DEPARTMENT OF HEALTH AND HUMAN SERVICES
OFFICE OF DIRECTOR

ACTION REFERRAL

TO	DATE
~~Liggett~~	7-30-13

DIRECTOR'S USE ONLY	ACTION REQUESTED
1. LOG NUMBER 000051	[ ] Prepare reply for the Director's signature DATE DUE _____
2. DATE SIGNED BY DIRECTOR cc: Mr. Keck, Kost, Deps, CMS file	[ ] Prepare reply for appropriate signature DATE DUE _____ [ ] FOIA DATE DUE _____ [X] Necessary Action

APPROVALS (Only when prepared for director's signature)	APPROVE	* DISAPPROVE (Note reason for disapproval and return to preparer.)	COMMENT
1.			
2.			
3.			
4.			

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-14-26
Baltimore, Maryland 21244-1850

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR MEDICAID & CHIP SERVICES

Disabled & Elderly Health Programs Group

June 28, 2013

Dear State Medicaid Director:

The purpose of this letter is to inform you that on September 30, 2013, the National Quality Enterprise (NQE) grant project, operated through Truven Health Analytics, Inc., will be concluding quality technical assistance (TA) activities related to home and community based services. The Centers for Medicare & Medicaid Services (CMS) is currently working with the NQE to develop a plan to close out the grant activities, including, but not be limited to:

- Voluntary technical assistance: New technical assistance requests made prior to August 15, 2013 will be considered on an individual basis and will require CMS approval;

- Mandatory technical assistance: CMS will establish a process with NQE to finalize the development of existing Correction Action Plans (CAPs) and transition mandatory TA activities and CAP oversight to CMS analysts. If CMS determines required elements have been met prior to September 30, 2013, mandatory TA activities will be concluded.

- Training: CMS is working with NQE to conduct training on the enhanced quality system changes prior to the close out of the grant.

CMS remains committed to the process of Continuous Quality Improvement in long term services and supports and is currently exploring options for continued education and training that will support states in achieving quality outcomes.

DEPARTMENT OF HEALTH AND HUMAN SERVICES

July 10, 2013

Dear State Director,

We deeply appreciate the work you do to help vulnerable children, youth and families. At the federal level, we strive to collaborate and provide resources to support you and your colleagues in that critical work. This guidance letter is intended to encourage the integrated use of trauma-focused screening, functional assessments and evidence-based practices (EBPs) in child-serving settings for the purpose of improving child well-being. The Department of Health and Human Services' (HHS) Administration for Children and Families (ACF), Centers for Medicare & Medicaid Services (CMS) and Substance Abuse and Mental Health Services Administration (SAMHSA) are engaged in an ongoing partnership to address complex, interpersonal trauma and improve social-emotional health among children known to child welfare systems. We look to state and tribal governments to further this important work.

I. Background

Complex trauma is a common yet serious concern for children, especially those referred to child welfare services. Rates of trauma exposure are approximately 90 percent among children in foster care.[1] These high rates of trauma have far-reaching consequences. The term "complex trauma" describes children's exposure to multiple or prolonged traumatic events, which are often invasive and interpersonal in nature. Complex trauma exposure involves the simultaneous or sequential occurrence of child maltreatment, including psychological maltreatment, neglect, exposure to violence and physical and sexual abuse. In addition to these traumatic events, a child's experience of these events can create wide-ranging and lasting adverse effects on developmental functioning, and physical, social, emotional or spiritual well-being. These adverse effects can include a child's physiological responses; emotional responses; ability to think, learn, and concentrate; impulse control; self-image; and relationships with others. Across the life span, complex trauma is linked to a wide range of problems, including addiction, chronic

[1] Stein, B., Zima, B., Elliott, M., Burnam, M., Shahinfar, A., Fox, N., et al. (2001). Violence exposure among school-age children in foster care: Relationship to distress symptoms. Journal of the American Academy of Child and Adolescent Psychiatry, 40(5), 588–594.

Without regard to foster care status, children with disabilities comprise approximately one-third of maltreated children between the ages of birth to nine years, almost one-fourth in the middle school years, and around one-sixth in the high school years. Furthermore, studies indicate that children with communication or sensory impairments and learning disabilities are at increased risk for abuse.[8] These studies underscore the need for a collaborative response to identify and meet the treatment needs of all children who have experienced trauma.

