

Joint CMS and ACF Informational Bulletin

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SUBJECT: Support for Family-Focused Residential Treatment-Title IV-E and Medicaid-Guidance

Background

The Substance Use-Disorder Prevention that Promotes Opioid Recovery and Treatment (SUPPORT) for Patients and Communities Act (SUPPORT for Patients and Communities Act), Public Law (P.L.) 115-271, was signed into law on October 24, 2018. The SUPPORT for Patients and Communities Act addresses the opioid epidemic through multiple provisions, some of which address and amend the Family First Prevention Services Act (FFPSA), particularly section 50712 of FFPSA. FFPSA was enacted under Title VII of division E of the Bipartisan Budget Act of 2018 (P.L. 115-123) (February 9, 2018).¹

Section 8081 of the SUPPORT for Patients and Communities Act directed the U.S. Department of Health and Human Services (HHS) to develop and issue guidance to states identifying opportunities to inform their considerations to support family-focused residential treatment programs² for the provision of substance use disorder (SUD) treatment. In accordance with Section 8081, this guidance addresses:

¹ The FFPSA amended title IV-B of the Social Security Act (42 U.S.C. 621 et seq.) and title IV-E of the Social Security Act (42 U.S.C. 671 et seq.).

² Pursuant to section 8081(a)(1) of the SUPPORT for Patients and Communities Act, the term *family-focused residential treatment program* is defined as “a trauma-informed residential program primarily for SUD treatment for pregnant and postpartum women and parents and guardians that allows children to reside with such women or their parents or guardians during treatment to the extent appropriate and applicable.”

- Existing opportunities and flexibilities under the Medicaid³ program, including waivers authorized under section 1115 or 1915 of the Act, for states to receive federal Medicaid funding for the provision of SUD treatment for pregnant and postpartum women, parents and guardians and, to the extent applicable, their children, in family-focused residential treatment programs.
- How states can employ and coordinate funding provided under the Medicaid program, the title IV-E program, and other HHS programs, such as the Substance Abuse and Mental Health Services Administration (SAMHSA) grant programs targeting pregnant and postpartum women, to support the provision of treatment and services provided by a family-focused residential treatment facility.
- How states can employ and coordinate funding provided under the Medicaid program and the title IV-E foster care program to support placing children with their parents in family-focused residential treatment programs. This would include title IV-E foster care maintenance payments (FCMPs) for a child placed with a parent who is receiving SUD treatment services in a licensed residential family-based treatment facility for substance abuse pursuant to the FFPSA.⁴

As required by section 8081(b)(1) of the SUPPORT for Patients and Communities Act, before drafting this guidance CMS and ACF solicited input from a range of stakeholders, including “health care providers with expertise in addiction medicine, obstetrics and gynecology, neonatology, child trauma, and child development, as well as health plans, recipients of family-focused treatment services, and other relevant stakeholders.” Feedback from the stakeholder group informed this guidance. Specifically, as requested by stakeholders, this guidance includes information about title IV-E and Medicaid requirements, what Medicaid and title IV-E funds can and cannot cover across the continuum of care for both parents and their children, links to existing guidance on coverage options for the treatment of neonatal abstinence syndrome (NAS),

³ The term *Medicaid Program* is defined in section 8081(a)(2) of the SUPPORT for Patients and Communities Act as, “the program established under title XIX of the Social Security Act (42 U.S.C. 1396 et seq.)” All states, the District of Columbia, and the U.S. territories have Medicaid programs designed to provide health coverage for low-income people. Although the federal government establishes certain parameters for all states to follow, each state administers their Medicaid program differently.

⁴ A “licensed residential family-based treatment facility for substance abuse” was added as an optional allowable title IV-E foster care placement to the Social Security Act by FFPSA and is defined by sections 472(a)(2)(C), 472(j) and 474(a)(1) of the Act (42 U.S.C. §§ 672(a)(2)(C), 672(j), 674(a)(1)). Please note that a “licensed residential family-based treatment facility for substance abuse” is a specific allowable placement type under title IV-E, whereas the term “*family-focused residential treatment program*” is a broader category of treatment program defined by and used in various other contexts in the SUPPORT for Patients and Communities Act.

and information on coverage options for a range of services that may be needed for parents and children.

