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Special Considerations for Children and Families Involved with the Child Welfare System

This section identifies unique issues to consider when adapting publicly financed managed care to meet the behavioral health needs of children in the child welfare system, and their families. These considerations are organized by a comprehensive framework of 15 components that were framed to address issues that have emanated from previous phases of the Health Care Reform Tracking Project (HCRTTP).

The HCRTTP has demonstrated that many children in the child welfare system obtain behavioral health services through managed care. The following reasons explain why it is important for those who plan and implement managed care to carefully address the needs of children and families in the child welfare system.

- ***The high prevalence of serious and complex behavioral health needs among the children and families served by the child welfare system.*** Children in the child welfare system tend to be extremely vulnerable and are at high risk for health, mental health, and developmental problems. For children placed in foster care, the trauma of separation from their families and the experience of multiple moves within the foster care system itself can

CRITICAL COMPONENTS*

- ◆ Collaboration
- ◆ Access
- ◆ Initial Screening and Comprehensive Behavioral Health Assessments
- ◆ Clinical Criteria and Utilization Review Procedures
- ◆ Treatment Planning
- ◆ Service Array
- ◆ Provider Issues
- ◆ Family Focus
- ◆ Cultural Competence
- ◆ Coordination of Care
- ◆ Quality Monitoring and Evaluation
- ◆ Information Technology and Management of Data
- ◆ Funding Strategies
- ◆ Training and Informational Materials
- ◆ Early Childhood Issues

*See Appendix B for definitions of each of these components.

increase their vulnerability and compound their mental health problems. Since the principal funding source for health and behavioral health services for children in the child welfare system is Medicaid, Medicaid managed care directly affects this population of children. In the managed care reforms surveyed by the HCRTTP, there was a 22% increase from 1997/98 to 2000 in those reforms that include children involved with the child welfare system—from 60% to 82%. When children in the child welfare system are included in the managed care plan, it is important to consider the special needs of this relatively small group of children who will require higher than average levels of services and supports.

In addition to the needs of the children, many parents, who experience the multiple stresses that lead to involvement with the child welfare system, also need mental health services and supports, as well as substance abuse services. If their needs are not identified and addressed by the managed care plans, it will be more difficult to ensure safety, permanency, and well-being for their children.

- ***The public system's responsibility for children in the child welfare system.*** All children are dependent on others for their care and well-being, but children in the custody of the state are uniquely dependent upon government agencies. When a court determines that the separation of a child from his/her parents is in the child's best interests because of an imminent risk of serious harm, the public system must ensure that all needs, including physical and behavioral health needs, are properly provided.³ Through the Child and Family Services Review process, the federal government requires that states also provide

³ Child Welfare League of America: Standards for service for abused and neglected children and their families (1989) CWLA.

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services to help parents increase their capacity to care for their children⁴.

- ***The judicial role in decision-making.***

The issue related to the authority of the courts is an important consideration for publicly funded managed care systems. Unlike most other children enrolled in Medicaid behavioral health plans, the courts are actively involved in planning for children in the child welfare system. Judges have the final authority to make decisions about the need for placement of a child, and they are charged with approving plans for a child's care when the child is under protective supervision. This authority might extend to ordering or approving plans for behavioral health treatment services for the child or the child's parents.⁵

- ***Federal mandates and state child welfare reforms demand greater accountability in ensuring safety, permanency, and well-being for children in the child welfare system, and greater linkage with behavioral health plans.***

The Adoption and Safe Families Act (ASFA) of 1997, and parallel child welfare reforms in many states and local communities, have increased the pressure on child welfare agencies to achieve permanency for children more quickly and to be held accountable for better outcomes for children and their families. Through the Child and Family Services Review (CFSR) process, the federal government requires that states demonstrate compliance with a number of safety, permanency, and well-being outcomes as well as system performance measures. One of the seven outcomes relates specifically to whether the children receive adequate services to meet their physical and mental health needs. As mentioned above, one of the major outcomes relates to the state's ability to provide services to help parents increase their capacity to care for their children. The CFSR process reaffirms the need for the child welfare system to forge linkages with other systems of support for families, including behavioral health managed care systems.

Consideration of each of the above factors is essential when children in the child welfare system enroll in a managed care plan. HCRTP findings serve as the basis for many of the special considerations discussed below in each component. These considerations are offered to

assist states and local communities in adapting their managed care plans to meet the behavioral health needs of children and families in the child welfare system. *Information that describes what some states and communities are doing related to the components is written in italics.*

1. Collaboration Considerations

The child welfare, mental health, health, Medicaid, court and school systems, as well as providers, families and other caregivers, share responsibility for meeting the behavioral health needs of children in the child welfare system. A key decision that must be made is whether children in the child welfare system and their families will be included in the managed care plan. If it is determined that these children and their families are to receive behavioral health services under the managed care system, top-level commitment to cross-system planning and implementation is required to ensure that their unique needs will be met. This will require:

Early and Significant Involvement of the Child Welfare System in Planning and Problem-Solving—It

is important for the special needs of children in the child welfare system to be addressed in system design, in contracts, in setting rates and rate structures, in the make-up of the provider network, and in developing special provisions to meet their needs. Therefore, child welfare representatives should be encouraged to be significantly involved in both early and ongoing planning. When the plan is implemented, at the child/family level, child welfare workers can function as care managers - tracking and advocating for services,

⁴ In March 2000, regulations went into effect for a new approach to federal oversight of state child welfare programs, known as the Child and Family Services Reviews (CFSR). Overseen by the Children's Bureau of the Administration for Children and Families, the review process consists of statewide self-assessment as well as an on-site review, which is conducted by a team of Federal, state, and peer reviewers. Information gathered is used to examine the states' success in meeting the major goals of child welfare—child safety, permanency and well-being. When states do not achieve “substantial conformity” with the required outcomes, they develop Program Improvement Plans to describe how they will reach substantial conformity.

⁵ Battistelli, Ellen. (1996). Making Managed Health Care Work for Kids in Foster Care: A Guide to Purchasing Services. *Child Welfare League of America*, 13.

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and adjusting plans to reflect child and family needs. *Collaboration at the system-level between the Medicaid agency, the MCO and the child welfare system is being done by states in a variety of ways—through co-location of staff, sharing of financial resources, cross-system training, designation of special liaisons, interagency collaborative teams, and interagency agreements.*

Strategies for Engaging the Courts—Given the role of the court in child welfare, it is important for the managed care plan to build effective relationships with court staff, Guardian Ad Litem, and CASA⁶ volunteers who may be working on behalf of children in the child welfare system. Building collaborative relationships enables the court to appropriately use its decision making power to improve access to behavioral health services for children and/their families. *Some states have used court improvement activities as a means of enhancing behavioral health assessments and access to treatment for children in child welfare. (See Section II, Philadelphia, PA as one example.*

DISCUSSION TOPICS – COLLABORATION

- What approaches will be used to gain top-level commitment for the collaboration across child-serving agencies, the courts, the purchaser and the MCO to sustain collaborative efforts?
- How will this top level commitment be evident at all levels in the child-serving agencies?
- What are the strategies for ensuring the active participation of the child welfare system during planning, implementation, and evaluation of the managed care plan?
- What are the mechanisms for ensuring ongoing communication, both formal and informal, between the child welfare system, the MCO and other child-serving agencies?
- What are the problem solving vehicles at both the system and individual child/family levels between the MCO, providers, and the child welfare system?
- What are the mechanisms for periodically assessing the costs and effectiveness of collaborative activities?

- How will representatives from the MCO and network providers be included in the state CFSR process?

2. Access Considerations

When child protective services (CPS) workers become involved with families, they need appropriate information in order to make decisions about child safety and family service needs. The CPS worker must gather information, conduct risks assessments, and attempt to understand the child's and family's strengths and needs, including any evidence of mental health or substance abuse issues that may affect child safety or family stability.

