



NOVEMBER 2016

STATE HEALTH CARE STRATEGIES
TO ADDRESS CHILDREN'S TRAUMA,
EXPOSURE TO VIOLENCE AND ACEs





Futures Without Violence (FUTURES) is a health and social justice nonprofit that advances policies, programs and groundbreaking public education campaigns created to end violence against women and children around the world. Providing leadership from offices in San Francisco, Washington, DC, and Boston, FUTURES has trained thousands of professionals, advocates and community influencers on improving responses to violence and abuse. The organization created the first public education campaign about domestic violence called “There’s No Excuse,” and was a driving force behind the passage of the Violence Against Women Act in 1994, a comprehensive federal response to the violence that affects families and communities.

We’d like to thank the following individuals and organizations for their helpful review of this paper:

- Clare Anderson, Chapin Hall
- Christina Bethel, Johns Hopkins Bloomberg School of Public Health
- Debbie Chang, Nemours
- Carrie Fitzgerald, FirstFocus
- Joan Jung, Asian Health Services
- Shelia Pires, Human Services Collaborative

This document was prepared by Lena O’Rourke of O’Rourke Strategies for Futures Without Violence.

TABLE OF CONTENTS

Introduction	4
Opportunities within the Changing Health Care System to Address Trauma and Violence.....	5
Increased Federal Government Support for Addressing Childhood Trauma.....	5
Power of the States.....	6
Using this Paper to Make Change in Your State.....	6
Preventing and Treating Symptoms of Trauma: Practice Implications	8
State Policy Levers for Improving Access to Trauma-informed Care for Children and Caregivers	9
Use Medicaid Flexibility to Design Trauma-informed Health Homes.....	9
<i>State Snapshots: Selected Medicaid Health Home Programs (New Jersey, Oklahoma, Iowa)</i>	11
Emerging Best Practice for Trauma Health Homes: <i>New York</i>	12
Adding Trauma Services to Medicaid Benefits Package.....	12
<i>State Snapshots: Evidence-based Trauma-informed Services in State Plans (Connecticut, Indiana, Michigan, Oklahoma, Arizona, Nebraska)</i>	14
Strengthen, Enhance, and Enforce EPSDT Benefit.....	15
<i>State Snapshots: Innovative Use of EPSDT (Colorado, Massachusetts, Iowa)</i>	16
Support Two-generation Solutions (including through EPSDT).....	18
<i>State Snapshot: Two-generational Solutions (North Carolina, Colorado, North Dakota, Minnesota, Illinois, Virginia, Colorado, Vermont, Wisconsin)</i>	18
Emerging Best Practice: <i>Asian Health Services, California</i>	19
Cover Home Visitation Under Medicaid.....	19
Blend Funding Sources to Provide Wraparound Coordination and Integrated Services.....	20
<i>State Snapshots: Wraparound Programs (Wisconsin, Arkansas, Connecticut)</i>	21
<i>State Snapshots: Co-location of Services (Michigan)</i>	22
Emerging Best Practice for Coordinated Services: <i>Whole Person Care Pilots, California</i>	22
Co-locating Financing of Health Care, Behavioral Health, and Other Social Services.....	22
Implement the State Option for Peer-to-Peer Supports.....	23
<i>State Snapshots: Peer-to-Peer Supports (Tennessee, Georgia)</i>	24
Support Enrollment for Foster Care Youth and Homeless Youth.....	24
Support Continuous Enrollment for Justice-involved Populations.....	25
Expand Scope of Practice Laws in the State.....	26
Promising Area: Medicaid in Schools.....	26
Conclusion	26
Endnotes	27
Related Resources	29



INTRODUCTION

American children are hurting. Not from the wars or disease that are afflicting so many other parts of the world, but from far more intimate acts of violence, loss and trauma. Two out of three children in this country will be exposed to violence, crime, abuse, or psychological trauma in a given year, and this experience often has lifelong consequences for their health, safety and educational and economic success. When breaking this down to a list of 10 “adverse childhood experiences,” commonly known as ACEs, about a quarter of children already have two or more and we know that for children exposed to violence, more than 90 percent also experience other ACEs. This includes exposure to domestic violence, physical or emotional abuse, being sexually abused, or having a parent with a mental health condition, substance abuse disorder or who has been incarcerated.

The consequences of ACEs are now irrefutable and include higher rates of suicide, substance abuse and mental health challenges, shorter life spans, higher rates of violence and criminal activity and poorer educational and economic outcomes. Most importantly, however, children who have been affected by ACEs, violence and trauma can heal. The often cascading effects of ACEs and exposure to violence in childhood can be mitigated if it is recognized and if appropriate actions are taken at the personal, clinical and policy levels.

The health care system plays an important role both in identifying children who may be exposed to extreme adversity and violence, currently and in the past, and in providing the evidence-based interventions that can help children heal from trauma and prevent health conditions and other poor outcomes associated with trauma and ACEs. The health care system is also central in supporting the greatest resource a child has: a stable, safe and nurturing parent or caregiver. Because health care providers also interact with parents, their potential to help children is even greater.

This paper will help states do just that by highlighting health care responses and payment strategies at the state level that promote or cover promising approaches for addressing immediate health issues associated with trauma and ACEs. It builds on a larger report produced by Futures Without Violence in 2015 called *Safe, Healthy and Ready to Learn*, which looked at multi-system interventions to prevent and address childhood trauma, violence and other ACEs. In that report, leading experts from multiple fields identified areas of action for maximum impact and specifically drew out the health sector as central to preventing and mitigating harm from childhood violence and trauma. (For a related report on how the education system can respond to childhood trauma, ACEs, and exposure to violence, go to: www.futureswithoutviolence.org/every-student-succeeds-act-funding-opportunities/.)

Opportunities within the Changing Health Care System to Address Trauma and Violence

Our health care system is undergoing a major transformation as policymakers have sought to improve and expand care to more people while lowering costs. As part of this effort, public and private payers are prioritizing coordinated- and community-based care, the integration of behavioral health with physical health and primary care, and addressing underlying social determinants of health.

This new paradigm holds tremendous potential for increasing services for children exposed to violence, and in preventing and treating the resulting trauma. Increasing the capacity of the health care system to recognize and respond to childhood trauma and ACEs will result in improved health care outcomes for children and adults, and likely a reduction in health care expenditures, given the health costs associated with trauma and ACEs.¹ This recognition has and should continue to motivate states and the federal government to act.

Increased Federal Government Support for Addressing Childhood Trauma

The federal government has taken many helpful actions in recent years to recognize and respond to the health needs of children and their families struggling with trauma and ACEs. In 2013, HHS released a letter to state officials on trauma-informed care.²

In this letter, federal policy makers identified using Medicaid, the nation’s public health insurance program for the poor, to monitor the development of children, and to prevent and/or intervene early for resulting trauma. Specifically, the letter identifies the Early and Periodic Screening, Diagnostic and Treatment (EPSDT) program as an important source of reimbursement for services for children who have experienced trauma and encourages early intervention.³ The benefit guarantees comprehensive coverage for children so that they receive all appropriate and medically necessary health and behavioral health care services with regular screenings and early identification of needed services. The letter clarifies that necessary health care, diagnostic services, treatment and other measures coverable under section 1905(a) of the Act must be made available to “correct or ameliorate any physical and mental illnesses or conditions discovered by the screening services, whether or not the services are covered under the state plan.” EPSDT remains the strongest tool for states and policymakers to cover children’s physical and behavioral health services, and is the door by which to ensure healing services for children in Medicaid, and in some cases can be used to cover the family together.

In addition, most children and adolescents enrolled in Medicaid, get their health care through a managed care arrangement, which has the potential to be advantageous in meeting the needs of struggling children and families. The insurers who manage these plans are required to provide **all** services in the state’s benefit package (including EPSDT and behavioral health services) and are able to offer additional services such as navigation, care coordination and other supplemental services that could include prevention, early intervention and trauma-informed services. Managed care plans can shine a spotlight on prevention and early intervention and may be a launching pad for the development of trauma-informed health systems.

Managed care arrangements also have tremendous flexibility to expand services through the use of additional types of service providers, including community health workers, and opportunities may exist to integrate trauma-informed or community-based providers into delivery systems. Plans may also find it in their best interest to invest their resources in enhanced care management services, trauma-informed services, and two-generation services in order to improve health outcomes and lower health care costs over time. While managed care offers new and exciting opportunities to expand coverage and services, advocacy and law changes may be required to realize this potential.



Power of the States

Ultimately individual states play the strongest role in determining what services children and families receive under Medicaid. States make choices about what services are covered, beyond the federally-mandated minimum benefits, what types of providers may participate, and how care is coordinated. States contract directly with the managed care entities and delineate what plans must cover, and can require coverage of specific types of community-based or population health services. The choices and policies that are implemented by state Medicaid programs have a direct ability to increase access to a wide range of trauma-informed services, as well as to shape the delivery system overall.

Many states have made strong choices on a range of health care policy and payment reforms, including:

- Expanding services for children in Medicaid by using existing flexibilities;
- Integrating community-based services and supports into health delivery systems;
- Increasing focus on early intervention and a new shift towards financing prevention;
- Developing two-generation solutions that serve the child and caregivers together; and
- Encouraging states to implement best practices and reimbursement strategies to support the needs of children who have been exposed to violence or may be experiencing trauma.

In each of these categories, some states already have used their Medicaid flexibilities to concretely and positively impact the availability of and access to services for children exposed to violence and to treat the resulting trauma.