I. Existing Opportunities and Flexibilities under Medicaid

States have multiple options for structuring their Medicaid program to receive federal matching funds for SUD services delivered to pregnant and postpartum women, parents and guardians, and their children in family-focused residential treatment facilities, and for the full continuum of care for SUD treatment services delivered outside the treatment facility. Generally, federal matching funds are only available for services provided in residential facilities with 16 beds or less (see the *Institution for Mental Disease Exclusion* section below for more on requirements related to facility size). Moreover, the extent to which services are eligible for federal matching funds depends on a range of factors, including the Medicaid eligibility category of the beneficiary, the benefits in section 1905(a) of the Act (referred to as “1905(a) benefits”) that states elect to cover within their Medicaid state plan, and other Medicaid authorities states may use to cover services. These factors are discussed below.

Medicaid Eligibility

The pathway to eligibility can have implications for the scope of Medicaid services available to beneficiaries. To be eligible for Medicaid, an individual must meet the requirements for a specific eligibility group. This section broadly describes several eligibility pathways and notes transitions in which gaps in Medicaid eligibility may occur.

Eligibility for Children

Federal law requires that states provide Medicaid eligibility to children under age 19 with household income at or below 133 percent of the federal poverty level (FPL), or a higher income standard established by the state (referred to as the “Infants and Children Under Age 19” Medicaid eligibility group (42 C.F.R. § 435.118)).⁵ States often cover younger age groups of children to higher income levels, and some states extend eligibility for children to individuals age 19 and 20. States also have the option to cover an optional group of uninsured children under age 19 in Medicaid with income above the level for the mandatory Medicaid children’s

⁵ The statutes that specifically require the minimum income standard to be at least 133 percent FPL are sections 1902(a)(10)(A)(i)(IV), (VI) and (VII); and sections 1902(l)(1)(B)-(D) and 1902(l)(2).

group.

Children under age 18 (or up to age 21, at the state title IV-E agency's discretion) for whom a title IV-E adoption assistance agreement is in effect or for whom title IV-E foster care maintenance or kinship guardianship assistance payments are being made are automatically eligible for Medicaid.⁶ Because children are enrolled in this Medicaid eligibility group based on their status as "IV-E children", this group could include young people who are pregnant or postpartum or who are parenting and who may otherwise also be eligible on the basis of being pregnant, or being a parent or caretaker.

As described in greater detail in the Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) section below, children under age 21 who are Medicaid eligible are entitled to all medically necessary services covered under state plan benefits in section 1905(a) of the Act, regardless of their eligibility pathway.

Eligibility for Parents and Other Caretaker Relatives

Medicaid eligibility for parents and guardians is provided through multiple pathways. Every state has a Medicaid eligibility group specific to parents and caretakers, which will generally include guardians, who live with a dependent child (referred to as the "Parents and Other Caretaker Relatives" Medicaid eligibility group). States have flexibility to define the kinds of relationships to dependent children that qualify a person as a "caretaker relative", and that definition may include guardians. The income standard applied to this eligibility group varies widely from state to state; for example, as low as 13 percent of the FPL in one state and as high as 216 percent of the FPL in another state.⁷ Parents may be eligible in other groups, such as in the Adult Group, which many states offer to individuals ages 19 through 64 who have income at or below 133 percent of the FPL.

There are multiple points at which a parent or guardian may lose Medicaid eligibility. Those covered under the Parents and Other Caretaker Relatives group must live with a dependent child under age 18 (or, at state option, age 18 and a full time student), and the parent or guardian must have primary responsibility for that child's care. When the dependent child turns 19 or the individual loses custody of the child, the parent or guardian may lose Medicaid eligibility. It may be helpful for a title IV-E agency to know the eligibility group in which a parent or guardian

⁶ A child who is placed in a licensed residential family-based treatment facility for substance abuse may receive title IV-E foster care maintenance payments without meeting the AFDC eligibility requirements. If such a placement does not meet the AFDC eligibility requirements, that child is not automatically eligible for Medicaid as a child receiving title IV-E foster care maintenance payments (section 472(j) of the Act (42 U.S.C. § 672(j)).

⁷ A listing of eligibility standards for each state is available at: <https://www.medicaid.gov/medicaid/national-medicaid-chip-program-information/medicaid-childrens-health-insurance-program-basic-health-program-eligibility-levels/index.html>.

is enrolled (if any) when engaged in case planning for a youth in foster care so as to help inform the case planning process, coordinate SUD services to the family and work toward permanency goals for the youth.

