CROSS-SYSTEM APPROACHES THAT PROMOTE CHILD WELL-BEING: STATE EXAMPLES FROM NORTH CAROLINA, PENNSYLVANIA, AND COLORADO

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Introduction: Child welfare has historically been called upon to collaborate with other agencies and programs in the course of doing business. Motivations for collaboration range from the identification of a true business process need, such as the use of appropriate court language for Title IV-E eligibility, to formal requirements in response to a federal or private grant that must include a list of community partners. While most professionals recognize the value of collaboration with various stakeholders, the experience of collaboration is sometimes challenging. Competing goals, different philosophies, and the protection of scarce funding resources can sometimes impede effective collaborative partnerships.

Collaborative efforts between child welfare and Medicaid have shown a long history of success. The Substance Abuse and Mental Health Services Association (SAMHSA)-sponsored Systems of Care grants have evolved into an effective model of service coordination and delivery in many areas across the country. The value in collaboration was recently highlighted in a Center for Health Care Strategies report, Faces of Medicaid: Children's Behavioral Health Care[1], which showed Medicaid expenditures (for both physical and behavioral health) were seven times greater for children in foster care than other children with Medicaid. The high cost of residential treatment, therapeutic group homes, and psychotropic medication are concerns to both state Medicaid agencies and child welfare.

[1]Pires, SA, Grimes, KE, Allen, KD, Gilmer, T, Mahadevan, RM. 2013. Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures. Center for Health Care Strategies: Hamilton, NJ

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In recognition of this convergence of interests from both a financial and programmatic perspective, the federal government has encouraged and required child welfare-Medicaid collaboration through legislation such as the Fostering Connections to Success and Increasing Adoptions Act (2008) and the Patient Protection and Affordable Care Act (2010). Examples of collaborative requirements include the following:

- The Health Care Oversight and Coordination Plan (Fostering Connections, 2008). This required component of the Child and Family Service Plan (CFSP) must be updated in the Annual Progress and Services Report (APSR). The child welfare agency must collaborate with pediatricians and other public entities, including Medicaid, on topics such as psychotropic medication protocols and oversight, child well-being assessments, sharing of health information, and multiple other issues. The child welfare agency is also required to provide a plan to ensure that youth aging out of care have health insurance, a health care power of attorney, and a health care proxy.
- The CFSP requires meaningful consideration of Medicaid stakeholders in service coordination for the children and families being served by the state. The primary purpose of this document is to facilitate the states' integration of all programs that serve children and families – a directive that certainly includes the state Medicaid agency that provides crucial physical and behavioral health care oversight for the foster care population. The Title IV-E State Plan also requires documentation of child welfare-Medicaid coordinated efforts.
- Two of the systemic factors measured by the Child and Family Services Review (CFSR) are enhanced by a healthy child welfare-Medicaid collaboration. One measure is the Agency Responsiveness to the Community, which looks at the child welfare agencies' efforts in working with other public and private community partners to develop and coordinate case planning and service provision. A second measure, Service Array and Resource Development, measures the availability of services in the state to meet physical, mental health, and educational needs. Identification and resource development is best conducted in a collaborative relationship.
- The CFSP also requires documentation on how the Chafee Foster Care Independence Program coordinates with the state Medicaid agency to implement the provisions of the Affordable Care Act requiring mandatory medical coverage for individuals under the age of 26 who were in foster care at 18 (or above depending on the state plan requirements pertaining to age).
- Multiple federal bulletins and letters have been issued from ACYF, CMS, and SAMSHA since 2011 that cover topics such as psychotropic medications, identification of mental health and substance use conditions, behavioral health services, and trauma-informed treatment. These bulletins and letters provide child welfare and state Medicaid agencies with the technical assistance and resources needed to develop an effective collaborative relationship to better serve children and families.

The following examples of child welfare-Medicaid collaboration go beyond treating collaboration as a superficial process where individuals are invited to participate in meetings and provide feedback on documents. They represent true partnerships where the relationship has evolved into the creation of a collaboration that benefits children and families and is consistent with the goals and direction of both state agencies.