A number of things could occur during initial stages of involvement with the child welfare system. For example, if all children in or at risk of foster care placement are eligible for the managed care plan, and if a child or parent's behavioral health issues are primary factors in jeopardizing child safety and family stability, the CPS worker might want to access immediate crisis intervention or assessment services. This would enable the CPS worker to:

- better understand the mental health and substance abuse issues in the family,
- de-escalate the immediate crisis,
- develop a safety and treatment plan that could be implemented in the home and community, and
- attempt to prevent unnecessary out-of-home placement for the child.

If children in placement are covered by the managed care plan, the CPS worker and the courts might want immediate access to assessment services that could help to:

- determine the appropriate level of care, and

⁶ Court Appointed Special Advocates (CASA)

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- identify placement resources that would work collaboratively with the child welfare system to achieve timely reunification or another permanent plan for the child.

Immediate access to behavioral health assessments and services is important not only to provide help for the child's and family's clinical needs but also to possibly prevent the need for placement of the child or, if placement is needed, to ensure that the placement chosen can meet the child's clinical, safety, and permanency needs. With appropriate and immediate access to home and community based therapeutic services, it may be possible to divert many children from placement; and if placement is required, to ensure timely reunification with birth families with appropriate therapeutic and other supports in place.

Throughout the time the child and family are involved with the child welfare system, it will be important to identify and remove access barriers, including consideration of the following provisions:

Streamlined Enrollment—Immediate eligibility and streamlined enrollment procedures, as well as ease of access when moving from acute care to extended care services, are important. *To accommodate access, some states and communities assume that children entering the foster care system are eligible for Medicaid until proven otherwise.*

Immediate Access to Crisis Intervention Services and Accessible Sites—In addition to mobile response capability, it is important for plans to locate assessment and service sites within reasonable geographic distances from family homes, to offer extended hours, and to have 24-hour availability for emergency care. *For example, Arkansas uses roving teams to provide multidisciplinary evaluations for all children who enter state protective custody. The assessments, which occur within 60 days, take place in 16 sites located around the state. This allows for interface with community providers and lessens the problem of having to transport children great distances.*

Expedited Consent—Mechanisms must be in place to address problems associated with obtaining consent from parents, guardians, the child welfare agency, or the court for assessment and treatment services. Any confusion about who is responsible for obtaining consent should be clarified during the planning phase. *The Family Court in Philadelphia created a brochure for parents to explain how they can help ensure that their children receive appropriate health and behavioral health services while in court-ordered placement. The brochure identifies the types of consent forms they may be asked to sign (including consent for mental health evaluation), why these consents are important, and what will be done with the information. The consent forms are discussed and signed during a pre-hearing conference with parents that takes place before each adjudicatory hearing.*

Clear Communication Between Child Welfare Agencies and MCOs Related to Eligibility Issues—Many managed care plans include special provisions for children and families involved with the child welfare system. These provisions, however, will not be triggered without a system to convey eligibility and enrollment information between child welfare agencies and managed care entities. For example, how will the MCO know when an enrolled child enters or leaves the child welfare system, when court orders for behavioral health services have been issued, or when a child changes placement?

Continuous Eligibility—In HCRTTP's 2000 *State Survey*, 73% of the reforms indicated that there were certain types of placements in which children in the child welfare or juvenile justice systems would lose eligibility for services from the managed care system, for example, residential treatment facilities, state or county operated public institutions, juvenile detention homes, out-of-state placements, and sometimes when returning home (depending on family income). Child welfare workers, courts, providers, and caregivers need to be aware of this possibility, take it into consideration when making placement decisions, and develop other strategies to access needed care. *Philadelphia has created a "managed care unit" that facilitates access to physical health care for children in foster care. The staff in*

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this unit know that certain changes in a child's placement can mean loss of eligibility for the managed care plan. They inform those who are making placement decisions and assist in finding other sources of care when the placement change must occur.

Communication with Caregivers and Providers—

When a child is separated from parents and placed in out-of-home care, kinship caregivers, foster parents, or group care providers may be charged with making certain the child has access to behavioral health services. It is important for the public purchaser, the child welfare agency, and the managed care contractor to define their respective roles in informing the child, the child's family, and any alternate caregivers about the managed care plan, the process for enrollment, and the extent of services that will be available to the child and family. Additional services, such as transportation and respite care for other children in the home, may be needed to support caregivers in accessing behavioral health services.

Accessing Services at Transition Points—During the time children and their families are involved with the child welfare system, their living arrangements and service needs will often change. As the managed care plan is being developed it is important to note the transitory nature of child welfare placements and the need to ensure access to services particularly during times of transition—including initial placement, change in placement, reunification or adoption. In addition, some children in foster care “age out” of the child welfare system without having a permanent placement. The child welfare agency and the managed care plan need to consider how these youth who exit the child welfare system (and perhaps lose eligibility for a child-specific managed care reform, but have continuing behavioral health needs) will transition to the adult behavioral health system.

DISCUSSION TOPICS – ACCESS

- Who will determine which children involved with the child welfare system will be included and excluded from the managed care plan ?

- How will it be determined which special provisions might be included to ensure that these children have streamlined eligibility and enrollment?
- Are there provisions for presumptive eligibility for Medicaid?
- What will be the system for enrolling children in the managed care system?
- Who is responsible for the initial referral and for monitoring time it takes for children and families to access needed services?
- Who will be responsible for obtaining consent for assessment and treatment services?
- Are there mechanisms to ensure that consent is obtained in a timely manner when the child first becomes involved with the child welfare system?
- What kind of immediate interventions will be available to the child and family?
- What outreach activities and print materials will be developed to inform parents, caregivers and other child welfare providers about the managed care plan and how they can access care?
- Who will be responsible for helping families—birth, kin, foster and adoptive families—to navigate the managed care system?
- What are the strategies for ensuring communication between the child welfare system and the MCO regarding issues affecting eligibility? For example, who will be responsible for informing the MCO when a child changes placement after initial enrollment?
- How will the plan ensure continuous eligibility for children when placements change?
- How will children aging out of child welfare who have continuing behavioral health needs access the adult services they need?
- How will the plan monitor access by children in the child welfare system?
- What problem-solving mechanisms will be used to address access barriers that are identified?

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3. Initial Screening and Comprehensive Behavioral Health Assessment Considerations

Some state child welfare agencies have policies and procedures in place to ensure that children who receive child protective services or are in the foster care system receive an initial health and behavioral health screen within a specified time period. Some states provide comprehensive behavioral health assessments for all children as they enter foster care. In the ideal, these assessments are then used by the child welfare worker, the family, and other members of the treatment planning team to develop an individualized service plan that addresses child safety, permanency, and well-being issues, including issues related to behavioral health needs. The courts often rely upon the assessments to make informed decisions that will affect the child and family in profound ways.

