NWIC | National Wraparound Implementation Center

Advancing Systems ✦ Enhancing the Workforce ✦ Improving Outcomes

Designing and Financing Systems of Care

Suzanne Fields and Dayana Simons

September 11, 2017

10:30a-12:00p

Portland State University

University of Washington

University of Maryland School of Social Work

THE INSTITUTE FOR INNOVATION & IMPLEMENTATION

SOC Financing Based On Design

- You can do most anything if you define:
  - What it is you want to do
  - How you want to do it
  - Why it should be done

FIRST

Did You Know?

An estimated 1 in 10 youth meets SAMHSA criteria for a Serious Emotional Disturbance (SED), defined as a mental health problem that has a significant impact on a child's ability to function socially, academically, and emotionally.

Among children aged 10 to 14 in 2016, death by suicide was more common than death from traffic accidents.

50% of adult mental illness manifests by the age of 14; 75% by the age of 24.

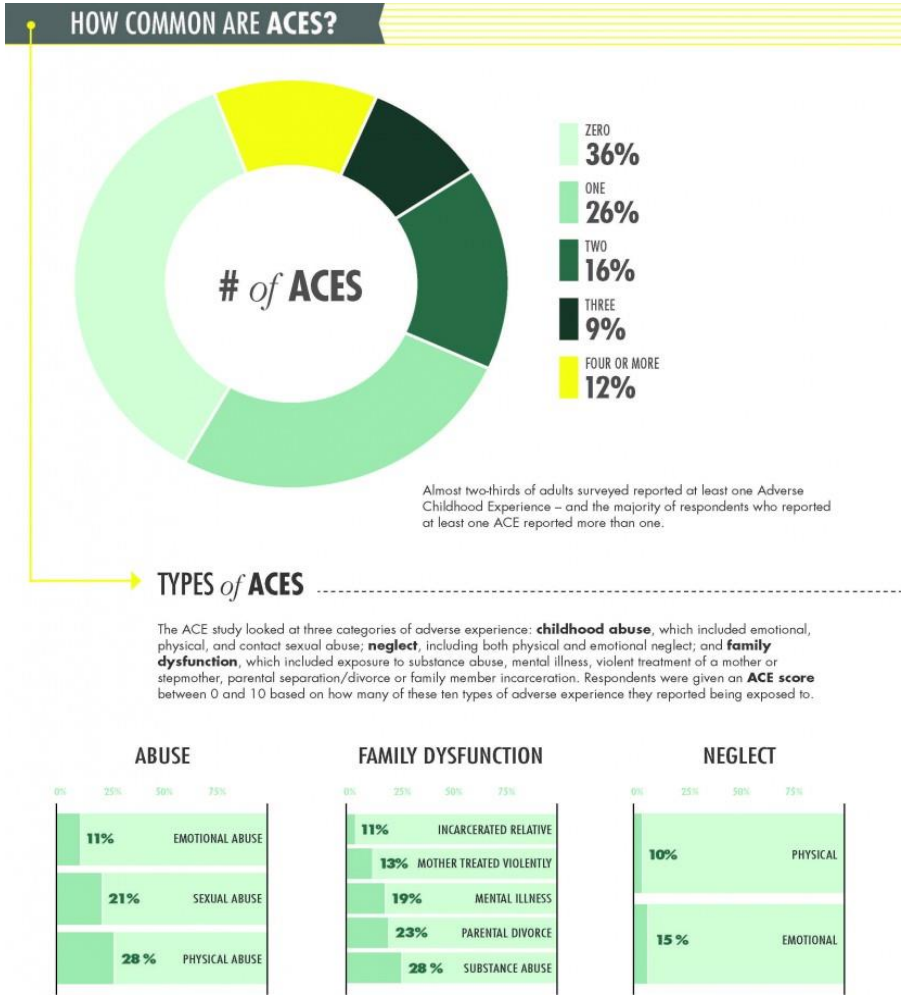
It is estimated that 20% of children and adolescents have a diagnosable mental, emotional, or behavioral disorder, costing the public $247 billion annually.

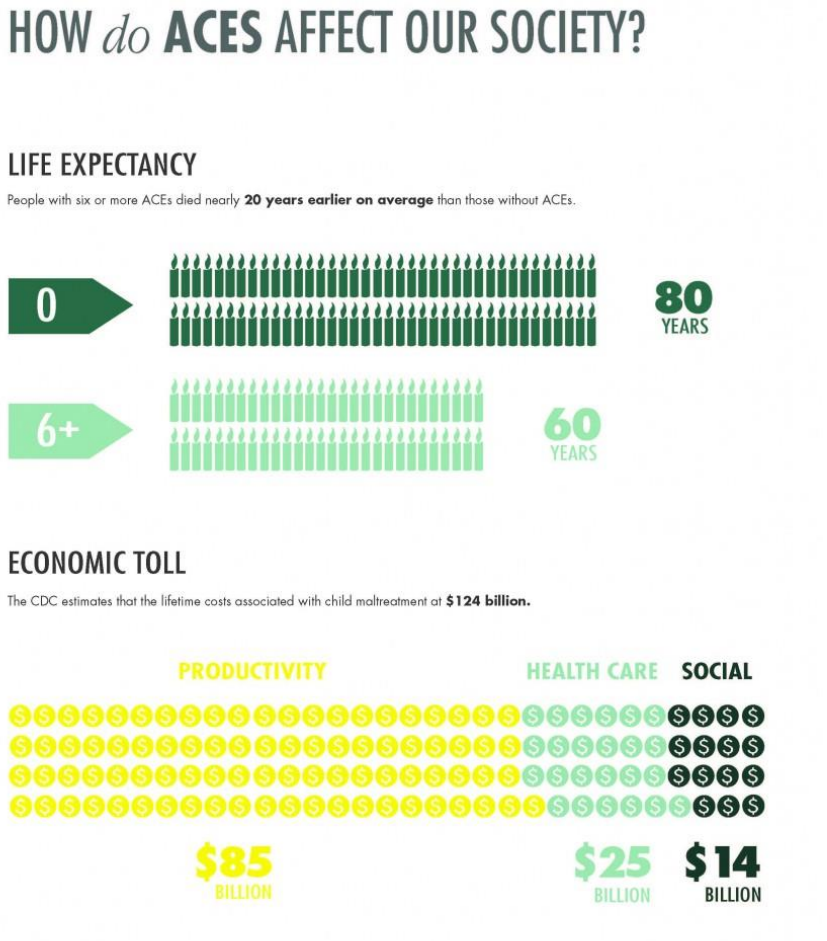
Major depression, which can be life-threatening, affects 12% of adolescents, with as many as 26% of young people experiencing at least mildly depressive symptoms.

An estimated 13-20% of children in the United States (up to 1 out of 5 children) experience a mental disorder in a given year.

In 2013, an estimated 21.6 million persons aged 12 or older (8.2%) were classified with substance dependence or abuse in the past year.

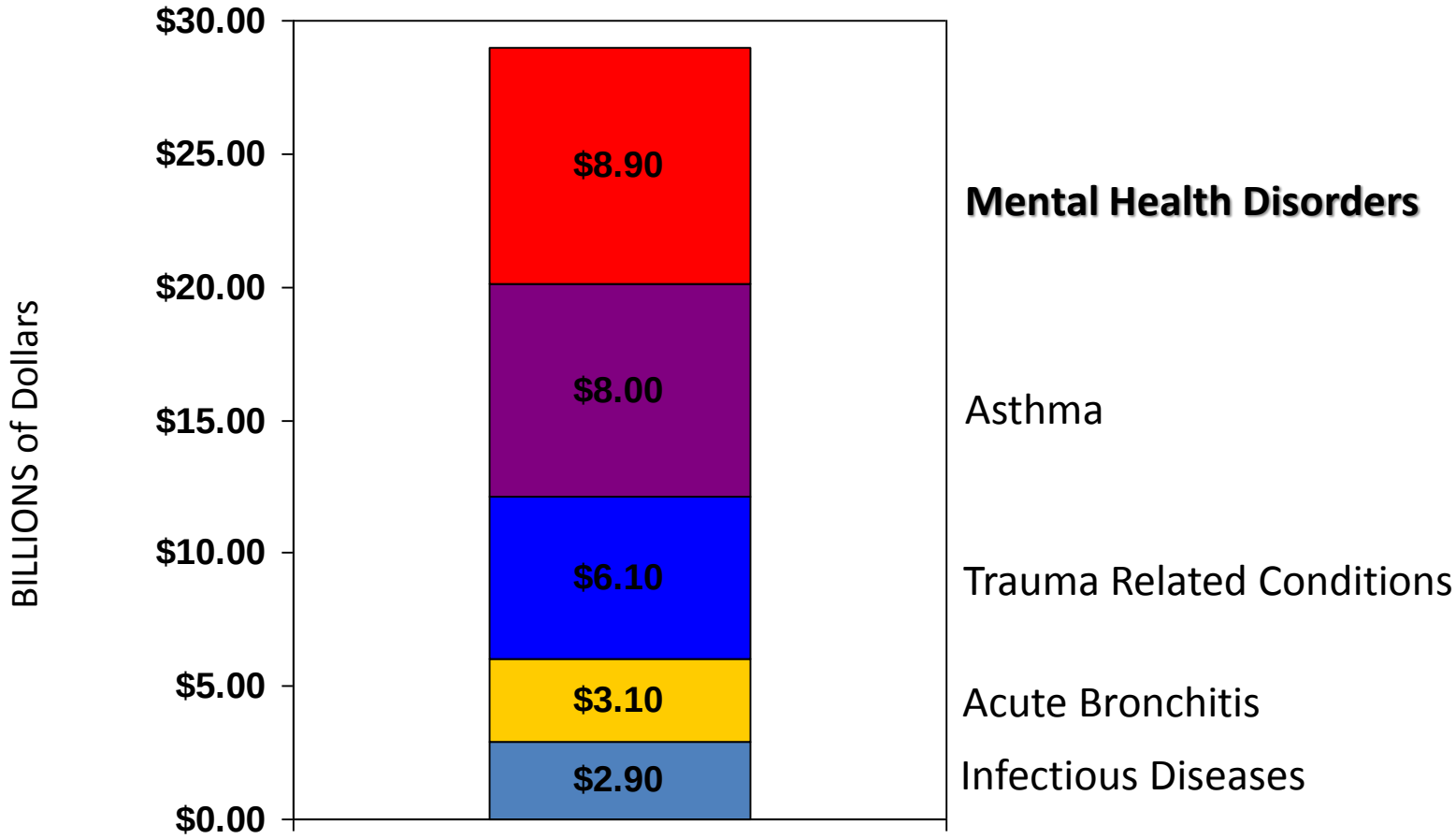
Adverse Childhood Experiences: ACES





http://www.preventconnect.org/2013/03/infographic-how-adverse-childhod-experience-affect-our-lives-and-society/