NORTH CAROLINA

Partnering For Excellence, Rowan County

Child welfare services in North Carolina are administered at the county level across 100 diverse urban and rural counties. In 2013, Benchmarks, an alliance of behavioral health, child welfare, and other social service agencies, began a pilot with funding through The Duke Endowment to improve behavioral health and well-being outcomes for children served through the child welfare system. This initiative, called Partnering for Excellence (PFE), selected Rowan County, a semi-rural county of 138,000 residents located an hour from Charlotte, for a pilot partnership between child welfare and the behavioral health Local Management Entity-Managed Care Organization, Cardinal Innovations.

PFE targets children ages 4-18 who receive child welfare in-home services or foster care services, and focuses on local practice, policy, and funding innovations that can improve outcomes for these children. PFE's goal is to improve outcomes by increasing the frequency of screening for psychological trauma and appropriate referrals for trauma-informed comprehensive clinical assessments and subsequent trauma-informed evidence-based treatment. PFE also aims to increase support to biological parents and caregivers to support reunification through a variety of interventions. Additionally, PFE is engaged with efforts to help child welfare, behavioral health providers, and school staff become more trauma-informed, and to support the development of an integrated treatment plan informed by a child's clinical assessment.

In order to implement a truly integrated approach to child welfare and behavioral health, PFE has developed a pipeline of interventions and programs. As children enter Department of Social Services (DSS) In-Home Services or DSS custody, workers who have received trauma training will screen all children for trauma and symptoms and refer them to partnering community clinicians who can provide trauma-informed, comprehensive assessments and evidence-based treatment. These clinicians, trained through the NC Child Treatment Program, receive a higher reimbursement rate from Cardinal Innovations for their services. Recommendations from the assessment are then shared with the Child and Family Team and integrated into the DSS service plan. Additionally, PFE provides the Resource Parenting Curriculum to foster parents and collaborates with providers to ensure that a high-quality service array is available for the child welfare population.

PENNSYLVANIA

System of Care Partnership

In 2009, Pennsylvania was awarded a grant from SAMHSA to establish systems of care to serve youth ages 8-18 with complex behavioral health issues and multi-system involvement. The System of Care Partnership was designed to build on and enhance cross-system efforts to integrate and effectively provide services to youth that had already been underway for several years.

The state leadership team that was established to lead the effort included top officials from the Office of Children, Youth, and Families, the Office of Mental Health and Substance Abuse Services, the Governor's Commission for Children and Families, Pennsylvania Commission on Crime and Delinquency, and the Juvenile Court Judges Commission. In addition, youth and family representatives comprised 50 percent of the state leadership team, sending a clear message that the system of care initiative was about changing the way that public agencies made decisions about serving youth and families.

Since 2009, the System of Care Partnership has added the Department of Drugs and Alcohol and the Department of Education (along with additional youth and families to maintain the 50 percent balance) to the state leadership team. The Pennsylvania System of Care Partnership has now grown to 20 counties, with additional counties expressing interest. Evaluation data indicate improved outcomes in behavioral health symptoms, school performance, family interaction, and juvenile justice involvement.

The Pennsylvania System of Care model has produced solid findings in regard to Medicaid cost reductions:

- Medicaid claims were decreased by 43 percent in the 12 months following enrollment, whereas the reduction in costs for the control group was only 20 percent for the same time period.

Savings were greatest for children who had been in residential treatment facilities before the initiation of wraparound services, an overall 38 percent reduction in claims. This finding indicates that the approach is particularly effective for youth using high-cost services such as residential treatment.[2]

Allegheny County Collaboration

The Allegheny County Department of Human Services (DHS) is a leader in public-private collaborations in Pennsylvania. Over the past 15 years, Allegheny DHS has nurtured a collaborative relationship with Community Care Behavioral Health Organization (CCBHO), the county's behavioral health managed care provider under the Pennsylvania HealthChoices program.[3] In addition to managing the behavioral health care of Allegheny County Medicaid eligible individuals, they also partnered with Allegheny DHS to manage the eligibility and distribution of other state-allocated treatment funds for low-income individuals who were not enrolled in Medicaid. This collaboration reduced the back and forth eligibility issues common to this population and the need for organizational overlap in the administration of these funds. The benefits of this collaboration include seamless enrollment and authorization to the client, reduced administrative costs, and timely payment to providers.