Using this Paper to Make Change in Your State

This paper highlights key flexibilities in Medicaid policy that a state can use to pay for trauma-informed prevention and services – and to design systems of trauma-informed care. Because Medicaid policies vary from state-to-state, and because there are few national tracking systems of these Medicaid policies, this is a non-exhaustive overview to help states and advocates identify existing state-level strategies to expand capacities to prevent and respond to trauma. This paper lifts up examples of state policies that have been implemented as a menu of opportunities to advance a prevention-focused, trauma-informed health care system. It asks the question: what can we do today, in our state, to make tangible progress to improve the health care system response to children exposed to violence, trauma, and ACEs?

To date, studies addressing a full return on investment for addressing ACEs in health settings do not exist given the long term and multi-generational impacts of addressing child trauma and ACEs early on and the nascent health care response. That said, new attempts to measure costs and cost savings are emerging. Engaging in that kind of research and monitoring results from other states' efforts should be supported.

Specifically, this paper offers concrete examples of ways states and health systems can promote the health of children and adolescents, caregivers, and communities who are exposed to violence and trauma. This paper focuses specifically on services for children and adolescents, and their caregivers, but we acknowledge that trauma-informed services are critical across the lifespan as well and states should seek to include services for adults as well.

The policy solutions include:

- Trauma-informed Health Homes;
- Adding trauma-informed services to the Medicaid benefit package;
- Strengthening EPSDT to better serve children exposed to violence and trauma;
- Implementing two-generation solutions (including through EPSDT);
- Expanding Home Visitation with Medicaid funding;
- Strengthening Wrap-around coordination and services;
- Co-locating financing of health, behavioral health and social services;
- Developing peer-to-peer support programs;
- Supporting coverage for foster care youth and justice-involved populations; and
- Expanding state “scope of practice” laws.

In each section, we outline a policy solution that is currently being used at the state level, and we identify why it may result in increased access to services for children exposed to violence. We identify why it may be a policy opportunity for other states, as well as the challenges of implementing it. Where possible, we discuss opportunities to integrate specific flexibilities into new delivery models. Some of the policy options presented require a lot of work and time to move forward; others can be implemented more swiftly at the clinic or organizational-level.



There will need to be careful thought given to some implementation challenges, such as the nationwide workforce shortages. This is not unique to trauma-informed services but will impact the availability of services for children in all states. It is important to ensure sufficient resources for provider training and support to address ongoing turnover in the workforce. State policymakers will need to consider ways to expand the workforce, including using non-licensed professionals (e.g., community health workers, peer mentors) and other staff to ensure children have access to needed services.

Separate conversations should also address making grant funds available to stand up evidence-based interventions and provide early training and resource development; these funds are not available through Medicaid. Resources will be needed to develop, review and revise policies and protocols, train providers on how to do the work, supply materials for the providers, and staff time to integrate trauma-informed services into wide-ranging systems. To be effective, staff time should be devoted to forging relationships with community-based partners and partnering and coordination across child-service systems. This will take staffing, training and, most critically, sufficient funding. States, local public health departments, and other child-serving agencies may identify or repurpose

other funds and grants to stand up the interventions or programs – and Medicaid can become a sustainable source of reimbursement for the health and behavioral health services once systems are in place.

States should also consider how Medicaid can partner with the healing and treatment efforts underway in other parts of the state government, including with justice, education and other public health efforts. Medicaid can be an important source of financing for health and behavioral health services and blending and braiding funding across silos can provide a strong foundation for integrated services.

No one solution or set of solutions will work in each state. The right solution will vary based on a number of factors including the structure of the state health insurance market, state politics, available funding sources, and the community-level support systems. Advocates, state policymakers, and other decision-makers should look inside their own states and map the available resources – and where there are opportunities to improve coverage and strengthen the availability of services for children exposed to violence. Working in partnership across all stakeholders, increased access to trauma-informed services is possible.⁴

Preventing and Treating Symptoms of Trauma: Practice Implications

This paper explores policies designed to cover health and behavioral health services using health insurance; it includes discussion of payment and reimbursement systems to maximize the ability of a child or family to access needed services that are covered primarily by Medicaid. There are clear practice implications for providers that will result from these state-level coverage decisions. While this paper only touches on the provider experience and how a provider would implement these policies in practice, additional policy analysis will be done to explore how best to implement these approaches and ensure adequate and sustainable funding at the provider level.

FUTURES, however, strongly recommends that as states innovate in this area two essential practice recommendations are kept at the fore: providers should be providing universal education to families, not simply screening through a rudimentary checklist and that changes should support reimbursement for early identification and care for mild symptoms – the goal should be to prevent a serious health problem not wait for it to inevitably arise before helping a child or family member.

More research is needed on what approaches to identifying, preventing and responding to symptoms of trauma are most effective, including research on self-administered or provider administered screening tools in the clinical setting and/or embedded in EHRs. Still FUTURES supports a universal education approach, rather than one that is disclosure driven (which may or may NOT be coupled with screening questions if they are delivered in a trauma informed manner). With a universal education approach, providers can promote prevention, resiliency, healing, and offer strategies that buffer the potential adverse impact of trauma on health regardless of if an individual is ready to disclose their experiences with trauma. This is particularly important for caregivers who may be concerned about punitive responses to screening forms. Rather, a universal education approach emphasizes the caring and supportive relationships that can help enhance resilience; and define concrete action steps to support parent or caregiver skills and children's resiliency. There are practice implications for how to safely and effectively implement these and other approaches, and a growing body of literature can provide examples and resources but this is not covered in depth here.

FUTURES also strongly supports early intervention and prevention for children and families exposed to violence. The policies outlined in this paper will provide coverage for a wide-range of services and support coverage of mild-to-moderate diagnosis before there is a behavioral health crisis. But health insurance may require a formal diagnosis (and sometimes a severe behavioral health diagnosis) to cover certain services. The federal government importantly gave support to states to address trauma early through the "the tri-agency trauma letter" that gives guidance to state Medicaid directors. It states:

"...Many of these children will demonstrate complex symptoms and/or behaviors that may not map directly to the [DSM] or the [ICD]...For example, there is currently no DSM diagnosis that adequately captures the range of child trauma effects...Yet, trauma-related symptoms are identifiable, can be clinically significant and can be addressed with appropriate interventions. For these children, appropriate screening, assessment and referral to evidenced-based practices are clearly indicated."

North Carolina has started down this path, allowing up to six outpatient behavioral health visits without requiring a diagnosis on the claim. Despite the challenges, it may be possible to cover preventative mental health services for a preliminary, time-limited manner without a diagnosis under Medicaid. We encourage programs to be restructured to allow for these prevention services in addition to evidence-based interventions, and for advocates to have these conversations with state policymakers when discussing policy change.



STATE POLICY LEVERS FOR IMPROVING ACCESS TO TRAUMA-INFORMED CARE FOR CHILDREN AND CAREGIVERS

Using Medicaid Flexibility to Design Trauma-informed Health Homes

Health homes are a promising care model for addressing child trauma. Health homes provide comprehensive care management and coordination services as well as a number of other supports and services to specific populations with chronic health or behavioral health conditions identified by the state.

A health home is not necessarily a physical place; it can be a network of providers with the primary care provider or clinic in the center. The health home acts as a gate keeper to coordinate care and advocate for the patients in their "home" and works to get them all needed services (but does not necessarily provide all the care themselves). Primary care providers frequently work with care coordinators, community health workers,⁵ and social workers to provide navigation services and supports to families. As a result, children who participate in health homes get a much higher level of coordinated services, as well as more consistent interaction with their providers.

Each state will determine a set of eligibility criteria for who can participate in a health home within the parameters of the regulations developed by the Centers for Medicare & Medicaid Services (CMS). Depending on the state process, a wide range of different types of providers or entities (e.g., a managed care plan; case manager) could administer a screening tool and recommend the patient to be assigned to the health home. Patients and caregivers may have to consent to having their care managed through a health home but the day-to-day process of using their insurance and accessing providers would not significantly change.

It is possible to develop a health home that integrates trauma approaches into its model, and may be possible to develop a health home that would be targeted at individuals who have been exposed to violence and designed to treat the resulting trauma symptoms. For children and caregivers, participating in a trauma-informed health home could mean coordinated access to the broad array of services that are covered by the state plan to heal and treat the impacts of trauma, as well as receive age-appropriate medical care. They would receive additional care coordination and case management services to help their families navigate the health system and make sure that needed services are received.



Opportunities

- States can develop or build on existing health homes in the state to include "exposure to violence/resulting trauma" as an eligibility category. This means that children and families exposed to violence or who present resulting symptoms of trauma could receive the personalized, coordinated services.
- Most states have existing health homes for a wide range of conditions. State administrators will be familiar with the process and payment structures, providers will understand how to participate, and there may already be provider networks developed.
- Many states have already designed and implemented health homes for patients with chronic conditions or serious emotional disorders. States could build on these and propose they include complex trauma as a condition for participating in health homes.
- States receive an enhanced federal match rate (90% FFP) for two years to provide for specific services that are provided through the health home authority.
- Federal policy makers have identified health homes as a key strategy for improving coordinated care and for funding care management.

Why It Works

- Participating beneficiaries receive care from a primary care or behavioral health provider who serves as the usual source of care and the convener of all needed health care services.
- Beneficiaries receive comprehensive care management, care coordination, mental health care, transitions from inpatient to other settings, family supports, and referrals to community and support services.
- Option exists to develop tiered payments to account for the severity of each beneficiary's condition in order to include beneficiaries with lower levels of acuity.



