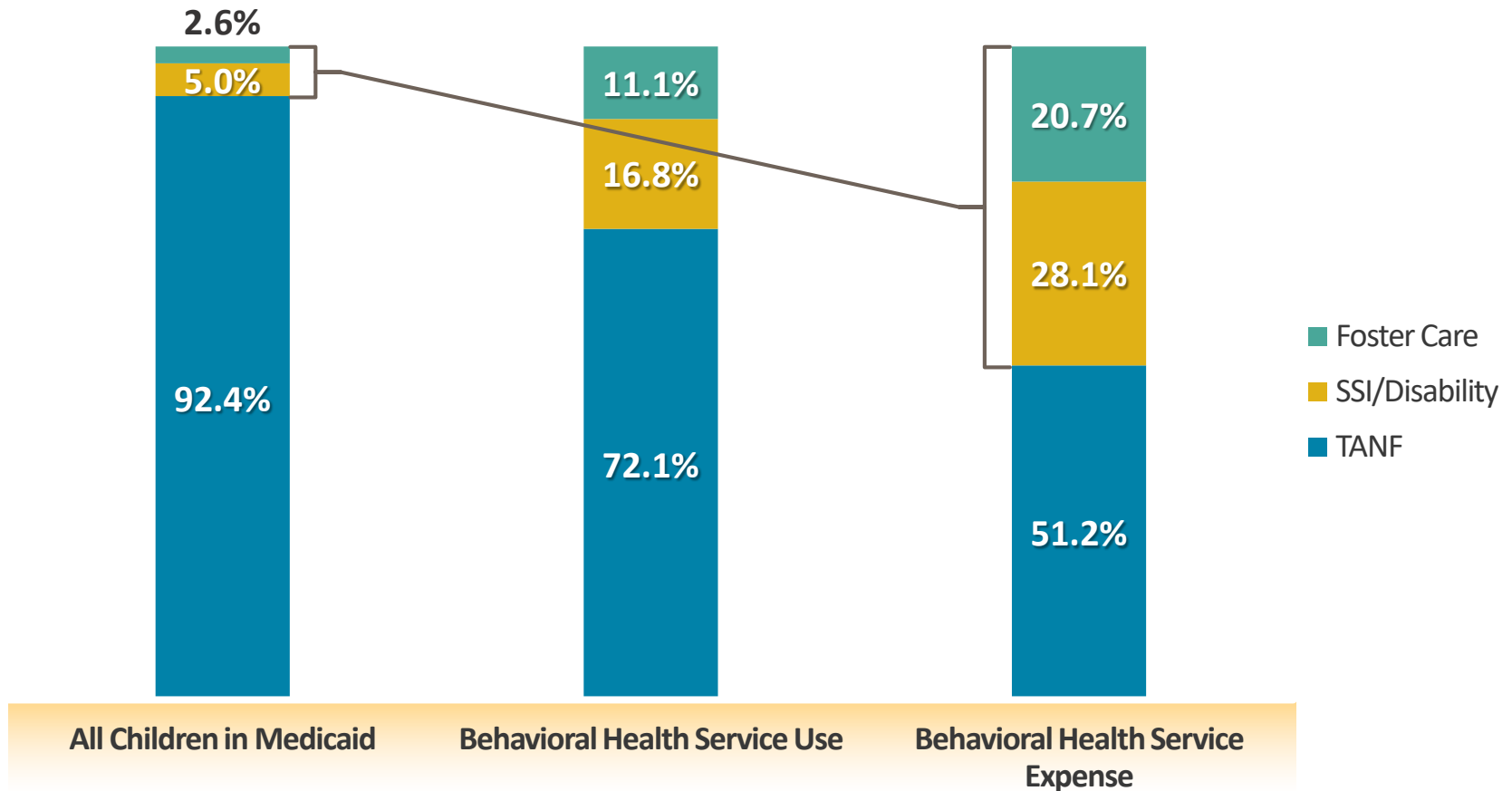
- Children in foster care have significant health and behavioral health needs
- They are not as healthy as Medicaid children in general (and Medicaid children are not as healthy as children in general)
- Chief among the health-related needs of children in foster care are behavioral health issues
- Most children in foster care are Medicaid-eligible
- Most children remain eligible for Medicaid when they leave foster care
- WI study – 85% remain eligible
- Children in foster care use more restrictive, more expensive services in Medicaid
- More likely to use inpatient psychiatric services, residential treatment, and psychotropic medications
- Child welfare was not intended to be a health or behavioral health care delivery system

