EXPAND ACCESS TO BEHAVIORAL HEALTH SERVICES FOR CHILDREN IN FOSTER CARE

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EXECUTIVE SUMMARY

Nearly all children and youth in foster care are eligible for Medicaid, which is the primary source of funding for both physical and behavioral health care for this population. A range of Medicaid-covered services is necessary to meet the significant health, behavioral, and other needs of foster children and youth. It is widely recognized that children and youth in the foster care system face significantly more behavioral health challenges than most other Medicaid enrollees. The recovery process is aided by treatment delivered by skilled child welfare staff and mental health providers who provide appropriate, trauma-informed, evidence-based services. Yet, a significant shortage of mental health providers persists across Texas. Furthermore, there is a shortage of providers trained specifically to diagnose and treat childhood trauma.

Failure to address the behavioral health needs of foster children can result in poor outcomes for children (e.g., difficulty finding and maintaining appropriate placements, nights spent in child welfare offices, delayed achievement of positive permanency outcomes) and costly outcomes for DFPS (e.g., longer lengths of stay at in-patient psychiatric facilities due to difficulty finding placements, and negotiation of single-case agreements).

Child Placing Agencies (CPAs) understand the complexities faced by foster children and youth, and are in a unique position to help meet the behavioral health needs of these children by enrolling in the Texas Medicaid program to provide the full array of behavioral health services, including Mental Health Targeted Case Management (MHTCM) and Mental Health Rehabilitation Services (MHR). Efforts to increase and sustain the number of CPAs who are enrolled in Medicaid to provide these services can increase the supply of behavioral providers and expand access to these services for children and youth in foster care. CPA participation in Medicaid can also increase access to evidence-based behavioral health care that is trauma-informed and provided in-home.

Approximately six CPAs in Texas are enrolled in Medicaid and credentialed to provide the full array of behavioral health services; however, these CPAs faced initial obstacles through the enrollment process and continue to face ongoing operational challenges. There are additional CPAs who are interested in becoming a Medicaid provider but face significant barriers to their participation. The Texas Legislature should provide funding to support CPA participation in Medicaid to expand access to behavioral health services for foster children and youth and to support positive outcomes for children, youth, and families.

OBJECTIVES, SCOPE & METHODOLOGY

Objectives: The purpose of this review was to identify options to increase and sustain child welfare providers enrolled in the Texas Medicaid program to provide behavioral health services.

Scope: Behavioral health services are defined to include the full array of services, including MHTCM and MHR. Child welfare providers include licensed CPAs contracted by the Texas Department of Family and Protective Services (DFPS) to provide residential child care services for children in its managing conservatorship.

Methodology: Data and information was collected using the following quantitative and qualitative research methods:

Best Practice Research: Information on the importance and status of behavioral health service delivery for children was collected through a review of relevant literature.

Focus Group: Qualitative information was collected during a focus group with Texas CPAs who are currently enrolled in the Texas Medicaid program to provide behavioral health services. Participants were asked to discuss obstacles to participating in the Texas Medicaid program as well as possible solutions.

Provider Survey: Texas CPAs were surveyed in May and June 2020 to collect information on the obstacles faced when considering Medicaid enrollment and credentialing as well as possible solutions.

ROLE OF MEDICAID IN SERVING CHILDREN AND YOUTH IN FOSTER CARE

Medicaid provides health coverage for most children and youth involved in the Texas foster care system. Nearly all children and youth in foster care are eligible for Medicaid, which is the primary source of funding for both physical and behavioral health care for this population. The most common eligibility pathway to Medicaid for children and youth in foster care is through Title IV-E eligibility. Title IV-E of the Social Security Act provides funding to support safe and stable out-of-home care for children who are removed from their homes. Children and youth in foster care who receive federal child welfare assistance under Title IV-E are automatically eligible for Medicaid. For children and youth in foster care who are not eligible under Title IV-E, there are other ways that they may be eligible to receive Medicaid, such as low income or disability.

Foster children and youth require a range of Medicaid-covered services to meet their significant health, behavioral, and other needs. Medicaid's Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) benefit, which is a mandatory service under the Medicaid program, provides comprehensive health coverage for children and youth under the age of 21. Medicaid services for this population include preventive,

screening, diagnostic, and treatment services necessary to ensure optimal physical and behavioral health. The EPSDT program can help ensure that health problems, including mental health and substance use issues, are diagnosed and treated early before they become more complex and their treatment more costly.