Eligibility for Pregnant and Postpartum Women

Federal law requires that states provide Medicaid eligibility to women who are pregnant and who have incomes at or below 133 percent of the FPL (referred to as the “Pregnant Women” Medicaid eligibility group (42 C.F.R. § 435.116)). Many states provide eligibility in the Pregnant Women group to women with higher incomes, up to 185 percent of the FPL or higher. Eligibility in the Pregnant Women group extends through pregnancy and postpartum through the end of the month during which 60 days elapse after the end of the pregnancy.

States have the flexibility to provide all eligible women in the Pregnant Women group with full Medicaid coverage or to limit coverage to only pregnancy-related services for certain individuals. This is because federal law provides full coverage only to women with income below a specific income standard that varies by state. All other women in the Pregnant Women group are only covered for services related to pregnancy or a condition that may complicate pregnancy, which may or may not be interpreted to include all services. Per 42 C.F.R. § 440.210(a)(2)(i), “Pregnancy-related services are those services that are necessary for the health of the pregnant woman and fetus, or that have become necessary as a result of the woman having been pregnant. These include, but are not limited to, prenatal care, delivery, postpartum care, and family planning services.” 42 C.F.R. § 440.210(a)(2)(ii) further states that, “services for other conditions that might complicate the pregnancy include those for diagnoses, illnesses, or medical conditions which might threaten the carrying of the fetus to full term or the safe delivery of the fetus.” Because the health of a pregnant woman is intertwined with the health of her expected child, most states consider all Medicaid-covered services as pregnancy-related services and to provide full Medicaid coverage for all women eligible under the Pregnant Women group.

States also have the option to provide more robust coverage to pregnant women than would be available to non-pregnant adults. Under 42 C.F.R. § 440.250(p), states have the option to provide extended services to pregnant women that are not available to non-pregnant adults. Such services must be related to the pregnancy or related to a condition that may complicate pregnancy and must be provided in equal amount, duration and scope to all pregnant women. States could, for example, opt to provide more robust SUD services to pregnant women.

The income eligibility level for the Parents and Other Caretaker Relatives group is often much lower than the eligibility level for the Pregnant Women group, so a parent covered under the Pregnant Women group may lose Medicaid eligibility after the postpartum period if she is not eligible for another group.

Non-Medicaid Eligible Parents with an Eligible Child

Medicaid-covered services are only available to Medicaid-eligible individuals. Services delivered in a family-focused residential treatment program directed solely to a non-Medicaid eligible parent or caregiver would not be coverable under the Medicaid program. However, some services that involve a non-Medicaid eligible parent or caregiver can be coverable if the services are for the direct benefit of the beneficiary, as described below.

Medicaid State Plan Flexibilities and Opportunities for SUD Services Delivered in Family-Focused Residential Treatment Programs

Many services that are essential to family-focused residential treatment may be covered through title XIX, under the benefits in section 1905(a) of the Act. Section 1905(a) authority enables states to provide a comprehensive array of SUD treatment services through state plan mandatory and optional benefits.

State Plan Requirements

Federal Medicaid law requires states to provide certain “mandatory” benefits under section 1905(a) of the Act (e.g., EPSDT, Federally Qualified Health Center services, Rural Health Clinic services, physician services, and nurse practitioner services). Federal Medicaid law also allows states the choice of covering other “optional” benefits for adults, including rehabilitative services, such as counseling and peer support services, or services provided by an “other licensed practitioner,” such as services of a licensed psychologist. Many states make use of multiple benefit categories to offer a comprehensive range of services. Some of the most common state plan benefits for coverage of SUD treatment services are described below. It should be noted that assessments or evaluations conducted to determine a beneficiary’s need for services and/or to develop an individual plan of care is an inherent activity of many benefits so will not be discussed separately.

Regardless of whether the benefit is optional or mandatory, and unless otherwise noted in the particular benefit, states must meet certain requirements in their state plans. Among other applicable standards, states must meet three foundational requirements: freedom of choice of providers; comparability of services; and statewideness of coverage. In accordance with 42 C.F.R. § 431.51, freedom of choice of providers means that beneficiaries must be able to choose to receive services from any qualified provider who undertakes to furnish services to them (including agreement to accept Medicaid payment and abide by applicable program standards). In accordance with 42 C.F.R. § 440.240, comparability of services means that states must offer services in the same amount, duration and scope to all members of a categorically needy eligibility group. Finally, in accordance with 42 C.F.R. § 431.50 services provided under the state plan must be available statewide, and not restricted to certain geographic locations in the state.