The Allegheny DHS-CCBHO collaboration has also increased the availability of Parent-Child Interaction Therapy (PCIT), an evidence-based intervention for young children with emotional and behavioral challenges that focuses on healthy family functioning. CCBHO worked with Allegheny DHS to ensure appropriate Medicaid reimbursement for PCIT through the development of unique modifiers for enhanced outpatient therapy rates as well as credentialing standards for PCIT providers. This collaboration also considered community needs through a thoughtful expansion of PCIT within Allegheny County. Through a DHS-CCBHO initiative, all PCIT providers were mapped in the county against census bureau data and child welfare data to identify target communities with high numbers of children ages 2-7 with involvement in child welfare services. As part of the Title IV-E Demonstration Project, Allegheny County DHS, with the support of the Heinz Foundation, is in the process of renovating potential PCIT delivery sites across the county to increase space for providers and access to PCIT. Allegheny DHS is also funding PCIT for families involved in child welfare who are not eligible for Medicaid. Both CCBHO and DHS understand the value of these investments as successful increases in family well-being outcomes is expected to positively impact the cost of overall health care and child welfare placement costs.

[2]Return on Investment in Systems of Care for Children with Behavioral Health Challenges; Stroul, Pires, Boyce, Krivelyova, & Walrath; National Technical Assistance Center for Children's Mental Health; April 2014.

[3]HealthChoices is Pennsylvania's mandatory managed care program for Medicaid recipients.

From a planning standpoint, CCBHO is an active participant in Allegheny County DHS Children's Cabinet meetings. This group serves in a planning and advisory capacity for children's systems in the county. CCBHO is also a member of the PCIT Advisory Committee and the county planning committee for the Title IV-E Demonstration Project. CCBHO maintains a high level of collaboration with Allegheny DHS in terms of distributing PCIT information to the communities and provider training, education, and support. This involvement is typical of the CCBHO collaborative efforts for any Allegheny DHS initiative to improve the health and wellness of families.

Pennsylvania is representative of a national opportunity to use collaborative funding of evidence-based interventions in child welfare to address the chronic issues of a high needs and high cost population. Whether or not a Title IV-E Demonstration Waiver is in place, the strategic use of state dollars to leverage Medicaid eligible services that impact not only behavioral health, but also child welfare placements, is a critical piece of the funding puzzle facing state administrators.

COLORADO

Targeted Medicaid Waiver Programs

States have the option to allow the provision of long-term care services in home/community based settings under the Medicaid program. Colorado has established Medicaid waiver programs targeting home and community-based services (HCBS) to children. These HCBS waiver programs (under the 1915 (c) waiver authority) provide extra Medicaid benefits and/or services to children with special needs, which otherwise would be unavailable (or difficult to obtain). The majority of the children served within these programs have very high needs and are at risk of placement into residential care (foster care, nursing facility, hospital, or Intermediate Care Facility). These waiver programs help children and youth learn and maintain skills needed to live in their homes and communities.

Colorado currently has five Medicaid waivers specifically targeted for children/youth, two of which are administered by the Department of Human Services (the Colorado child welfare agency). The Children's Habilitation Residential Program (HCBS-CHRP) is a waiver that provides habilitative services such as behavioral services, massage/movement, and cognitive services specifically for children and youth in out-of-home placement.

The chart below shows the five children's Medicaid waiver programs, and the programs' details.[4]