More than 30 states, including Texas, enroll their foster care population in Medicaid managed care. STAR Health is the statewide, comprehensive Texas Medicaid managed care program for children in DFPS conservatorship as well as young adults in DFPS paid placements. STAR Health provides a full-range of Medicaid-covered medical and behavioral health services. These services are available to these children no matter where they are in the state and even when they move. The Texas Health and Human Services Commission (HHSC) contracts with Superior HealthPlan to administer STAR Health.

BEHAVIORAL HEALTH NEEDS OF CHILDREN AND YOUTH IN FOSTER CARE

Foster children and youth suffer from serious physical, mental, developmental, and psychosocial problems rooted in childhood adversity and trauma. Children and youth placed in foster care often enter care with significant health issues, including mental health and substance use disorders. Health issues may be related to poverty and other at-risk conditions, such as parental substance use or mental illness. The actual abuse or neglect, including medical neglect, also contributes to poor health, as can the disruption caused by removal from the home and placement in foster care. It is widely recognized that children and youth in the foster care system face significant behavioral health challenges. Several studies have documented the increased prevalence of emotional and behavioral disorders in the foster care population.

- Many academic studies have found that up to 80 percent of children and youth in foster care exhibit a serious behavioral or mental health problem requiring intervention.

- The foster care population faces significantly more health needs than most other Medicaid enrollees. According to the Medicaid and CHIP Payment and Access Commission (MACPAC), children eligible for Medicaid based on foster care assistance have much higher rates of behavioral health diagnoses than other children in Medicaid. Specifically, 49 percent of these children had diagnoses of mental health disorders and 3 percent had diagnoses of substance use disorders whereas for other children in Medicaid, the figures were 11 percent and less than 1 percent, respectively.

- According to the American Academy of Pediatrics (AAP), up to 80 percent of children in foster care enter with a significant mental health need. The AAP Health Foster Care America Initiative identifies mental and behavioral health as the “greatest unmet heath need for children and teens in foster care.” Factors contributing to the mental and behavioral health of children and youth in foster care includes the history of complex trauma, frequently changing situations and transitions, broken family relationships, inconsistent and inadequate access to mental health services, and the over-prescription of psychotropic medications.

- A study conducted by the Substance Abuse and Mental Health Services Administration (SAMHSA) that compared children receiving Medicaid who were in foster care with those not in care found that the children in foster care had much higher rates of behavioral disorders. This same study showed that youth aged 12 through 17 in foster care had three times as many behavioral/mental health diagnoses and were more than twice as likely to require inpatient care of any kind compared to youth not in foster care.

- A study in the journal Pediatrics found that children in foster care are twice as likely as others to have learning disabilities and developmental delays, five times as likely to have anxiety, six times as likely to have behavioral problems, and seven times as likely to have depression.

NEED FOR TRAUMA INFORMED BEHAVIORAL HEALTH SERVICES

Foster children and youth are vulnerable to the effects of trauma. Traumatic experiences overwhelm a child's natural ability to cope and places them at a greater risk for developing behavioral health and substance use disorders. Trauma interferes with normal child development and causes long-term harm to a child's physical, social, emotional, and spiritual well-being. SAMHSA defines trauma as the result of "an event, series of events, or set of circumstances that is experienced by an individual as physically or emotionally harmful or life-threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being." Acute trauma occurs from single events that are limited in time (e.g., car accident, shooting, or earthquake). Children who are exposed to multiple traumatic events over time that are severe, pervasive, and interpersonal in nature, such as repeated abuse and neglect, face complex trauma. Complex trauma may interfere with a child's ability to form secure attachments to caregivers and many other aspects of healthy physical and mental development.

