safe children | strong families | supportive communities

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 Panel

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

Stefanie Polacheck, Senior Program Officer, Center for Health Care Strategies, Stefanie Polacheck spolacheck@chcs.org

Sheila Pires, Senior Consultant at the Center for Health Care Strategies, and Senior Partner, Human Service Collaborative, sapires@aol.com

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Background Context

- Affirming our values and the national context
- Importance of understanding the range of resources that can be leveraged to support the outcomes we want for children and families, including prevention, placement with kin, and timely reunification, etc.
- Not recommending or endorsing one approach versus another; rather, providing information, considerations and examples for CW leaders to support engagement in these conversations

CHCS Center for Health Care Strategies, Inc.

Advancing innovations in health care delivery for low-income Americans

Introduction to Managed Care in Medicaid for Child Welfare

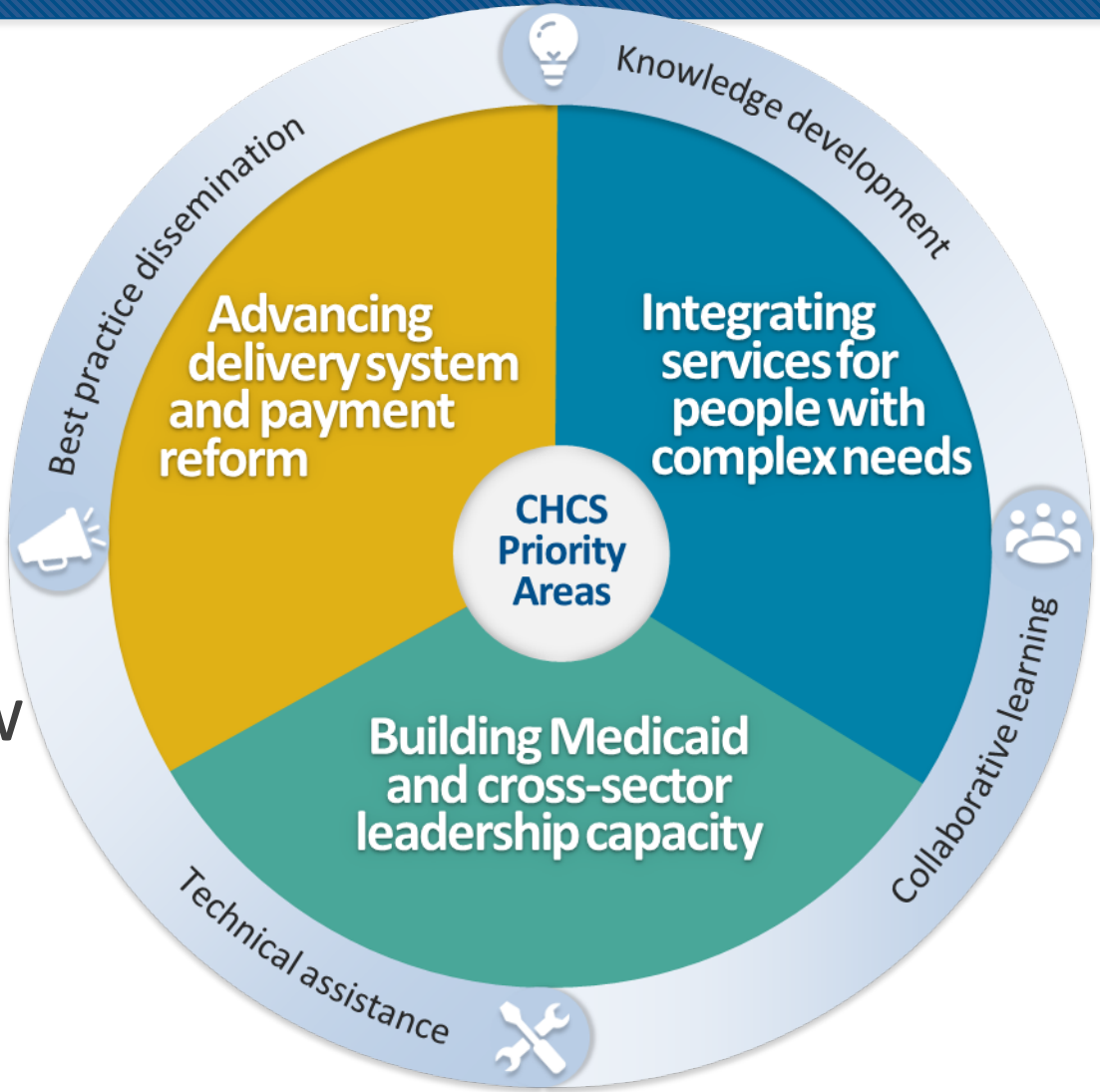
June 2, 2021

Sheila A. Pires, CHCS Senior Consultant and Managing Partner, Human Service Collaborative