Mental Health:
Costliest Health Condition of Childhood



Soni, A. (April 2009) STATISTICAL BRIEF #242: The five most costly children's conditions, 2006: Estimates for the U.S. civilian noninstitutionalized children, ages 0-17

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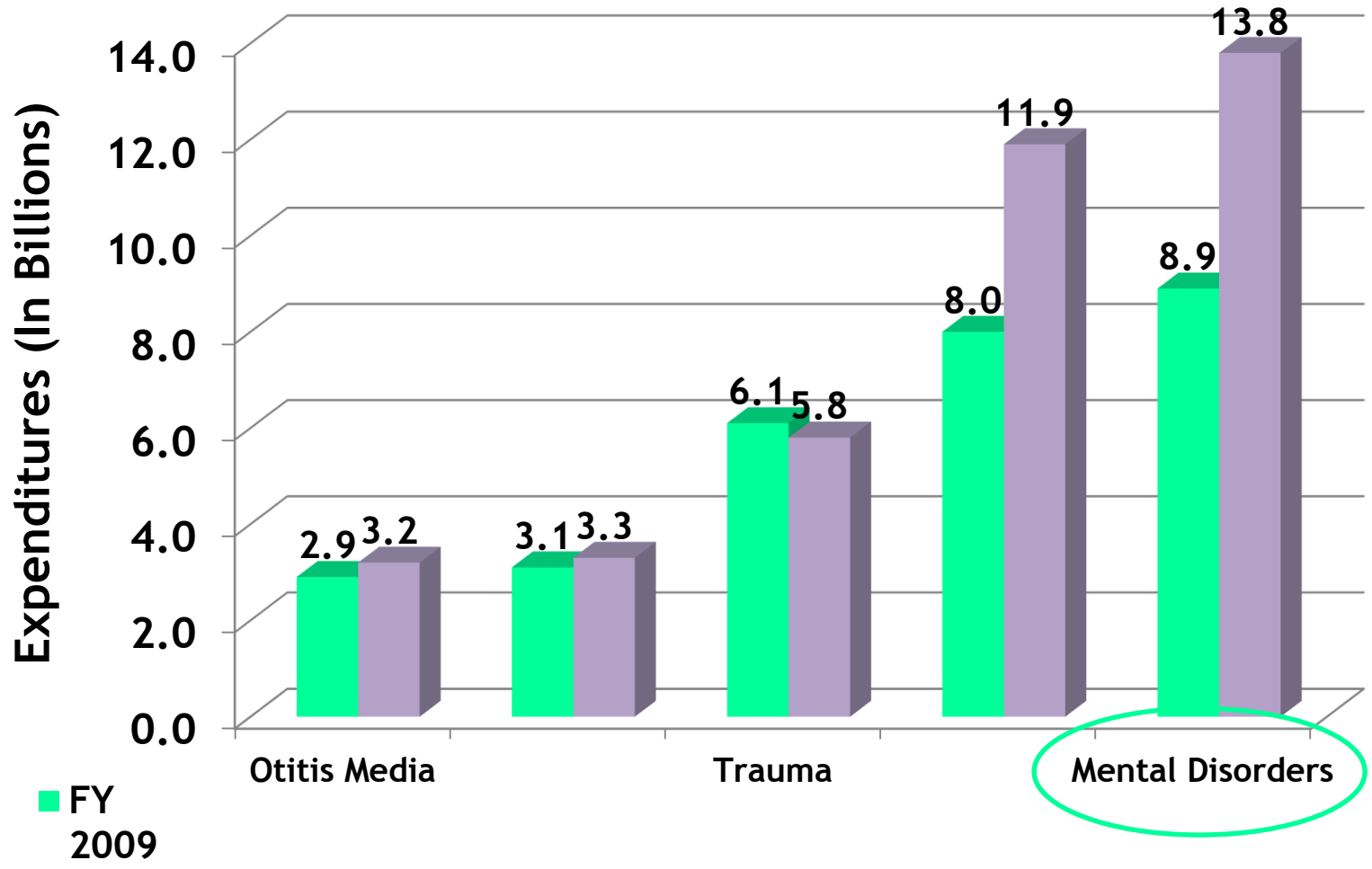
Expenditures for the Five Most Costly Conditions in Children (in Billions)



Source: Center for Financing, Access, and Cost Trends, Agency for HealhCare Research and Quality, 2009, 2011

The Costs Of A Poor Response

Emotional, behavioral and MH disorders in childhood/ adolescence associated with:

- School dropout: estimated cost to society: $292,000 for each dropout over their lifetime

  (http://www.pbs.org/wgbh/frontline/article/by-the-numbers-dropping-out-of-high-school/)

- Substance abuse: estimated cost to society: $740 billion annually in costs related to crime, lost work productivity and health care

  (https://www.drugabuse.gov/related-topics/trends-statistics#supplemental-references-for-economic-costs)

- Criminality: estimated costs to society of a 'life of crime': $1.3million - $1.5million

  (https://www.ncbi.nlm.nih.gov/pmc/articles/PMC2836594/)

A System of Care Is…

A spectrum of effective, community-based services and supports for children and youth with or at-risk for mental health or other challenges and their families that…

…is organized into **coordinated networks;**

…builds meaningful **partnerships** with families & youth;

…addresses **cultural and linguistic needs**

…in order to help families function better at home, in school, in the community, and throughout life.

Fundamental challenge & rationale for building SOC:

No one system controls everything.
Every system controls something.

Stroul, B., Blau, G., & Friedman, R. (2010).

System of Care Core Values

Family-driven and youth-guided	Home- and community-based	Strengths-based and individualized	Trauma-informed	Culturally and linguistically competent	Connected to natural helping networks	Data-driven, quality and outcomes oriented

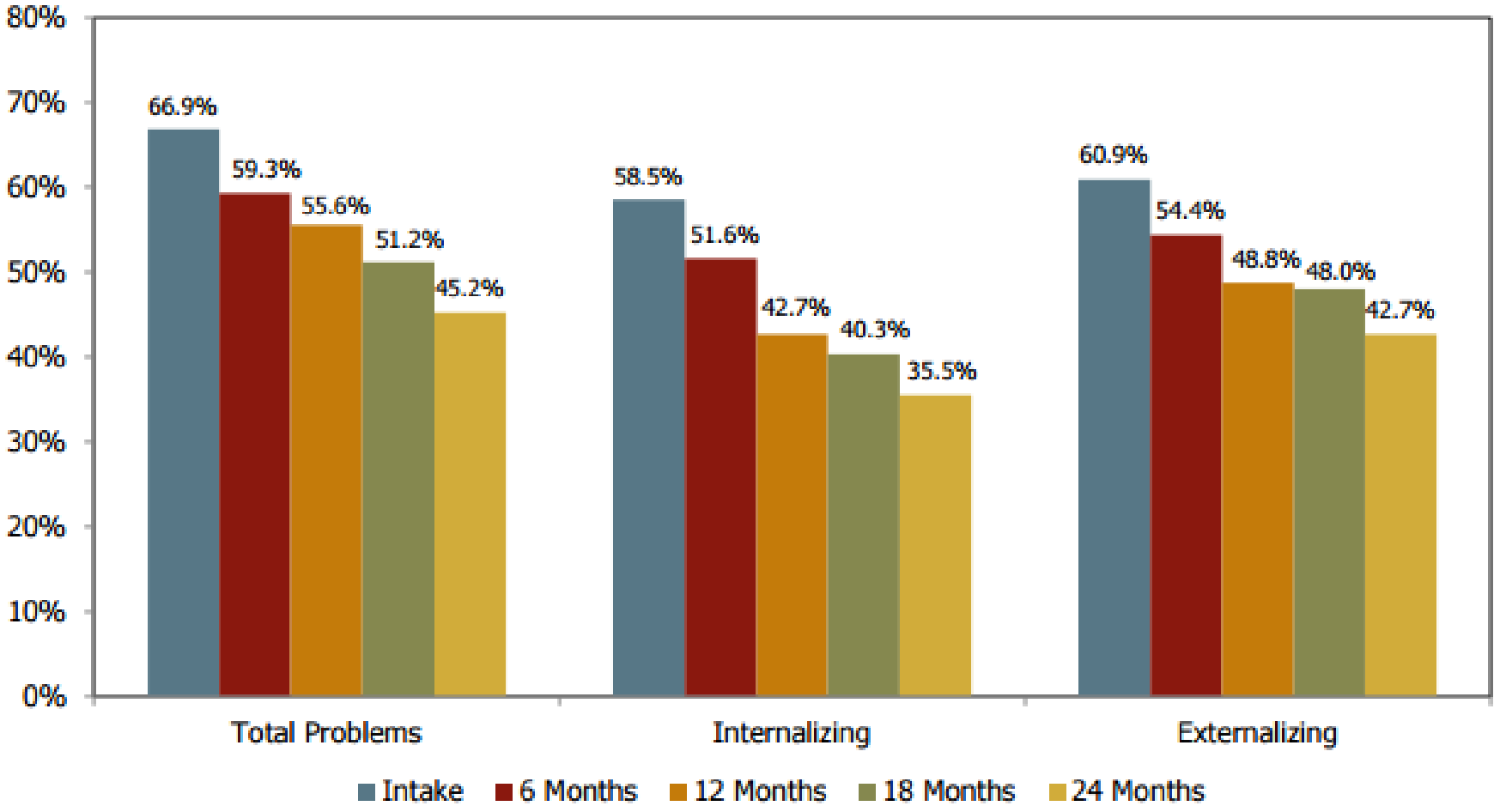
Let’s take a closer look at the impact we have seen from implementing a system of care approach….