Despite the importance of comprehensive behavioral health assessments, child welfare agencies frequently cite problems in getting assessments completed in a timeframe and manner that is useful in planning for services or guiding court decisions. Issues identified as barriers could be addressed when the child is enrolled in the managed care plan if special considerations are given to the following:

Ensure That Assessment Tools and the People Conducting Assessments Address the Impact of Abuse, Neglect, and Placement—Providers who conduct initial behavioral health screens and comprehensive assessments need to understand the impact of abuse and neglect, be knowledgeable of the life experiences of children in the child welfare system, and place behavioral health findings in the broader context of the trauma a child and family may have experienced. *In some states, clinics that specialize in the screening and assessment of children in the child welfare system provide these services for the MCOs.*

Identification of Parental Behavioral Health Needs—Given the prevalence of behavioral health problems in the parents of children in the child welfare system and the shortened timeframes for making decisions about permanent living arrangements for children, it is

essential that the behavioral health needs of parents are identified during the screening and assessment processes. Strategies for treatment for parents must be created, even if the parents are not “eligible” for services through the child’s managed care plan. *Child welfare agencies in several states and communities have agreed to fund services for parents that cannot be funded through the managed care plan.*

Coordination of Behavioral Health Assessments and Child Welfare Safety and Risk Assessments—Child welfare agencies are responsible for assessing whether a child is, or can be, safe in a particular environment. It is important to coordinate the timing of the mandated risk assessments and behavioral health assessments so that child welfare workers, treatment providers and families have access to the findings of **both** assessments early in the development of child/family service plans. *A number of interagency initiatives that serve children with behavioral health needs incorporate the results of risk assessments in the individualized treatment planning process.*

Systems are needed to:

- identify and refer all children for initial behavioral health screens and, as indicated, comprehensive assessments
- monitor follow-up on recommendations made
- include procedures for re-assessments at transition points in the child’s life—including change in placement, plans for unsupervised visitation, reunification with families, or achievement of another permanency option.

Adequate Funds and Clear Payment Responsibilities—Since multiple systems are involved with children and families in the child welfare system, it is important to clarify who is responsible for conducting and paying for the initial screens and, when indicated, the comprehensive behavioral health assessments. This may be particularly relevant if the court orders certain assessments that would not otherwise be provided. Consideration should be given to adjusting Medicaid eligibility procedures so that children who enter, or are at-risk-of entering, foster care are instantly eligible for

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Medicaid-funded initial screens, comprehensive assessments, and any follow-up services that are recommended.

In addition, since the screens and assessments for children and families in the child welfare system may require special expertise and more time, it is particularly important to ensure that reimbursement rates for initial screens and comprehensive assessments are adequate and that there are no built-in disincentives for professionals to identify needs that will result in additional service costs. *Florida requires a very comprehensive behavioral health assessment for all children who enter state custody. In order to ensure that the assessments are comprehensive, providers may bill Medicaid for up to 20 hours per assessment at \$50/hour.*

DISCUSSION TOPICS – SCREENING AND ASSESSMENT

- How will it be determined which children will be screened initially and which children will need and receive a comprehensive behavioral health assessment?
- If screens and assessments for children involved with the child welfare system are not covered by the managed care plan, who will provide and pay for them?
- How will referrals for screening and assessment be handled?
- Who will be charged with collecting medical records and any prior assessments and providing information to the MCO and those responsible for the current assessment?
- Who will be responsible for establishing the timelines for conducting screening and assessments for child welfare populations?
- How will the frequency, the nature, and the responsibility for re-assessments, particularly at transition times in the child's life, be determined?
- How will behavioral health, physical health, child welfare risk and family assessments, and educational assessments be integrated?

- How will the managed care plan ensure that the professionals conducting the assessments are knowledgeable about child welfare and the impact of abuse and neglect on children and their families?
- How will the plan ensure that the screening and assessments are conducted in a child-friendly setting to minimize trauma to the child?
- What role will the child welfare agency have in the selection or adaptation of screening and assessment tools? How will the screening and assessment approaches identify behavioral health needs of family members? Who will provide and pay for needed services for parents if only the child is eligible?
- Who will be responsible for providing and paying for behavioral health screening and assessments ordered by the courts?
- Who will have access to the results of the assessments? How will both the “need to know” and confidentiality be addressed when results are shared?
- Who will be charged with following up on assessments to ensure that recommended services are provided?
- What role will family members or other caregivers have in the assessment process? What information from the assessments will be shared with birth families or other caregivers?
- How will it be determined whether the reimbursement rate for screening and assessment is adequate to compensate providers for the additional time required to conduct assessments for children in the child welfare system and to participate in additional activities such as service plans and testifying at court hearings?

4. Clinical Criteria and Utilization Review Considerations

According to the 2000 HC RTP survey, 63% of public managed care reforms reportedly include clinical decision-making criteria specific to children's behavioral health care. Overall, 62% of these reforms with child-specific criteria reportedly have increased consistency in clinical decision-making. However,

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some respondents in earlier site visits noted that medical necessity criteria and review procedures are too narrowly defined to authorize the appropriate type, level, and duration of services for children in the child welfare system.

The child welfare system and managed care both value (perhaps for different reasons) placements and services that are least restrictive and, whenever possible, delivered in the communities where children and families live. Both child welfare and managed care plans share a belief that service decisions should be backed by evidence-based decision support tools that can be used reliably by professionals—thus promoting consistency across the system in how children and families are served. However, if the medical necessity criteria do not allow for consideration of psychosocial, environmental, and safety factors in making clinical decisions, it may be particularly problematic. In the context of the previously described child welfare mandates that relate to safety, permanency, and well-being, e.g., the Child and Family Services Review process, states must be able to demonstrate and document that services were provided to meet the health and behavioral health needs of children and that needed services were provided to parents to enhance their capacity to care for their children.

The special clinical and non-clinical needs of children and families in the child welfare system require consideration of the following issues:

Broad and Flexible Interpretation of Medical Necessity Criteria and Clarity in Payment Responsibility—If medical necessity criteria are used to guide service decisions, the unique factors associated with serving children in the child welfare system and their families should be understood and addressed. For example, it is not uncommon for the child’s clinical needs to improve prior to the time that non-clinical family issues are resolved and reunification or permanency achieved. When this occurs, the managed care plan may determine that the child’s continued stay in a therapeutic setting no longer meets established medical necessity criteria. However, before deciding that the child must be moved, it will be important to

weigh the potential consequences that result from disrupting a stable placement.

Since these children may need continuing care for non-clinical reasons, the managed care plan and the child welfare agency will need to clarify payment responsibility for services or placements that do not meet medical necessity criteria, especially for those mandated by the courts. (*See description of Philadelphia, PA in Section II for approaches to this issue.*)

Consistent Criteria Across Managed Care Organizations (MCOs)—When states/localities using more than one MCO allow each MCO to define and interpret medical necessity criteria, this can cause confusion and inconsistency in care, especially for children in the child welfare system who move from one MCO to another as their placement location or status changes. Using consistent criteria and procedures across MCOs helps to alleviate this problem. *According to the HCRTP 2000 State Survey, several states reported standardized criteria and processes when contracting with multiple MCOs.*

Adaptation of Utilization Review Standards to Fit Child Welfare—In designing authorization and review procedures, it is important for public purchasers and MCOs to recognize that children in child welfare will be more likely to require extended care than most other children. It might be beneficial to adapt the timelines for continuing stay reviews for children involved with the child welfare system. *For example, most children in therapeutic foster care require time to adjust and progress. If utilization reviews occur too frequently or too quickly, it creates unneeded paperwork and threatens placement stability for the child. In a state faced with such restrictions, the MCO and the child welfare agency came to a compromise on the amount of time a child could remain in a therapeutic foster home before the review occurred.*

Taking into Account the Availability of Services—A significant portion of the children in the child welfare system have serious and complex behavioral health needs and may require placement in a hospital or other therapeutic setting while involved with the child welfare system. Clinical criteria are often used to restrict initial admission to, or reduce lengths of stay in,

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restrictive settings. While reducing the inappropriate use of restrictive forms of out-of-home care is important, decisions should be made in the context of available, alternative services. When considering the issues of safety and permanency, it is essential that public purchasers and MCOs do not restrict access to any services or placement level in the absence of a full array of home and community-based alternatives.

