

# What are promising practices for using Medicaid State Plan Amendments and waivers to address the needs of children and youth in foster care?

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

Virtually every child and youth in foster care is eligible for Medicaid and receives health care services through a Medicaid provider. Children in foster care are [more likely](#) to have both physical and behavioral health conditions requiring treatment. Given the shared responsibility that Medicaid and child welfare agencies have for this population, state agencies are increasingly looking to collaborate more effectively to improve health outcomes for children and youth involved in the child welfare system. Part of this process requires a shared understanding of the financing mechanisms available to fund services through Medicaid.

State Medicaid agencies have two primary vehicles for making changes to the services and benefits provided to beneficiaries: state plan amendments (SPAs) and waivers. This issue brief outlines how these vehicles are structured and how they may be used to address the health needs of children and youth involved in the child welfare system.



## State Plans

A Medicaid state plan is an agreement between a state and the federal government describing how that state will administer its Medicaid program. Through the state plan, the state provides assurance of how it will abide by federal rules. It also defines the parameters for how and when the state will be able to claim federal matching funds. The state plan describes the groups of individuals to be covered, services to be provided, methodologies to reimburse providers, and administrative activities in the state. Given that state plans address programmatic areas that comply with federal rules, no waivers are required for services addressed within the state plan. Further, the federal government negotiates the state plan through one part of state government (referred to as the “single state entity”) even if the administration of certain Medicaid services and financing are delegated to other entities within state government. For example, the state Medicaid agency may be the “single state entity” and negotiate certain services that are delivered by and with the match funding provided by the Department of Mental Health.

## State Plan Amendments

A state’s Medicaid state plan does not have to be updated unless a change is made. When updates are needed, agreement between the state and federal government is facilitated through the state’s submission of a State Plan Amendment (SPA). Given that state plans address programmatic options allowed under existing federal rules, SPAs are only used to make changes to a state’s plan that also comply with existing federal rules. Any changes proposed in a SPA must:

- Be a permanent Medicaid state plan change;
- Apply statewide;
- Have comparability of services (i.e., services available to any categorically needy recipient are not less in amount, duration, and scope than those services available to a medically needy recipient); and
- Allow for choice of providers (managed care exception).

Unlike waiver proposals (discussed below), SPAs do not need to be budget neutral. Once approved by the federal government, changes made through a SPA remain in place indefinitely and do not require renewal.

Examples of optional benefits to address the needs of a specific population, such as child-welfare involved children and youth, can be implemented through a SPA are:

- **Targeted Case Management:** Medicaid allows states to implement [targeted case management](#) (TCM) services for specific groups of beneficiaries throughout their state. These services include case management aimed at addressing physical health, behavioral health, and social needs through referrals and coordination of care. A long-standing concern about the use of TCM for child welfare-involved children relates to the case management function provided by the child welfare agency and the potential for trying to maximize federal Medicaid dollars for those services. States

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using TCM for their Medicaid-covered child welfare/foster care population will need to be clear about the services each will cover.

- **Rehabilitation Option:** Rehabilitation services are used in many ways, most often for the rehabilitation of individuals with mental health needs. These services are delivered in community-based settings, including the home, and vary significantly based on the state and population they serve. States also may use the Rehab Option to pay for the therapeutic component of residential treatment, therapeutic group homes and therapeutic foster care. The [Rehab Option](#) has been widely adopted among states as it allows them to expand the service array and types of providers available to address the mental health, substance use and physical health treatment needs of Medicaid beneficiaries. It is applicable to children and youth in foster care covered by Medicaid.

### Medicaid Waiver Authorities

If a state is interested in the flexibility to implement services or coverage for a population not allowed under existing federal rules and receives federal matching funds to do so, the state may request this flexibility through a [waiver](#) of specific federal Medicaid rules. Existing federal law provides the federal government the ability to waive specific provisions of Medicaid policy in order to demonstrate certain innovations as long as the proposed waiver request advances the purposes of Medicaid. Certain Medicaid program elements are not able to be waived, such as the federal matching payment system known as the Federal Medical Assistance Percentage.

Unlike SPAs, states must demonstrate that their waiver proposals are budget neutral, meaning that the federal government will pay no more with the waiver in place than they would if it were not. Waivers are approved for a specific time period that varies based on waiver type, and must be renewed if the state would like to retain the flexibility provided.

### Relevant Waivers

Various provisions of federal law provide the Centers for Medicare & Medicaid Services (CMS) with the ability to waive certain Medicaid policies. Two key waiver options relevant to support services for child-welfare involved populations include: (1) 1915(c) home-and community-based services (HCBS) waivers; and (2) 1115 research and demonstration project waivers.

Within broad federal guidelines, states can develop [1915\(c\) HCBS waivers](#) to meet the needs of Medicaid beneficiaries for whom long-term services and supports in their home or community are more appropriate than in an institutional setting. As of May 2020, forty-seven states and the District of Columbia currently operate at least one 1915(c) waiver. There is no limit on the number of HCBS waivers a state may operate — currently, more than 300 HCBS waiver programs are active nationwide. In 2009, nearly 1 million individuals were receiving services under HCBS waivers.