Stefanie Polacheck, Senior Program Officer

About the Center for Health Care Strategies

A nonprofit policy center dedicated to improving the health of people with low incomes



Select CHCS Initiatives

Delivery System and Payment Reform

- Advancing Implementation of CDC's 6|18 Initiative
- Advancing Primary Care Innovation in Medicaid Managed Care
- Value-Based Payment Technical Support for the Medicaid Innovation Accelerator Program

Services for People with Complex Needs

- Community Management of Medication Complexity Innovation Lab
- Complex Care Innovation Lab
- Helping States Support Families Caring for an Aging America
- Promoting Integrated Care for Dual Eligibles

Medicaid and Cross-Sector Leadership Capacity

- Medicaid Leadership Institute
- State Medicaid Academies
  - California
  - Massachusetts
  - New Hampshire
  - New Jersey
  - Rhode Island
  - Vermont

Agenda

- Considerations and Context
- Definition of Terms and Trends
- Poll #1
- Customization for the Foster Care Population
- Poll #2
- Next Steps
- Q&A

Considerations and Context

- States have taken different approaches to Medicaid for serving the foster care population:
  - Exclusion from managed care
  - Standard managed care plans
  - Foster care-only specialty managed care plans
- As most states enroll the foster care population in managed care,[1] this session is intended to share information and considerations, as child welfare agencies and managed care entities have opportunities to increase collaboration and improve outcomes for children, youth, and families.

[1] 2018 Managed Care Features By Enrollment Population. Retrieved on January 12, 2021 from: https://data.medicaid.gov/Uncategorized/2018-Managed-Care-Features-By-Enrollment-Populatio/6e5c-d5iu/data.

Taking Stock of Various Options to Advance Outcomes

Medicaid & Medicaid MCOs
- Intensive in-home services
- Mobile crisis response and stabilization
- Wraparound
- Peer support
- TF-CBT, FFT, MST, MDTFC, PCIT
- Substance use disorder treatment
- Screening and assessment
- Workforce development

MCO Reinvestment Dollars
- Workforce Development
- CANS Implementation
- EBP Capacity Development
- Psychotropic Med Consultation

Examples:
- Magellan funded kinship navigators to help prevent placement disruption due to child's behavioral health challenges
- Value Options funded training for providers in the Incredible Years

Child Welfare (IV-E and IV-B)
- Team Decision Making
- Family Finding
- Strengthening Families
- Permanency Roundtable
- Workforce Development
- Kinship Supports
- Psychotropic Med Consultation

Other Systems (e.g., BH, PH, TANF, JJ)
- Workforce Development
- CANS Implementation
- Non-Medicaid families
- Psychotropic Med Consultation
- Nurse Home Visiting
- Housing supports
- Transportation

Definition of Terms and Trends

Definition of Managed Care

Centers for Medicare and Medicaid Services Definition

- Managed Care is a health care delivery system organized **to manage cost, utilization, and quality**.
- Medicaid managed care provides for the delivery of Medicaid health benefits and additional services through contracted arrangements between state Medicaid agencies and managed care organizations (MCOs) that accept **a set per member per month (capitation) payment** for these services.
- By contracting with various types of MCOs to deliver Medicaid program health care services to their beneficiaries, states can reduce Medicaid program costs and better manage utilization of health services.
- Improvement in health plan performance, health care quality, and outcomes are key objectives of Medicaid managed care.

Older Definition (Medical Dictionary)

Managed Care is a cost containment system that directs the utilization of health benefits by (a) restricting the type, level, and frequency of treatment; (b) limiting the access to care; and (c) controlling the level of reimbursement for services.