DISCUSSION TOPICS – CLINICAL CRITERIA AND UTILIZATION REVIEW

- How will child welfare agencies participate in developing:
 - medical necessity criteria
 - level of care criteria
 - prior authorization procedures
 - utilization review procedures?
- What special allowances might be needed for children in the child welfare system?
- How will the clinical criteria and review procedures be standardized across multiple MCOs?
- How will the adequacy and availability of home and community-based services be assessed initially and over time?
- Who will be responsible for providing and paying for court-ordered or other services that do not meet levels of care or medical necessity criteria?
- What mechanisms might be developed to track denials of care for children in the child welfare system?
- What problem-solving mechanisms can be created between child welfare, the MCO, and the purchaser when the criteria or the interpretation of them are brought into question?

5. Treatment Planning Considerations

Both child welfare agencies and behavioral health providers may engage the child and family in a planning process to develop “plans” for services. Child welfare agencies must develop with families a service plan⁷ for children receiving child protection, family preservation, foster care, or adoption services. This plan includes **goals related to safety, permanency, and well-being**. It includes needed health and

behavioral health services for the child and/or parent. The behavioral health provider may also engage the child and family in an examination of child and family behavioral health needs, resulting in a treatment plan⁸ that describes the services and supports that will be provided to reach clinical goals.

Special considerations related to treatment and service planning children in the child welfare system highlight the need for:

Coordination Between Behavioral Health And Child Welfare Planning Processes and Resulting Plans—It is important for child welfare agencies and publicly funded managed care systems to consider ways that the child welfare and behavioral health planning processes and the resulting plans can be coordinated to reduce confusion for the child and family and to ensure that services provided by both systems support safety, permanency, and the attainment of clinical goals. *Some child welfare agencies have begun to address this issue by the use of family conferencing approaches to service and treatment planning. The end result of family conferences is a comprehensive plan, developed by a team that might include the child welfare worker, behavioral health and child welfare providers, the child’s Guardian Ad Litem, the child, the child’s immediate and extended family, and the child’s current caregiver. The plan integrates the child and family’s behavioral health treatment goals and services into the overall service plan that addresses safety, permanency, and well-being concerns.*

Assessments that Guide Treatment and Service Plans—Children should receive child welfare and behavioral health services that are appropriate to their needs and not simply what is available. If the service and treatment plans are not developed jointly, at a minimum, the child welfare system and the MCO should consider strategies for ensuring that **both** systems have access to relevant assessment information when deciding on the clinical and non-clinical services that will be provided to the child and the family. This

⁷ In this report the term “service” plan refers to the mandated child/family service plan which focuses on a placement goal for the child, is regularly reviewed, and is periodically presented to the court for approval.

⁸ The term “treatment” plan is used to refer to the plan for behavioral health services and treatment.

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assessment information should be used to guide the treatment planning process.

Approach to Working with Families—It creates difficulties for families if child welfare and behavioral health providers do not share similar values and approaches toward working with families in developing service plans and treatment plans, e.g., one system telling the family what they are expected to do and the other system asking the family what services they need. It is important for managed care plans and the child welfare system to discuss the approach to service planning that will be used by front line workers and providers.

DISCUSSION TOPICS – TREATMENT PLANNING

- How will the behavioral health treatment and child welfare service planning processes and the resulting treatment and service plans be coordinated?
- How will MCOs/providers and the child welfare system create similar and consistent approaches for involving families in the service and treatment plan process?
- What strategies could be implemented to provide mental health and substance abuse consultation to child welfare workers so they may better understand the child's and family's needs when developing the service plans?
- How will the child welfare assessments related to safety, permanency, and well-being be shared with and used by the MCO to develop treatment plans?
- How will behavioral health assessments be shared with and used by child welfare to develop the service plan (related to safety, permanency, and well-being)?
- What are the mechanisms to ensure that the MCO is aware of any court-orders the child or family may have for services when treatment plans are developed and services authorized?
- What special provisions might be used to ensure that caregivers have the support services needed to participate in the development and implementation of the child's treatment plan?

6. Service Array Considerations

Children involved with the child welfare system and their families have therapeutic and non-therapeutic service needs. In terms of behavioral services, they need access to both acute and extended care. They also need to have their behavioral health services coordinated with non-clinical services to ensure that all interventions are directed towards achieving safety, permanency, and improved well-being.

According to the HC RTP 2000 *State Survey*, most managed care plans do cover both acute and extended care for children. However, other child-serving systems, including child welfare, may also share responsibility and resources for some behavioral health services and for providing a host of non-clinical services and supports. Regardless of who has the responsibility for creating and paying for services, children in the child welfare system and their families require:

A Full Array of Acute and Extended Care Therapeutic Services—While it would be helpful to obtain all of these services through the behavioral health system, essential services used by children in the child welfare system may not be covered by the managed care plan. The child welfare agency and the MCO need to determine how children will access non-covered services and clarify payment responsibilities. It is also important for the child welfare system and the managed care plan to identify any barriers that may jeopardize the ability of a child to move smoothly from one service to another as needs change. This may be particularly important for children who receive some extended care services through the managed care plan and other services through child welfare or other child-serving systems.

In some states, child welfare agencies and MCOs share the cost of extended psychiatric care. For example, Massachusetts has a program in place for transitioning children from intensive psychiatric placements to a lower level of care. The BHO pays for the first 30 days of service in the lower level of care, and the Department of Social Services (DSS) picks up the cost on day 31. This enables a child to move out of an unnecessarily intensive and restrictive psychiatric placement, thus reducing costs, while providing DSS with 30 days to arrange payment in

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the lower level of care, or to determine if the child is ready to move back to the community with support services. While resolving some problems, it has been noted that this plan can mean yet another short-term placement if the child does not stay long in the step-down placement. In Connecticut, the Department of Children and Families (DCF) and the MCO share costs for children in custody who are placed in inpatient psychiatric care. The MCO pays for the first 15 days of care, DCF and the MCO share the cost for the next 45 days, and after 60 days, DCF pays the full cost.

An Ongoing Process to Assess and Address the Adequacy and Availability of Services—It is important that the managed care plan and the child welfare system jointly assess service gaps and develop strategies with other child-serving systems for increasing capacity or adding new services. Gaps could relate to services for a particular subgroup of children, such as adolescents or children with mild to moderate behavioral health needs; the availability of services in both urban and rural areas; and, as previously noted, the availability of home and community-based services and step-down options that can be used as alternatives to restrictive placements or hospitalization.

DISCUSSION TOPICS – SERVICE ARRAY

- How will the child welfare agency participate in the determination of which services will be included in the managed care plan?
- How will children access excluded services? Who will provide them and who will pay for them?
- How will the managed care plan assess the service needs of the children in the child welfare system initially and over time?
- If gaps or duplication in services for children in the child welfare system are identified, who will determine how services will be added, expanded, or streamlined? How will child welfare participate in that process?

7. Provider Considerations

The HCRTTP has explored a range of provider issues that have a direct impact on the delivery of services to children in the child welfare system, including: provider skills, the availability of specialty providers, reimbursement rates, and administrative burdens. The HCRTTP found that child welfare providers (i.e., providers who traditionally have provided family support, foster care, behavioral health, and related services to the child welfare population) are not included in provider networks in 47% of the reforms. If children and families involved with the child welfare system are to be included in the managed care plan, their unique needs should be considered in developing the provider network, including their need for:

Providers With Knowledge and Experience In Working with Children in the Child Welfare System and Their Families

The exclusion of child welfare providers has both clinical and fiscal implications. If a provider with experience in working with children in the child welfare system is not in the managed care system network, the child welfare agency may have to pay for that provider's services outside the network or choose to use a network provider who may not be as familiar with the child and his/her service needs. It is important for the managed care plan and the child welfare agency to work together to ensure that network providers have the knowledge and skills required to meet not only a child's clinical needs but also to:

- understand and address issues of safety and permanency,
- understand the trauma the child may have experienced,
- accept and work effectively with the child's birth parents and other caregivers, and
- work well with child welfare staff.