Childhood trauma has a substantial, compounding, life-long impact on health and well-being. Replicated studies on Adverse Childhood Experiences (ACEs) demonstrate that childhood stress is linked to poor health outcomes, including obesity, diabetes, depression, heart disease, cancer, and stroke as well as alcohol and drug abuse, low graduation rates, and poor employment outcomes. Across the life span, traumatic experiences have been linked to a wide range of problems, including addiction, depression and anxiety, and risk-taking behavior. Adverse effects can include changes in the following areas

- emotional responses
- ability to think, learn, and concentrate
- impulse control
- self-image
- attachments to caregivers
- relationships with others

Children who have experienced trauma should receive appropriate trauma-informed medical and mental health treatment. Effective programs and services for foster children and families use trauma-informed approaches to recognize and respond to the impact of trauma. Professionals who work with foster children and youth must be aware of a child's trauma history and its effects, or their actions and responses to the child may inadvertently trigger trauma memories, worsen symptoms, or further traumatize the child. The recovery process is aided by treatment delivered by skilled child welfare staff and mental health therapists who provide appropriate, trauma-informed, evidence-based services.

SHORTAGE OF BEHAVIORAL HEALTH PROVIDERS TO TREAT CHILDREN AND YOUTH IN FOSTER CARE

When community-based, trauma-informed behavioral health services are not readily available, some of the poor outcomes for children can include:

- Placement disruption – Foster parents may not be able to cope with the needs of children with behavioral health conditions. This is exacerbated by an inability to access appropriate services
- Difficulty finding appropriate placements – As of December 2019, CPS had 10 children without placement. This trend fluctuates over time, but has improved significantly compared to May 2019 when over 100 children lacked placement. Some factors that have lowered this number include the availability of treatment foster care and the expansion of the Community-Based Care model, where finding placement for each child is a requirement. However, this can still occur.
- Nights spent in child welfare offices – This issue was more prevalent in 2015, but is directly related to the difficulty finding placements.
- Delayed achievement of positive permanency – Studies have established the link between the number of placements and poor permanency outcomes; the greater the number, the longer the time in care and the reduced chances of both reunification and adoption.

There can be significant cost outcomes for DFPS as well, including:

- Extended length of stay in psychiatric hospitals due to lack of placement – According to Disability Rights Texas, 584 children spent 14,000 days in psychiatric hospitals beyond the point of medical necessity in 2017, at a cost of $643 per day (total of $8.8 million).
- Use of single-case agreements to secure placement for a child – The number of children with these agreements has been declining, but the use of these agreements is significantly more costly than if the child was able to be served under the established rate structure. As of May 2020, there were 145 children with these agreements at a cost of $1.6 million. Between September 2019 and May 2020, DFPS reports spending between $1.6 - $1.9 million per month on these agreements.

SHORTAGE OF BEHAVIORAL HEALTH PROVIDERS TO TREAT CHILDREN AND YOUTH IN FOSTER CARE

According to the American Psychological Association (APA), many children and adolescents lack access to needed mental health and substance use services. A study conducted by the University of Michigan found that 7.7 million children and youth across the United States have at least one treatable mental health disorder, but that half of these children do not receive treatment from a mental health professional. APA supports this finding that less than half of children with mental health needs get treatment, services, or support. Furthermore, only one in five get treatment from a mental health worker with special training to work with children. Untreated mental health needs among children and youth affect not only the young person and their family, but also schools, communities, workplaces, and the nation as a whole.

A comprehensive study released by the Cohen Veterans Network and the National Council for Behavioral Health in 2018 found that American mental health services are insufficient, and despite high demand, the root of the problem is lack of access – or the ability to find care. According to the American Academy of Child and Adolescent Psychiatry (AACAP), there are average delays of 8 to 10 years between the onset of symptoms and intervention. The longer the lag time is between symptom onset and treatment, the more difficult and costly mental disorders are to treat. One significant reason for the delays in treatment is the lack of access to trained pediatric mental health professionals.

A significant shortage of mental health providers persists across Texas. Some Texas families cannot find mental health care because of the lack of providers in their area or may have to travel long distances to

receive care. The federal Health Resources and Services Administration and the Texas Primary Care Office work together to determine when a geographic area qualifies for designation as a Health Professional Shortage Area (HPSA). As of May 2019, 206 whole counties in Texas have been designated as a Mental Health HPSA. An additional four counties have partial Mental Health HPSA designations. According to the AACAP, most Texas counties have no practicing child psychiatrist. Of the counties with a child psychiatrist, all but one (i.e., Kendall County) have either a high or severe shortage of these practitioners.