Children's Faces of Medicaid Study

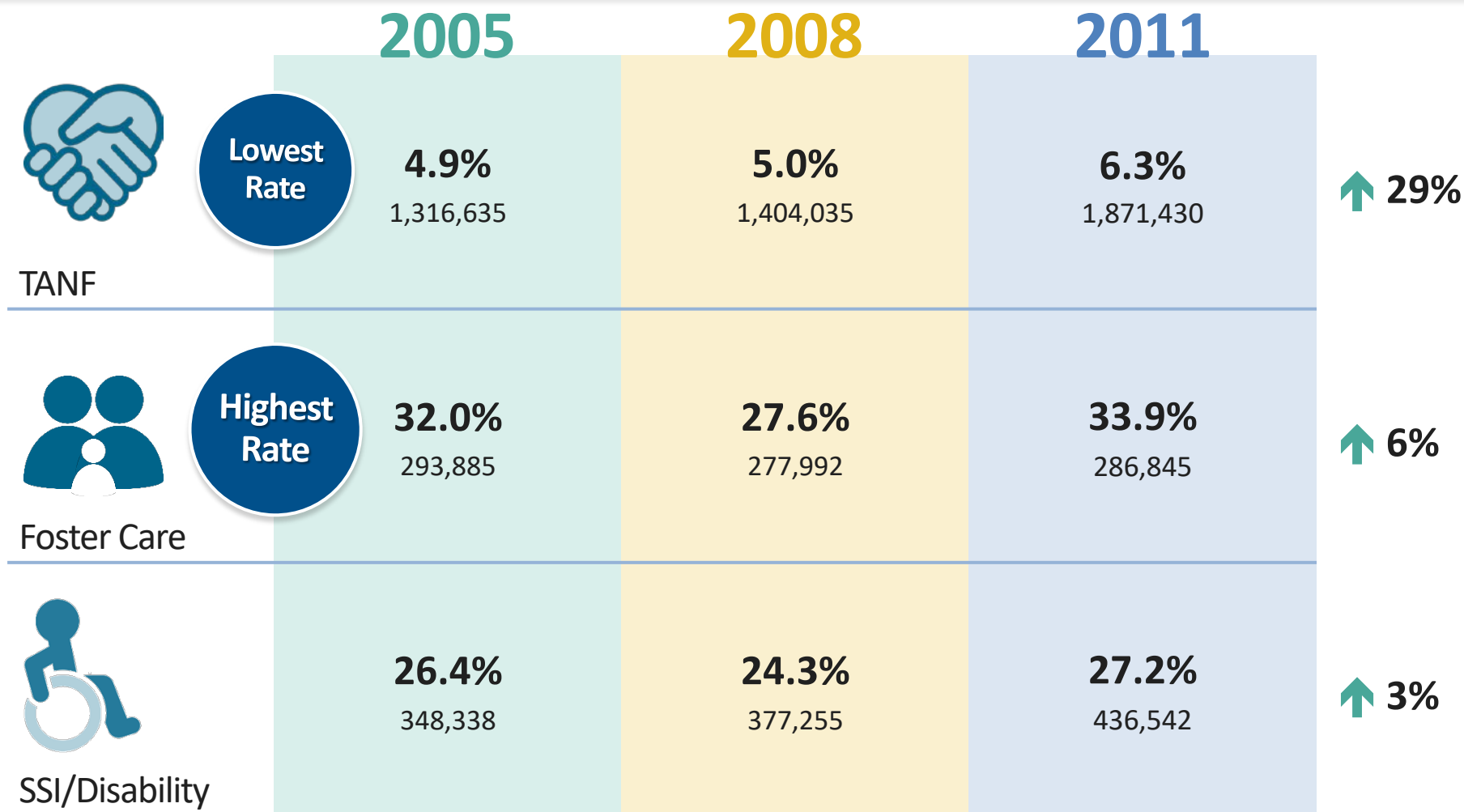
<https://www.chcs.org/resource/faces-medicaid-examining-childrens-behavioral-health-service-utilization-expenditures/>

Children in foster care represent less than 3% of the Medicaid child population, but they represent 11% of children in Medicaid who use behavioral health care and account for 21% of total child behavioral health spending in Medicaid.