For an example, see the description of the Kinship Center in Section II. In California, the Kinship Center, an organization with expertise in serving adoptive families, became a provider for the county managed mental health plan.

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Adequate Rates For Providers—The child welfare agency and the managed care plan should work to ensure that there are no disincentives (e.g., lower reimbursement rates or administrative burdens) for child welfare agencies to participate in the MCO network. Since children in the child welfare system may require longer than average services, the MCO also should ensure that there are no penalties for providers if children need extended or specialized services. It is advisable for the MCO and the state to periodically assess the adequacy of reimbursement rates for providers serving children in the child welfare system.

Knowledge and Inclusion of Smaller, Community-Based Agencies—Smaller agencies may have limited infrastructure and few professional staff with credentials to be in a position to participate formally in the MCO network. It is, however, important for the MCO and the child welfare agency to find ways to engage a wide array of community, non-traditional agencies to support children in the child welfare system and their families. Managed care plans might consider using community liaisons, who know how to develop and find needed resources and work with child welfare workers to access appropriate community services and supports.

Inclusion of Specialists—The provider network needs to include specialists who understand the unique needs of children who have been abused or neglected and their families. For example, specialized skills are needed in working with victims and perpetrators of sexual abuse; in addressing separation, loss, and attachment issues in children and families following placement; and in recognizing and addressing issues that may arise pre- and post-adoption, or after reunification with the birth family.

Continuity in Providers—For a variety of reasons, children involved with the child welfare system often experience frequent planned and unplanned placement changes—from county to county, out of state, from one type or level of placement to another, and in and out of their own homes. Sometimes this means moving out of the geographic area covered by their managed care plans. Managed care systems need to be aware of the possibility of frequent moves and develop a plan

both to minimize disruption of care by providers and to follow-up on service needs identified in a child's previous placement.

In California, the Mental Health Director's Association adopted an Intra-County Memorandum of Understanding for Foster Youth in Out-of-Home/Out-of-County Care in 1998. This MOU was developed to facilitate a system of care approach to meeting the mental health needs of children in foster care who reside out-of-county (in a county different from the county where they came into custody). Such a MOU is necessary in California because when children in foster care move to another county, the county of origin is responsible for funding mental health services in the child's new home county. The county mental health plan, the department of social services, and probation (when involved) are expected to collaborate prior to the child's move to determine whether appropriate providers are available in the new county and how the child's behavioral health needs can be met.

DISCUSSION TOPICS –
PROVIDER ISSUES

- How will traditional child welfare providers participate in the provider network? How will they be recruited?
- What strategies might be used to include small, community-based, non-traditional providers?
- How will the MCO identify and recruit the types of specialists needed by children in the child welfare system?
- How will the rates and payment structures to providers who will serve children in the child welfare system be determined? How will the sufficiency of rates be assessed?
- What are the mechanisms that could be developed to allow a child to continue with the same provider when he/she moves from one MCO geographic area to another?
- What supports or incentives will be included to encourage behavioral health providers to participate collaboratively in activities such as family conferences, service planning meetings, and court hearings?

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- What role will the child welfare agency have in monitoring the quality of care of providers within and outside of the network who serve children and families involved with child welfare?

8. Family Considerations

In the HCRTTP 1999 *Impact Analysis*, child welfare stakeholders emphasized that managed care plans need to take into account the child’s “bigger picture”, i.e., that a child’s involvement with the child welfare system is temporary and that services must address the needs of the family as well as the child. When a child is in the foster care system, it is necessary for the managed care plan to begin first by expanding the definition of “family.”

Special considerations related to families include the following:

Instilling a Family Focus In Treatment Planning—If there are no specific safety issues (or court orders) that prevent birth families from being involved with their children, it is important for the managed care plan to incorporate requirements for birth family involvement at the service delivery level and to specify the services and supports that will be available to allow them to actively participate in treatment planning. Family involvement not only helps to ensure that the child’s behavioral health needs are identified and met, it also helps the family to define services and supports that would enable them to continue or resume parenting responsibilities. Since the vast majority of children in the child welfare system are eventually reunited with birth families or kin, it is critical that they be engaged in planning for that eventuality.

Clarifying Who Is Considered “Family”—Children involved with the child welfare system may have several “families.” They may live with or be working towards reunification with their birth parents or other kin. They may currently be living with extended family or foster families. Children who cannot return to their birth families may be placed with adoptive families. It

is important for the child welfare agency and the MCO/provider to have mechanisms in place for communicating the role of the various caregivers in a child’s life and in determining how all of the caregivers will be involved in and/or kept informed about their child’s treatment.

Coordinated Family-focused Interventions—Since both the behavioral health and child welfare agencies may be working separately with the family on different issues, it is important for them to ensure that family-focused interventions are coordinated and intended to reach mutually desirable goals. In addition, it is possible that the child may receive services through one MCO and the family or siblings through another. When this is the case, it is important to consider mechanisms for collaborative work with families between MCOs and between providers.

Services for Parents and Other Family Members—As previously noted, many parents involved with the child welfare system struggle with mental health problems or substance abuse. A 1994 study found that substance abuse was a factor in the placement of 75% of the children entering foster care.⁹ It is critically important for child welfare agencies and managed care plans to find or provide services for parents, even if they are not eligible for Medicaid or a member of the same MCO as their child. *The preservation of families is dependent upon parents receiving appropriate services. Some managed care plans have contracted with providers to offer substance abuse treatment services for families involved with the child welfare system. They have found that when parents participate in substance abuse treatment, children are more likely to remain at home or to return home.*

Ongoing Communication & Specialized Training—It is important to ensure that families are fully informed about their child’s behavioral health needs. Training on behavioral health issues and management techniques should be provided for families—birth, kin, foster, or adoptive families. This is particularly important prior

⁹ United States General Accounting Office. (1994). *Foster Care: Parental drug abuse has alarming impact on young children*. Report No. HEHS-94-89. Washington, DC.

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to reunification or adoption to ensure that progress made while the child was in foster care is sustained in the home and community.

Family Involvement at the System Level—Families need to be involved in system planning, in implementation, and evaluation efforts. For children in the child welfare system, it is important to gain the insights of birth, foster, kin and adoptive parents.

Assessing Family Satisfaction—Since children in the child welfare system may be included in several “families” - their birth families, foster parents, extended family members, guardians, and adoptive parents – it is important that satisfaction surveys reach each of the child’s caregivers.

DISCUSSION TOPICS – FAMILY FOCUS

- What contract requirements might ensure that the parents and/or caregivers of children in the child welfare system are given opportunities to participate in planning for their child(ren)?
- What supports might be included to enhance family participation?
- For children in foster care, who will determine how birth and foster families will be involved?
- When it has been determined (by the child welfare agency or the court) that contact between the child and birth family members is not appropriate, what are the mechanisms to ensure that the MCO has that information?
 - In those cases, who is responsible for keeping the birth family informed about the treatment plans?
 - When the situation changes and birth family contact is encouraged, how will the MCO be informed?
- What are the mechanisms to ensure that the focus of interventions is on the entire family and not just the identified child?
- When a child is served by one MCO and the family is served by another MCO, what are the mechanisms for collaborative planning and service coordination between MCOs?

- If behavioral health services for parents are not included, how will family members access those services and who will pay for them?
- What are the requirements in contracts that support family involvement at the system level, and what are the special provisions for including families involved with the child welfare system? (For example, will there be family-to-family support strategies, advocacy, or support organizations specifically for families involved with the child welfare system that are supported by the managed care plan?)