Children and youth in foster care are even less likely to receive adequate treatment and services for their mental health needs. According to MACPAC, youth in the child welfare system have high levels of unmet need for mental health care. Foster parents say that even with Medicaid coverage they struggle to meet the extraordinary health needs of their children. Part of the trouble is too few doctors accept Medicaid, including mental health specialists. The number of mental health providers relative to the number of children who need this care is inadequate. This shortage of mental health professionals is coupled with the high prevalence of mental health conditions in this population.

Furthermore, there is a shortage of providers trained specifically to diagnose and treat childhood trauma, which impacts the receipt of timely and appropriate behavioral health care for foster children and youth. Among existing mental health providers, there are few who are trained specifically to address the unique needs of foster children and their families. Understanding the role of childhood trauma in the emergence of child mental health disorders is extremely important because it will direct the child toward appropriate treatment. Adopting trauma-informed approaches to care is key to preventing misdiagnoses and making sure children are receiving appropriate treatment. Unfortunately, there is a shortage of mental health professionals with the appropriate training in trauma-focused therapies, and funding is insufficient to ensure that all children who might benefit from these interventions can access them. These families have limited access to mental health and other therapeutic service providers who are trauma-informed and understand the complexities faced by foster children and youth.

Children and youth in foster care also lack access to behavioral health services that are provided at their home. In many areas of Texas, the only services available are provided in centers operated by Local Mental Health Authorities (LMHAs) that do not exclusively serve children. LMHAs are a network of 39 public community-based mental health centers across the state of Texas serving both adults and children (not exclusively children involved

in the child welfare system). Limited access to in-home behavioral health care is a barrier to care, as some foster parents face difficulties when accessing in-office services due to lack of transportation and child care for other children in the home as well as an inability to take time off work.

MHTCM and MHR are critical Medicaid services for certain children and adults with mental illness. MHTCM includes case management for targeted groups and is designed to assist individuals with accessing other needed behavioral health services. MHR is assistance with maintaining or improving functioning when helping a person achieve a rehabilitation goal in their treatment plan and includes multiple individual services, including crisis intervention services, medication training and support, and skills training and development mental rehabilitation services.

SERVICE	ELIGIBLE POPULATION
MH TCM	The priority population that can receive MHTCM as part of the Texas Medicaid Program must, regardless of age, have a single diagnosis of chronic mental illness or a combination of chronic mental illnesses (as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders), and who have been determined via a uniform assessment process to be in need of these services or children aged 3-17, with serious emotional disturbance (excluding a single diagnosis of substance abuse, intellectual or developmental disability, or autism spectrum disorder) who have a serious functional impairment or who: • Are at risk of disruption of a preferred living or children care environment because of psychiatric symptoms, or • Are enrolled in special education because of a serious emotional disturbance.
MH Rehab	Mental health rehabilitative services can be provided to a person with a serious mental illness as defined in the latest edition of the American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders. • Youth 3 to 17 years old with serious emotional disturbance who have a serious functional impairment, or • Are at risk of disruption of a preferred living or child care environment because of psychiatric symptoms, or • Are enrolled in special education because of a serious emotional disturbance.

Providers who offer these services are "comprehensive providers," meaning they must offer the full array of services included under MHTCM and MHR. Until 2013, the only comprehensive providers of Medicaid MHTCM and MHR were LMHAs Statute previously limited the provision of MHTCM and MHR to LMHAs. Senate Bill 58 (Eighty-Third Legislature, 2013), directed managed care organizations (MCOs) to "develop a network of public and private providers of behavioral health services and ensure adults with serious mental illness and children with serious emotional disturbance have access to a comprehensive array of services." This legislation expanded the provider types able to offer MHTCM and MHR to include any provider type who meets requirements. Six CPAs have completed requirements for Medicaid participation, and they operate in all CPS regions except Region 10 (El Paso).