CHART 4. MEDICAID ENROLLMENT, BEHAVIORAL HEALTH SERVICE USE, AND EXPENSE BY AID CATEGORY, 2011



Children in Foster Care Have the Highest Rate of Behavioral Health Service Use Among All Children in Medicaid



Rates of More Restrictive Behavioral Health Services and Psychotropic Medications Used by Children in Foster Care

- Highest rate of use for residential/group care
 - » 3x higher rate than TANF population
 - » 1.5x higher rate than SSI population
- Highest inpatient psychiatric hospitalization rate
 - » 69% higher than TANF population
 - » 12% higher than SSI population
- High psychotropic medication utilization rate and use of concurrent psychotropic medications

Source: Pires, S., McLean, J., and Allen, K., (2018) *Faces of Medicaid Data Series: Examining Children's Behavioral Health Service Use and Expenditures, 2005-2011*. Center for Health Care Strategies: Hamilton, NJ.

Psychotropic Medication Fast Facts

- 23% of children in foster care use psychotropic medications paid for by Medicaid (compared to 27% of children on SSI and 4% of TANF children)
- Children in foster care are more likely to receive 2 or more concurrent psychotropic medications than other aid categories of children – almost half of children in foster care receiving psych meds receive 2 or more
- Of children receiving 3, 4, or 5 or more of anti-psychotics, 42% are in foster care (42% are on SSI, 18% are TANF)
- Children in foster care have highest mean expenditures for psychotropic medications of any aid category of children – driven primarily by use of antipsychotics

- **Source:** Pires, S., McLean, J., and Allen, K., (2018) *Faces of Medicaid Data Series: Examining Children's Behavioral Health Service Use and Expenditures, 2005-2011*. Center for Health Care Strategies: Hamilton, NJ.

POLL: Has your state analyzed Medicaid data for children in foster care?

- Yes
- No
- Unsure

Medicaid Services for Children in Child Welfare

Types of Services Medicaid Can Cover

- Intensive Care Coordination Using Wraparound
 - Therapeutic Foster Care
 - Home Visiting Services
 - Family and Youth Peer Support
 - Mobile Response and Stabilization Services
 - Respite
 - Substance Use Services
 - Intensive In-Home Services
 - Screening and Assessment
 - Supported Independent Living
 - Evidence-Based Therapies
 - Other Home and Community Based Services
- Access may be constrained by: eligibility criteria (e.g. 1915c waivers, 1915i State Plan); enrollment caps (1915c waivers); medical necessity criteria; rates; provider capacity

CMS/SAMHSA May 2013 Joint Information Bulletin - Mental Health Services for Children and Youth

Intensive Care
Coordination:
Wraparound
Approach

Parent and Youth
Support Services

Intensive In-
Home Services

Respite

Mobile Crisis
Response and
Stabilization

Flex Funds

Trauma Informed Systems and
Evidence-Based Treatments
Addressing Trauma

Intensive Care Coordination: Wraparound Approach

Intensive Care Coordination

- Assessment and service planning
- Accessing and arranging for services
- Coordinating multiple services
- Access to crisis services
- Assisting the child and family to meet basic needs
- Advocating for the child and family
- Monitoring progress

➤ Need low care coordinator: child/family ratios (1:10)

Wraparound Approach

- Team-based process to develop and implement individualized care plans
- Focuses on all life domains
- Includes clinical interventions and formal and informal supports
- Wraparound “facilitator” is a dedicated care coordinator who organizes, convenes, and coordinates the process
- Child and family team for each youth that includes the child, family members, involved providers from child-serving agencies, key members of the child’s formal and informal support network
- **Examples:**
 - ✓ GA – Medicaid Rehab Option and Money Follows the Person
 - ✓ IN – 1915 i
 - ✓ LA – 1915 b/c
 - ✓ MA – Targeted Case Management-State Plan
 - ✓ PA – Medicaid Admin
 - ✓ OK – Health Home