9. Cultural Competence Considerations

While 64% of the respondents to the *2000 State Survey* indicated that requirements for cultural competence under the managed care system were stronger than in the previous system, respondents in the 1997 and 1999 site visits indicated that despite including cultural competence requirements, managed care reforms have had little, if any, effect on the overall level of cultural competence of managed care systems. Considering the factors identified below, the lack of adequate attention to and impact on cultural competence in managed care has a particularly significant impact on the child welfare system.

Disproportionate Representation of Children of Color in the Child Welfare System—A number of studies have shown that for numerous reasons, children of color, particularly African-American children, are over-represented in the child welfare system. African American children come into foster care at greater rates, remain in care longer¹⁰, and are more likely to be served in out-of-home placements than are Caucasian children.¹¹

¹⁰ Greenblatt, Sarah. (1997). The Adoption and Safe Families Act of 1997: A Quick Look and Implications for Practice. *Permanency Planning Today*,3(2).

¹¹ Tom Morton. (1998). National Study of Protective, Preventative and Reunification Services Delivered to Children and Their Families. Atlanta: Child Welfare Institute.

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Culturally Competent Managed Care Systems Can Help—Culturally competent managed care systems can provide the opportunity to lessen the problem of disproportionate representation by:

- promoting early identification of children in need of mental health services
- providing services tailored to each child’s cultural context
- offering culturally appropriate services to parents affected by mental illness or substance abuse
- initiating mental health and substance abuse services in communities that have historically under-served people of color.¹²

Valuing Cultural Competence At The System Level—It is important for the managed care plan to actively recruit diverse providers, ensure training on the importance of culturally competent practice, offer linguistically and culturally appropriate services to all enrolled children and their families, and report progress in meeting standards for cultural competence to the public purchaser.

Track Service Utilization Or Outcomes By Culturally Diverse Groups—Few managed care reforms currently track outcomes by diverse groups. The child welfare agency, the purchaser, and the MCO all have a responsibility to ensure that evaluation and ongoing monitoring identifies any disparity in access to services or outcomes for children of color or from diverse cultural and linguistic backgrounds. It is important for them to develop mechanisms for responding to any evidence of bias.

DISCUSSION TOPICS – CULTURAL COMPETENCE

- How will cultural issues be considered in designing, implementing, and evaluating the managed care plan? How will cultural issues specifically related to children in the child welfare system be addressed?
- What are the mechanisms to ensure that screening, assessment tools and clinical criteria are free of cultural or racial biases that could jeopardize quality of care?
- How does the MCO ensure that providers who conduct behavioral health assessments are knowledgeable about the impact of linguistic and cultural patterns on assessment results?
- How will the MCO and providers demonstrate prior experience and skill in working with diverse populations, including those in the child welfare system?
- What training on culturally competent practice will be provided for MCOs and providers, specifically addressing the issues related to child welfare?
- What is the approach for recruiting an adequate number of culturally diverse and linguistically competent staff and providers?
- How will the child welfare system or MCO track the behavioral health utilization, outcomes, and costs of serving racially and culturally diverse children and families?

10. Coordination of Care Considerations

Children in the child welfare system and their families receive services from multiple systems and multiple care managers. For this reason, it is extremely important to coordinate the care they receive. The critical coordination issues described below relate to: coordination of health and behavioral

¹² J. McCarthy, J., Meyers, J., and Jackson, V. (1999). *The Adoption and Safe Families Act: Exploring the Opportunity for Collaboration Between Child Mental Health and Child Welfare System*. Washington, DC: Georgetown University Child Development Center and Washington Business Group on Health, 27.

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health care; coordination between the child welfare worker and the behavioral health care manager; and continuity at transition points for children within the child welfare system.

Coordination Between Health And Behavioral Health Care—Many children in the child welfare system experience poor health; inadequate previous medical care; incomplete, non-existent or “lost” medical records due to frequent moves and multiple placements; and a lack of coordination between physical health and behavioral health services. Enrollment in a managed care system offers some opportunity for improving current practice through better initial gathering of information and ongoing mechanisms for coordination between the MCO and other health and child-serving systems.

It is important to clarify which agency has the primary responsibility for obtaining medical records and histories and confidentiality releases, and then forwarding appropriate information to all parties serving the child and family at the time the child is referred for behavioral health services, as well as each time the child experiences a move. The MCO should have an organized method for documenting, storing, updating, and sharing health and behavioral health care information among the various agencies that are providing services to the child—including the MCO, child welfare agency, foster and birth parents, the providers—ideally through a health passport or shared computerized information system. *While many states and communities have developed health passports to track a child’s medical care, fewer are including information about behavioral health care in the passport.*

Coordination Between the Child Welfare Worker and the MCO/Provider Care Managers—Care coordination and case management for children in the child welfare system have historically been the responsibility of public or private child welfare workers. However, when the child is enrolled in a managed care plan, the MCO also has responsibility for managing and coordinating behavioral health services. These overlapping responsibilities between the child welfare system and the MCO can create problems in delineating primary responsibility and accountability.

Since a fundamental purpose in both systems is to coordinate the provision of services to individual children and families, it is important for the MCO and the child welfare agency to clearly define the care management duties of each system in order to reduce duplication and confusion. *Many states have used cross-training and ongoing problem-solving mechanisms to address this.*

Care Coordination During Times of Transition—To further complicate the challenges in coordination, children in the child welfare system experience many transitions - both in moving from one placement to another while in foster care, and when they achieve permanency through reunification, adoption, independence, or guardianship. For a variety of reasons—including high child welfare staff turnover and changing MCO provider networks—they may also experience several different workers or care managers during their involvement with the child welfare system. Each time a worker changes or a child moves, he or she is faced with building new relationships. There also is a risk that vital information may be lost, that follow-up to recommendations may not occur, and that new relationships will have to be created with MCOs and providers. It is important for the MCO and the child welfare agency to anticipate and respond to these transitions and challenges, to minimize disruptions to the child, and to ensure continuity of care for the child and family in each new placement.

DISCUSSION TOPICS – COORDINATION OF CARE

- How will physical and behavioral health care services be coordinated?
- How will mental health and substance abuse services be coordinated?
- How will primary care providers, behavioral health providers, and child welfare workers communicate with each other and with the child’s parents and caregivers?
- What are the provisions to ensure that health and behavioral health information on a child is shared from the time of initial enrollment until the child exits the child welfare system? How will health

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and behavioral health care information follow the child who may experience frequent moves?

- What are the mechanisms for coordinating the work of MCO coordinators with child welfare workers and other child-serving systems?
- What are the strategies for care coordination during predictable and unpredictable times of transitions for children in the child welfare system and when child welfare workers or behavioral health care managers change?
- How will the reimbursement rates for care coordination/case management activities be determined?
- What authority or input, if any, will child welfare workers have in authorizing and coordinating behavioral health assessments and services?
- What are the mechanisms for resolving differences between the child welfare worker and the MCO regarding services needed by the child and family?

11. Quality Monitoring and Evaluation Considerations

Evaluation of a managed care system often has various components, including assessing whether the system adhered to procedural requirements, whether services provided were appropriate to identified needs, whether children and their families benefited from the services received, whether defined outcomes were achieved, and how customers rate their satisfaction. Plans may also include a range of quality assurance and improvement mechanisms and be subjected to independent evaluations. Despite the desire to develop sound approaches to monitoring and evaluation, the HCRTTP has found that many managed care systems struggle to collect and use data to guide services at the individual service level or to use aggregate data to evaluate performance and drive future planning.

When children involved with the child welfare system are included in the managed care plan, it is important to isolate and compare the data related to their care from the data related to all other enrolled children.

