

How can Medicaid-funded services support children, youth, and families involved with child protection?

BY THE [CENTER FOR HEALTH CARE STRATEGIES](#)

Nearly all children and youth involved with a child protection agency are eligible for Medicaid, which is their primary source of funding for physical, behavioral, and dental health care. The extent to which the Medicaid benefit structure and service delivery system are customized for children in child protection is critical to whether states can meet the federally mandated goals of safety, permanency, and social and emotional well-being. It is well documented that children involved with child protection have significant health care needs. Nationally, their expenditures in Medicaid are driven more by behavioral health care than physical health care, illustrating the critical importance of effective Medicaid delivery systems in all facets of care.

Some states have undertaken collaborative efforts across child protection, Medicaid, and behavioral health systems to ensure that Medicaid financing can help meet the needs of children and their caregivers. These collaborations can inform other states about effective Medicaid financing strategies and how to approach necessary systemic changes. This brief describes the fundamentals of Medicaid financing, covered services, and coverage of evidence-based practices as they relate to services for children and youth involved with a child protection agency.



ISSUE BRIEF

TRANSFORMING CHILD WELFARE SYSTEMS

Medicaid financing

Medicaid is jointly financed through a partnership between the federal government and states in which state funds are matched by federal funds to pay for services covered by Medicaid. State funds that are used for the match can come from various department budgets that consist of state general funds.

Some states use child welfare general state revenues as the state or “non-federal” match to expand home- and community-based services. State dollars used for these Medicaid-covered services draw federal match dollars at a 50% or higher match rate, so use of child welfare general revenue for Medicaid-eligible services for children in foster care, most of whom are Medicaid-eligible, makes more sense than spending 100% state-only dollars. For example, in Milwaukee County, Wis., the child welfare system provided \$450,000 in state match funding to expand mobile response and stabilization services for children involved with the child protection agency. Paired with the federal Medicaid match, this contribution supported a \$650,000 program expansion without need of additional state dollars. If child welfare general revenue is redirected for use as a state Medicaid match, there must be assurances that children in child protection receive services in compliance with Medicaid regulations. Robust communication mechanisms between the state Medicaid and child protection systems are critical to resolve issues that may arise.

Medicaid-covered services

Medicaid provides a benefit package that includes various services to address medical needs, including behavioral health needs. Within Medicaid there is a comprehensive set of key services that most children involved with child protection should have access to in order to address their needs.

Screening and assessment

State child protection agencies typically have timeframes for which children entering foster care must have physical and behavioral health screenings and assessments to address needs as soon as possible. State Medicaid agencies can require that [Early Periodic Diagnosis and Treatment](#) screenings include a comprehensive physical, developmental, and behavioral health assessment; they can further require that screenings occur within the stipulated timeframes. For example, 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 protection, enhanced rates were negotiated for this medical examination. Mental health screening is also required for children in out-of-home placements and must be completed within the first 30 days.

Home- and community-based services

A robust Medicaid benefit plan covering a broad range of home- and community-based behavioral health services and supports is essential to enable children to remain in home and community settings. In addition to traditional treatment services — such as individual, group, and family therapy; medication review and administration; and evaluation — children involved with child protection need access to a variety of additional services. States may

provide these services through the Medicaid benefit plan, home- and community-based waivers, and/or state general funds. Following are key services for children involved with child protection agencies:

- Intensive in-home services
- Intensive care coordination using fidelity Wraparound
- Mobile crisis response and stabilization
- Therapeutic foster care
- Respite care
- Family and youth peer support
- Family training
- Substance use treatment
- Therapeutic mentoring
- Behavioral assistance
- Non-emergency transportation

Several of these services are particularly important for children and families involved with — or at risk of involvement with — the child protection system. [Intensive in-home services](#) includes treatment, in-home behavioral support, and education for caregivers on how to manage challenging behaviors, learn new skills in parenting, and address other family issues that may contribute to stress in the home. [Family peer support](#) provides families with partners who have lived experience to serve as mentors and advocates during the service delivery process, which greatly increases family engagement. Similarly, [youth peer support](#) can be especially helpful to older youth in the child welfare system, including those who are aging out.

Intensive care coordination

Coverage of intensive care coordination at low care coordinator to child ratios (1:8 to 1:10) is critical for children with complex needs who are involved with multiple systems. Many state Medicaid programs reimburse for intensive care coordination (ICC) using fidelity [Wraparound](#) (ICC/Wraparound). Massachusetts Medicaid covers ICC/Wraparound through a redefinition of targeted case management to support a wraparound practice model. New Jersey also uses targeted case management billing codes to reimburse for intensive care coordination provided through its care management organizations, which use a wraparound approach.

Mobile crisis response services

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

COVERED SERVICES IN NEW JERSEY

Three new services were added to the Medicaid benefit package as a result of an 1115 Medicaid Waiver: youth support and development; services for youth in transition to adulthood; and non-medical transportation that is part of a child and family's individualized service plan.

Additionally, flexible funds are available to pay for services and supports that are part of the individualized service plan but not covered by Medicaid, such as tutors and housing assistance.