#1

Enrollment in a SOC resulted in
significantly improved clinical outcomes

- Improvement in behavioral & emotional symptoms
- Fewer internalizing and externalizing symptoms
- Improvements in levels of clinical impairment
- Fewer suicidal thoughts & attempts

% of Children & Youth Scoring in Clinically Elevated Range on CBCL (Child Behavior Checklist)



Grantees Initially Funded in 2009–2010

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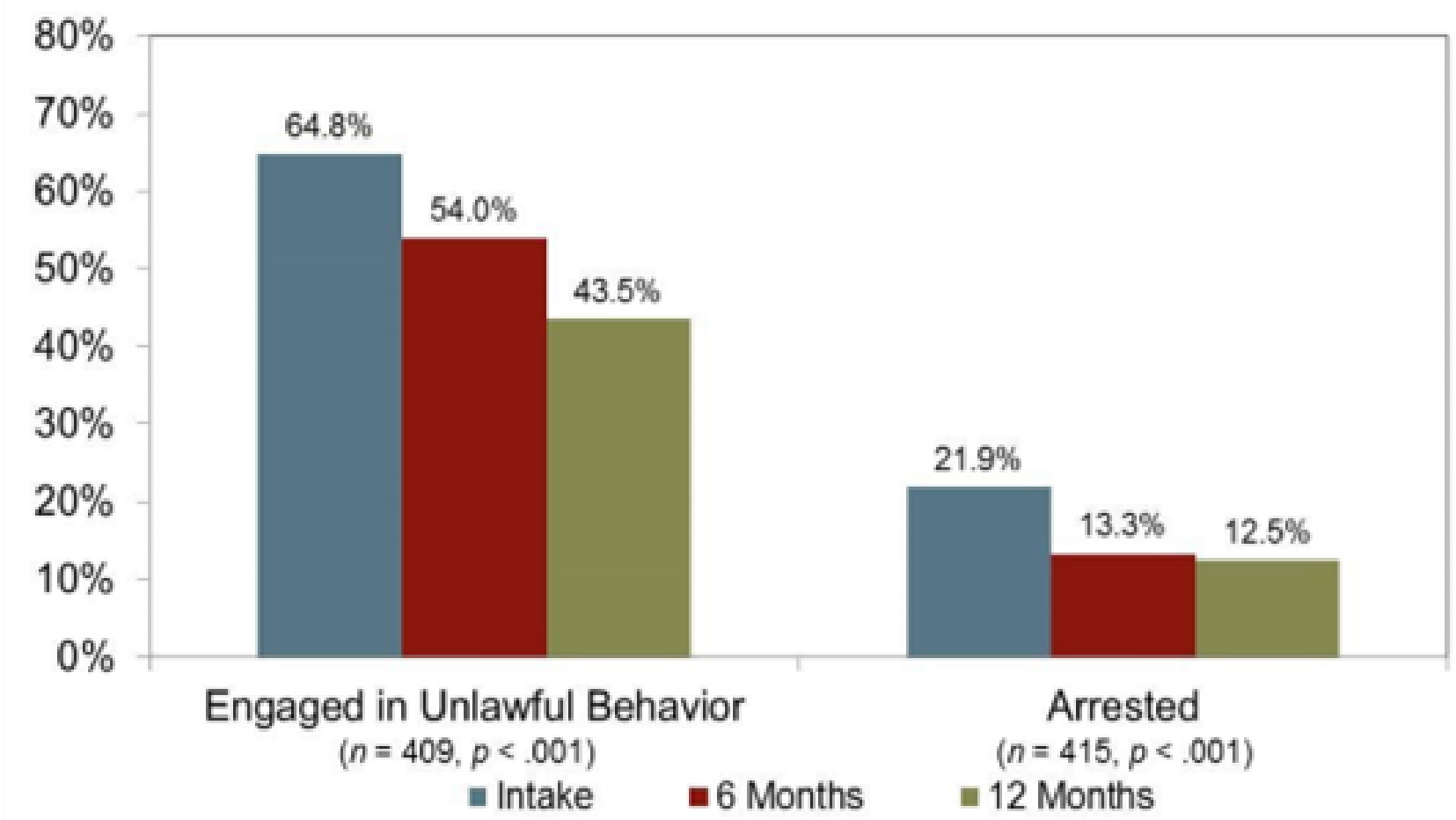
#2