Challenges to Consider

- Health home proposals are developed by the state and approved in partnership with CMS. As a result, it can take a long time for health homes to get approved.
- Because it is a formal negotiated process between the state Medicaid department and federal policymakers, this process will require significant long-term advocacy and stakeholder relationships across providers, advocates, hospitals and others.
- It will be important to appropriately define the eligibility criteria for exposure to violence and trauma (see New York State's definition on next page).
- While health homes can be tiered for different levels of acuity, health homes focus more on the treatment and healing of their patients. Prevention services are not the core focus of health homes because they are designated for populations with chronic conditions to begin with.

Key Advocacy Steps

- CMS and the Substance Abuse and Mental Health Services Administration (SAMHSA) have developed a guide to assist states to prepare for implementing health homes for individuals with behavioral health needs and have identified this as a key for priority populations.⁶
- Develop relationships with state Medicaid departments.
- Develop a broad-based coalition of stakeholders and experts to help design the program.
- Understand the existing state health homes, if they exist. Questions to ask include: who is currently eligible? How broad are the existing networks and do they include behavioral health providers? Are there pediatric networks of providers who participate in health homes?
- Research how the health home was developed in your state and what steps it will take to develop a trauma-informed health home. For example, would the state need approval from the state legislature? Is it possible to add an "exposure to violence and trauma" as eligibility category when submitting an existing waiver renewal to CMS? These questions might best be answered by partners within the Medicaid agency.

IOWA



Includes children with serious emotional disabilities. Team of health care professionals: Team comprised of a lead entity and qualified integrated health home. Team to include: physicians, nurse care coordinators, social workers, behavioral health professional, and peer support specialist/family support specialist.

NEW JERSEY



New Jersey has implemented a health home for children with behavioral health challenges. It provides comprehensive care management; care coordination; health prevention; and provides individual and family supports. It integrates a wide range of behavioral health and medical services, and attention is paid to the symptoms of complex trauma.

OKLAHOMA⁷



Oklahoma has developed a health home for children with serious mental health issues that includes a strong behavioral health wraparound and coordination efforts. It includes specific requirements for coordination between the health home and the primary care providers, and includes participation from the community mental health centers. Requires that all participating children get all required EPSDT screenings including behavioral health screenings. Includes children with serious emotional disabilities. Team of health care professionals: Team comprised of a lead entity and qualified integrated health home. Team to include: physicians, nurse care coordinators, social workers, behavioral health professional, and peer support specialist/family support specialist.

STATE SNAPSHOTS

Selected Medicaid Health Home Programs implemented for a range of conditions, including serious and persistent mental health conditions. These do not inherently include trauma services but provide a snapshot of how these three states have implemented health homes.

Emerging Best Practice for Trauma Health Homes: New York

In New York State, an existing health home program is designed to serve children and adults with serious mental health conditions. The state has issued a request to CMS proposing to add “trauma” as a qualifying condition for participation in a coordinated care health home. While it has not yet been approved, CMS has provided guidance supporting the provision of integrated care management such as that provided by Health Homes to children who have experienced trauma. The definition included in the draft Health Home Application to Serve Children was modeled on this CMS guidance therefore NY is confident that this addition to our eligibility criteria will be accepted, but will finalize this based on conversations with CMS.⁸

Copied below is the definition that NY has included in their proposal: Definition of Trauma and at Risk for Another Condition.⁹

- Trauma is defined as exposure to a single severely distressing event, or multiple or chronic or prolonged traumatic events as a child or adolescent, which is often invasive and interpersonal in nature. Trauma includes complex trauma exposure that involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence, and physical and sexual abuse.
- A child or adolescent who has experienced trauma would be defined to be at risk for another chronic condition if they have one or more functional limitations that interfere with their ability to function in family, school, or community activities, or they have been placed outside the home.
- Functional limitations are defined as difficulties that substantially interfere with or limit the child in achieving or maintaining developmentally appropriate social, behavioral, cognitive, communicative, or adaptive skills, or for a child who experienced trauma due to child maltreatment, a functional limitation is defined as a serious disruption in family relationships necessary for normal childhood growth and development.

The state has an existing screening tool, Child and Adolescents Needs and Strengths (CANS-NY), used to assess children for their eligibility to be covered in the Trauma health homes model and to determine the acuity of their condition. The tool is being modified and tested to include screening questions for exposure to trauma.

Enrollment in a health home must be “appropriate;” in other words, the beneficiary must need the more intensive level of care coordination provided by a health home. To be deemed appropriate, the beneficiary is assessed to determine if the person is:¹⁰

- At risk for an adverse event;
- Has inadequate social/family/housing support or has serious disruptions in family relationships;

- Has inadequate connectivity with healthcare systems;
- Does not adhere to treatments or has difficulty managing medications;
- Has deficits in activities of daily living;
- Has recently been incarcerated; and
- Is concurrently eligible or enrolled, along with their child or caregiver

The health home will pay providers on a tiered rate structure based on the acuity of the patient. A flat rate will be paid for “outreach” activities.

Adding Trauma Services to Medicaid Benefits Package

In a 2013 joint memo from the U.S. Department of Health and Human Services’ Center for CHIP and Medicaid Services (CMCS) and the Substance Abuse and Mental Health Services Administration (SAMHSA),¹¹ the Administration outlined a wide range of interventions as examples of what could be covered by Medicaid for children’s behavioral health. Expanding the state Medicaid benefit package to increase the number of trauma services covered can greatly improve the health system’s response to violence. In other words, specific services or interventions would be listed as a covered, billable service through Medicaid in the state. This ensures that children have access to the services and that providers get reimbursed for delivering the service.

Examples of evidence-based interventions covered by state plans include:

- Multi-systemic Therapy, an evidence-based in-home services intervention that has been implemented in many states.¹²
- Parent-Child Interaction Therapy, an evidence-based intervention identified as a promising practice by CMS.¹³
- Intensive-in-home services, therapeutic interventions to prevent out-of-home placement settings and typically includes individual and family therapy, skills training and behavioral interventions.¹⁴
- Trauma-Focused Cognitive Behavioral Therapy (TF-CBT), an evidence-based intervention that helps children and their families recover from the negative effects of traumatic exposure.

To receive a service covered by the state plan, a child would need to meet the medical necessity criteria for the service. For example, the pediatrician or other provider (e.g., counselor) would determine that the child and/or family needed to get TF-CBT. The child would get a diagnosis, prescription and/or referral for the service. A licensed behavioral health provider would directly administer the therapy and then bill the Medicaid department or managed care organization for TF-CBT according to the state’s rules and prior authorization processes. That provider would get reimbursed the pre-negotiated rate for providing the TF-CBT.



Opportunities

- Includes specific best and emerging practices on a list of reimbursable services making it easier for families to access the services when needed.
- Federal policymakers support a wide-range of evidence-based services that a state could include in their state plan.
- Provides clear guidance to providers that these interventions are best practices for the states.
- May increase utilization of the services if providers are incentivized to provide them with adequate rates and training.
- Administratively easy for states to implement and for providers to bill for.
- Services included in a state plan will be medical and behavioral health services, and a priority will be on evidence-based services. Typically, coverage include services for patients with higher acuities of mental health conditions but a state could provide coverage for patients with mild to moderate symptoms, or provide more early intervention and prevention services.

Why it Works

- Many states have had success with this strategy and cover specific trauma-informed interventions in their state plans. Some states provide specific billing codes for each of these services.
- Adding services to state plans does require CMS oversight but does not require a waiver or other long process.

- Some states have also used a strategy of promoting specific interventions and offering more generic billing codes. For example, Parent-Child Interaction Therapy is typically billed to Medicaid in states who choose to offer it as either individual or family mental health therapy. Intensive in-home treatments receive Medicaid funding as a bundle rate for clinical services but relies on other sources of state (or external) funding for the non-clinical components of the services.¹⁵
- Medicaid funding or other provider reimbursements can sustain innovative implementation of interventions.

Challenges

- Start-up costs in terms of provider training, purchase of interventions and test kits, and other certification requirements. Additional grant funding or start-up funds may be necessary in order to start a program up.
- It is important to acknowledge that the models may not be culturally and linguistically appropriate for all communities.
- Prevention services or interventions that focus on early assessment and prevention not a state priority.
- Scope of practice state laws will still limit who can actually provide the services.
- Significant behavioral health workforce shortages exist in some communities and it may be difficult to find a qualified provider.
- This tactic, while administratively easy to administer, does not inherently include case management or care coordination services. Caregivers and families may need additional health system navigation services.

Key Advocacy Steps

- Identify what the State Medicaid Plan currently covers. This can be done in partnership with providers or directly with the State Medicaid Department. Are there existing general billing codes that are commonly used to cover these interventions or will a specific code be necessary?
- Work with policymakers to identify the specific service to include in the state plan and to develop a plan to have the service covered;
- Some states may require legislative approval to include new services, others may be able to do it administratively;
- Partner with a wide range of stakeholders to demonstrate the efficacy and desirability of the intervention; and
- Identify possible sources of start-up funds for interventions. For example, The Community Mental Health Services Block Grant could provide start up, as could Title IV-B, Part 1 & 2. There are also some relevant discretionary grants through SAMHSA and or the Children’s Bureau within HHS. Medicaid managed care organizations can use administrative funds or reinvestment funds to start up a PCIT program.¹⁶

STATE SNAPSHOTS

Selected State Snapshots: Evidence-based trauma-informed services in state plans

CONNECTICUT

Connecticut offers TF-CBT through outpatient community mental health clinics across the state.¹⁷ These services are offered to children ages 4-18 who have behavioral or emotional problems that are related to trauma even if they do not meet the full diagnosis of PTSD or other serious mental health disorder. Individual sessions with the parent and with the child, as well as joint family sessions are part of this intervention. Connecticut's Department of Children and Families promotes other evidenced-based trauma interventions, including PCIT¹⁸ and Medicaid will reimburse for these services. Provider training for this certification is funded through the Connecticut Department of Children and Families. The services are available to children on the state's Medicaid and CHIP programs. They are billed to Medicaid (and to private insurance) as outpatient mental health services.