[Under the 1915\(c\) Cost Neutrality Policy](#), states must assure that the average per capita expenditure during each waiver year not exceed 100 percent of the average per capita expenditures that would have been made during the same year for the level of care



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### Managed Care Implementation through SPAs and Waivers

The majority of states deliver some or all Medicaid services through [managed care organizations](#) (MCOs). Increasingly, children in foster care are enrolled in managed care some states enroll children in foster care in specialty MCOs that are only responsible for children in foster care. SPAs and certain waivers are used to create the managed care model used in a state and support the implementation of Medicaid managed care programs to provide additional opportunities to address the unique health-related needs of this population by waiving certain federal requirements. Managed care plans also have the flexibility to use reinvestment dollars and what is called “in lieu of services” to provide services that are outside of the state plan.

### Jurisdictional examples

#### Innovations Using Medicaid State Plan Amendments

- **Massachusetts:** Following a class-action EPSDT lawsuit and significant reform regarding all Medicaid funded children’s behavioral health services, Massachusetts used a SPA to allow the use of targeted case management (TCM) to implement Wraparound Intensive Care Coordination for children with behavioral health needs, as well as intensive in-home services, family support, and therapeutic mentoring. Massachusetts also uses the Medicaid Rehabilitation Services Option to assist children and youth with disabilities, including those with serious behavioral health needs, to live in community-based settings.
- **New Jersey:** New Jersey uses the Medicaid Rehabilitation Services Option to support community-based services within their [Children’s System of Care](#), and uses TCM to ensure care coordination using Wraparound for children with serious behavioral health needs.

#### Innovations Using Home- and Community-Based Waivers

- **Michigan:** [Michigan uses a 1915\(c\) waiver](#) for youth in child protection with serious emotional disturbances who meet the criteria for risk for psychiatric hospitalization without intensive community-based services. The state shifts child protection funds to the behavioral health authority to maximize the Medicaid match. This provides increased dollars for more intensive home- and community-based services for children and youth who show “substantial impairment” on the Child and Adolescent Functional Assessment Scale. Services are delivered within a system of care framework.
- **New York:** New York has a series of home- and community-based services (HCBS) waivers; the waiver for children in foster care is known as Bridges to Health and is accessible only to children and youth in foster care. Several waivers in NY have been [combined into one single](#) 1915(c) Children’s Waiver and address services for children with serious emotional disturbance, developmental disability, or who are medically fragile, and provide for services, such as accessibility modifications, crisis response, care coordination, and respite, among others.

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- **Utah:** Historically, Utah’s 1915(c) HCBS waiver for children and adults with developmental disabilities was used to support children and youth in foster care; however, it did not specifically say so. In 2004, CMS [heavily scrutinized](#) the use of the waiver for youth in foster care, but in the end approved “exceptional needs payments” for caregivers.
- **Wisconsin:** Wisconsin uses a 1915(c) waiver to reimburse foster care providers who care for children or youth with increased physical, emotional, and/or behavioral health needs at a higher, or exceptional, rate above other set rates. Many conditions are noted for their correlation to the need for increased personal care. During its waiver renewal process in 2003, Wisconsin clarified that funds will not be used to cover Title IV-E eligible costs, such as room and board or maintenance payments to address [CMS’ concerns regarding third-party liability](#).

**Innovations Using 1115 Research and Demonstration Project Waivers**

- **Arizona:** [Arizona](#) was the last state to implement Medicaid in 1982 and did so in conjunction with an 1115 Waiver to operate managed care. The waiver provided the state broad flexibility to implement innovative strategies for children and youth in foster care. There is a single Medicaid physical and dental health plan for children and youth in foster care. Behavioral health services are delivered through a managed care system overseen by the Arizona Department of Health Services, Division of Behavioral Health Services. Within this structure, Arizona strives to serve children and youth in foster care, incorporating:
  - \* Risk-adjusted rates;
  - \* Using child welfare funds to draw down additional Medicaid match;
  - \* Specific child welfare-focused Medicaid practice guidelines and protocols;



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- \* Co-location of behavioral health and child welfare staff;
  - \* Respite and family peer support;
  - \* 72-hour behavioral health screens following a child's entry into care;
  - \* Focus on appropriate psychotropic medication use;
  - \* Specialty providers; and
  - \* Utilization tracking for child welfare involved children and youth.
- **Massachusetts:** Under an 1115 waiver in place since 1997, [Massachusetts](#) operates a capitated managed care system described as a physical health and behavioral health integrated care system. Within this system, the state provides the following for children and youth, including those in child protection:
    - \* Mandatory behavioral health screening (part of EPSDT);
    - \* A continuum of HCBS services;
    - \* Peer support; and
    - \* Mobile crisis with longer-term crisis team involvement.

### Conclusion

There are several options for states seeking to use Medicaid provisions to improve access to behavioral health services for children and youth in foster care. In implementing any of these programs, state Medicaid, child welfare, and behavioral health agencies need to work collaboratively to ensure that the program design meets both the requirements of the Medicaid program and the needs of the population being served.



*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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