Involving child welfare stakeholders in the design of the monitoring and evaluation plan will enhance the likelihood of including child welfare system outcomes and indicators in the plan. Consideration should be given to:

Collection and Use of Data Specifically Related to Children in the Child Welfare System and their Families—Examining data on children and families in the child welfare system confirms whether services are meeting their needs and if they are faring at least as well as other enrolled children and families. At a minimum, data related to service utilization, outcomes, satisfaction, and costs should be tracked and reported on children in the child welfare system and compared with similar data for all enrolled children or pre-defined performance benchmarks. When the child welfare system has contributed funds to the managed care plan, it is especially important to know if this investment is cost-effective and if the intended outcomes are being achieved. *Seventy-four percent (74%) of the managed care reforms in the HCRTTP's 2000 State Survey reported that they track the use of behavioral health services by children in the child welfare system. However, only 35% of those reforms that track this information use it for system planning.*

Development of Specific Performance Standards and Monitoring Procedures for Children in the Child Welfare System—If managed care plans are to serve children and adolescents in the child welfare system, they need to examine specific child and family outcomes that look not only at behavioral health issues but also at the safety, permanency, and well-being requirements of the child welfare system. *Some managed care reforms have jointly defined system performance standards and child/family outcomes in ways that do address the specific mandates of the child welfare system.* Data elements particularly relevant to the child welfare system include things such as placement stability and proximity to the child's community and family; child status in key life domains; the restrictiveness of placements; access to community-based services; timeliness of achieving permanency; family satisfaction; and crisis management.

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Grievance and Appeals Mechanisms—Together the state, the MCO and the child welfare agency need to decide who can file a grievance or an appeal regarding service denials or quality of care issues on behalf of a child in the child welfare system—the child’s birth parent, the foster parent, and/or the child welfare worker? It is also important for the state and the MCO to track and report actions taken in response to all grievance and appeal processes and decisions for children in the child welfare system. Many states have statutes and laws regarding the use of independent review organizations that should include consideration of any special circumstances relating to children and families in the child welfare system.

Assessing Satisfaction from the Perspective of Child Welfare—Most managed care plans include provisions for periodically assessing satisfaction from a number of perspectives. As was mentioned previously, if children involved with the child welfare system are included in the plan, it is important to assess the satisfaction of parents and any other caregivers of the child. In addition, other child welfare stakeholders—including child welfare workers and administrators, child welfare providers (especially those who have been brought into the network), and the courts—should be surveyed. The results can be used to guide system improvements, specifically for children involved with child welfare.

DISCUSSION TOPICS – QUALITY MONITORING AND EVALUATION

- What is the role of the child welfare agency in the development of initial outcome and system performance measures and in creating grievance and appeals processes?
- What are the responsibilities of the MCO and of the child welfare system in tracking and reporting specific performance measures related to children in the child welfare system?
- How will utilization, outcomes, and costs for children and families in the child welfare system be tracked and reported separately from other enrollees, and who will be responsible for this?
- What other data does the child welfare system need to obtain from the MCO?

- How will data be aggregated for the child welfare population and used for system planning? What will be the child welfare agency’s role in this effort?
- How will grievance and appeals for children in the child welfare system be tracked separately from other children?
- What are the specific mechanisms to ensure that families and caregivers of children in the child welfare systems fully understand grievance and appeals procedures? Who is responsible for transmitting that information?
- What kind of processes need to be created to determine the satisfaction of child welfare stakeholders with the managed care plan? For example, how will child welfare workers and administrators; birth parents, foster parents, and other caregivers; child advocates; and the courts be invited to provide input?

12. Information Technology Considerations

The HC RTP has found that in many managed care reforms, inadequate management information systems are considered to be a major impediment to effective communication of vital information and system accountability. Child welfare agencies attempt to collect a variety of essential information, including relevant health and behavioral health care history, on the child and family at the time the child’s case file is opened. For some states, child and family behavioral health information is stored in the state’s automated child welfare data system. Child welfare data must be periodically reported to federal agencies and used in the previously described Child and Family Services Reviews. However, like managed care systems, automated management information systems used by child welfare agencies have historically been problematic. New technology is being tested in child welfare and in the managed care arena. *Increasingly, web-based systems, with appropriate security safeguards, are being used to facilitate the storing and electronic sharing of information between various agencies and professionals involved with a child and family.*

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Adequate Management Information Systems and the Capacity to Share Information Across Systems—

Regardless of the system used, it is important that vital information collected by the child welfare agency is appropriately shared with the MCO at the time the child is enrolled and throughout the time the child is involved with the child welfare system. Similarly, relevant information collected by the MCO and providers must be available to the child welfare agency to document that services were provided to address the child's health and behavioral health needs. A system must be in place to facilitate this sharing of data.

When the managed care plan is being developed it is important for the public purchaser, in collaboration with other child-serving systems, to clearly define the data that will be collected, from which sources, for what purposes, at what frequency and to ensure that the MCO contract holds the contractor accountable for developing the technological capacity to meet data collection and reporting requirements. The child welfare system needs to work with the MCO to create the capacity for the MCO's data system and the child welfare data system to share relevant information. It is important for the MCO to fully understand the health and behavioral health data requirements of the Child and Family Services Review process and to work with the child welfare system on how documentation and reporting will occur.

Mechanisms to Ensure Compliance with Confidentiality Requirements—The Health Insurance Portability and Accountability Act of 1996 (HIPAA) has far reaching implications for children's services systems and any organization that uses technology to manage information related to health care billing or service delivery. The child welfare agency and the MCO will have to ensure compliance with all HIPAA standards. With appropriate safeguards, confidentiality issues should not prohibit the sharing of information.

DISCUSSION TOPICS – INFORMATION TECHNOLOGY AND DATA MANAGEMENT

- How will the health and behavioral health information that the child welfare worker obtains be made available to the MCO?

- How will the MCO's data for children in the child welfare system be shared with child welfare?
- Will both the child welfare and MCO data systems store this information? Will the systems be web-based, allowing for electronic transfer or uploads?
- How will the child welfare agency work with the MCO in meeting reporting requirements of the Adoption and Safe Families Act and ensure that all information required by the CFSR is documented?
- Who will be responsible for quality assurance of the data system to ensure the timeliness, security, and accuracy of data?
- How will confidentiality issues be monitored and handled? What are the mechanisms to ensure compliance with all HIPAA requirements?
- Will penalties and bonuses be included in MCO contract for the accurate and timely collection and reporting of data?

13. Funding Considerations

Multiple funding streams and procedures are involved in providing services for children in the child welfare system including, in many states, publicly financed managed care. Special funding issues to consider include:

Accountability for Shared Funding—In order to maximize resources, it is important for states to consider how funds from various child-serving agencies can be combined within the managed care plan to offer a wide variety of services and supports. The HCRTP 2000 State Survey found that 21% of the managed care reforms included funds from the child welfare system. When child welfare funds are contributed to the managed care plan, it is necessary to define how those funds are to be used and to periodically report actual expenditures. The child welfare system must be guaranteed that it will not lose money. If child welfare funds are contributed, then the children and services that were covered by those funds prior to being moved to the managed care plan must be covered within the managed care plan.

If behavioral health funds are given to the child welfare agency to provide services excluded from the managed

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care plan, it is important to define how those funds will be tracked and reported. Interagency agreements can be used to clarify how funds will be transferred and used. *Many state and community interagency initiatives, designed to meet the behavioral health needs of children from multiple systems, have successfully blended or braided funds from different child-serving agencies and created systems to track the use of these funds.*

Adequate Reimbursement Rates—A major factor affecting the likelihood that children and adolescents in foster care will receive the full extent of services they require is the adequacy of the reimbursement for the MCO and for the providers. The state and the managed care plan should periodically assess the adequacy of rates and make adjustments as needed to ensure accessibility to high quality services for children and families in the child welfare system.