INDIANA, MICHIGAN, OKLAHOMA

Indiana explicitly covers Trauma-Focused Cognitive Behavioral Therapy but only for children and youth in residential facilities¹⁹ (including small detention facilities). Medicaid pays for the coverage under the Rehabilitation Option for eligible families; the Department of Child Services pays for the rest.

Michigan covers Trauma-Focused Cognitive Behavioral Therapy and Parent Management Training-

Oregon Model Evidence-based practices are covered under Medicaid when delivered by a certified clinician and are covered under billable service codes such as home-based therapy or individual or family therapy.²⁰

Oklahoma offers TF-CBT services and other "promising practices trauma treatment models" to all children through outpatient mental health clinics.²¹

ARIZONA, NEBRASKA

Arizona covers Functional Family Therapy, Multidimensional Treatment Foster Care, and Cognitive Behavioral Therapy. They use existing billing codes for assessment, case management and therapy. Billing code matrices were developed to help providers determine how to bill.²²

Nebraska covered Parent Child Interaction Therapy and Child-Parent Psychotherapy services as specific Medicaid covered services.²³ Prior approval is needed based on medical necessity; and providers need to have demonstrated the training credentials for consulting the services. PCIT must be billed utilizing CPT code 90847 U7 and CPP must be billed utilizing CPT code 90847 U8. Both of these services will be reimbursed at the fee-for-service and managed care rates established for CPT code Family Psychotherapy 90847.

Strengthen, Enhance and Enforce EPSDT Benefit

The Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit ensures that children and families receive the early screenings, and are appropriately referred to treatment for potential problems identified. For children exposed to violence, EPSDT can serve an important periodic developmental check for resulting symptoms of trauma, and to identify and provide the needed treatment for the child and family. Of note, EPSDT covers a wide range of behavioral health screenings designed for early detection and intervention, and some state plans include specific screening for adverse childhood experiences and exposure to violence.²⁴ EPSDT is guaranteed to every child and adolescent covered by Medicaid (in FFS or managed care). The preventive and curative nature of EPSDT helps to ensure that health problems, including behavioral health issues, are identified and treated early.

In practice, providers and advocates may face practical challenges to fully implementing EPSDT, including provider reimbursement, state utilization management techniques (e.g., strong medical necessity definitions), and lack of provider and community education. In order to realize the potential of the benefit, it is critical to enhance and enforce EPSDT. There are many state-level policy improvements that can be made to better implement EPSDT, assure access to service, and provide adequate reimbursement.

Opportunities

- EPSDT screening can be done by a wide range of providers, schools, community health workers, home visitation specialists and more. These providers can do initial screenings and assessments and work with pediatricians to develop a plan of care.
- EPSDT can be implemented in flexible ways to allow a wide range of sites outside of the pediatrician's office (e.g., schools, community-based organizations) or a wide range of providers (e.g., community health workers) to participate in the screening, assessments and navigation.
- Robust education to providers and communities about EPSDT can make a real difference in getting more children screened and linked to services.

Why It Works

- EPSDT covers all medically necessary behavioral health services for the child, and in some cases, it can also cover services for the caregiver or the family together. It covers all federally allowable services even if they are not in a given state's plan.
- It is the legal underpinning for coverage and can help children exposed to violence and trauma access all the medically necessary services they need.
- Can provide care coordinators and navigators to help families navigate the maze of services.



Challenges

- Significant provider education is necessary to make sure that the children get the screenings and treatment.
- States often implement strict utilization management processes (e.g., prior authorization) on services that can make accessing care difficult. It is expensive to provide all medically necessary treatment.
- Care coordinators are needed to help families navigate the maze to get the kids the services they need.
- State reimbursement can be a challenge for providers.

Key Advocacy Steps

- Identify which EPSDT improvement strategy to pursue. This will be a reflection of state politics, environment and an assessment of how it works now. Consider different strategies:
- Provider education campaign to disseminate tools and resources for implementing EPSDT;
- Expand the types of providers who do screening, assessments and navigation;
- Consider partnership with community health workers, public health clinics and foster care program;
- Expand coverage under EPSDT to specific services for caregivers and families;
- Fund case managers and additional partnerships between advocates and pediatricians;
- Work with the state Medicaid program to identify solutions and funding for expanding services;
- Partner with state medical societies and other organizations to develop necessary education materials for providers so that they understand how EPSDT works, and the full scope of services that a child exposed to violence may be able to receive; and
- Conduct a state assessment to identify where and why EPSDT is not realizing its promise for expanding trauma-informed services.

COLORADO²⁵

Redesigned its EPSDT administrative case management program and uses “medical home navigators” who provide case management services, such as educating children and families about EPSDT benefits and linking them to providers. Colorado also incentivizes providers participating in medical homes to do EPSDT screenings by paying bonuses. Early findings from Colorado show an increase in referrals for treatment.

MASSACHUSETTS²⁶

Provides integrated and comprehensive home and community-based mental health services for children with serious emotional disorders. Services may include comprehensive care coordination; family trainings and support; in-home therapy and behavioral health services.

IOWA

Medicaid agencies contract with Maternal and Child Health agencies to provide TA and training for EPSDT. Through a reciprocal agreement, Medicaid gives the Title V service agency a list of potentially eligible families, and the Title V providers notify them about their potential eligibility.

but services directed solely at the mother would only be coverable under Medicaid if the mother is covered by Medicaid. If, however, the services would be considered for the direct benefit of the child and would be delivered to the mother and child together, the services could be covered by the child’s insurance. Maternal depression screening is an important service for all mothers, in particular those who are victims of violence.

Opportunities

- Increase screening for maternal depression—or other exposure to violence and resulting trauma—by allowing pediatricians to screen at the well-child visits.
- Expand access to a wider range of screening and education for caregivers who are victims of violence, and serve as a prompt for the development of care plans for the caregiver and child.
- It is one of the few ways to fund services for the caregiver and child together.
- Directly cover services and interventions, such as trauma-informed family therapy, in the state plan.
- Linking services for parents to EPSDT or creating Medicaid “family accounts” which are billable for children and parents together.³⁰
- Make two-generation supports and services available that are comprehensive, systemic, and trauma-informed.

What is working

- States are increasingly promoting two-generation solutions for families and are interested in expanding coverage to mothers and children together.
- Allows significant flexibility to design programs that work for the whole family.
- CMS has reaffirmed that EPSDT may be used to cover maternal depression screenings; and that two-generation services may be covered for the caregiver and child if the services are for the direct benefit of the child.

Challenges to Consider

- Significant education is needed to ensure that providers have the tools they need to implement two-generational strategies.
- The availability of providers for women who need services can also be a challenge.

Key Advocacy Steps

- To cover certain types of services such as group therapy, there may be Medicaid requirements that need to be considered. It will be important to work with state policymakers to understand what, if any limitations, there are.
- Ensure there are no statutory barriers to treating (and billing) for two generation solutions.

Support Two-generation Solutions (including through EPSDT) – Parents and Children Together

To heal a child, it is often not enough to simply provide care to the child. For instance, in homes where there is domestic violence or a parent who is suffering from mental illness or substance abuse, it may be necessary to serve both a parent and a child. In some instances, joint treatment such as parent-child psychotherapy is advised. In others, addressing a mother’s depression may be what the child most needs to be safe and healthy. These “two-generation” services work to strengthen family bonds and treat individual symptoms in the child and primary caregiver, usually the child’s mother.

States have options to cover two-generation solutions under Medicaid but this is an emerging best practice and only a limited number of states cover these strategies.²⁷ The most powerful tool to implement two-generation strategies is EPSDT. To cover services for a caregiver, or for the caregiver and child together, a state must cover a range of services for the benefit of the child, that serve the caregiver and child together, or that would allow services

for the caregiver to take place in a pediatric setting. States are permitted to cover interventions in pediatric settings, such as parental education or assessment, so long as these services cannot be considered treatment for the caregiver (treatment services for the sole benefit of the caregiver would have to be referred out or billed to the caregiver’s insurance).

A May 2016 Informational Bulletin from the Centers for Medicare and Medicaid Services discussed using Medicaid to support two-generation solutions – and explicitly maternal depression screening and treatment.²⁸ This Bulletin amplifies the important United States Preventive Services Task Force (USPSTF) recommendation for screening for depression in the general adult population, including pregnant and postpartum women. Some states offer depression screening for mothers by a pediatrician at a well-child visit under EPSDT.²⁹ In this model, a pediatrician uses the well-child visit for the child – but also provides certain screenings or services for the mother. States that cover maternal depression screening by pediatricians do so under the child’s Medicaid number. If a problem is identified as a result of the EPSDT screening, states have an obligation to provide the medically necessary diagnostic and treatment services for the child—



Two-generation Solutions

NORTH CAROLINA³¹

If a child or adolescent (up to age 21) enrolled in Medicaid is exhibiting negative behavioral health symptoms as a result of their parent's behavioral health and the parent does not have their own coverage, treatment of the child AND parent may be covered under Medicaid--the parent can be included in treatment.



COLORADO, NORTH DAKOTA AND MINNESOTA³²

Pediatric providers may bill for postpartum depression screening on the mother using the infant's Medicaid ID.