CPA PROVIDER BARRIERS TO MEDICAID PARTICIPATION

DFPS contracts with licensed CPAs to provide residential child care services for children in its managing conservatorship. As of August 31, 2019, there were 387 CPAs licensed by HHSC (note this count includes branch offices). As of August 31, 2019, more than two-thirds (67.9 percent) of the 17,247 children in foster care were placed in CPA foster homes.
These entities provide care, supervision, assessment, training, education, and treatment services to meet the needs of these children. CPAs train foster and adoptive parents and find homes for children. CPAs receive payments from the state for the care of foster children of which a portion is passed on to foster families.

CPAs are in a unique position to help meet the needs of children with behavioral health needs by enrolling in the Texas Medicaid program to provide the full array of behavioral health services, including MHTCM and MHR. Efforts to increase and sustain the number of CPAs who are enrolled in Medicaid to provide these services can expand access to behavioral health services for children and youth in foster care. CPA participation in Medicaid can also increase access to evidence-based behavioral health care that is trauma-informed and provided in-home.

The process for any provider (CPA or other) to provide MHTCM and MHR through Medicaid includes the following two key internal steps (internal preparations and training) and two external steps (Medicaid enrollment and MCO contracting/credentialing).

Internal Preparations

- Develop and hire qualified staff (Community Services Specialist, Qualified Mental Health Professional- community services, Family Parnters, and Peer Provers)
- Technolog y investments

MCO Contracting/ Credentialling

- Complete contracting documents
- Submit credentialing application through State Credentials Verification Organization
- Obtain approval from each plan's credentialing committee

Medicaid Enrolllment

- Meet Enrollment criteria
- Obtain HHSC approval for enrollment
- Obtain National Provider Identifier (NPI) number from the National Plan and Provider Enumeration System (NPPES)
- Complete and submit Texas Medicaid enrollment application to the Texas Medicaid and Healthcare Partnership (TMHP) (online or via paper)
- Provide any additional information requested by TMHHP, HHSC, or the HHSC Office of Inspector General (OIG) in connection with the processing of the applcation
- Be approved by HHSC for enrollment and enter into a written provider agreement with HHSC

Training
• Social Skills and Aggression Replacement Techniques (START) • Preparing Adolescents for Young Adulthood (PAYA) • Seeking Safety • Nurturing Parent Program • Barkley's Defiant Child/Defiant Team • Wraparound Planning Process through the Texas Institute of Exchellence in Mental Health at the University of Texas at Austin

CPAs encounter financial, administrative, and other barriers at each step of this process as well as ongoing operational challenges once they are enrolled and credentialed. Results from a focus group conducted with CPAs currently participating in the Texas Medicaid program, as well as a survey of CPAs at various stages of the Medicaid enrollment process, revealed the following impediments to enrollment:

- Participation required significant funding for start-up and continued operational expenses to meet staffing, information technology, and facility requirements.
- Limited training slots for certain evidence-based services, such as wraparound.
- State Medicaid enrollment process length and requirements.
- MCO credentialing process length and requirements.
- Lengthy delay between completing the Medicaid enrollment and credentialing process and serving clients, while incurring staffing costs.
- Compliance with requirements to separate case management and service provision functions organizationally, to avoid conflict of interest requirements. Some providers have established separate legal entities to provide BH services.

Once credentialed, additional operational challenges include:

- Additional administrative effort required to maintain working relationships with Medicaid MCOs due to MCO staff turnover.
- Failure of STAR Health MCO to list enrolled and credentialed CPAs as providers of behavioral health services in STAR Health provider directory.
- Inadequate rate structure to support certain direct and indirect costs.
- Navigating MCO prior authorization processes.
- Difficulty maintaining workforce due to high turnover among qualified mental health professionals (QMHPs).
- Inability to submit claims due to delays with receiving initial access to the Clinical Management for Behavioral Health Services (CMBHS) system. CMBHS is used statewide by contracted substance use and mental health treatment service providers to submit data to the state to fulfill contract requirements.
- The system includes clinical tools that standardize the assessment, diagnosis, and level-of-care determination and treatment processes. Providers also use it to document the services provided and submit claims.
- Continued operational challenges with CMBHS after access is granted by the state.

CPAs reported a range of start-up and recurring costs to support becoming comprehensive behavioral

health providers in the Texas Medicaid program, ranging from $100,001 to over $700,000. Furthermore, CPAs interested in becoming a Medicaid provider were unsure of or did not have an identified funding source to support this effort, suggesting this could be a barrier to their participation in the Texas Medicaid program.