Many of these children will demonstrate complex symptoms and/or behaviors that may not map directly to the Diagnostic and Statistical Manual of Mental Disorders (DSM) or the International Classification of Diseases (ICD). For example, there is currently no DSM diagnosis that adequately captures the range of child trauma effects.[9] Many children who have experienced complex trauma will not meet the criteria for a diagnosis of Post-Traumatic Stress Disorder (PTSD). Yet, trauma-related symptoms are identifiable, can be clinically significant and can be addressed with appropriate interventions. For these children, appropriate screening, assessment and referral to evidence-based practices are clearly indicated. To this end, ACF released an Information Memorandum (ACYF-CB-IM-12-04 http://www.acf.hhs.gov/programs/cb/resource/im1204) to encourage child welfare agencies to focus on improving the behavioral and social-emotional outcomes for children who have experienced abuse and/or neglect.

II. The Interplay between Child Trauma and Psychotropic Medications: HHS Response

The focus on improving child well-being through screening, assessment and evidence-based practices cannot be achieved without a discussion of the use of psychotropic medications with this population. Children and youth in foster care are far more likely than their peers to receive psychotropic medications, including atypical antipsychotic medications, which carry a high risk of side effects.[10] There is reason to believe that such widespread and at times problematic use of these drugs is a reaction to the clinical complexity of symptoms among children exposed to complex trauma and the lack of appropriate screening, assessment and treatment.[11]

There has been increasing concern at HHS and among stakeholders, families and youth about the safe, appropriate and effective use of psychotropic medications among children in foster care. Multiple divisions within HHS, including ACF, CMS, Food and Drug Administration (FDA), and SAMHSA, have been working together for nearly two years to strengthen oversight and monitoring of psychotropic medications with this population.

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[8] Stalker, K., & McArthur, K. (2012). Child abuse, child protection and disabled children: A review of recent research. Child Abuse Review, 21(1), 24-40.

[9] Griffin, G. (2010). Illinois Childhood Trauma Coalition White Paper: Child Trauma as a Lens for the Public Sector. Chicago, IL: ICTC.

[10] Medicaid Medical Directors Learning Network and Rutgers Center for Education and Research on Mental Health Therapeutics. Antipsychotic Medication Use in Medicaid Children and Adolescents: Report and Resource Guide from a 16-State Study. MMDLN/Rutgers CERTs Publication #1. July 2010. Distributed by Rutgers CERTs at http://rci.rutgers.edu/~cseap/MMDLNAPKIDS.html.

[11] Raghavan, R., Inoue, M., Ettner, S.L., Hamilton, B.H. and Landsverk, J. (2010). A preliminary analysis of the receipt of mental health services consistent with national standards among children in the child welfare system. *American Journal of Public Health.* 100(4): 742

assessment data can inform broader outcomes monitoring and system-level decisions about service array planning and contracts. Examples of functional assessment tools for young children and adolescents can be found at the following ACF links: http://www.acf.hhs.gov/programs/cb/resource/well-being-instruments-early-childhood and http://www.acf.hhs.gov/programs/cb/resource/well-being-instruments-adolescence.

- *Trauma screening* involves brief evaluation of potential trauma symptoms and/or history. Such screening can indicate a potential need for further assessment and treatment. Trauma screening instruments can be administered quickly by a range of professionals and can be conducted independently or as part of a broader screening and/or assessment process. Information on trauma screening tools can be found at SAMHSA's National Child Traumatic Stress Network's Measures Review Database: http://www.nctsn.org/resources/online-research/measures-review.
- *Mental health assessment* involves an in-depth clinical evaluation of an individual's mental health status. These more intensive assessments may include a diagnostic interview in combination with standardized mental emotional and behavioral assessment tools. Mental health assessments allow for evaluation of symptoms and the possible determination of a mental diagnosis or condition. A mental health assessment may also take into consideration experiences of traumatic events, previous and current risk factors, and emotional strengths and needs. A mental health assessment includes an evaluation of symptoms and is the basis for treatment planning. Mental health assessments can more deeply inform the use of evidence-based practices (EBPs) for trauma-related needs and mental, emotional, or behavioral disorders or conditions. The ACF Information Memorandum (ACYF-CB-IM-12-04 http://www.acf.hhs.gov/programs/cb/resource/im1204) on social-emotional well-being identifies a number of EBP's, including Trauma-Focused Cognitive Behavioral Therapy, Multi-Systemic Therapy and Parent-Child Interaction Therapy, among others. Many of the EBPs designed to address child trauma include parents as part of the treatment in order to provide parenting strategies and supports that improve outcomes for their children. More information on trauma-related EBPs can be found through SAMHSA's National Child Traumatic Stress Network (www.nctsn.org) and the National Registry of Evidence-based Programs and Practices (http://www.nrepp.samhsa.gov/) websites.
- *Outcome Measurement and Progress Monitoring*: Measuring success by tracking child-level well-being outcomes allows systems to ensure that services are achieving desired improvements in children's health and functioning. Using data from screening and assessments, systems can gauge the effectiveness of interventions with both individual children and the population served. At the child level, these data allow for the matching of specific characteristics and needs of individual children with appropriate, responsive interventions. At the system level, an iterative process of reviewing aggregated data can be used to tailor and refine an array of services to address the needs of the population.