Intensive In-Home Services

- Combination of therapy and behavioral consultation from licensed clinicians and skills training and support from paraprofessionals
- Small caseloads to allow team to work with the child and family intensively
- Therapeutic interventions delivered in homes and other community settings
- Improve youth and family functioning and prevent out-of-home placement in inpatient or residential treatment settings
- Typically delivered by a team
- Gradual transition to other formal and informal services and supports

Components

- Individual and family therapy
- Skills training
- Behavioral interventions

Examples:

- ✓ NJ – State Plan
- ✓ MA – State Plan

Peer Services: Parent and Youth Support Services

- Providers of peer support services are family members or youth with “lived experience” who have personally faced the challenges of coping with serious mental health conditions, either as consumer or caregiver
- Provide support, education, skills training, and advocacy in ways that are both accessible and acceptable to families and youth

Peer Support Services Include:

- Developing and linking with formal and informal supports
- Instilling confidence
- Assisting in the development of goals
- Serving as an advocate, mentor, or facilitator for resolution of issues
- Teaching skills necessary to improve coping abilities

Examples:

- ✓ NJ – Medicaid Admin
- ✓ TX – 1915 c
- ✓ AL – Medicaid State Plan
- ✓ AR – 1915i
- ✓ FL – 1115 (“in lieu” of service)

Respite Services

- Intended to assist children with living in their homes and community
- Temporarily relieve primary caregivers to promote child well-being
- Provide safe and supportive environments on a short-term basis
- Provided either in the home or in approved out-of-home settings

Examples:

- ✓ LA – 1915b/c
- ✓ MT – 1915 i

Mobile Crisis Response and Stabilization Services

- Defuse and de-escalate difficult mental health situations
- Prevent unnecessary out-of-home placements, particularly hospitalizations
- Provided in the home or any setting where crisis is occurring
- Crisis stabilization period with transition to ongoing services
- One-to-one crisis stabilizers

Examples:

- ✓ WI – State Plan
- ✓ CT – State Plan
- ✓ NJ – State Plan

Crisis Team

- 24/7 mobile crisis response in home and community
- Typically a two-person team is on call and available to respond
- May be comprised of professionals and paraprofessionals (including peer support) providing training in crisis intervention skills
- Works with child and family to resolve immediate crisis
- Helps them identify potential triggers and strategies to deal with future crises

Flex Funds: Customized Goods and Services

- Purchase non-recurring set-up expenses (furniture, bedding, clothing)
- One-time payment of utilities, rent or other expenses as long as the youth and family demonstrate the ability to pay future expenses
- Academic coaching, memberships to local girls or boys clubs, etc.
- Particularly useful when a youth is transitioning from residential treatment setting to family or independent living
- Available to individuals participating in various Medicaid waivers and/or the 1915(i) program

Examples:
MD – 1915i
LA – 1915 b/c

Trauma-Informed Systems and Evidence-Based Trauma Treatments

- Increased awareness of the impact of trauma
- Children and youth with most challenging mental health needs often have experienced significant trauma

Adverse Childhood Experience Study (ACES)

- Reported short and long-term outcomes of childhood exposure to trauma including mental health, health and social problems

Example:

- ✓ CT – training workforce in trauma-Informed care and providing training and coaching for clinicians in evidence-based practices such as Trauma-Focused Cognitive Behavioral Therapy
- ✓ NY – trauma as a qualifying condition for Medicaid health homes

Adolescent Substance Use Services CMS/SAMHSA Joint Informational Bulletin: January 2015

- Identification - Screening, Assessment
- Outpatient Treatment for Youth with Substance Use Disorders
 - » Individual Counseling/Therapies
 - » Group Counseling
 - » Family Therapy
 - » Intensive Outpatient Treatment
 - » Partial Hospitalization
- Medication-Assisted Treatment
- Case Management/Targeted Case Management
- Continuing Care
- Recovery Services and Supports
 - » Youth Peer-to-Peer Recovery Coaching/Peer Mentoring
 - » Technological Support Services
 - » Parent/Caregiver Support
- Residential Treatment

Example: VA, NJ - cover broad SUD benefit for youth

POLL: Do you know what services your state's Medicaid benefit covers?