PROVIDE FUNDING TO INCREASE CPA PARTICIPATION IN MEDICAID

Medicaid providers knowledgeable about the child welfare population and trained in effective practices are fundamental to providing effective care. Providers are needed with expertise that is relevant to children in child welfare, such as abuse, attachment disorders, and trauma. Increasing and sustaining the participation of CPAs in Medicaid can improve access to behavioral health providers who are trauma-informed and understand the complexities faced by foster children and youth. There is a cohort of at least 11 child welfare providers who have expressed interest in becoming and/or are at various stages in the process to participate in the Texas Medicaid program. The Texas Legislature should provide funding and administrative relief to help these and other CPAs overcome barriers to participation in Medicaid and expand access to behavioral health care for foster children and youth, through the following recommendations:

(1) Provide $1.2 million in state funds and include a related rider in the DFPS bill pattern to create a grant program whereby CPAs interested in providing Medicaid-funded behavioral health services could apply for funding to cover start-up costs and ongoing expenses. This program would include a matching funds requirement for the provider agency.

(2) Include a rider in HHSC's bill pattern requiring the Commission to work with managed care organizations (MCOs) to address the operational challenges experienced by child welfare providers of TCM and Rehab including issues with contracting and credentialing, listing in the provider directory, and other administrative processes as needed, and provide a report to the Legislature on the implementation of these efficiencies.

These recommendations improve upon a prior unsuccessful attempt to address this issue. In the FY2018—19 General Appropriations Act, Rider 77, Medicaid Services Capacity for High-Needs Children in the Foster Care System, HHSC received an appropriation of $2.0 million in All Funds for a statewide grant program to increase access to targeted case management and rehabilitative services for high-needs children in the foster care system. HHSC has not publicly reported on the implementation of this rider. These recommendations target funds to CPAs, whereas Rider 77 made funds available to LMHAs and other organizations. These recommendations appropriate the funding to DFPS instead of HHSC. DFPS has the statutory mandate to ensure the care of foster children and the contractual relationship with CPAs, providing a strong incentive for the successful implementation of this rider. In addition, the Department has a greater ability to focus on its implementation, given its more limited span of authority compared to HHSC.

BEST STATE PRACTICES

ARIZONA

There is alignment between the Medicaid agency, the regional behavioral health authorities who administer the state's BH Services, and the child welfare agency in meeting the BH needs of foster children. Notable features of the state's approach include

- A single MCO serves foster children (Comprehensive Medical and Dental Program).
- Inclusion of specialized Medicaid services in the array (Multisysemic Therapy) and high needs case management
- Manditory inclusion of the Wraparound process for all children recieving BH services including foster children
- BH providers required to undergo specialty training on "a day in the life in child welfare".
- Regional Behavioral Health Authorities are mandated to contract with specialty child welfare providers to ensure access to trauma-informed, child welfare system-informed providers and these providers are required to be Medicaid-enrolled.
- The state's Medicaid rate structure includes risk-adjusted capitation rates for chilren in care.

MASSACHUSETTS

Following an EPSDT-related court order, collaboration between the Medicaid, behavioral health, child welfare, juvenille jusice, and other agencies improved significantly and a new initiative was developped:the Children's Behavioral Health Initiative (CBHI) . Key features of the state's response to meet the BH needs of Medicaid children, including foster children, include:

- The state's four MCOs procurred a network of care management entities (Community Service Agencies - "CSAs") to serve children with serious behavioral health challenges. There are currently 32 CSAs- one in each of the 29 child welfare service areas,and three specialty CSAs that serve any child meeting the criteria for intensive care coordination.
- The state required MCOs to use the same core network of providers.
- The state expanded the Medicaid service array to include home-and community-based services, including in-home therapy, family support and training, mobile crisis services, and therapeutic mentoring, and a Wraparound approach.
- CBHI staff developed provider guidelines on working with child welfare system-involved children.
- MCOs are required to establish provider networks with expertise in trauma-informed care. Simmons College developed a certificate program for advance study in trauma-informed care for the child welfare population.

Source: Center for Health Care Strategies, Inc. "Making Medicaid Work for Children in Child Welfare: Examples from the Field," June 2013.

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