One cross-systems example that includes the core components described above is the Comprehensive Community Mental Health Services for Children and Their Families Program (Children's Mental Health Initiative, or CMHI) administered by SAMHSA. CMHI is based on the System of Care (SOC) approach, which is an organizing philosophy and framework designed to create a coordinated array of effective community-based services and supports. The SOC

development, and support to ensure a well-qualified child-welfare workforce. The approach encouraged in this letter is consistent with the requirement that states must describe, in their CFSPs, their efforts to provide child-welfare services on a statewide basis, to expand and strengthen the range of services available, and to develop and implement services that improve child outcomes (SSA section 422(b)(4)(A)) in order to receive title IV-B funding.

Through the PSSF program, states are required to spend 90 percent or more of the funding they receive on four specified categories of services: community-based family support, family preservation, time-limited reunification and adoption promotion and support. These services prevent maltreatment among at-risk families, address problems in a timely manner with families whose children have been placed in foster care so reunification can occur and support adoptive families to enable them to make a lifetime commitment to children.

Title IV-E funding use is limited to certain costs of providing for the care of children whom the title IV-E agency determines to be eligible. Funds are available for monthly maintenance payments for the daily care and supervision of eligible children and administrative costs to manage the program, such as recruiting foster parents and costs related to designing, implementing, and operating a statewide data collection system.

Under the title IV-E Foster Care and Adoption and Guardianship Assistance Programs, title IV-E agencies can also use title IV-E funding to support targeted child welfare training activities. Relevant allowable training topics can include referral to services, placement of the child, development of the case plan, case reviews and case management and supervision. Title IV-E agencies may offer training on the nature and consequences of child trauma, the use of screening and assessment tools and practices, and the array of EBPs to address trauma, including when they might best be applied.

Although these funds can be used to provide training to title IV-E child welfare staff, foster/adoptive parents, employees of private child placing and child care agencies, and other individuals listed in section 474(a)(3)(B) of the SSA, these dollars cannot be used to train individuals to treat child or family problems or behaviors. That type of training would support the delivery of social services rather than the administration of the title IV-E plan. More details on opportunities and limitations for using this authority to support training needs are provided in the Child Welfare Policy Manual (http://www.acf.hhs.gov/cwpm/programs/cb/laws_policies/laws/cwpm/policy_dsp.jsp?citID=116#2541).

New Child Welfare Legislative Authority

New child welfare legislative authority was provided through the *Child and Family Services Improvement and Innovation Act* (P.L. 112-34), which allows HHS to approve up to ten waiver demonstration projects in each of federal fiscal years (FFYs) 2012, 2013 and 2014. These demonstration projects, while providing no additional funding, allow child welfare agencies greater flexibility in using titles IV-E and IV-B funding to implement services that are likely to improve outcomes for children and families involved in the child welfare system.

States can choose to use this flexibility to build capacity related to training, screening, assessment and EBPs to improve the well-being of children who have experienced complex trauma. The development and implementation of these demonstration projects can be

Mental Health and Substance Abuse

In 2011, SAMHSA designated trauma as one of its key strategic initiatives, recognizing the central role that traumatic experiences play in mental health, physical health, and substance use disorders. During the past decade, SAMHSA has made significant investments in understanding different types of trauma across the life span, developing trauma-specific therapeutic interventions, and developing and implementing the concept of trauma-informed care in care-giving organizations. SAMHSA is continuing to develop and refine its working concept of trauma and guidance for a trauma-informed approach, which will be the foundation for establishing measures for population surveillance, clinical encounters, quality measures and a standardized approach to training on trauma.