ILLINOIS³³

Pediatric primary care screening for maternal depression can be billed on infants Medicaid ID. If the mother is diagnosed with depression, Medicaid will reimburse for treatment under the mom's ID if the mom is enrolled in Medicaid or another state-funded MCH program. If the mother is not eligible for Medicaid or other program, the provider will refer for additional mental health resources.



VIRGINIA³⁴

Reimburses pediatric providers for administering and interpreting the Behavioral Health Risks Screening tool which screens for postpartum depression, substance abuse and IPV, as well as infants who may be at risk for developmental secondary issues because of their family situation. Screenings may be billed under the infant's Medicaid benefit up to age two.³⁵



COLORADO, VERMONT, WISCONSIN

Reimburse for "family visits" under EPSDT using the AMA health and behavior codes that reimburse for assessment and intervention services—including to families—for addressing the child's physical health, mental health and overall well-being.



Emerging Best Practice: Asian Health Services, California

There is an emerging care delivery model that successfully blends prevention and peer supports into regular medical practice. It supports the direct well-being of the child through a two-generation visit that combines well-child visits, maternal health, and positive parenting.

Asian Health Services, a federally-qualified health center (FQHC) in northern California, has pioneered this approach of a group well-baby visit that combines infant medical services with maternal screenings, parent education, and community/peer supports. They provide well-baby visits for small groups of about six infants typically between 0 and 18 months on their regular periodicity schedule. Families are scheduled for a 90-minute or two-hour session. As families assemble or just before they leave, the pediatrician provides well visits, while a nurse or medical assistant does infant vaccines, and the medical team provides maternal screenings (e.g., post-partum depression screening). The bulk of the visit provides a group parenting session, where community health workers or the pediatrician provide extra tools for parents about positive parenting, including sessions about healthy child development, positive discipline, and avoiding shaken baby syndrome.

Anecdotal evidence suggests that the mothers responded extremely well to having an hour to discuss the things that really mattered to their families—as opposed to having 5 minutes with the pediatrician during a regular well-baby visit. The quality of the communication with the health center and their providers was stronger, and they felt supported by their peers.

The providers were able to give the mothers additional support and spend more time with the babies who needed additional services. Because Asian Health Services has behavioral health specialists and social workers on staff, they were also able to directly refer patients to the on-site social workers for additional services if needed, such as in the case of postpartum depression.

Their program was developed using start-up funds from HRSA, who provided \$50,000 for parent education support groups. These funds covered the cost of the start-up and the piloting.

As a federally qualified health center, Asian Health Services' bundled payment rate from Medicaid can help cover the costs for the physician/pediatrician; in addition, the Medicaid rate provides coverage for the interdisciplinary staff, including a nurse and a medical assistant, and helps make the program financially self-sustaining.

Additional costs, such as room set up and clean up, are paid for out of the PPS cushion. In order to make the model self-sustaining, the health center needed at least six infants (or 6 PPS visits) in the hour period, and that would cover some portion of the community health worker salary. Most of the community health workers salary is paid for out of the grant.

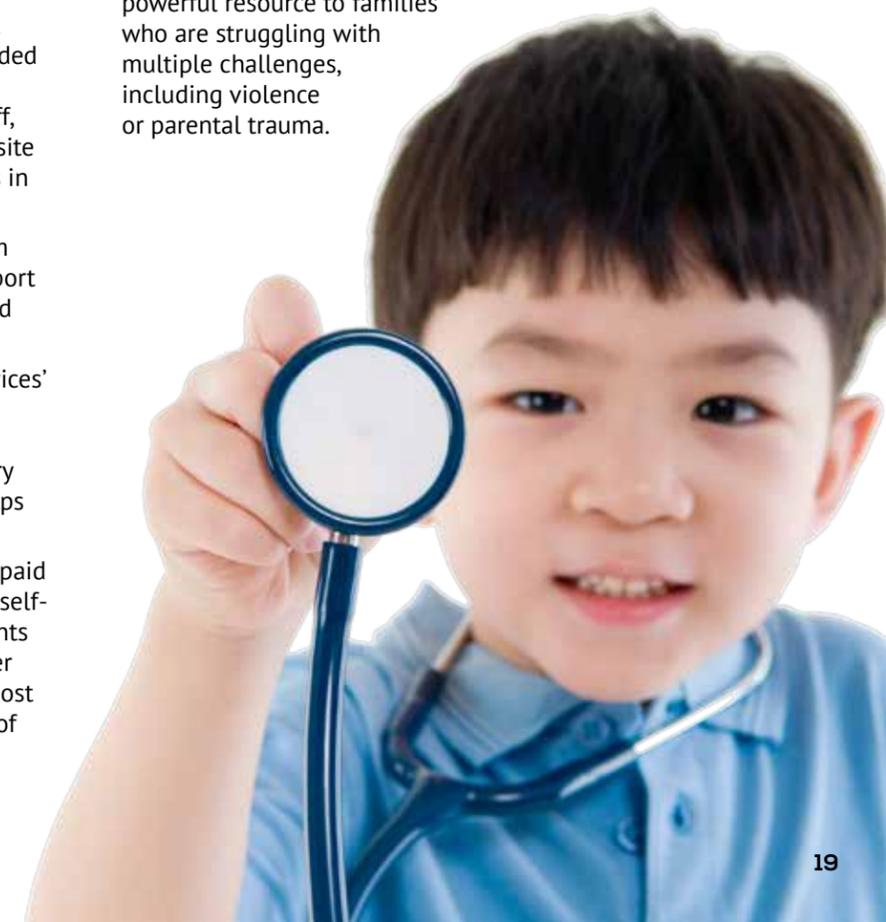
This novel program has expended the grant, but the infrastructure is financially stable enough for the program to continue.

There are some limitations to this model. A behavioral health component would be a desirable add on. However, social workers cannot bill for general prevention services under state law. The health center could only be reimbursed for the social workers time if there is a patient diagnosis code. As a result, it is not possible to offer preventive behavioral health services in this model at this time. Similarly, there is not funding at all for early development specialists in a primary care model. While a desirable outcome, it is not possible to bill and be reimbursed for these services.

Since the Asian Health Center's scope of services includes behavioral health services, if a patient is diagnosed and referred for services, with a diagnosis such as post-partum depression, it is possible to have them treated because they will have the diagnosis.

Cover Home Visitation Under Medicaid

Home visitation is a powerful tool for prevention and early identification of health, family or educational challenges a baby or young child might face. In home visitation, trained staff, including nurses or community health workers, brings support and evidence-based intervention and prevention strategies into the homes of pregnant women and families with young children. The services typically provided in home visitation, including screenings, care coordination, family support and counseling, potentially providing a powerful resource to families who are struggling with multiple challenges, including violence or parental trauma.



In March 2016, the Health Resources and Services Administration (HRSA) and CMS released an Informational Bulletin that outlines how states can fund their home visitation programs, and identified home visiting as a critical support for children.³⁶ The Bulletin specifically identifies how states can use their Medicaid program to fund the health care aspects of a home visitation program.

There is no state plan option called “home visiting” under the Medicaid program – but many of the individual components of home visiting will be covered by the program (some non-medical/behavioral health components may need alternate sources of funding). Examples of home visiting services that could be covered include: case management services; preventive services (including preventive maternal screenings for depression or exposure to violence); home health and therapy visits; and expanded services to pregnant women. Home visitation can be used to perform EPSDT periodic assessments and screenings for children and adolescents.

In addition, states have the flexibility to allow additional types of providers, such as community health workers, to become licensed Medicaid providers to expand their capacity to do prevention services and home visitation.

Opportunities

- Existing Medicaid authority allows states to provide health education and prevention services in a wide range of settings including in non-traditional settings and in the home.
- Expanding Medicaid’s coverage of home visitation programs would increase the number of children and caregivers who could receive home visitation.
- Financing home visitation through Medicaid could create a sustainable financing stream for community health workers and advocates.
- Easing workforce shortages by using community health workers and other professionals to become licensed Medicaid providers to participate in home visitation programs to serve children and families exposed to violence.

Why It Works

- States have tremendous flexibility to design their home visitation programs under Medicaid and can do it through traditional Medicaid or through managed care arrangements. Michigan’s Maternal and Infant Health Program, which includes home visiting, is financed under the traditional Medicaid plan. Kentucky uses Medicaid funding through the Targeted Case Management program. Minnesota covers home visiting as an added benefit for families enrolled in their managed care plans.³⁷

Challenges to Consider

- The location of the service is often a challenge for reimbursement in traditional models of care. The focus for Medicaid reimbursement should be on the specific services (e.g., home visitation; screening/assessment etc.), the qualifications of the provider and who is eligible to receive the service.
- Education and training of home visitors would not be reimbursable under Medicaid and additional funding would be needed to ensure on-going training and supervision.
- Additional funding may be required to cover certain non-medical aspects of home visitation.
- Training and systems of coordination will need to be developed between home visiting programs and medical homes/pediatricians.

Blend Funding Sources to Provide Coordination and Integrated Services

Recognizing that efficiencies can be found by coordinating across social services programs, a state can blend their Medicaid funding with other state and federal funding to improve the coordination of services and comprehensive care management and, in some cases, better manage the integration of physical and behavioral health services.

Opportunities

- Provide comprehensive health and behavioral health services in partnership with other social services for children exposed to violence.
- Care coordination services can be provided by a wide range of providers. In many models the primary point of contact is not the primary medical care provider (as it is in the health home). This opens programs up to using a wide range of coordinators, case workers, and community health workers.