Coverage of evidence-based practices

Specific coding strategies are needed to cover evidence-based interventions, particularly behavioral health interventions relevant to children served by child protection, including [Trauma-Focused Cognitive Behavioral Therapy](#). In Arizona, providers can bill these services to Medicaid using the billing code for [Multisystemic Therapy](#). Other evidence-based practices that do not have a distinct billing code are reimbursed using existing codes for services such as assessment, case management, and therapy. Billing code matrices were developed to help providers determine how to bill Medicaid in their states for practices such as [Functional Family Therapy](#), [Multidimensional Treatment Foster Care](#), and [Cognitive Behavioral Therapy](#).

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

Additionally, in some states, Medicaid benefits are supplemented by state funds that are used to finance services that are not eligible for Medicaid-financing. For example, child welfare funds may pay for room and board while Medicaid funds pay for therapeutic services and, in some states, for respite.

Additional Medicaid contributions

Beyond paying for health care services, Medicaid collaboration can be helpful for setting policy, accessing data, and directing the type and quality of health care in a state. Child protection agencies may also find it beneficial to work closely with Medicaid to access claims data to track the provision of services, leverage Medicaid's ability to set policy, including provider type and qualifications, and measures of outcomes and performance. The financing and oversight of the benefit plan is Medicaid's primary role, but these additional roles can also provide benefits for children involved with child protection.

Monitoring and consultation on psychotropic medications

Children and youth involved with child protection are prescribed psychotropic drugs at a higher rate than Medicaid-enrolled children in general and are at higher risk for [polypharmacy](#). Medicaid is the primary payer for these psychotropic medications and, in many states, child protection and Medicaid leaders are collaborating to determine best practices, ensure effective monitoring, and implement relevant practice protocols. For example, Massachusetts has implemented consultation to primary care practitioners on the appropriate use of psychotropic medications. In addition, data from the Medicaid pharmacy system are analyzed for children involved with child protection to identify outliers, including both children and prescribers, so that a system to address these cases can be implemented. This is an example of how Medicaid claims data can be beneficial. Medicaid can partner with child protection agencies to ensure children receive psychotropic medications appropriately.

DEVELOPING QUALIFIED PROVIDERS

- A specialty provider initiative in **Arizona** sought to develop expertise to ensure that the Medicaid behavioral health provider network includes providers with specific skills. The state developed practice protocols that outline procedures for coordinated service planning and delivery to guide behavioral health service delivery to children in child welfare.
- **Tennessee** developed a Specialty Provider Network for the child welfare population within its Medicaid managed care system.

Qualified providers and practice protocols in the Medicaid network

Medicaid providers trained in effective practices are fundamental to providing high-quality care. Providers are needed with expertise relevant to issues such as sexual abuse, attachment disorders, and trauma. Medicaid can set provider expectations to assure the provider system has the necessary set of qualifications. Additionally, practice guidelines and protocols are important to highlight the unique needs of the children involved with a child protection agency. Child protection and Medicaid can work together on policy development and practice protocols to positively influence the service delivery system and assure high-quality effective services are provided to children involved with child protection.

Tracking child protection-related outcomes, and expenditures

A critical strategy is to incorporate and monitor performance expectations specific to children involved with child protection, and to track service utilization, outcomes, and expenditures for this population. Collecting this information from Medicaid managed care entities and providers allows Medicaid, child protection, and behavioral health to make decisions based on data and implement strategies to improve quality and outcomes. In Massachusetts, data are collected to track the number of children in psychiatric hospitals awaiting placement, which has

been reduced significantly, likely due to tracking this data. In New Jersey, outcomes-based contracts are used with providers that require information on key indicators, some particularly relevant to child protection, such as stability of children and families, well-being, and permanency.

Leveraging the Family First Prevention Services Act

What distinguishes states with more effective Medicaid delivery systems is their long-standing collaborative approaches between child protection, Medicaid, and behavioral health systems that respect the pressures facing each system while also developing common goals and understanding of the unique needs of this population. Often, federal opportunities create further incentive for child protection and Medicaid systems to work together to improve the quality and lower the cost of physical and behavioral health care for children in child welfare. A recent mandate in child protection, the [Family First Prevention Services Act](#), provides an opportunity for these systems to develop an evidence-based service array to both prevent the entry of children into foster care and placement disruption among children who are in adoptive or relative guardian homes. The act calls on states to develop an array of effective mental health, substance use, and parenting programs, some of which can be funded through Medicaid and others through child welfare Title IV-E.

There are many tools within Medicaid to support the needs of children and families involved with child protection, including direct Medicaid financing models, and policy and claims data. Collaboration between child protection and Medicaid, as well as with behavioral health and public health systems, will ensure the most efficient use of resources, maximize access to services, ensure high-quality care, and achieve positive outcomes for children, youth, and families.



This technical brief was developed by the [Center for Health Care Strategies](#) and Sheila A. Pires as part of a series designed to help state child welfare agency staff understand the Medicaid landscape, and to coordinate with their Medicaid partners in providing timely and quality health-related services to children and youth in foster care. This builds on earlier work by Ms. Pires, Human Service Collaborative, and Beth Stroul, Management and Training Innovations, and complements three other briefs that cover options for ensuring consistent Medicaid eligibility and Medicaid financing for children's residential treatment.

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