Since 2001, SAMHSA has funded the National Child Traumatic Stress Initiative (NCTSI) to develop, disseminate, implement, and evaluate screening, assessment, and treatments for children, adolescents, and families experiencing a wide range of traumas. These include child physical and sexual abuse, community violence, homelessness, disaster, and medical and war-time and refugee related traumas. The NCTSI has brought improved access and availability of trauma screening, assessment and treatment interventions across the child age range for states and local communities and to children in multiple service sectors, including mental health, child welfare, juvenile justice, education, primary care and homeless/runaway settings.

SAMHSA's National Center for Trauma Informed Care (NCTIC) has promoted the implementation of a trauma-informed approach to care that prevents the re-traumatizing of individuals who enter treatment systems and recognizes the pervasiveness of trauma in lives of individuals in care-giving systems, whether health, human services, criminal justice, or primary care.

While SAMHSA does not have specific authorities or funding mechanisms focusing on children in the child-welfare system, it has significant funding efforts that focus on children with mental health needs that are inclusive of children who may be child-welfare connected. Children who have experienced trauma often have complex clinical presentations and thus qualify for mental health-funded programs and practices. Relevant SAMHSA funds are described below in the categories of State Block Grants funds and Discretionary Funding Awards.

SAMHSA Block Grants

SAMHSA awards formula-driven Mental Health Block Grants and Substance Abuse Block Grants to states and territories. The parameters for funding are established by law. However, there has been significant flexibility for states to determine how these funds are used. States use the Block Grant funding for treatment, recovery supports, prevention and other services that are not covered by Medicaid, Medicare or private insurance, or for services for individuals who are not insured. Specifically, the Block Grant funds priority treatment and support services for individuals without insurance or for whom coverage is terminated for short periods of time; and, priority treatment and support services not covered by Medicaid, Medicare, or private insurance for low-income individuals and that demonstrate success in improving outcomes and/or supporting recovery.

Medicaid

CMS is committed to working in partnership with states to ensure coverage of needed benefits and establish effective service delivery options for children and youth who have experienced complex trauma. CMS is prepared to offer technical assistance to states pursuing the opportunities described below and throughout this letter.

Under the EPSDT benefit, eligible individuals are entitled to periodic screening services (well-child exams) as defined by the statute. One required element of such screening services under section 1905(r) of the Social Security Act (the Act) is "a comprehensive health and developmental history (including assessment of both physical and mental health development)." CMS expects that part of this assessment should include an age-appropriate behavioral health screening. Early detection and treatment of behavioral health issues, including mental illness and substance use disorders, is important in the overall health of a child and may reduce or eliminate the effects of a condition when identified and treated early. Additionally, as the statute specifies, other necessary health care, diagnostic services, treatment and other measures coverable under section 1905(a) of the Act must be made available to "correct or ameliorate" any physical and mental illnesses or conditions discovered by the screening services, whether or not the services are covered under the state plan.

In addition to the required periodic screenings, Medicaid-eligible children are entitled to inter-periodic screenings in order to identify a suspected illness or condition not present or discovered during the periodic exam.[15] An inter-periodic screening may also trigger the need for further diagnostic or treatment services, including services related to behavioral health issues. A change in living circumstance (like a foster care placement move), a change or presentation of acute behavioral health needs (like a school suspension due to behavior, an inpatient psychiatric admission, or a referral to residential psychiatric care), and entry into the foster care system are all events that may elicit the need for an inter-periodic screening.

We describe below a variety of authorities and service-delivery approaches. Under some of these authorities, enhanced Federal Financial Participation (FFP) is available.

State Plan Services Described in Section 1905(a) of the Act

Services to meet children's behavioral health needs may be covered under several service categories described under section 1905(a) of the Act. For example, certain behavioral health services may be covered under rehabilitative services at 42 CFR 440.130(d), including interventions such as cognitive behavioral therapy, crisis management services, peer supports, or family therapy. Other service categories support reimbursement for targeted case management or services provided by licensed practitioners such as psychiatrists, psychologists, or clinical social workers.