What Is Working

- Some states have successfully blended different funding streams to provide holistic care to children.
- It is possible to use wraparound models for various levels of acuity, though to date, most programs focus on children with relatively high behavioral health needs.

Challenges to Consider

- Designing a blended or braided funding approach will involve bringing together state and local officials across many departments.

Key Advocacy Steps

- Identify key partners across all social services and health care services to bring to the table.
- Discuss how systems of care would work, and how care could be managed across sectors.

STATE SNAPSHOTS Wraparound Programs

MILWAUKEE, WI³⁸



- Award-winning wraparound program for children and adolescents who are identified by Child Welfare or the Juvenile Justice System as having a severe mental health disorder and/or being at-risk for immediate incarceration or placement in a psychiatric facility. Also serves non-system involved families and transition-age youth experiencing trauma.
- Wraparound Milwaukee provides wraparound coverage and intensive care coordination to the child and the family. It combines several streams of funding including the state Medicaid program, the county Behavioral Health Division the County’s Department of Courts and Delinquency Services, and the Milwaukee Child Welfare Department.
- It is run out of the county’s behavioral health division and acts as a public care management entity.

ARKANSAS³⁹



- Wraparound program for families involved with a child who has a severe or moderate behavioral health care need.
- The children must be at high risk of placement outside the family; have been assessed and diagnosed with a mental, behavioral, or emotional disorder – but it may be a moderate level of need; and have persistent challenges and or interactions with at least two state systems.
- Each site is run by a community care director. And the “team” is lead by a wraparound specialist who facilitates wraparound meetings, supports the family and is responsible for coordinating services; and meets with families regularly to complete the wraparound process.
- The Wraparound program also employs Family Support Partners as peer counselors. They have direct interaction with the families and the care team as appropriate.

CONNECTICUT⁴⁰



- Wraparound program that was an outgrowth of a Mental Health Transformation State Incentive Grant.
- WrapCT is made up of family members, advocates, managers and behavioral health providers who work together formally at child and family team meetings.
- Families are able to share how the support and services they are receiving are progressing and how they are making progress on their individual services plan.

EMERGING BEST PRACTICES FOR COORDINATED SERVICES: WHOLE PERSON CARE PILOTS, CALIFORNIA

As part of their recent comprehensive Medicaid redesign, California has implemented a new program called Whole Person Care. It is designed to address patients with many social and medical needs and to increase integration among counties, payers, providers and other social services. With this approach, the sites hope to increase coordination, reduce inappropriate emergency and inpatient utilization, increase access to housing and supportive services, and improve health outcomes for high need clients. Target populations can include Medicaid beneficiaries who are at risk for repeated inpatient admissions, including those with chronic conditions, mental health or substance use disorders, and those who are experiencing (or are at risk to experience) homelessness.

This model is designed to test the impact of providing housing and other supportive, and care coordination services, on improved health outcomes and costs savings. Though new for 2016 and not focused on children, this model holds promise for children exposed to violence and trauma as it focuses on providing stable housing, and other needed support services to improve the stability and health of families facing homelessness, including after incarceration.

Co-locating Financing of Health Care, Behavioral Health, and Other Social Services

State governments often have multiple different agencies that are responsible for handling aspects of health care and behavioral health care, and a different system for child welfare. A simple solution to improve coordination and reduce inefficiencies for Medicaid-eligible children who are also known to the child welfare system, is to physically co-locate services. Specifically, some states are looking at Medicaid financing of health and behavioral health liaisons in child welfare offices.⁴¹ This allows greater coordination between eligibility and caseworkers, as well as an integrated computer system.

Opportunities

- Physically co-locating benefit offices/services in the same office, or placing designated Medicaid enrollment or financing staff in child welfare offices ensures coordination of benefits, appropriate enrollment, and an easier time navigating services for families.

Why it Works

- States increasingly are interested in co-locating financing and eligibility determinations in a single “no wrong door” setting.
- Helps provide benefit coordination, as well as the identification of potential eligibility.
- Helps identify children who might need additional behavioral health services and allow for faster and earlier intervention before there is a crisis.

Challenges to Consider

- Requires coordination and cooperation between different agencies and across departments.

STATE SNAPSHOT

Co-location of Services

MICHIGAN



- To facilitate enrollment and access to physical health services, the child welfare system in Michigan has health liaison officers placed within county child welfare offices.
- These liaisons are experts in working with the Medicaid health plans and their staff, as well as with child welfare staff and foster families. When a child enters care, the liaison officer facilitates enrollment in a health plan and ensures that health care services continue without disruption if the child transitions to a new foster home or another placement.
- For behavioral health services, children’s mental health clinicians placed within Michigan’s child welfare agencies work directly with child welfare staff to identify children who are eligible for services under the 1915 (c) Medicaid Home and Community-Based Services Waiver for children with serious emotional disturbances. The services provided by these “access staff” are covered under Medicaid as assessment services.

Key Advocacy Steps

- Identify partners and champions in the child welfare and state Medicaid departments.
- Discuss ways to streamline benefits, eligibility and systems so that co-location is possible.
- Identify the key areas in which referrals and early identification for children will benefit both departments.

Implement the State Option for Peer-to-Peer Supports

State Medicaid programs can cover peer-to-peer support programs, including for families exposed to violence.⁴² CMS clarified that peer-to-peer support is available to parents when the service is for the benefit of the child.⁴³

Peer support providers may be parents or family members of a child with a similar mental illness or substance use disorder.⁴⁴ They may be a youth or young adult who has experienced trauma, substance abuse, or mental health challenges and is in recovery. They provide positive peer-to-peer supports for caregivers that focus on positive parenting, early and preventive support to children, and help navigating other social and medical services.

Medicaid funds are used differently from state to state. In some states, family-run organizations may bill the state directly as Medicaid providers, while in others, these organizations provide direct peer support services through subcontracts with traditional providers who do the Medicaid billing, or providers hire their own peer mentors and bill for their services.

Opportunities

- Many states have implemented a peer support program through Medicaid’s rehabilitation option.⁴⁵
- Peer support providers are paid lay professionals who provide support and guidance to families.
- The relatively low start-up, training, and supervision costs make it possible to start up a program, though continued support and development will be needed.

Why it Works

- Provides an early opportunity to support caregivers and to work on preventing the symptoms of trauma in families exposed to violence.
- There are a wide range of funding opportunities and the ability to design peer support programs in flexible ways.



A wide range of organizations may establish or facilitate peer-to-peer support organizations including family-based organizations and advocacy organizations if the state designates them to provide peer services and CMS approves.

Challenges to Consider

- Reimbursement for peer-to-peer support programs are established through Medicaid and may be low;
- Significant start-up funds for training and implementation might be needed and would not be funded under Medicaid;
- Significant provider education is needed about the benefit in order to ensure appropriate referrals for services and that ordered services are medically necessary;
- Partnership with medical and behavioral providers are critical for the long-term support of patients but are hard to establish in separate organizations; and
- Training and supervision requirements for lay providers, including peer-to-peer supports, will vary by state.

Key Advocacy Steps

- Identify the most likely source of state Medicaid authority to establish a peer-to-peer program. Is it a partnership with providers? A separate program under existing case management functions?
- Identify the supervision requirements in the state and plan to address.

STATE SNAPSHOTS

Peer to Peer Supports⁴⁶

TENNESSEE⁴⁷



- Tennessee has a Family Support Specialist Certification Program and a Peer Support Specialist Certification Program. They train individuals to help coordinate formal and informal supports for families, serve as an advocate or mentor, and provide education on system navigation. The Certified Family Support Specialist is a person who has self-identified as a caregiver of a child with an emotional or behavioral disorder who has successfully navigated the child-serving systems. The individual successfully completes the state training and certification program and becomes employed by an agency licensed by the state. They work under the direct supervision of a mental health professional and provide direct peer-to-peer support services.

GEORGIA⁴⁸



- Services are delivered statewide by Certified Peer Support Specialists. Participants must be referred to a peer support program by a licensed practitioner, elect to receive the service, and must have a primary mental health issue. Services are authorized initially for a six-month period. They may be delivered one-on-one or in a group setting and consist of activities that promote self-directed recovery.

Support Enrollment for Foster Care Youth and Homeless Youth

States can make the important choice to allow their Medicaid program to support continued health insurance coverage for foster care and homeless youth, and for adolescents aging out of foster care. Simplifying eligibility, providing case management, and educating providers and case workers will help keep this population covered—and accessing needed health and mental health services.

Adolescents aging out of foster care who are on Medicaid are eligible to stay on Medicaid through age 26 regardless of their income.⁴⁹ States have the opportunity to promote this policy by finding and enrolling youth as they transfer out, and ensuring that enrollment is easy and continuous. In addition, promoting continuity of services, as well as enrollment, for these youth will make accessing needed services more seamless and effective.

It's important to note that states are required to cover all former foster care youth who were previously covered by Medicaid in their state. They can extend the coverage to former foster care youth who now reside in the state, but who aged out in another state. This policy option would dramatically increase the ability of former foster care youth to get coverage without regard to where they live.

Homeless youth will also benefit from simplified enrollment and case management services and policies. In addition to state outreach to enroll and retain enrollment, policies such as continuous eligibility (and not needing to renew frequently) will help homeless youth maintain their coverage and access to services. In addition, policies that provide case managers, care coordinators, or medical social workers will increase the utilization of services by homeless youth by helping them navigate the health care system.