Risk-Based Financing

- Capitation: Purchaser pays management entity a fixed rate per eligible user
  - Incentives:
    - Prevent eligible users from becoming actual users (e.g., engage in prevention; make it difficult to access services)
    - Control the type and volume of services used
- Case Rate: Purchaser pays management entity a fixed rate per actual user who meets defined criteria
  - Incentive:
    - Control the type and volume of services used

Definitions of Key Terms

Integrated MCO: Financing and management of physical and behavioral health care are integrated (even if BH management is subcontracted out by prime managed care contractor)
Example: Tennessee

Behavioral Health Carve Out: BH services are financed and managed separately from physical health care
Example: Pennsylvania

Integrated with a Partial Carve Out: Financing and management of physical health and an "acute care" BH benefit are integrated and BH beyond "acute" is carved out in a separate financing and management arrangement
Example: Michigan

Population Carve Out: Financing/management of BH is in a separate arrangement for a specific population
Example: New Jersey

Or **Specialty Managed Care Arrangement** for health and behavioral health for a specific population
Examples: Texas, Florida, Georgia, Kentucky for the foster care population

Key Terms Definitions

Left Out: Services and/or populations that remain in fee-for-service; are not in managed care

Examples: Wyoming, South Dakota

Administrative Services Organization (ASO): Purchaser pays management entity an administrative fee; typically not risk-based

Example: Connecticut

Accountable Care Organization (ACO): Network of doctors and hospitals that share financial and medical responsibility for providing coordinated care to patients in hopes of limiting unnecessary spending and improving quality

Examples: Colorado, Oregon

Managed Care Trends: Integration at the Payer (Medicaid) Level

Research has shown that…

- When physical and behavioral health dollars are integrated, there is a risk of behavioral health dollars being absorbed by physical health services
- When adult and child behavioral health dollars are integrated, there is a risk of child behavioral health dollars being absorbed by adult services

…especially in the absence of customization within the design for children with serious BH challenges, children in foster care, risk-adjustment strategies, strong contractual performance measures, and monitoring mechanisms.

See publications and issue briefs published by the Health Care Reform Tracking Project at:
http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm

Managed Care Trends: Foster Care Carve Outs and/or Special Benefits

Advantages:

- Easier for child welfare staff and resource parents to deal with one MCO, rather than multiple MCOs
- Care is not disrupted if child moves from one county to another
- Focus of MCO is only on foster care population
- Might lend itself to better utilization and cost data on the foster care population to support quality initiatives

Managed Care Trends: Foster Care Carve Outs and/or Special Benefits

Concerns:

- TANF and SSI-enrolled children need the same service array as the foster care population (while prevalence rate for behavioral health is higher for children in foster care than TANF population, there are many more TANF children)
- Children's placement in foster care should be time-limited (median LOS in 2018 was 14.7 months; close to half of children who left care in 2018 were in care for less than one year), but children tend to remain Medicaid-eligible and in need of services
- Can lead to unintended consequence of parents having to relinquish custody to access care (especially an issue for children with serious behavioral health challenges)
- Child with an MCO (e.g., new to foster care) could have provider relationship disrupted if provider is not in foster care carve out network

Poll Questions

- Does your state have Medicaid managed care?
  - » Yes
  - » No
  - » Not sure
- If your state has Medicaid managed care, are children in foster care included in managed care?
  - » Yes
  - » No
  - » Not sure
- Does your state use multiple MCOs for the foster care population or one?
  - » Multiple MCOs
  - » One MCO
  - » Not sure

Customizing Medicaid Managed Care for Children in Child Welfare

How Might Medicaid MCOs Support System Reforms?

What Can MCOs Do?	
Put **families and youth with lived experience** on their advisory bodies and quality review teams	Engage families and youth with lived experience as **system navigators and peer mentors**
Pay for Wraparound, peer support, respite, in-home services, and mobile crisis and stabilization services – if not in State Plan or Waiver, as "substitution services" to prevent higher costs	Use reinvestment dollars to support **evidence-informed approaches**
Partner with State and providers on delivering quality care and **tracking outcomes**	Implement the CLAS standards for **health care equity**
Provide data on service utilization for children in foster care	**Support child welfare reforms**, e.g., Family First Prevention Services Act

Medicaid Managed Care: Services for Prevention and Family Supports

- States can engage MCOs in Family First planning efforts and MCOs can play a role in prevention.
  - » Consider how best to leverage Medicaid and child welfare funding to develop a robust prevention service array.

- Medicaid MCOs may cover services provided to parents under the following circumstances:
  - » The parent is Medicaid eligible, enrolled in their own managed care plan, and receives covered services as an individual
    - Examples: Psychotherapy, substance abuse treatment
  - » The parent participates in services directed to the child, covered by the child's MCO
    - Examples: Parent-Child Interaction Therapy, Family Peer Support

Eligibility and Enrollment: State Policies that Affect Access

- Presumptive eligibility or fast track enrollment
- Continued eligibility for youth transitioning out of foster care at age 18 (2014 ACA requirement – to age 26)
- Transition coverage upon leaving foster care (any age)
  - AZ: 60 days of coverage post-foster care exit
- Youth involved in both foster care and juvenile justice
  - Suspend rather than terminate Medicaid eligibility if youth is in juvenile justice facility – now required by SUPPORT Act