Beginning in 2013, enhanced FFP is authorized under section 1905(b) of the Act, as amended by section 4106 of the Affordable Care Act, if states elect to provide coverage of preventive

[15] Section 5140(B), *State Medicaid Manual.*

Health Homes

Section 2703 of the Affordable Care Act provides states with the option to cover health home services for beneficiaries. Health homes provide comprehensive care management; care coordination; health promotion; comprehensive transitional care from inpatient to other settings, including appropriate follow-up care; individual and family support; referral to community and support services; and the use of health information technology to link services. States can target health home models to specific populations based on specified chronic conditions, including serious or persistent mental health conditions. While age is not an allowable targeting criteria for health home participation, CMS recognizes that the available providers and the treatment modalities and protocols may involve different approaches for children as compared to adults for key health home activities such as coordinating, managing, and monitoring services; therefore, states may develop different qualifications and protocols for health home providers that serve different age groups based on distinctions between the health home needs of the population.

To assist states in the development of health homes, health home services receive enhanced FFP of 90 percent for the first eight quarters following establishment of a specific health home model. States have significant flexibility in the design of health home models, including in the development of payment methodologies. For example, states may structure a tiered payment methodology that accounts for the severity of each individual's chronic conditions and the capabilities of the designated providers. States may submit alternative models that are designed to improve service delivery, provide for quality health outcomes for participants and help document evaluative measures.

In collaboration with SAMHSA, CMS has developed a guiding document (http://www.samhsa.gov/healthreform/docs/Guidance_Doc_Health_Homes_Consultation_Proces s.pdf) to assist states to prepare for implementing health homes for individuals with behavioral health needs.

Links to states with health homes include the following: http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Approved-Health-Home-State-Plan-Amendments.html.

Managed Care

States may deliver Medicaid-covered services through managed care plans. States must continue to assure access to the full set of state plan services, including EPSDT. In addition, managed care plans may be required by contract to provide care management and coordination activities. States receive approval from CMS to operate a managed care delivery system through a variety of authorities, including under a state plan option, section 1915 waivers, and section 1115 demonstration projects. While 42 CFR Part 438 provides that children in foster care out-of-home placements and children receiving foster care adoption assistance cannot be mandated into managed care under the state plan option, some states have used waiver authority to mandate enrollment for this population. Currently, states are using three managed care models to serve children in foster care: plans that serve the general Medicaid population; plans with special

CMS also recently released the Center for Medicaid and CHIP Services CMCS Informational Bulletin on Prevention and Early Identification of Mental Health and Substance Use Conditions, which addresses prevention of and early intervention for mental health conditions in children, youth, and adults; see (http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf). This bulletin includes information regarding screens that can be used to identify the early onset of mental illness (encompassing conditions related to trauma and suicide), or substance use, including strategies for enhancing states' efforts to comply with EPSDT requirements.

V. Quality Impact of Addressing Child Trauma

For children and youth exposed to adverse events and involved with the child welfare system, integrated use of trauma-focused screening, functional assessments, and EBPs in child-serving settings will likely result in improved social, emotional and health outcomes. When care coordination is optimal, mechanisms for seamless information sharing and assessment-driven treatment planning create a system in which youth are regularly screened and assessed for needs and receive high-quality, efficacious interventions that improve social and emotional well-being.

Key to success is measuring outcomes and using on-going progress monitoring to determine the extent to which the approach taken is making a difference. Quality improvements may include:

- Reduction in the number of children with a clinical level of need receiving no services;
- Increase in the number of children receiving evidence-based screening, assessment and treatment;
- Reduction in the use of "deep-end" services, including emergency department visits for acute crisis stabilization and residential treatment for extended periods;
- Reduction in the use of psychotropic medication prescribing practices that do not conform with the American Academy of Child and Adolescent Psychiatrists Practice Parameters;
- Reduction in the number of psychotropic medications prescribed and a reduction in the total number of youth with prescriptions for psychotropic medications;
- Reduction in the use of foster home placements to include re-entries into care;
- Net increase of Medicaid-participating EBP-trained clinicians; and
- Improvements in child functioning across well-being domains and reductions in trauma symptoms.

Integrated approaches in the area of child behavioral health have had success in reducing costs while improving care. The following link describes a state's cost-effective innovations based on collaboration among agencies serving children in foster care who have experienced complex trauma: http://www.wsipp.wa.gov/rptfiles/12-04-1201.pdf.

VI. Conclusion

The impact of complex trauma for children who have experienced maltreatment can be profound, derailing them from healthy development, impairing social and emotional functioning, and compromising health. These effects can be addressed, however, and children can heal and recover. CMS, SAMHSA, and ACF are committed to improving the life outcomes for children

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