Waiver Type	Children's HCBS Waiver (Children's HCBS)	HCBS - Children With Autism Waiver	Children's Extensive Support Waiver	Children's Habilitation Residential Program	Waiver for Children With a Life-Limiting Illness
What is the primary purpose of this waiver?	To provide Medicaid benefits in the home or community for children with disabilities who would otherwise be ineligible for Medicaid due to excess parental income and/or resources. Children must be at risk of nursing facility or hospital placement. Children must meet additional targeting criteria.	To provide Medicaid benefits in the home or community for children with a medical diagnosis of Autism. Children must meet additional targeted criteria.	To provide Medicaid benefits in the home or community for children with developmental disabilities or delays that are most in need due to the severity of their disability. Children must meet additional targeted criteria.	To provide habilitative services for children and youth in foster care who have a developmental disability and extraordinary needs. Children must be at risk for institutionalization.	To provide Medicaid benefits in the home for children with a life limiting illness. To allow the family to seek curative treatment while the child is receiving palliative care
What ages are served?	Birth through **age 17**	Birth through **age 5**	Birth through **age 17**	Birth through **age 20**	Birth through **age 18**
Who is served?	Children with disabilities in the home at risk of nursing facility or hospital placement	Children medically diagnosed with Autism with intensive behavioral needs who are at risk of institutionalization in an Intermittent Care Facility (ICF)	Children with intensive behavioral or medical needs who are at risk of institutionalization. Children, birth through age 4, must have a developmental delay. Children, 5 through 17, must have a developmental disability.	Children age 0-20 years of age, who are in the custody of the County Department of Human/Social Services, residing in an out-of-home CHRP approved placement and have a developmental disability (developmental delay age 0-4)	Children with a life limiting illness who can be safely cared for in the home and who are at risk of institutionalization in a hospital
What is the active enrollmetn cap on the program?	**1,308** Children	**75** Children	**393** Children	**160-200** Children	**200** Children

[4]Colorado Department of Health Care Policy and Financing

Core Services Program

In 1994, the Colorado Department of Human Services (CDHS) established the Core Services Program. The Core Services Program is authorized by the state legislature to provide strength-based resources and support to families when children/youth are at imminent risk of out-of-home placement and/or in need of services to maintain a placement in the least restrictive setting possible. The Core Services Program combines the consistency of centralized state administrative oversight with the flexibility of a county-run system in order to respond to the complex and changing needs of children and families across Colorado. This model has allowed local management to tailor individualized services to meet the needs of children and families.

The Core Services Program has primarily been funded with General/State dollars, which are used to cover the cost of services for youth in at-risk households (such as day treatments, therapeutic interventions for abuse, mental health services, and other county designed services). During the 2013 calendar year, there were over $44 million in Core Service expenditures.

The statewide Core Services Program was developed to address four goals:[5]

1. Focus on **family strengths** by directing intensive services that support and strengthen the family and protect children/youth
2. **Prevent out-of-home placement**
3. **Return children/youth** in placement to their own home, or unite children/youth with their permanent families
4. **Provide services** that protect children/youth

The legislative authorization of Colorado's Core Services Program requires access to specific services statewide, while maintaining flexibility at the local level. Each of the 64 counties and one Colorado tribal nation[6] develop annual plans to address the four goals above through locally tailored strategies and services. Each jurisdiction designs a unique mix of required and county-designed services, resulting in a multifaceted array of services and opportunities.

[5]Core Services Program Evaluation, 2013 Report
[6]Southern Ute Indian Tribe

The program is structured as a state-supervised, county-operated system with CDHS overseeing funding allocations. In addition, policies and procedures for the program are set at the state level, in collaboration with county staff. While the state provides oversight, each county operates its Core Services Program to meet the unique needs of families and communities. Colorado counties are able to use state dollars to provide children and families with services to address multiple risk factors. The structure of county-based services allows for preventative and therapeutic services to be provided to families prior to their involvement in the child welfare system. Many of the Core Services Programs are serving families with children at risk for removal to foster care, residential placement, or institutionalization. This helps to address child and family issues proactively, which minimizes the need for deep-end services. Based on a study conducted by the Colorado State University, School of Social Work, without the Core Services Program, counties would have spent an additional $68 million on out-of-home placements in 2013. The Core Services Program also provides local jurisdictions with the flexibility to utilize additional funding to serve their populations' needs and cover any gaps between Medicaid and other funding sources that may not be available.

CONCLUSION

State child welfare agencies are faced with the serious challenge of ensuring children's safety, permanency, and well-being in a system that is often overburdened, underfunded, and under intense public scrutiny. Children in foster care and families served by child welfare have complex histories of trauma and poverty that lead to significant psychosocial and health needs and high costs to both the child welfare and Medicaid system. By implementing collaborative practices and financing across departments at the state and local level, both child welfare and Medicaid agencies can effectively reach these children and families, provide evidence-based interventions, and improve outcomes in a cost-effective manner.

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