Considerations: Trauma-Informed Screening and Early Intervention

3/27/13 CMCS and SAMHSA Informational Bulletin and 7/11/13 SMD Letter

- Incorporate state child welfare requirements for physical, behavioral, and dental health screens within specified timeframes
  - AZ: Urgent response requiring behavioral health screen within 72 hours of entering care and "fast track" linkage to services
  - MA: Medical screening required within 7 days and comprehensive exam within 30 days, including behavioral health
  - MA: Mandate use of standardized screening tools and inclusion of behavioral and developmental (not only physical health) screens
- Quality payments for providers meeting trauma-informed standards
- May require enhanced rate (e.g., MA)

Considerations: Service Coverage

- Cover a broad array of behavioral health home- and community-based services (May 7, 2013 CMCS and SAMHSA Informational Bulletin)
  - AZ: In-home services; respite; life skills training; family and youth peer support; therapeutic foster care; case management; supported housing; supported employment; mobile crisis intervention; crisis stabilization; transportation; Wraparound process
  - MA: In-home services; family peer support; mobile response; therapeutic mentoring; behavior management therapy and behavior therapy monitoring; intensive care coordination using a Wraparound approach
  - NJ: Mobile response and stabilization; therapeutic group home care; treatment homes/therapeutic foster care; intensive care management; Wraparound process; behavioral assistance; intensive in-home/community services; transportation; youth support and development

Considerations: Diagnosis Requirement Flexibility

- Allow children to access some services without an initial mental health diagnosis
- California allows children under 21 to access family therapy without an initial mental health diagnosis if any of these risk factors exists:
  - Separation from a parent/guardian due to incarceration or immigration
  - Death of a parent/guardian
  - Foster home placement
  - Food insecurity, housing instability
  - Exposure to domestic violence or other traumatic events
  - Maltreatment
  - Severe and persistent bullying
  - Experience of discrimination based on race, ethnicity, gender identity, sexual orientation, religion, learning differences, or disability

Considerations: Provider Network

- Mandate inclusion of providers knowledgeable about the child welfare population
  - AZ: Sexual abuse, trauma
  - MA: State required same network of providers across all MCOs for behavioral health home- and community-based services (Rosie D); requirements for expertise in trauma-informed care
  - TN: Best Practices Network
- Allow out-of-network specialists if needed
- Develop protocols and practice guidelines related to children in foster care and interface with child welfare system
  - AZ: How to work with the child welfare agency and the courts; clinical needs of the child welfare population

Considerations: Orientation and Training

- Incorporate orientation/training for MCOs on foster care population, child welfare system, role of court
- Training for child welfare on MCO scope, requirements, and operations
- Incorporate training for Medicaid providers on effective practices
- Wraparound approach (MA, MI, NJ, LA, OK)
- Trauma-Focused Cognitive Behavioral Therapy and Parent Management
- Trauma-informed care (AZ, MA)
- Screening tools (MA)

Considerations: Customized Care Coordination

- Incorporate intensive care coordination using Wraparound approach for children with serious behavioral health challenges (CMCS/SAMHSA Informational Bulletin, May 7, 2013)
  - Growing number of states – MA, LA, NJ; PRTF Waiver Demo states; CHIPRA Care Management Entity Quality Collaborative states – better outcomes, lower per capita costs.
- Require that every child has a designated primary care provider and coordination between physical and behavioral health care providers
- Require coordination with Part C – Early Intervention (AZ)

Considerations: Psychotropic Medications

8/24/12 and 11/23/11 CMCS Informational Bulletin and SMD Letter

- Require tracking and monitoring of outlier use, e.g., too young, too many, too much, (growing number of states) – interface with Drug Utilization Review Board (WY)
- Require consultation to prescribers, including primary care providers (MA, VT, OR, NY, IL)
- Orient MCOs to state's informed consent and assent policies in child welfare
- Provide coverage and training for treatment alternatives (aggression, sleep disorders)

Considerations: Values-Based, Goal-Oriented Utilization Management Criteria

- Access: Require no prior authorization for basic behavioral health outpatient services (MA)
- Coordinated Care: Require that plans of care developed through Wraparound process determine medical necessity, with outlier management (AZ, MA, NJ, LA)
- Require no “fail first” criteria to access services or medication
- Prior authorization for certain psychotropic meds, e.g., antipsychotics for young children (MD)