In addition, some services are generally not coverable under 1905(a) of the Act, including:

- Room and Board (if not a facility for which Medicaid can cover room and board)
- Childcare
- Housing costs in the community
- Education
- Housekeeping⁸
- Job training
- Groceries
- Non-medical transportation⁹
- Legal aid

Beyond these parameters, state plan benefits allow for a degree of flexibility, and can be configured to cover the entire continuum of care for substance abuse treatment, from initial screening and assessment, to outpatient and residential care, medication assisted therapy (MAT), and care coordination. Some services that are for the direct benefit of the child may involve a non-Medicaid eligible parent or caregiver. For example, parent-child interaction therapy may be coverable if the service is for the direct benefit of the Medicaid-enrolled child. Finally, Medicaid covers discrete services as opposed to programs, although individual service components in a program may be coverable. States are encouraged to contact CMS with questions about whether a specific service or program component is coverable.

Common Benefit Categories for SUD Treatment

1. Diagnostic Services Benefit

Practitioners typically need to determine a beneficiary's diagnosis as a prelude to treatment. The diagnostic services benefit is an optional benefit in section 1905(a)(13) of the Act. Medicaid regulations at 42 C.F.R. § 440.130(a) define diagnostic services as, "any medical procedures or supplies recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, to enable him to identify the existence, nature, or extent of illness, injury, or other health deviation in a beneficiary."

⁸ Note that light housekeeping may be considered an Instrumental Activity of Daily Living, and may be coverable under Section 1915(c) waivers, 1915(l) or 1915(k) state plan options.

⁹ At the state's option, non-medical transportation can be covered under section 1915(c) waivers, or under sections 1915(i) or 1915(k) of the state plan.

2. Rehabilitative Services Benefit

States often use the rehabilitative services benefit to provide Medicaid coverage for SUD treatment services. Rehabilitative services are an optional benefit as specified in section 1905(a)(13) of the Act. Medicaid regulations at 42 C.F.R. § 440.130(d) broadly define rehabilitative services as, “any medical or remedial services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his practice under State law, for maximum reduction of physical or mental disability and restoration of a beneficiary to his best possible functional level.” Examples of services that states could cover under the rehabilitative services benefit include counseling and therapy, peer support services¹⁰, medication-assisted treatment (MAT),¹¹ crisis intervention, and medication management. Care coordination could also be covered under the rehabilitative services benefit if the service entails coordination of mental health and SUD treatment services and does not meet the requirements for case management or targeted case management described below.

3. Case Management Services Benefit

Section 1905(a)(19) and 1915(g)(2) of the Act define case management as services that will assist a Medicaid-eligible individual in gaining access to needed medical, social, educational, and other services. Case management services are considered targeted case management (TCM) services when the services are not furnished in accordance with Medicaid statewideness or comparability requirements. This flexibility enables states to target case management services to specific populations and/or to specified geographic

¹⁰ Note that peer support services have certain requirements as stated in the August 15, 2007 State Medicaid Director Letter (SMDL) (#07-011) available here: <https://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD081507A.pdf>. In addition, in 2013 clarifying guidance, CMS noted that the parents/legal guardians of Medicaid-eligible children can receive peer support services when the service is directed exclusively toward the benefit of a Medicaid-eligible child and meets the requirements of the 2007 SMDL. The clarifying guidance is available on page 4 of this Informational Bulletin: <https://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf>.

¹¹ MAT is a service that includes the administration of an FDA-approved medication along with counseling and behavioral health therapies, to treat opioid use disorder, and is usually covered under the rehabilitative services benefit. For more on how states may cover MAT, see the 2014 Informational Bulletin, *Medication Assisted Treatment for Substance Use Disorders*, available at: <https://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-11-2014.pdf>. See also the CMS forthcoming guidance on section 1006(b) of the SUPPORT Act that addresses the requirement for states to provide MAT as a state plan benefit beginning October 1, 2020 and ending September 30, 2025.

areas. Because the statute permits states flexibility to target Medicaid case management services by age, type or degree of disability, illness or condition, or any other identifiable characteristic or combination of characteristics, states may, for example, target case management services for individuals with SUD and their Medicaid eligible children.