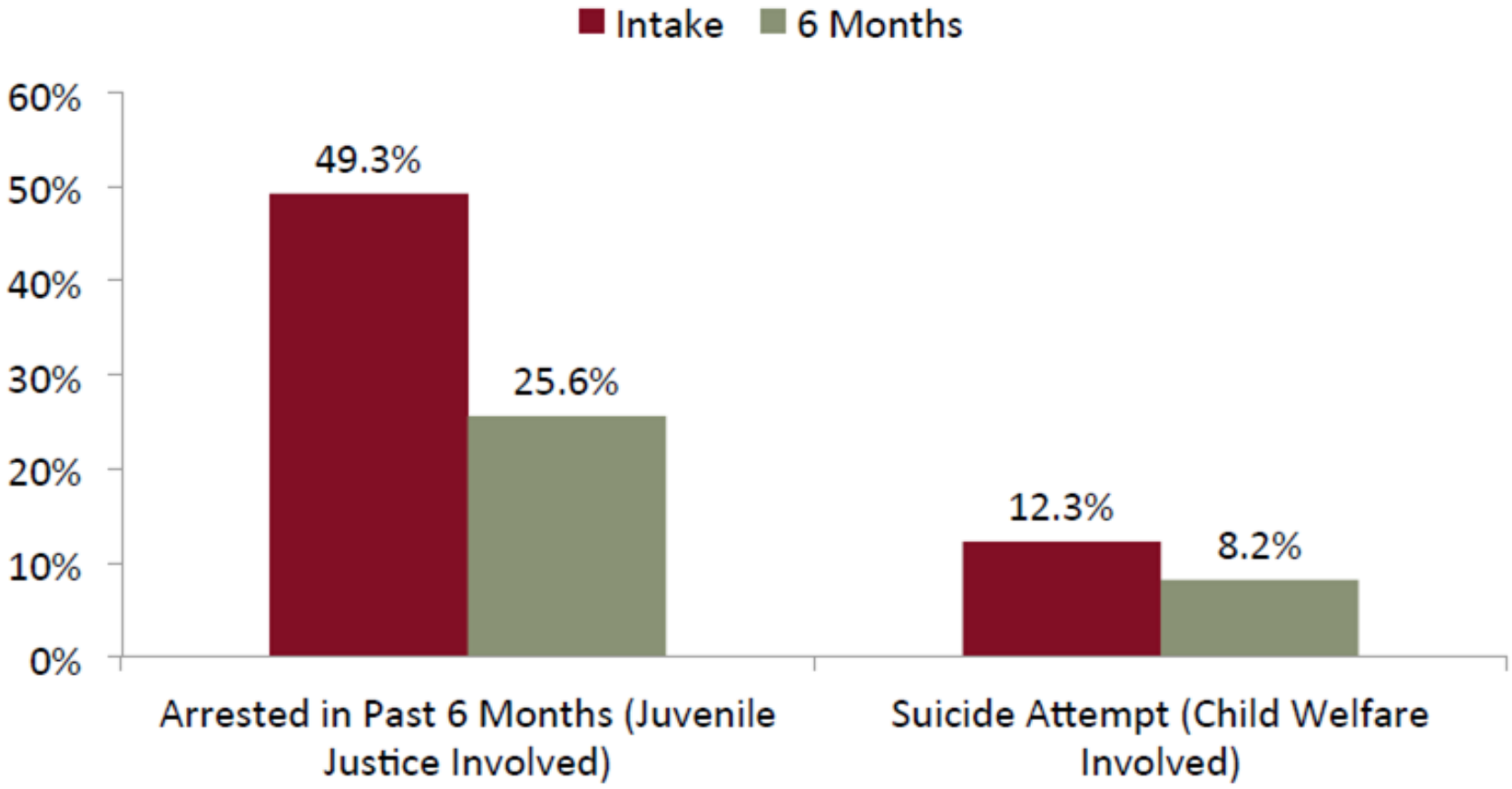
After enrollment in a SOC, youth were

less likely to be arrested

% of Youth Involved in Juvenile Justice System for Youth Receiving SOC Services



Reduced Arrests and Suicide Attempts for Youth Receiving SOC Services



#3

After enrollment in a SOC, children were

less likely to visit an emergency room

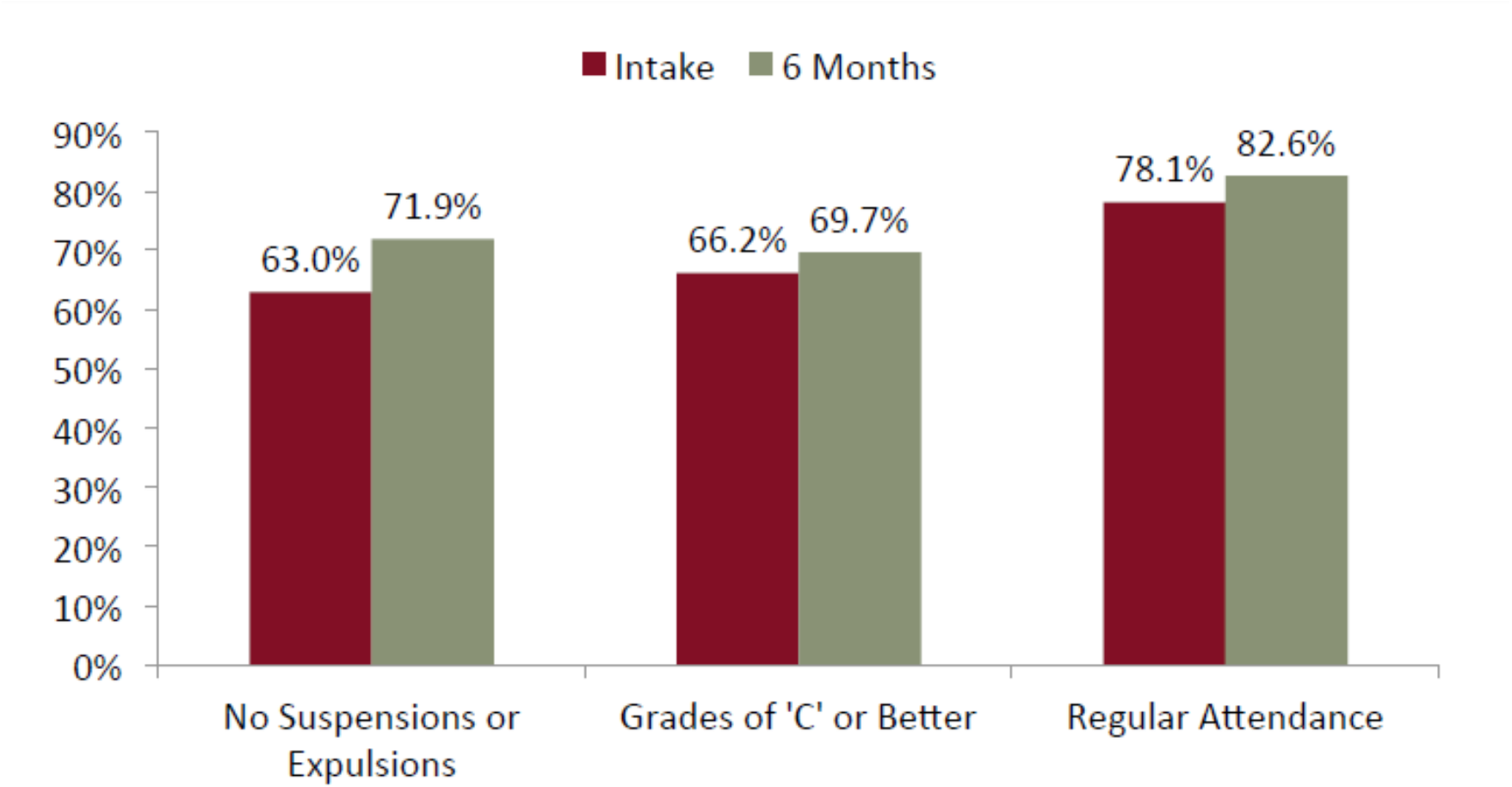
#4

Enrollment in a SOC resulted in

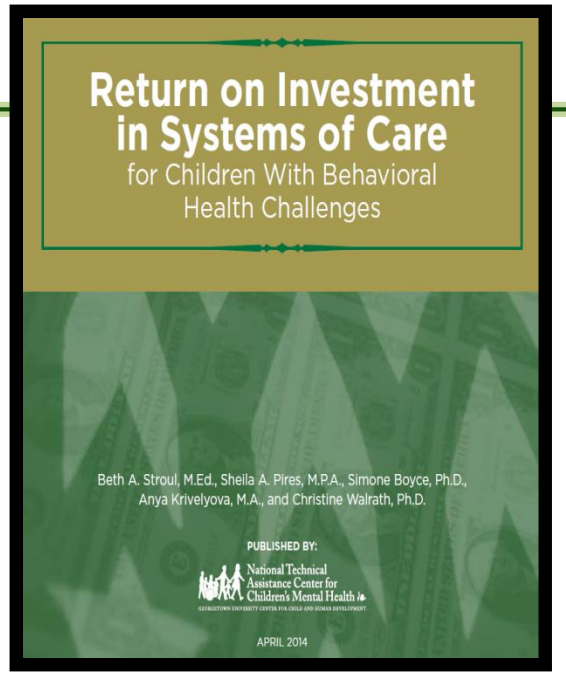
improved educational outcomes

- **Higher rates of educational achievement**
- **Improved school attendance**
- **Fewer suspensions & expulsions**

Improved Educational Outcomes for Children & Youth Receiving SOC Services



SOC Work & Cost Savings are Realized as a Result of…



- Fewer out-of-home placements/diversion from higher levels of care
- Fewer ER visits
- Fewer arrests
- Greater capacity for caregivers to work
- Youth served in SOCs are less likely to receive psychiatric inpatient services. From the 6 months prior to intake to the 12-month follow up, **the average cost per child served for inpatient services decreased by 42%.**
- Youth in SOCs are less likely to be arrested, resulting in **a 55% reduction in average per-youth arrest-related costs.**

To Recap: Systems of Care ***WORK!***

- ↓ behavioral & emotional problems
- ↑ Increased behavioral & emotional skills
- ↓ suicidal ideation & attempts
- ↓ substance use problems
- Improved functioning in school & in the Community
- Improved ability to build relationships

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SYSTEM DESIGN

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Services & Supports

Home- and Community-Based Treatment and Support Services

- Assessment and evaluation
- Individualized, intensive care coordination using Wraparound
- Outpatient therapy – individual, family, group
- Medication management
- Intensive in-home services
- Substance use intensive outpatient services
- Mobile crisis response and stabilization
- Family peer support
- Youth peer support
- Respite services
- Therapeutic behavioral aide services
- Therapeutic mentoring
- Behavior management skills training
- Youth and family education
- Mental health consultation
- Therapeutic nursery/preschool
- School-based behavioral health services
- Supported education and employment
- Supported housing
- Transportation

Out-of-Home Treatment Services

- Therapeutic foster care
- Therapeutic group home care
- Residential treatment services
- Inpatient hospital services
- Inpatient medical detoxification
- Crisis respite services

Specific evidence-informed interventions and culture-specific interventions can be included in each type of service.

Stroul, B. (2016). TA Network for Children's Behavioral Health, Baltimore, MD.

Early Childhood Systems of Care

- The service array for early childhood SOCs differs from those serving older youth and young adults in that it includes promotion and prevention, in addition to treatment services, and most services are infused into natural settings for young children and their families.
- The need for cultural and linguistic competence in services and supports is just as important for early childhood SOCs, as culture plays a major role in child-rearing practices and behavioral expectations.
- The workforce for early childhood SOCs is broad and may include child care providers, teachers, primary care staff, mental health providers, child welfare workers and others. These providers may not be trained in social-emotional development and early identification of mental health problems, which has led to a significant shortage of mental health professionals with the training and skills to effectively serve infants and young children.


TECHNICAL ASSISTANCE TOOL

FEBRUARY 2016

SAMHSA THE TA NETWORK

Considerations in System of Care Expansion: Expanding Early Childhood Systems of Care

Evolution of Early Childhood SOCs

http://www.fredla.org/wp-content/uploads/2016/04/Expanding-early-childhood-systems-of-care.pdf