Considerations: Data and Performance Requirements

- Require specific tracking and reporting of: Foster care population penetration rate and utilization (services and medications), stratified by age and race/ethnicity
- Performance expectations (not only HEDIS)
  - AZ: PH-access to primary care, adolescent well care visits, annual dental visits, immunization measures; BH-emotional regulation, avoiding delinquency, stability of living situation, substance abstinence, children in psych hospitals awaiting placements
  - NJ: PH-timeliness of assessments and comprehensive exams; exams in compliance with EPSDT guidelines; semi-annual dental checks; immunization measures; BH-access to BH services following EPSDT assessment; clinical and functional outcomes using CANS
- Require periodic focus groups/surveys with child welfare workers, youth, and families/caregivers
- Require electronic health record/health passport and interface with child welfare IT system (CCWIS/SACWIS)

State Example: New York State Medicaid MCO Data Requirements

MCO BH QM must review and analyze data and develop/approve interventions related to:

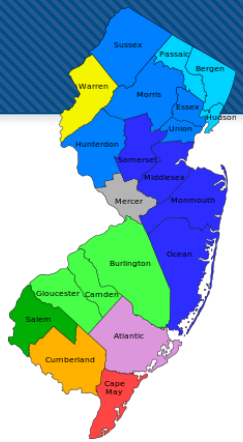
- **Under and over utilization of BH services** and cost data
- Inpatient admission and readmission rates, trends, and ALOS
- Inpatient and outpatient civil commitments
- Follow-up after discharge from MH inpatient, SUD inpatient, and residential
- SUD initiation and engagement
- ER and crisis service use
- BH prior authorization/denial and notices of action
- **Psychotropic medication use with a separate analysis for foster care**
- Rates of initiation and engagement of individuals with FEP
- Addiction medication use
- **Transition issues for 18-23-year-olds, focusing on continuity of care**

For children eligible for home- and community-based services:

- Use of crisis and crisis diversion services
- Prior auth/denial and notices of action
- **HCBS utilization**
- **HCBS quality assurance performance measures** as determined by the state and pending CMS requirements
- **Enrollment in Health Home**

Medicaid Managed Care Organization Children's System Transformation Requirements and Standards. Retrieved May 28, 2021 from: https://www.heah.ny.gov/health_care/medicaid/redesign/behavioral_health/children/docs/2017-07-31_mc_plan_rqmts.pdf

State Example: New Jersey Tracking & Reporting Evidence of Progress



- Increase in access to behavioral health care for children and youth
- Decrease in over-reliance on out-of-home treatment
- Decrease in over-reliance on detention with 9 centers closing
- Decrease by 70% the population of youth who are on probation
- The only state hospital has closed
- All children with behavioral health challenges are now being served within NJ
- Decrease in use of restraint, seclusion, and coercion in all out-of-home treatment interventions.

Considerations: Administrative Requirements

- Designated liaison within MCO to child welfare system
- Regular meetings between MCOs, Medicaid, and child welfare system for trouble-shooting and quality improvement
- Inclusion of families and youth with lived experience in quality review process, as system navigators, peer mentors, and advisory body members
- "Warm line" for child welfare workers and caregivers
- Require reinvestment back into child home and community services
- Capacity to train, coach, and develop the capacity of providers, administrators, staff, families/youth to implement desired reforms ("Centers of Excellence")
- Designate child health units or staff in child welfare to interface with MCOs; Medicaid administrative case management and Title IV-E can both be used to help finance this capacity (NJ, UT)

Poll Question

- Do you know which Medicaid managed care organizations are in your state?
  - Yes
  - No
  - Not sure
- Are you partnering with MCOs to improve outcomes for children and families, such as through Family First Prevention Services Act planning and implementation?
  - Yes
  - No
  - Not sure

Moving forward

Considerations: Child Welfare Collaboration with Managed Care

- Understand how Medicaid managed care is organized in your state
- Determine whether children in foster care are included in Medicaid managed care in your state
- Find out what the requirements are of Medicaid managed care organizations with respect to children in foster care and children and families involved with the child welfare system
- Build relationships with your state Medicaid agency to have input into contract specifications and quality improvement initiatives for the child welfare population
- Build relationships with Medicaid MCOs to educate them about child welfare and launch quality improvement initiatives
- Consider how you can bring those with lived experience to better inform the work and collaboration with MCOs

Question & Answer

Visit CHCS.org to…

- **Download** practical resources to improve the quality and cost-effectiveness of Medicaid services
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PLEASE SEND ANY FOLLOW-UP QUESTIONS OR SUGGESTIONS TO KMRESOURCES@CASEY.ORG

THANK YOU!