Risk Arrangements and Incentives/Penalties—If risk-based arrangements are to be developed for providers who will serve children in the child welfare system, it will be important for the managed care plan to identify and address any potential unintended consequences that could result. For example, providers should not be penalized when a specified number of children exceed a certain level of service. Instead, the MCOs could offer incentives for providers to attain specified outcomes that are developed collaboratively with the child welfare agency. *A few states have developed risk-adjusted rates for children in the child welfare system.*

Identifying and Addressing Cost Shifting—It is important for the managed care plan to have the capacity to track and monitor cost-shifting in a systematic way and to develop mechanisms to prevent it. The HCRTTP found that cost-shifting is less likely to occur in reforms that incorporated strategies to clarify responsibility for providing and paying for services across child-serving systems.

DISCUSSION TOPICS – FUNDING STRATEGIES

- Will the plan include funds from other child-serving systems?

- If funds from multiple sources are used, how will the state and the MCO clarify payment responsibilities across child-serving systems?
- What are the options for transferring and blending funds?
- Once funds have been blended, how will expenditures by funding source be tracked and accounted for?
- How are the costs of providing behavioral health services to children in the child welfare system going to be assessed initially and on an ongoing basis?
- Will there be any special considerations made for the increased costs associated with these children and families?
- What are the options for providing incentives to providers who can demonstrate effectiveness in working with children and families in the child welfare system?
- What are the approaches that could be used to create more flexible use of funds, such as addressing service code, authorization, and encounter reporting barriers between the child welfare system and the purchaser?
- How will the state and the MCO periodically assess the overall adequacy of funds for serving children, especially those in the child welfare system?
- How will decisions be made about whether to limit profits? If profits are to be limited, how will the amount of this limit be set?
- What will be the approach to reinvestment of some profits or savings specifically for children in the child welfare system?
- What are the mechanisms for ensuring that risk-based financing arrangements do not adversely affect access to care, specifically for children in the child welfare system?
- What are the mechanisms for tracking cost-shifting across systems and for resolving the problem?

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14. Training Considerations

Child welfare stakeholders in HC RTP site visits cited multiple training needs on the part of MCOs and providers to familiarize them with the service needs of children and families involved with the child welfare system. Child welfare workers and families needed training about the managed care plan. They frequently lacked adequate information about the managed care system to make appropriate decisions and to secure needed services. Many respondents highlighted the need for systematic ways to offer cross-system training.

Training MCOs about the Special Issues Associated with Serving Children in the Child Welfare System—According to the HC RTP 2000 State Survey, more than half of the reforms do train MCOs about the unique needs of children and families involved with the child welfare system. This can significantly enhance the ability of the MCO to serve this population. The child welfare system—including social workers, the courts, caregivers, and families—can contribute in developing the training curricula and/or conducting the training.

Training Child Welfare Audiences about MCO Policies and Operations—It is equally important for the MCO to provide training to enable caregivers and child welfare workers to navigate the managed care system. This is occurring in many managed care systems. Providing supportive services, such as transportation, can increase the likelihood that parents and caregivers can attend training. MCOs can work with the child welfare agency to develop training materials appropriate for child welfare audiences.

Training for Providers—If child welfare providers and practitioners are included in the network, they may need specialized training on new skills and approaches required for success—including short-term treatment and wraparound approaches, family-focused service interventions, cultural competence, home and community-based alternatives. The MCO and the child welfare system should collaborate in the development of this training.

Training for Families—As previously noted, families of all types need specialized training to help them understand and respond appropriately to the behavioral health needs of their children and to recognize their own behavioral health needs.

DISCUSSION TOPICS – TRAINING

- Who will be involved in developing the plan for cross-training between MCOs and child welfare?
- What supports—such as transportation allowances or child care—might be provided to encourage caregivers to attend training?
- What training will be provided to ensure that providers and MCOs have the knowledge and skills to work with children and youth who may have experienced severe and chronic abuse, sexual abuse, and neglect—including skill building in civil and criminal court testimony, conducting extensive court-ordered evaluations, understanding the child’s legal and placement status, communicating with the people who share responsibility for the child?
- What training on evidence-based practices and new interventions will be provided to child welfare providers and practitioners in the network to ensure they have the new skills and approaches required for success—including short-term treatment and wraparound approaches, family-focused service interventions, cultural competence, home and community-based alternatives?
- What training will be provided to families—birth, kin, foster, and adoptive families—to help them understand and manage the care of children with mental health or substance abuse treatment issues?
- What will be the role of the child welfare agency and of families in the child welfare system in developing the training plan or facilitating training?

15. Early Childhood Considerations

Children under the age of five are entering the child welfare system at increased rates. Infants are the largest single-year age group who are victims of abuse and neglect. Thirty-eight percent (38%) of the children who entered foster care in FY1998 were under

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the age of five.¹³ Given this reality, it is critical for the behavioral health system to offer a range of services that are appropriate for meeting the mental health and developmental needs of young children, including being able to identify their unique needs and respond through services that are developmentally appropriate.

Ability To Identify And Meet The Behavioral Health Needs Of Young Children—The first challenge is to identify mental health needs in very young children. It is important for the professionals who are completing the initial behavioral health screens and comprehensive assessments, to be sensitive to the developmental and unique needs of very young children and to understand the impact of abuse or neglect on child development. The assessment tools must be developmentally appropriate. *Some states and communities are using Medicaid's Early and Periodic Screening, Diagnosis and Treatment program as the funding source for comprehensive developmental and mental health assessments for young children involved with the child welfare system. For an example of a community's effort to provide and fund developmental services for young children, see the description of the Seedling Project (a program of the Kinship Center) in Section II.*

Adequate Services for Young Children—The most recent HC RTP survey indicates that 56% of all reforms provide “few” or no services to the early childhood population. If the very young children in the child welfare system are included in the managed care plan, the MCO should work with the child welfare system and other early childhood providers to better define and build capacity to meet their mental health and developmental needs.

Coordination with Existing Service Systems for Young Children—Young children (from birth through age two) with disabilities or delays are eligible for early intervention services and supports under Part C of the Individuals with Disabilities Education Act (IDEA). If enrolled in Medicaid, they are also entitled to the full array of EPSDT services. Managed care plans need to be knowledgeable about the early intervention resources provided through Part C and to have links to the early intervention systems in their communities so that young children with developmental problems and their families will be referred to the system of services available through Part C of IDEA.

DISCUSSION TOPICS –
EARLY CHILDHOOD

- Given their unique and complex needs, how will it be determined whether young children should be included in the managed care plan or served outside the plan?
- If they are covered, how will children in need of a developmental screen be identified? What will be done to ensure that the current behavioral health screens and assessments appropriate to identify needs in very young children?
- How will the plan assess whether there are adequate types of in-home and community-based services for young children who may have many developmental and mental health needs in addition to histories of abuse or neglect?
- How will the plan identify and recruit providers knowledgeable about early childhood issues?
- How will behavioral health services be coordinated with other early childhood providers, including IDEA, Part C and EPSDT?
- What early childhood funding sources can be included in to the plan?
- What are the options for providing consultation specific to early childhood issues to caregivers and professionals that interact with the child everyday—child welfare workers, the pre-schools, day care providers, families, caregivers?

16. Using the Framework of
Comprehensive Components

All of the components discussed in this section would be evident in an *ideal* managed care system. They have been presented and discussed here, not as a prescription for how all managed care systems should work, but rather as important issues for public purchasers and managed care entities to consider when designing or refining a comprehensive managed care approach to address the behavioral health needs of children and families involved with the child welfare system. To be consistent in format and to carry the theme of a comprehensive framework into real life examples, we use these components as the organizing framework for describing the four site examples in the following section.

¹³ *Child Welfare Outcomes 1998: Annual Report*. Washington, DC: U.S. Department of Health and Human Services, Administration for Children and Families, Administration on Children, Youth and Families, Children's Bureau, A-2 and A-6.