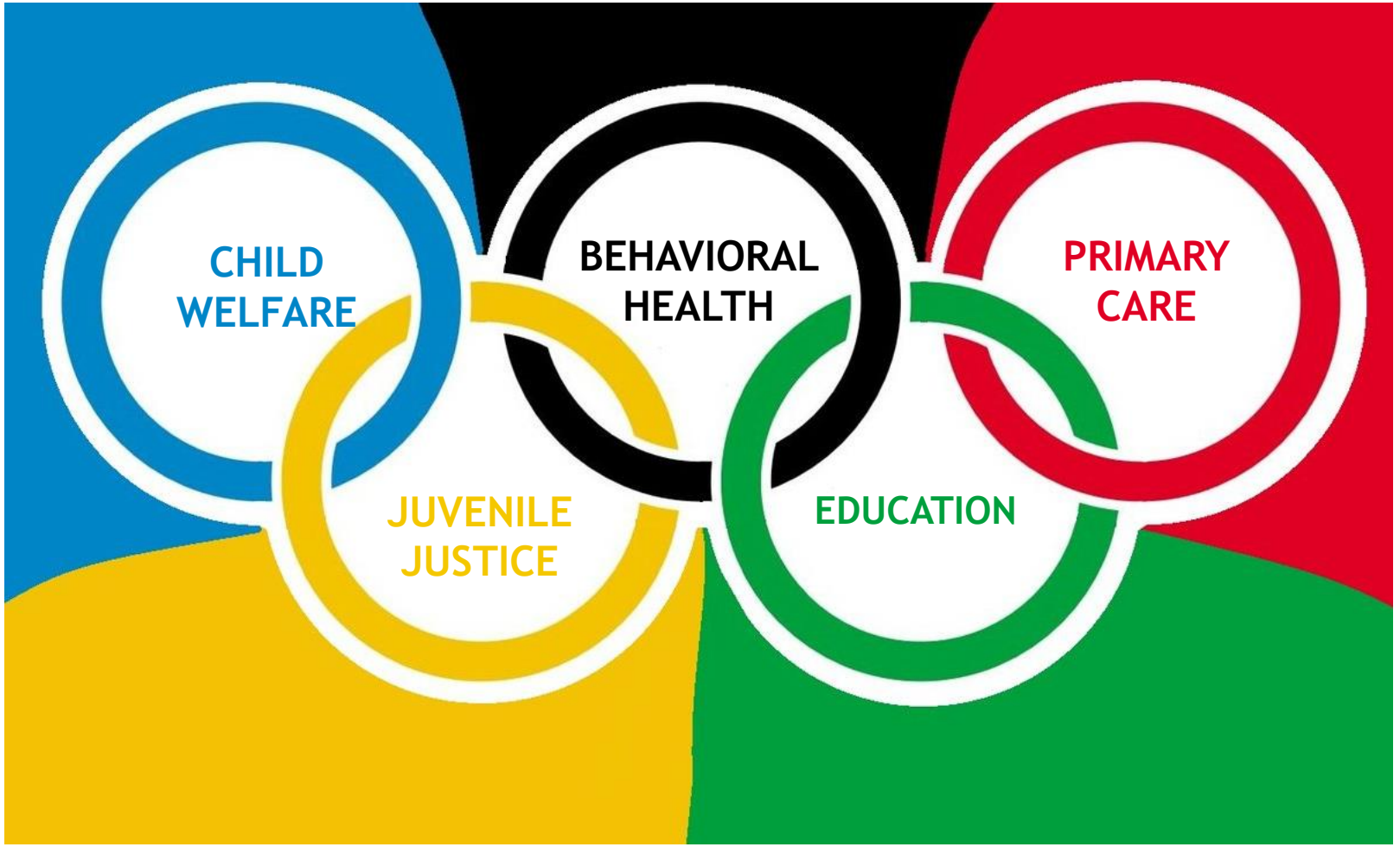
Transition Age Youth (TAY)

The services from which young adults typically age out include:

- Eligibility for children's behavioral health services;
- Case management;
- Supervised, supported, or group home settings;
- Educational support;
- Specialized vocational support, preparation, and counseling;
- Preparation for independent living; and
- Social skills training.

Substance Abuse and Mental Health Services Administration, Center for Behavioral Health Statistics and Quality. (May 6, 2014). The CBHSQ Report: Serious Mental Health Challenges among Older Adolescents and Young Adults. Rockville, MD.

Link with System Partners



Effective System-Building Process

Leadership & Constituency Building

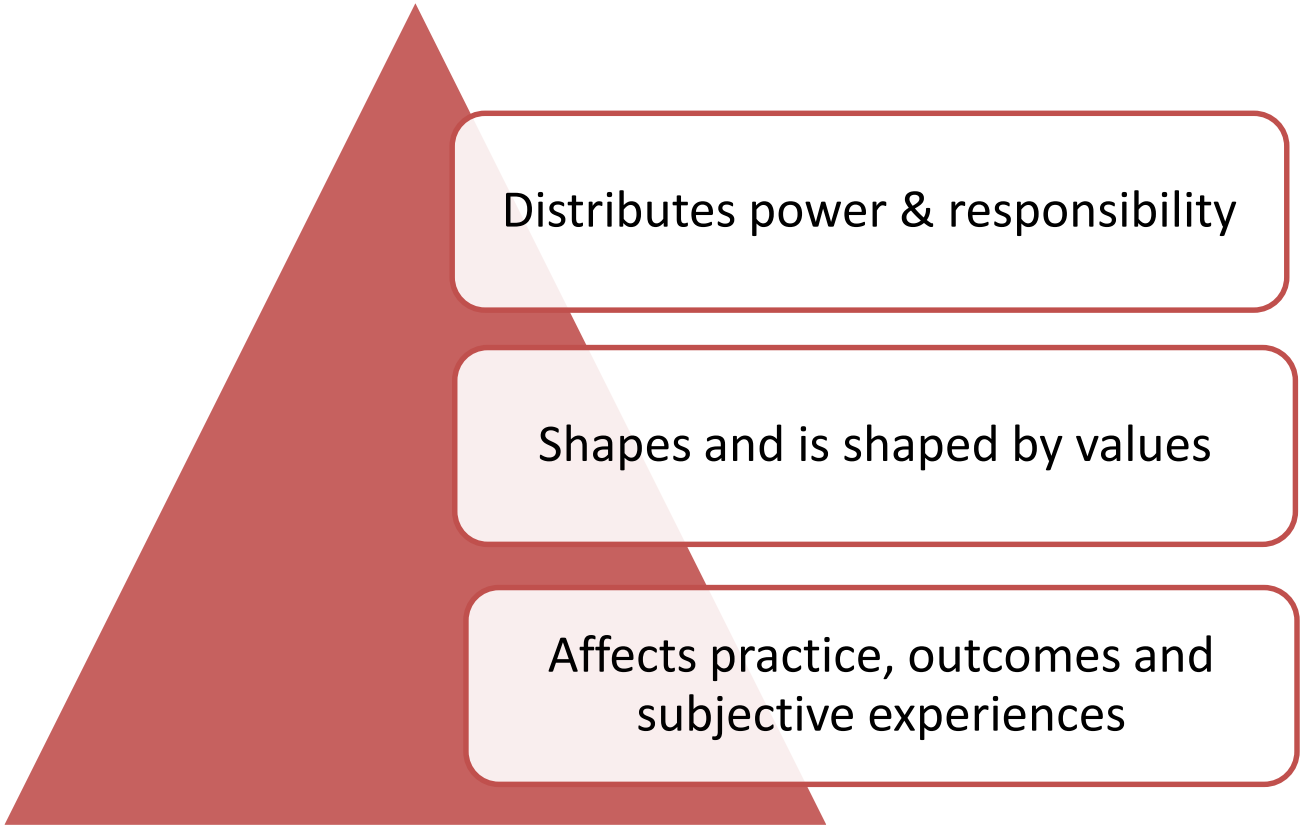
A Strategic Focus Over Time

Orientation to Sustainability

Pires, S. (2002).*Building Systems of Care: A Primer.* Washington, D.C.: Human Service Collaborative.

Structure Organizes Functions

"Something Arranged in a Definite Pattern of Organization"



Pires, S. (1995). *Structure*. Washington, DC: Human Service Collaborative.

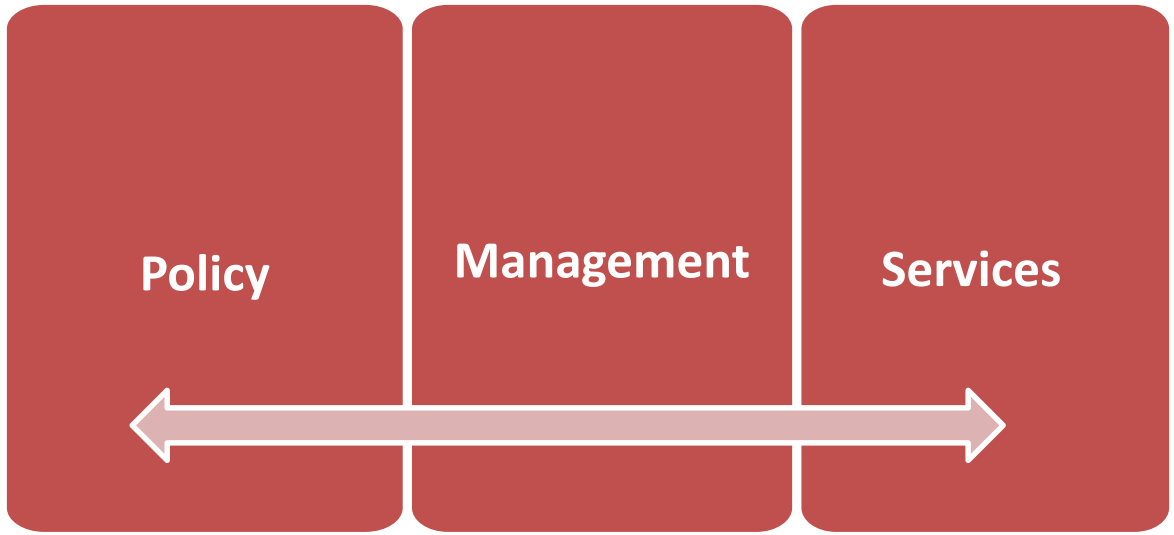
System of Care Functions Requiring Structure

- Planning
- Governance-Policy Level Oversight
- System Management
- Benefit Design/Service Array
- Evidence-Based Practice
- Outreach and Referral
- System Entry/Access
- Screening, Assessment, and Evaluation
- Decision Making and Oversight at the Service Delivery Level
  - Care Planning
  - Care Authorization
  - Care Monitoring and Review
- Care Management or Care Coordination
- Crisis Management at the Service Delivery and Systems Levels
- Utilization Management
- Family Involvement, Support, and Development at all Levels
- Youth Involvement, Support, and Development at all Levels

- Staffing Structure
- Staff Involvement, Support, Development
- Orientation, Training of Key Stakeholders
- External and Internal Communication
- Social Marketing
- Provider Network
- Protecting Privacy
- Ensuring Rights
- Transportation
- Financing
- Purchasing/Contracting
- Provider Payment Rates
- Revenue Generation and Reinvestment
- Billing and Claims Processing
- Information Management & Communications Technology
- Quality Improvement
- Evaluation
- System Exit
- Technical Assistance and Consultation
- Cultural and Linguistic Competence

Pires, S. (2002).*Building Systems of Care: A Primer*. Washington, D.C.: Human Service Collaborative.

Structuring Family and Youth Involvement Throughout the System



Pires, S. (2002). *Building systems of care: A primer.* Washington, D.C.: Human Service Collaborative.