Opportunities

- Cover all former foster care children to age 26, without regard to where they were in foster care.
- Adopt Medicaid simplification measures that would allow for continuous 12-month eligibility and presumptive eligibility.
- Simplify enrollment paperwork needed to get and keep coverage.
- Educate child welfare staff and partners about enrollment options, as well as provide health insurance literacy training so that they can help navigate using insurance.
- Enroll homeless youth in Medicaid or CHIP and assigned a care coordinator or a medical home in a primary care setting.

Where it's Happening

- California is already covering all undocumented children with full scope Medicaid; Expanding to this population will dramatically increase the number of children with access to covered services.
- States expanding Medicaid may also want to consider presumptive eligibility for parents for certain adult services to be delivered in non-routine settings. For example, New York's presumptive eligibility for reproductive health services for women provides an opportunity to link reproductive health services for young adults in/around pediatric settings.⁵⁰

Challenges to Consider

- State politics will play a big role in how expansive Medicaid enrollment is;
- Enrollment simplification strategies are very effective at reducing the number of beneficiaries who churn on and off the program—but increased enrollment means higher costs to the states and there will be budgetary concerns for these populations; and
- Need to demonstrate the return on investment for providing continuous coverage.

Key Advocacy Steps

- Identify the existing processes for enrollment and simplification in the state. This is best done in partnership with the Medicaid Department.
- Convene a cross-sector stakeholder group that brings together representatives from all impacted agencies (e.g., Children and Family Services; Juvenile Justice).
- Plan an education campaign to foster care youth—and social service programs that interact with these youth, to educate them about health insurance options when they age out of foster care.
- Consider partnering with local health justice organizations or advocates where there may be existing expansion campaigns.

Support Continuous Enrollment for Justice-involved Populations

Policy on Medicaid coverage of children and adolescents in the juvenile justice system varies widely from state to state. Medicaid policy largely prohibits coverage of individuals who are incarcerated. However, states can make a variety of choices that can strengthen the ability of individuals to maintain Medicaid coverage and to access care before and after they are in an institutional setting. For example, states can choose to cover children and adolescents through all stages of the juvenile justice process up until

they are incarcerated, then suspend (not terminate) coverage when entering an institution. States can also opt to facilitate the re-enrollment or re-activation upon release. Success is strengthened by careful coordination between the Medicaid department and the Juvenile Justice Department.

Opportunities

- Adopting Medicaid simplification measures that streamline enrollment for justice-involved populations.
- Suspending, not terminating, Medicaid coverage, making it easier for individuals to maintain enrollment when they are released. Seventeen states, plus Washington, DC have implemented policies to suspend coverage during the entire duration of incarceration; another 17 states will suspend coverage for a certain period of time (e.g., 30 days).⁵¹

Why It Works

- Suspending coverage ensures that beneficiaries are able to immediately and efficiently get reenrolled in coverage. This means that they will have access to needed mental health services, prescription drugs and other health care services immediately upon release.
- Many prisons already have systems in place to help facilitate release to the community; they are able to easily “turn on” the Medicaid coverage at discharge.
- Suspending coverage is an administratively easy solution, reducing paperwork.

Challenges to Consider

- For suspension policies to work effectively, the Medicaid Department and Justice Departments must coordinate to ensure seamless transition.
- Federal policy can be unclear about the availability of Medicaid for non-prison justice settings and when coverage must be terminated.

Key Advocacy Steps

- Develop a list of existing state policies for Medicaid coverage of justice-involved populations.
- Convene a working group of advocates, Medicaid, and justice policy-makers to explore how the systems can work together to implement policies to promote health insurance coverage of justice-involved children and adolescents.

Expand Scope of Practice Laws in the State

State laws define the types of providers who may deliver medical and behavioral health services in a state—and to provide services in the state, providers must operate under the scope of state law and under their license. Depending on the type of provider or level of licensure, some providers may operate with supervision or by limiting their scope of services. Expanding the type of providers able to provide medical and behavioral health services would add to the state workforce capacity, increasing access for beneficiaries, and help provide sustainable financing for a wider range of providers.

Opportunities

- Expand the range and types of providers, including community-based providers, who can provide assessment, care coordination and other medical and behavioral health services to address the workforce shortages.

Why It Works

- Delivery of preventive services by non-licensed providers (under the supervision of a licensed provider) is encouraged by the Affordable Care Act as a mechanism to expand capacity and increase the availability of preventive services.
- States have successfully expanded the types of providers that can bill for specific and specialized Medicaid services, including independent certified nurse practitioners (IL), clinical nurse specialists (IL), licensed independent social workers (IA), mental health providers (NC) family support workers who provide home visiting care (VT),⁵² and family and youth peer mentors (MA, LA, OK).

Challenges

- Scope of practice law is regulated by states and there can be complex structures in place to navigate; often licensing and funding for health care providers comes through different departments in the same state.
- Provider trade groups will have a deep investment in scope of practice laws.
- A broader provider network may increase costs to Medicaid.

Key Advocacy Steps

- Work with providers, advocacy groups and other partners to develop an effective advocacy campaign.

Promising Area: Medicaid in Schools

Schools, school-based health centers and the mental health professionals who provide services to children in schools are a critical part of the health and mental health services team for children who are exposed to violence and trauma. Local Education Authorities (LEAs) are able to draw down reimbursement for health-related services provided to Medicaid-enrolled children through the school system. This is particularly true of kids who are eligible for special education services through IDEA: Medicaid must provide reimbursement for medically necessary services provided under IDEA if provided by a licensed Medicaid provider under the scope of state law.

State policies to improve the availability of services in schools vary dramatically from state to state but hold great promise for expanding access to trauma-informed services. This is a promising area for future research and study.

CONCLUSION

States have many tools to improve coverage and access to services for the well-being and improved health of children. From prevention and early intervention to solutions that work to strengthen families and serve the caregiver and child together, Medicaid is an important source of coverage for children, and reimbursement for providers. Bolstered by federal guidance and payment, and reflecting the growing recognition about the lifetime impacts of trauma and exposure to violence, the health care system is now poised to play an even greater role in helping children thrive.

The solutions presented in this paper will require collaboration among federal and state policymakers, and with advocates and health care providers – but they all represent concrete examples of policy in practice. Advocates, state policymakers and other decision makers should look inside their own states and map the available resources – and where there are opportunities to improve coverage and strengthen the availability of services for children exposed to violence. Working in partnership across all stakeholders, increased access to trauma-informed services is possible.

ENDNOTES

- 1 Trauma-Informed Care: Opportunities for High-Need, High-Cost Medicaid Populations. March 2015. Center for Health Care Strategies, Inc. http://www.chcs.org/media/TIC-Brief-031915_final.pdf
- 2 <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>
- 3 <http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>
- 4 Megan H. Bair-Merritt, MD, MSCE; Barry Zuckerman, MD. Exploring Parents' Adversities in Pediatric Primary Care. *JAMA Pediatrics*. 2016;170(4):313-314. doi:10.1001/jamapediatrics.2015.4459.
- 5 American Public Health Association has adopted the following definition of a community health worker: A community health worker is a frontline public health worker who is a trusted member of and/or has an unusually close understanding of the community served.
- 6 <http://www.integration.samhsa.gov/integrated-care-models/guidancehealthhomesconsultationprocess.pdf>
- 7 Customizing Health Homes for Children with Serious Behavioral Health Challenges. Prepared for Us. Substance Abuse and Mental Health Services Administration. Sheila A. Pires. March 2013
- 8 Overview of Final Health Home Application to Serve Children and Other Design Updates. November 2014. https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children_qa.htm
- 9 https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/docs/2014-10-5_hhsc_webinar.pdf
- 10 Overview of Final Health Home Application to Serve Children and Other Design Updates. November 2014. https://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/hh_children_qa.htm
- 11 Coverage of Behavioral Health Services for Children and Adults with Significant Mental Health Conditions. Joint CMCS and SAMHSA Informational Bulletin. May 7, 2013. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-05-07-2013.pdf>
- 12 <http://mstservices.com/resources/funding-and-medicaid-standards>
- 13 Joint CMCS and SAMHSA Informational Bulletin: Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions. May 7, 2013. <http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf>
- 14 Department of Children and Family Services. <http://www.ct.gov/dcf/cwp/view.asp?a=2558&q=314366>
- 15 Intensive Home-based Treatment (IHBT) Frequently Asked Questions. Ohio. <http://mha.ohio.gov/Portals/0/assets/Treatment/IHBT/faqs.pdf>
- 16 <http://www.blueprintsprograms.com/funding/parent-child-interaction-therapy>
- 17 For a full list of the CT community mental health outpatient clinics, as well as their intake procedures, visit: http://www.ct.gov/dcf/lib/dcf/behavioral_health/pdf/tf_cbt_referrals_at_opccs.pdf
- 18 http://www.ct.gov/dcf/lib/dcf/trauma-informed_care/pdf/trauma-informed_care_-_policy_september_2012.pdf
- 19 <http://www.in.gov/dcs/files/residentialservicestandardbehavioralhealth.pdf>
- 20 Making Medicaid Work for Children in Child Welfare: Examples from the Field. Center for Health Care Strategies. June 2013. http://www.chcs.org/media/Making_Medicaid_Work.pdf
- 21 For a full list of the OK mental clinics offering TF-CBT, visit: <http://oklahomatfcbt.org/>
- 22 Making Medicaid Work for Children in Child Welfare: Examples from the Field. Center for Health Care Strategies. June 2013. http://www.chcs.org/media/Making_Medicaid_Work.pdf
- 23 <http://dhhs.ne.gov/medicaid/Documents/pb1316.pdf>
- 24 CT includes screening for ACEs as part of their EPSDT bundle. http://www.ct.gov/dcf/lib/dcf/three_branch_institute/may4-2015/halsey.pdf
- 25 Improving the Lives of Young Children: Opportunities for Care Coordination and Case Management for Children Receiving Services for Developmental Delay. December 2010. Urban Institute. Carrie Hanlon
- 26 <http://www.rosied.org/page-73524>