- Yes
- No
- Unsure

Medicaid Strategies to Address Drivers of Poor Outcomes and High Costs for Children and Families in Child Welfare

Strategies to Address Drivers of Poor Outcomes and High Costs

- Driver: Use of emergency room for regular care or for chronic conditions such as asthma that can be managed on an outpatient basis
 - » Strategy:
 - Medical home, WI

- Driver: Inappropriate Use of Psychotropic Medications
 - » Strategies:
 - Red flag monitoring (too young, too many, too much) and consultation to/education of prescribers as in OR and WY
 - Psychiatric consultation to primary care docs as in MA (MCPAP)
 - Informed consent supported by access to psychiatric consultation as in IL and VT

Wisconsin Foster Care Medical Home and Wraparound Milwaukee Interface

Foster Care Medical Home:
Children's Hospital



Wraparound Milwaukee

- Designated primary care provider
- Coordination of medical care
- Coordination with behavioral health

- Credentialing of BH providers for Children's
- Mobile response and stabilization services
- Intensive care coordination using fidelity
- Wraparound for children with significant behavioral health conditions

Strategies to Address Drivers of Poor Outcomes and High Costs

- Driver: Use of Residential Treatment

- » Strategy: Effective home and community-based alternatives and intensive care coordination using fidelity Wraparound as in MA, NJ, WI

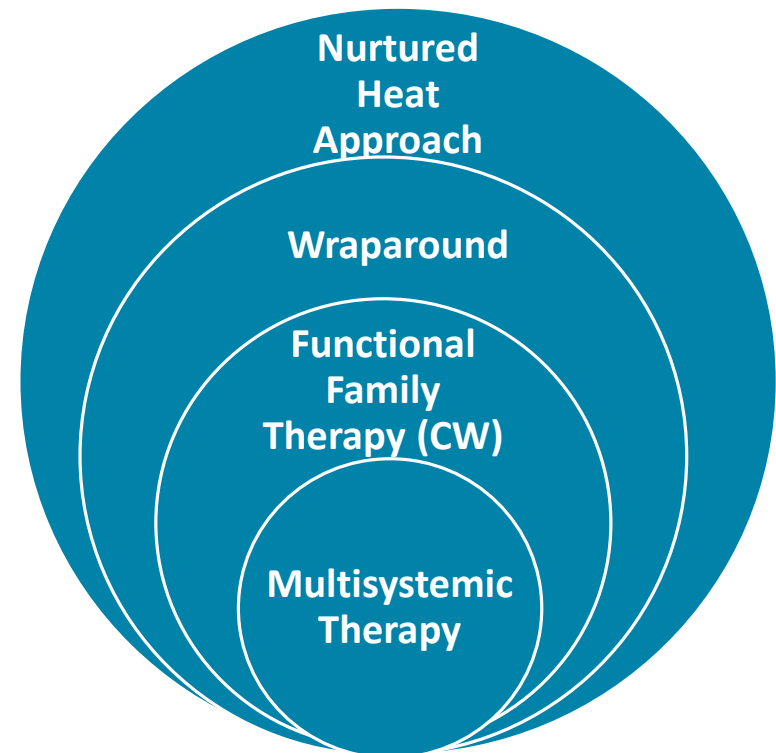
- Driver: Use of traditional outpatient therapies and difficulty accessing community mental health services

“Based on current evidence of the effectiveness of interventions in community mental health settings, there is no reason to assume that the outpatient mental health services provided to foster children are effective in improving outcome” (James, S., Landsverk, J., Slymen, D. and Leslie, L. Predictors of Outpatient Mental Health Service Use—The Role of Foster Care Placement Change Ment Health Serv Res. 2004 September; 6(3): 127–141)

- » Strategy: Enhanced rates to CMHCs to serve children in child welfare (MI) and to provide evidence-based practices (CT)

Evidence Based and Informed Approaches in New Jersey

- The Nurtured Heart Approach Large Scale Adoption
- Wraparound for youth with Moderate and Complex Needs with Behavioral Health, Substance Use, Intellectual/Developmental Disabilities, including children in child welfare
- Functional Family Therapy for youth engaged with Juvenile Justice and Child Welfare Systems
- Multisystemic Therapy specific for youth engaged with Family Court



Strategies to Address Drivers of Poor Outcomes and High Costs

- Duplication of Services (e.g., multiple assessments, multiple care coordination)
 - » Strategies: common screening/assessment tools; fidelity Wraparound approach with dedicated care coordinator, low ratios (1:10) – growing number of states
- Placement disruptions in child welfare (also associated with longer lengths of stay and higher costs for Medicaid)
 - » Strategies: Mobile Response and Stabilization – CT, NJ, WI, NV