Structuring Cultural & Linguistic Competence

Cultural Competence:

"The integration of knowledge, information, and data about individuals and groups of people into clinical standards, skills, service approaches and supports, policies, measures, and benchmarks that align with the individual's or group's culture and increases the quality, appropriateness, and acceptability of health care and outcomes."

(*Cross et al., 1989*)

Linguistic Competence:

"The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities."

(*Goode & Jones, 2004*)

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SYSTEM FINANCING

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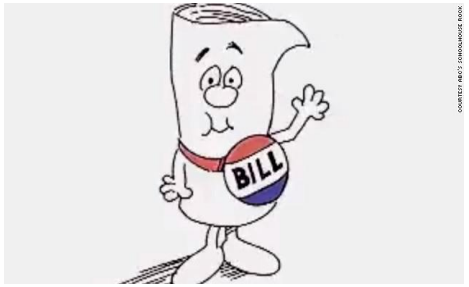
Funding Approaches

- Covered benefit through:
  - Medicaid
  - Private insurance
- Block grant
- General revenue
- Component of health home

Know Your State

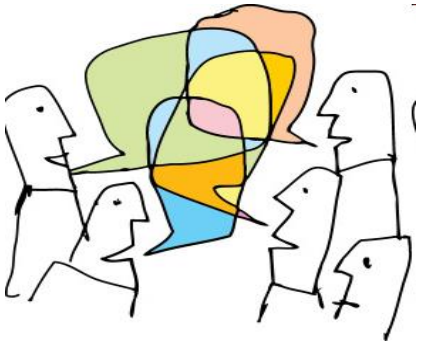
How does your state cover services for children and adults?

- Research state policies and partners



- Watch your state's legislature for changes to Medicaid (budget bill and appropriations)

- Engage with state leaders



Systems of Care:
A Non Categorical Approach

- A SOC, by definition, is non-categorical; that is, it crosses agency and program boundaries and approaches the service and support requirements of families and youth holistically.
- It adopts a population focus across systems.

S. A. Pires, Building Systems of Care A Primer, 2nd Edition, Spring 2010, GUCCHD

Thinking Non Categorically… Strategies

- **Learn one another's languages**
  - (e.g. Medicaid vs. mental health)
- **Align requirements and processes**
  - (e.g. certification requirements & terms)
- **Shared information systems to integrate data across systems**
  - (e.g. NJ CYBER, Synthesis Wraparound Milwaukee; proprietary example – TMS Wrap logic)
- **Define and monitor outcomes that can only be achieved through collaborative strategies**
  - (e.g. reducing out-of-home placements)

ILLUSTRATION 2.17A

Examples of Sources of Funding for Children/Youth

Medicaid
- Medicaid Inpatient
- Medicaid Outpatient
- Medicaid Rehabilitation Services Option
- Medicaid Early Periodic Screening, Diagnosis, and Treatment (EPSDT)
- Targeted Case Management
- Medicaid Waivers
- TEFRA Option

Substance Abuse
- SA General Revenue
- SA Medicaid Match
- SA Block Grant

Mental Health
- MH General Revenue
- MH Medicaid Match
- MH Block Grant

Child Welfare
- CW General Revenue
- CW Medicaid Match
- IV-E (Foster Care and Adoption Assistance)
- IV-B (Child Welfare Services)
- Family Preservation/Family Support

Juvenile Justice
- JJ General Revenue
- JJ Medicaid Match
- JJ Federal Grants

Education
- ED General Revenue
- ED Medicaid Match
- Student Services

Other
- Temporary Assistance for Needy Families (TANF)
- Children's Medical Services/Title V—Maternal and Child Health
- Mental Retardation/ Developmental Disabilities
- Title XXI—State Children's Health Insurance Program (SCHIP)
- Vocational Rehabilitation
- Supplemental Security Income (SSI)
- Local Funds

S. A. Pires, Building Systems of Care A Primer, 2nd Edition, Spring 2010, GUCCHD

Financing Strategies to Support Improved Outcomes for Children, Youth and Families

FIRST PRINCIPLE: Strategic Agenda for Populations of Focus Drives Financing

REDEPLOYMENT Using the money we already have The cost of doing nothing Shifting funds from high cost/poor outcome services to effective practices Moving across fiscal years	**REFINANCING** Generating new money by increasing federal claims The commitment to reinvest funds for families and children Foster Care and Adoption Assistance (Title IV-E) Medicaid (Title XIX)
RAISING OTHER REVENUE TO SUPPORT FAMILIES AND CHILDREN Donations Special taxes and taxing districts for children Fees and third party collections including child support Trust funds	**FINANCING STRUCTURES THAT SUPPORT GOALS** Seamless services: Financial claiming invisible to families Funding pools: Breaking the lock of agency ownership of funds Flexible Dollars: Removing the barriers to meeting the unique needs of families Incentives: Rewarding good practice

Adapted from Friedman, M. (1995). *Financing strategies to support improved outcomes for children*. Washington, DC: Center for the Study of Social Policy.

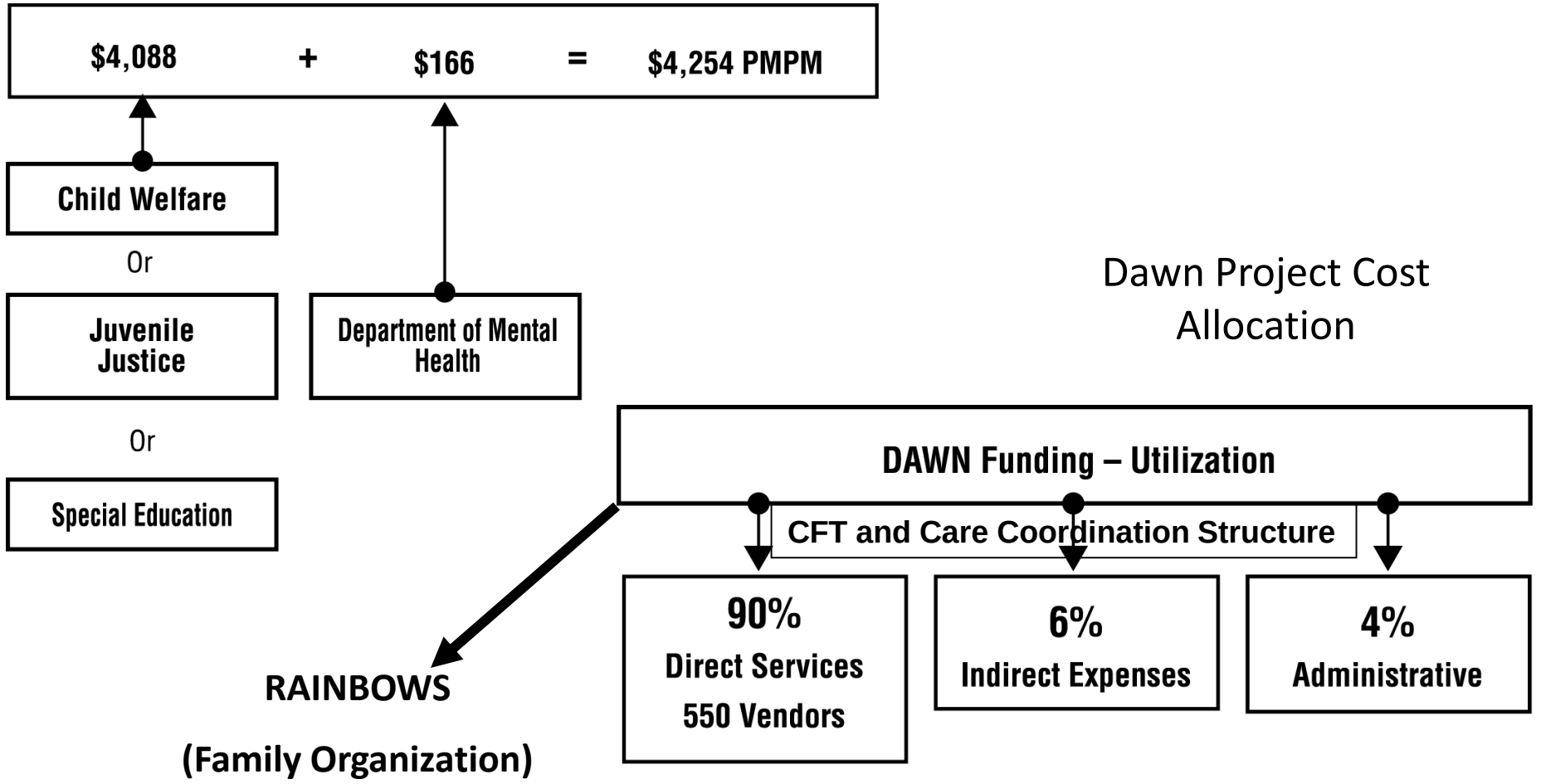
Financing Strategy: Redirect / Redeploy Funds

Strategies:

- Dollars from high cost/poor outcome services (e.g., residential, detention, group homes)
- Invest / re-invest savings per youth served in home and community-based service capacity
- Promote diversification/"re-engineering" of residential treatment facilities