- 27 *Improving the Lives of Young Children: Meeting Parents' Health and Mental Health Needs through Medicaid so Children Can Thrive.* Urban Institute. Olivia Golden and Karina Fortuny. March 2011. <http://www.urban.org/UploadedPDF/412315-Meeting-Parents-Health.pdf>
- 28 *CMCS Informational Bulletin. Maternal Depression Screening and Treatment: A Critical Role for Medicaid in the Care of Mothers and Children.* May 11, 2016
- 29 *Improving the Lives of Young Children: Meeting Parents' Health and Mental Health Needs through Medicaid so Children Can Thrive.* Urban Institute. Olivia Golden and Karina Fortuny. March 2011. <http://www.urban.org/UploadedPDF/412315-Meeting-Parents-Health.pdf>
- 30 *Children do better when their caregivers do better: the need for intergenerational family services in pediatrics.* Nov 23, 2015. CHOP Policy Lab. <http://policylab.chop.edu/blog/children-do-better-when-their-caregivers-do-better-need-intergenerational-family-services>
- 31 *States Try Innovative Approaches to Identify and Treat Maternal Depression.* Georgetown Center for Children and Families. November 2014. <http://ccf.georgetown.edu/all/innovative-approaches-identifying-treating-maternal-depression-mothers-children-enrolled-medicaid/>
- 32 *States Try Innovative Approaches to Identify and Treat Maternal Depression.* Georgetown Center for Children and Families. November 2014. <http://ccf.georgetown.edu/all/innovative-approaches-identifying-treating-maternal-depression-mothers-children-enrolled-medicaid/>
- 33 *States Try Innovative Approaches to Identify and Treat Maternal Depression.* Georgetown Center for Children and Families. November 2014. <http://ccf.georgetown.edu/all/innovative-approaches-identifying-treating-maternal-depression-mothers-children-enrolled-medicaid/>
- 34 *BabyCare Provider Fact Sheet.* Department of Medical Assistance Services. Virginia. http://www.dmas.virginia.gov/Content_atchs/mch/mch-bcare_facts.pdf

- 35 Virginia Medicaid. Provider manuals. <https://www.virginiamedicaid.dmas.virginia.gov/wps/portal/ProviderManual>
- 36 *Coverage of Maternal Infant and Early Childhood Home Visiting Services.* March 2, 2016. <https://www.medicaid.gov/federal-policy-guidance/downloads/cib-03-02-16.pdf>
- 37 *Medicaid Funding of Community-based prevention.* Nemours. June 2013
- 38 <http://county.milwaukee.gov/WraparoundMilwaukee.htm>
- 39 <http://humanservices.arkansas.gov/dbhs/Pages/ChildrensServices.aspx>
- 40 www.ct.gov/dmhas/site/default.asp
- 41 *Making Medicaid Work for Children in Child Welfare: Examples from the Field.* Center for Health Care Strategies. June 2013. http://www.chcs.org/media/Making_Medicaid_Work.pdf
- 42 *Dear State Medicaid Director Letter. SMDL #07-011.* August 15, 2007. <http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf>
- 43 *Clarifying Guidance on Peer Support Services Policy.* May 1, 2013. <https://www.medicaid.gov/medicaid/benefits/downloads/clarifying-guidance-support-policy.pdf>
- 44 *Becoming a Medicaid Provider of Family and Youth Peer Supports: Considerations for Family Run Organizations.* February 2014. Center for Health Care Strategies. http://www.chcs.org/media/Medicaid-FYPS-Considerations-for-FROs_FINAL_rev.pdf
- 45 *CMS does not track which states use the peer supports model. The most recent available listing of state adoption of peer supports can be found at the Center for Health Care Strategies.* <http://www.chcs.org/media/Family-Youth-Peer-Support-Matrix-reformatted-070714.pdf>
- 46 *CMS does not track which states use the peer supports model. The most recent available listing of state adoption of peer supports can be found at the Center for Health Care Strategies.* <http://www.chcs.org/media/Family-Youth-Peer-Support-Matrix-reformatted-070714.pdf>
- 47 <http://www.tn.gov/behavioral-health>
- 48 *The Impact of Medicaid Peer Support Utilization on Cost.* Glenn Landers and Mei Zhou. Medicare & Medicaid Research Review. 2014: Volume 4, Number 1. https://www.cms.gov/mmrr/Downloads/MMRR2014_004_01_a04.pdf
- 49 *The Affordable Care Act and Youth Aging Out of Foster Care: New Opportunities and Strategies for Advocacy.* Dina Emam and Olivia Golden. Sparc. April 2014. <http://www.clasp.org/resources-and-publications/publication-1/The-Affordable-Care-Act-and-Youth-Aging-Out-of-Foster-Care.pdf>
- 50 *Children Do Better When Their Caregivers Do Better: The Need for Intergenerational Family Services in Pediatrics.* Nov 23, 2015. CHOP Policy Lab. <http://policylab.chop.edu/blog/children-do-better-when-their-caregivers-do-better-need-intergenerational-family-services>
- 51 *Medicaid Eligibility for People Getting Out of Prison is Smart Policy.* Families USA. <http://familiesusa.org/product/medicaid-suspension-policies-incarcerated-people-50-state-map>
- 52 *Improving the Lives of Young Children: Increasing Referrals and Follow-up Treatment in Medicaid and CHIP.* Urban Institute; Jennifer E. Pelletier and Genevieve M. Kenny. December 2010

RELATED RESOURCES

Policy Solutions:

Safe, Healthy, and Ready to Learn: Policy Recommendation to Ensure Children Thrive in Supportive Communities Free from Violence and Trauma

In partnership with leaders from health, education, justice, and child development fields, Futures Without Violence (FUTURES), with the support of The California Endowment, Blue Shield of California Foundation, and the Lisa and John Pritzker Family Fund, developed public policy recommendations to prevent and address childhood exposure to violence and trauma.

www.futureswithoutviolence.org/safe-healthy-and-ready-to-learn-executive-summary-full-report/

Funding Opportunities in the Every Student Succeeds Act to Ensure All Students are Safe, Healthy, and Ready to Succeed

Every Student Succeeds Act (ESSA), Public Law No: 114-95, has greatly increased the flexibility of states to design an educational system that best serves the needs of all their children, including how a state designs its accountability system, to the interventions it chooses for low-performing schools, to its teacher evaluation system, to how it spends its federal funds in a variety of areas. The purpose of this guide is to provide states and school districts with an inventory of how they can use the new law and the funding it provides to support positive school climates, and in particular prevent and respond to the needs of children suffering from exposure to violence and the effects of trauma.

www.futureswithoutviolence.org/every-student-succeeds-act-funding-opportunities/

Public Awareness:

Changing Minds

A national public education campaign to address children's exposure to violence and childhood trauma, Changing Minds was developed by Futures Without Violence, in collaboration with the US Department of Justice and The Ad Council. The Changing Minds campaign offers proven ways to help children heal from the trauma of witnessing violence in their school, home, or community for teachers, coaches, counselors, nurses and other adults who regularly interact with kids. Free,

downloadable campaign materials are available for your community's or organization's use and/or co-branding at www.ChangingMindsNOW.org.

Program Resources:

Promising Futures: Best Practices for Serving Children, Youth, and Parents Experiencing Domestic Violence

This is a website designed to help advocates and organizations support children and parents facing domestic violence, which includes best practices, evaluation tools, and research-informed strategies to mitigate the negative effects of domestic abuse on a child and help break the cycle of violence.

<http://promising.futureswithoutviolence.org/>

Defending Childhood

Repeated exposure to trauma and violence can disrupt brain development and increase the risk of serious illness, psychological issues, and dangerous behavior later in life. The Defending Childhood Initiative, launched in 2010 in eight sites throughout the country, promotes safe and thriving communities by providing families with the essential services they need to break the cycle of violence.

www.defendingchildhood.org/

Start Strong: Building Healthy Teen Relationships

Was a national program in 11 communities throughout the country aimed at promoting healthy relationships among 11 to 14-year-olds and identifying promising ways to prevent teen dating violence. The Start Strong website offers a wealth of information for community leaders, educators, parents, and advocates including testimonials, program tools and ideas, case studies, lessons learned, guides for crafting school policies, and more.

<http://startstrong.futureswithoutviolence.org/>

National Health Resource Center on Domestic Violence

Exposure to violence at an early age is linked to a host of health problems that can last into adulthood. FUTURES works with health care providers to identify and respond to children's exposure to violence and trauma — advancing the early interventions in clinical settings that promote resiliency and help children heal. The website provides tools and resources for: (1) adolescent health care providers to counsel their young patients about healthy relationships and to screen for and respond to dating violence; and (2) pediatric providers to address children's exposure to violence and childhood trauma.

www.futureswithoutviolence.org/health/national-health-resource-center-on-domestic-violence/

FUTURES
WITHOUT VIOLENCE®



San Francisco

100 Montgomery St, The Presidio
San Francisco, CA 94129-1718
TEL. 415.678.5500

Washington, DC

1320 19th St NW, #401
Washington, DC 20036-0343
TEL. 202.595.7382

Boston

50 Milk Street, 16th Floor
Boston, MA 02109
TEL. 617.702.2004

www.futureswithoutviolence.org | info@futureswithoutviolence.org