Example of Maximizing Child Welfare and Medicaid Resources to Support Mobile Response and Stabilization Services Expansion

■ Milwaukee County, WI

- » Child welfare contributed \$500,000 in general revenue to expand mobile response and stabilization services to prevent placement disruptions in child welfare – approx. 40% of total cost
 - Dedicated teams
 - In-home crisis stabilizers
- » Is a Medicaid-billable service – Medicaid covers approx. 60% of cost
- » \$500,000 contribution by child welfare plus \$750,000 Medicaid Match = \$1.25m program expansion (approx.)

Strategies to Address Drivers of Poor Outcomes and High Costs

■ Driver: Failure to intervene early

» Strategies:

- Coverage of home visiting and early childhood interventions – MN
- Coverage of early childhood consultation, e.g. Michigan's Child Care Expulsion Prevention Program
- Coverage of early childhood home visiting – WA, ND

Addressing Parental Mental Health and/or Substance Use Disorders

Medicaid

- Cover mental health and substance use disorder services for adults who are eligible for Medicaid
- Cover evidence-informed interventions for Medicaid-eligible child that incorporate family engagement, education, skill-building and support, e.g. home visiting
- Cover 1:1 crisis stabilizers for child (WI, NJ, CT, NV)
- Cover family and youth peer support (growing number of states as State Plan service)
- Cover respite for families of child with special needs or serious behavioral health challenges

Child welfare

- Family First Prevention Services (for adults who are not Medicaid-eligible and for non-Medicaid covered services)

Mental Health and Substance Abuse

- Block grant funding for adults not Medicaid-eligible or services not covered by Medicaid

TANF

- Can be used for substance use counseling and linkage to services (not treatment)

POLL: Are you working with your state's Medicaid agency as you plan for Family First implementation?

- Yes
- No
- Unsure

Illustrating the Impact of State 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. 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, family peer support for his grandmother, care coordination, and use of a small amount of flexible funds to pay 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.*

Lessons from States: Customization for Children in Child Welfare in Medicaid

Medicaid service delivery and payment models need to reflect attention to state child welfare, Medicaid and behavioral health system policies and goals.

- Collaborative planning, design, implementation needed
- Explore potential for Medicaid match from child welfare – most children are Medicaid eligible; many services paid for by child welfare are Medicaid-allowable (NJ, AZ, MI)
- State agencies need to approach implementation in partnership with managed care entities

Some Immediate Next Steps – If you don't know already, find out:

- What services are covered under Medicaid for children, youth, young adults and adults?
- What Medicaid options are used to cover which services? e.g.
 - » 1915c waiver – has capped enrollment, defined population and certain services that only 1915c-eligible children can access
 - » 1915i State Plan Amendment – has defined population and certain services that only 1915i-eligible population can access
 - » State Plan Amendment – all Medicaid-eligible children can access if they meet medical necessity criteria
- What other factors may hinder access? e.g.
 - » Medical necessity criteria
 - » Provider availability – willingness to serve children and families in child welfare
 - » Rates
- What are the major concerns/pressures facing your State Medicaid agency? e.g. cost pressures, quality concerns – How can changes in Medicaid related to children and families in child welfare help the State Medicaid agency address these concerns?
- Is there someone in the State Medicaid agency who is or can become a champion within State Medicaid for child welfare?

Impact of Changing Environment

- More children in child welfare are enrolled in capitated managed care
- Greater interest among state funders and MCOs in value-based purchasing (outcomes tied to payment; inclusion of social determinants)
- Changes in entitlement programs – e.g. Title IV-E
- Child welfare and EPSDT lawsuits
- Federal and state budget issues

Next Webinar: Medicaid Managed Care

- What managed care is
- How managed care is organized in different ways in states
- Implications for children and families in child welfare
- How to customize Medicaid managed care design and contracting to address the needs of children and families involved in child welfare

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QUESTIONS?
COMMENTS?

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AND A LINK TO THE RECORDING & MATERIALS

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SUGGESTIONS TO KMRESOURCES@CASEY.ORG

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FOR ADDITIONAL RESOURCES

THANK YOU!