Pires, S. 2010. Human Service Collaborative

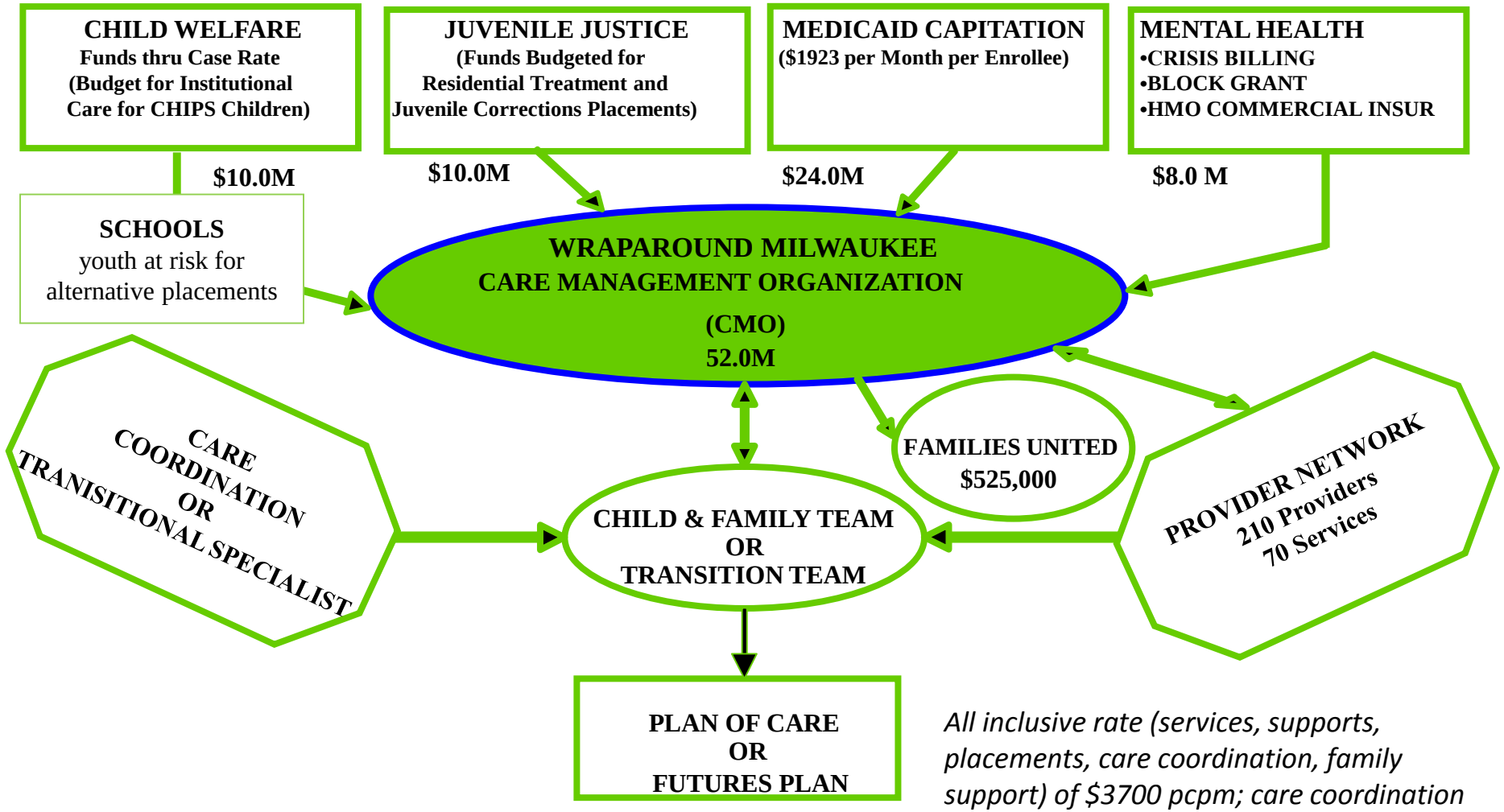
DAWN Project (Indianapolis, IN): Redirected and Braided Funds



2005 CHOICES, Inc., Indianapolis, IN

Wraparound Milwaukee: Redirected and Pooled/Blended Funding (circa 2015)

Mobile Response & Stabilization co-funded by schools, child welfare, Medicaid & mental health



All inclusive rate (services, supports, placements, care coordination, family support) of $3700 pcpm; care coordination portion is about $780 pcpm

Examples of Refinancing

Milwaukee County, WI

- Schools and child welfare contributed $450,000 each to expand mobile response and stabilization services (prevent placement disruptions in child welfare, prevent school expulsions)
- As a Medicaid-billable service; contributions from schools and child welfare generate $180,000 to the school contribution and $200,000 to child welfare's in Federal Medicaid match dollars

New Jersey

- Reallocated child welfare and mental health general revenue dollars to enhance match for Medicaid system of care innovations

New Jersey: Refinancing

BH, CW, MA $$ - Single Payer

Department of Children and Families
Division of Children's System of Care (CSOC)

Dept. of Human Services
Division of Medical Assistance and Health Services (Medicaid)

Rutgers Training & TA Institute

CANS

Contracted Systems Administrator-
PerformCare – ASO for child BH carve out

- 1-800 number
- Screening
- Utilization management
- Outcomes tracking

Provider Network

Mobile Response & Stabilization Services

Medicaid and DCF-certified providers

Family Support Organizations

Family/Youth peer support, education and advocacy

Youth M.O.V.E.

*Care Management Entities- CMOs

Lead non profit agencies managing children with serious challenges, multisystem involvement

Adapted from State of New Jersey 2010

Financing Strategy: Raising New Revenue

- California:
  - *Proposition 63* - 1% income tax on millionaires
- King County, WA:
  - *Mental Illness and Drug Dependency* - 0.1% sales tax for programs and services
- IA, IL, MO, OH:
  - Local tax levy tax for mental health services
- Florida counties:
  - Children's trust funds
- NYC and SC:
  - Social Impact Bonds

Adapted from Human Service Collaborative Slide

Medicaid Financing

- The federal government matches state Medicaid spending on an open-ended basis
- The current matching rate ranges from 50% to 73%, based on a state's per capita income.
  - The federal government contributes **more** in poorer states
  - Changes to eligibility and services may impact state budget
- Under the ACA, newly eligible beneficiaries qualify for higher match, starting at 100% in 2014-16 and phasing down to 90% in 2020 and beyond

Medicaid Operates Differently in Each State

- *"If you've seen one state Medicaid program…. You've seen one state Medicaid program."*

- States use different Medicaid authorities (plans and waiver) as funding mechanisms to cover services
- Important to understanding how Medicaid functions in ***your*** state

Federal Medicaid Pays for:

Mandatory Benefits	Optional Benefits
Inpatient hospital services	Prescription Drugs
Outpatient hospital services	Clinic services
EPSDT: Early and Periodic Screening, Diagnostic, and Treatment Services	Physical therapy
Nursing Facility Services	Occupational therapy
Home health services	Speech, hearing and language disorder services
Physician services	Respiratory care services
Rural health clinic services	Other diagnostic, screening, preventive and rehabilitative services
Federally qualified health center services	Podiatry services
Laboratory and X-ray services	Optometry services
Family planning services	Dental Services
Nurse Midwife services	Dentures
Certified Pediatric and Family Nurse Practitioner services	Prosthetics
Freestanding Birth Center services (when licensed or otherwise recognized by the state)	Eyeglasses
Transportation to medical care	Chiropractic services
Tobacco cessation counseling for pregnant women	Other practitioner services
	Private duty nursing services
	Personal Care
	Hospice
	Case management
	Services for Individuals Age 65 or Older in an Institution for Mental Disease (IMD)
	Services in an intermediate care facility for Individuals with Intellectual Disability
	State Plan Home and Community Based Services- 1915(i)
	Self-Directed Personal Assistance Services- 1915(j)
	Community First Choice Option- 1915(k)
	TB Related Services
	Inpatient psychiatric services for individuals under age 21
	Other services approved by the Secretary
	Health Homes for Enrollees with Chronic Conditions – Section 1945

https://www.medicaid.gov/medicaid/benefits/list-of-benefits/index.html

Performance Specifications and Medical Necessity Criteria

- **MEDICAID REIMBURSEMENT REQUIRES:**
  - **A DIAGNOSIS AND MEDICAL NECESSITY CRITERIA**

- **Performance Specifications** define:
  - What the service is
  - Including purpose, description and components of the service
  - Who can provide it

- **Medical Necessity Criteria** = Clinical Criteria
  - Determines medical necessity for the service

Understanding Medical Necessity Under EPSDT

Early and **P**eriodic **S**creening, **D**iagnostic and **T**reatment services

"A service need not cure a condition in order to be covered under EPSDT. Services that maintain or improve the child's current health condition are also covered in EPSDT because they "ameliorate" a condition. **Maintenance services are defined as services that sustain or support rather than those that cure or improve health problems**."

https://www.medicaid.gov/medicaid/benefits/downloads/epsdt_coverage_guide.pdf

a·me·lio·rate: make (something bad or unsatisfactory) better.
synonyms: improve, make better, better, make improvements to, enhance, help, benefit, boost, amend

Google online dictionary

Medicaid State Plans

- State Medicaid plans are contracts between states and the federal government that outline the scope of the Medicaid program, including who it covers, services it provides, and how payment is rendered.
- States submit their Medicaid “State Plan” to the Centers for Medicare and Medicaid Services (CMS) for federal approval
- State Plan details eligibility, policy options, procedures and other operating information
- To make changes to an existing State Plan, the state submits a *State Plan Amendment* or *SPA*

Medicaid State Plan Authorities Used in Funding Children's Services

- **1905(a)** – Targeted Case Management, Rehabilitation Services
  - New Jersey
  - Massachusetts
- **1915(i)**
  - Maryland
  - Montana
- **Section 2703 Health Home**
  - Oklahoma
  - New Jersey
  - Missouri

Medicaid Waiver Authorities

- Provide flexibility to design and improve state programs
- Expand services to individuals not otherwise eligible under the SPA
- Provide services not otherwise covered under the SPA
- Test new approaches to delivering care
- Budget neutral (i.e. cannot cost more)
- Time-limited but renewable

Medicaid Waiver Authorities Used in Funding Children's Services

- **Section 1115 Demonstrations**
  - Arizona
  - New Jersey
- **1915(b) Freedom of Choice (Managed Care)**
  - California
  - Iowa
- **1915(c) Home and Community-Based Services**
  - New York
  - Texas
- **Concurrent - 1915 (b) and (c)**
  - Michigan
  - Louisiana
  - Wyoming

Section 1115 Demonstration Waivers

- Allows program flexibility to test new or existing approaches to financing and delivering Medicaid and CHIP.
- Expand eligibility to individuals who are not otherwise Medicaid or CHIP eligible;
- Provide services not typically covered by Medicaid; or
- Use innovative service delivery systems that improve care, increase efficiency, and reduce costs

1915(c) Home and Community-Based Services Waivers

- Authorized under Section 1915 of the Social Security Act.
- Fee-for-service programs, meaning that the provider is paid for each service the patient receives (such as a test or procedure)
- Require individuals to meet criteria that are set by the state and based on a person's level of need
- Cannot be limited to a certain ethnic or racial group but can be limited in other ways:
- May be statewide or geographically limited in coverage
- May be limited to a certain medical diagnosis (e.g., mental health, developmental disability)

CMS/SAMHSA May 2013 Joint Information Bulletin

- Intensive Care Coordination: Wraparound Approach
- Parent and Youth Peer Support Services
- Intensive In-Home Services
- Respite
- Mobile Crisis Response and Stabilization
- Flex Funds
- Trauma Informed Systems and Evidence-Based Treatments Addressing Trauma

Challenges and Opportunities

- **Rate setting**
  - Supervision, travel, in-person v. telephonic, documentation, training and coaching, etc.
- **State budgetary environment**
  - 49/50 states have a balanced budget amendment
- **Provider participation**
  - Do you have sufficient workforce to deliver the services? To supervise staff? For training and coaching?
- **Administrative Burden**
  - Demonstrations require evaluation; does your state have sufficient data collection and analysis capabilities?

Integration at the Medicaid System Purchaser 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, 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 Rule Extends Application of MHPAEA

- The parity requirements under MHPAEA are only **not** applicable when the state delivers physical health services under a fee-for-service (FFS) Medicaid delivery model.
  - This is important to children's behavioral health in states without Medicaid managed care.
  - CMS is also encouraging states to require managed care organizations (MCOs) to provide documentation of its parity findings and analysis in the contract, as such documentation is not required in the MHPAEA rule.

Coverage and Authorization of Services: Medical Necessity, Practice Guidelines

- Must identify, define, and specify the amount, duration, and scope of **each service** required
- Must specify what constitutes **"medically necessary services"**
    - Prevention, diagnosis, and treatment of enrollee's disease
    - Ability to achieve age-appropriate growth and development
    - Ability to attain, maintain, and regain functional capacity
- For those with LTSS, ability to have the benefits of community living, person-centered goals, and live and work in setting of their choice
- Practice guidelines may be used:
    - If they are based on valid and reliable clinical evidence
    - If they have been adopted in consultation with network providers
    - If they are periodically reviewed and updated

Customizing Medicaid for Children in Child Welfare: Financing Incentives

- **Risk-adjusted rates** for the foster care population
  - AZ BH carve out: capitation rate is 29% higher than for Medicaid children in general
- **Incentive payments** to providers (MI BH carve out)
- Ensure **adequate intensive care coordination rates** using fidelity wraparound (e.g., specified care coordination rate or "pass-through" case rate for high utilizers)
- **Enhanced screening rate** for comprehensive physical, behavioral, and developmental screens (MA)
- 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)
- **Require reinvestment** back into child home and community services

Pires, S. 2013. Human Service Collaborative: Washington, DC

Customizing Medicaid for Children in Child Welfare: Utilization Management

- Access: N**o prior authorization for basic behavioral health outpatient services** up to certain limit (MA)
- Coordinated Care: require that **plans of care developed through Wraparound process determine medical necessity** (with outlier management) (AZ, MA, NJ, LA)
- **No "fail first" criteria** to access services or medications
- **Prior authorization for certain psychotropic meds**, e.g. antipsychotics (MD)

Pires, S. 2013. Human Service Collaborative: Washington, DC

Customizing Medicaid for Children in Child Welfare: Administrative Requirements

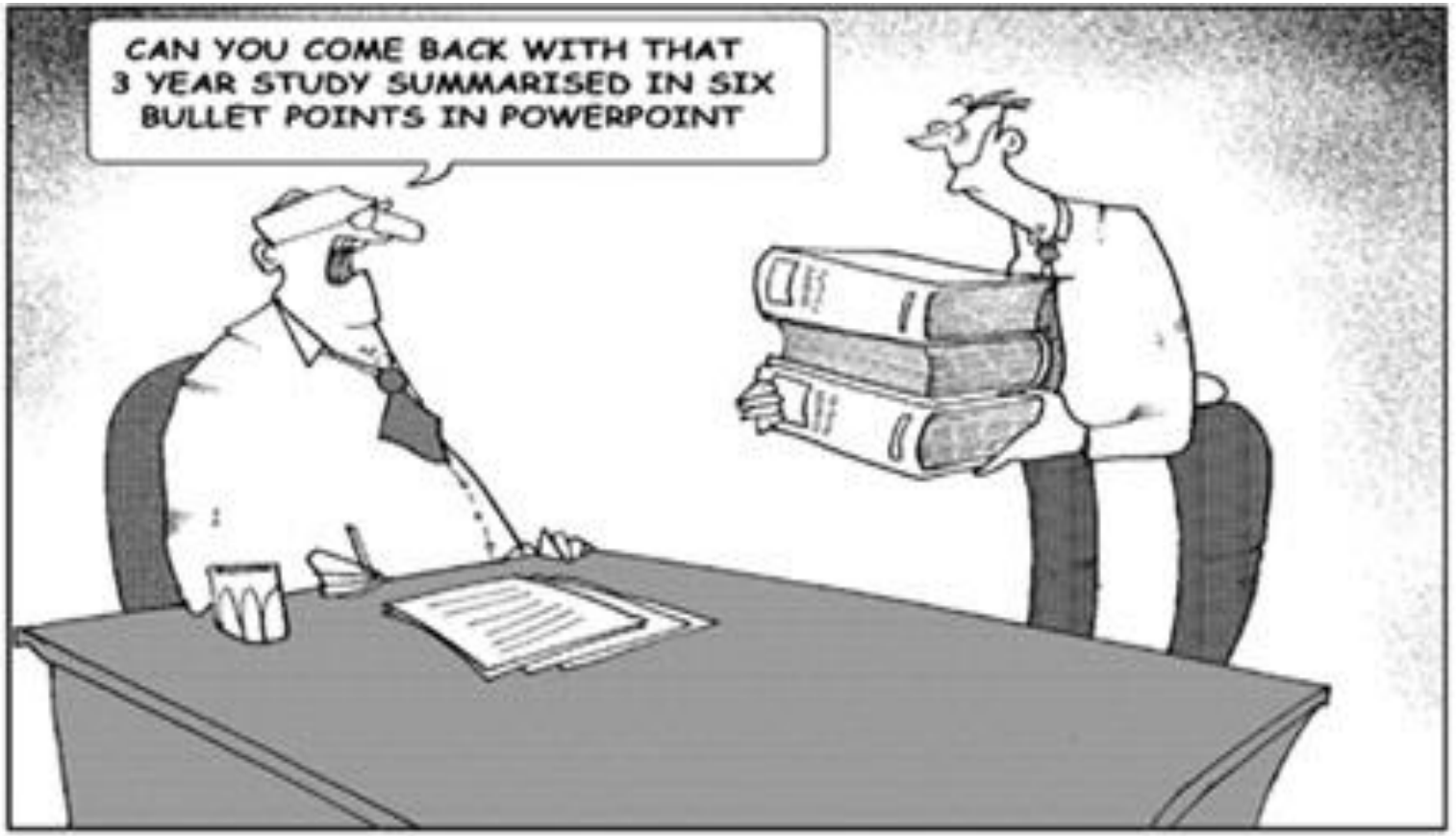
- **Designated liaison** within MCO to child welfare system
- **Periodic meetings** between MCOs, Medicaid and child welfare system for trouble-shooting, quality improvement
- **Inclusion of families and youth** with lived experience in quality review process, as system navigators, as advisory body members
- **"Warm line"** for child welfare workers and caregivers
- **Child health units** or designated child welfare agency staff to interface with MCOs
  - NJ, UT: Using Medicaid administrative case management and Title IV-E to help finance this capacity

Pires, S. 2013. Human Service Collaborative: Washington, DC

Key Takeaways

- One size does not fit all
- Learning the languages of state agencies, funders, providers, etc. facilitates collaboration *and helps them learn your language*
- **Financing should be based on design**
  - Define first:
    1. What you want to do
    2. How you want to do it
    3. Why it should be done
  - Then determine the Medicaid authority/other funding source(s)

Key Takeaway



Questions or Thoughts

Resources

- CMCS Informational Bulletin - Prevention and Early Identification of Mental Health and Substance Use Conditions
  - http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf
- Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions
  - http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf
- CMCS Informational Bulletin: Clarification of Medicaid Coverage of Services to Children with Autism
  - http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf
- Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Youth with Substance Use Disorders
  - http://medicaid.gov/federal-policy-guidance/downloads/cib-01-26-2015.pdf
- CMS Informational Bulletin: Medicaid Payment for Services Provided without Charge (Free Care)
  - https://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf
- CMS Informational Bulletin: Medicaid Managed Care Regulations with July 1, 2017 Compliance Dates
  - https://www.medicaid.gov/federal-policy-guidance/downloads/cib063017.pdf
- Section 1115 Waiver Information
  - https://www.medicaid.gov/medicaid/section-1115-demo/about-1115/index.html