In general, allowable activities under the case management benefit are those that include assistance in accessing a medical or other service, but do not include the direct delivery of the underlying service. Required services in the case management benefit include a comprehensive assessment, development of a care plan, referral and linkage to needed services, and monitoring and follow-up to ensure needs are being met. Examples of these services include assistance in accessing transportation, appropriate child care, and other services critical in meeting the medical, social, and educational needs of Medicaid eligible parents or guardians and their Medicaid eligible children.

Case management does not include, and federal matching funds are not available with respect to expenditures for, services defined in 42 C.F.R. § 440.169 when the case management activities are an integral and inseparable component of another covered Medicaid service.¹² Likewise, case management does not include, and federal matching funds through Medicaid are not available with respect to expenditures for, services defined in 42 C.F.R. § 440.169 when the case management activities constitute the direct delivery of underlying medical, educational, social, or other services to which an eligible individual has been referred, including for foster care programs. These include services such as, but not limited to, the following: research gathering and completion of documentation required by the foster care program; assessing adoption placements; recruiting or interviewing potential foster care parents; serving legal papers; home investigations; providing transportation; administering foster care subsidies; making placement arrangements¹³.

In addition, federal matching funds through Medicaid are only available for case management services or targeted case management services if there are no other third parties liable to pay for such services, including as reimbursement under a medical, social, educational, or other program, except for case management included in an individualized education program (IEP) or individualized family service plan (IFSP) consistent with section 1903(c) of the Act.¹⁴ (See “Administrative Costs” in section III for information on case management activities allowable under the title IV-E Foster Care Program.)

¹² State Medicaid Manual 4302.F.

¹³ 42 C.F.R. § 441.18(c).

¹⁴ See also section 1902(a)(25) of the Act on third party liability.

4. Other Licensed Practitioner Services Benefit

Section 1905(a)(6) of the Act provides states flexibility in covering medical or remedial care or services provided by licensed practitioners within their scope of practice as defined by state law. As set forth in 42 C.F.R. § 440.60(a), other licensed practitioner services are, “any medical or remedial care or services, other than physicians’ services, provided by licensed practitioners within the scope of practice as defined under State law.” For example, this benefit could cover the services of a licensed clinical social worker to furnish counseling or a licensed nurse to administer medications to treat depression or other mental illnesses.

5. Home Health Services Benefit

Home health services are a mandatory benefit under Medicaid. To be covered, home health services must be ordered by a physician according to a written plan of care. In accordance with federal regulations at 42 C.F.R. § 440.70, the three mandatory component services are: nursing services, home health aide services, and medical supplies, equipment and appliances. The optional components are physical therapy, occupational therapy, speech pathology, and audiology services.

6. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services Benefit

The EPSDT benefit provides a comprehensive array of prevention, diagnostic, and treatment services for low-income infants, children and adolescents under age 21, as specified in section 1905(r) of the Act. The EPSDT benefit is more robust than the Medicaid benefit for adults and assures that children receive early detection and care, so health problems are averted or diagnosed and treated as early as possible. States are required to provide screenings at regular intervals and as needed, and are required to provide all Medicaid coverable, medically necessary services covered under section 1905(a) of the Act needed to correct or ameliorate physical and mental health conditions (including substance use disorders), whether or not they are covered in the state plan. For more on the EPSDT benefit, see [EPSDT – A Guide for States](#).

Separate from the Medicaid EPSTD benefit, title IV-B and E agencies are required to develop a Health Care Coordination and Oversight Plan for children and youth in foster care that includes developing a schedule of health screenings. We encourage state Medicaid agencies and title IV-E agencies to coordinate the use of EPSDT screenings and services for youth in foster care. See section III below for more information on the Health Care Coordination and Oversight Plan requirements.

7. Home and Community-Based Services

There are multiple other Medicaid coverage authorities that offer states flexibility in how they provide home and community-based services that a Medicaid beneficiary may need

for continued SUD treatment. These authorities are described in greater detail below.¹⁵ They also help ensure continuity of care for foster care children, as required by the Health Care Coordination and Oversight Plan (see section III for more information).

Health Home Benefit - Section 1945 of the Act

Through the Medicaid Health Home optional state plan benefit, states can establish health homes to coordinate care for people with Medicaid who have chronic conditions (including SUD) as set forth in Section 1945 of the Act. Specifically, health home providers integrate and coordinate all primary, acute, behavioral health and long term services and supports to treat the whole-person to promote wellness. The health home works with beneficiaries to educate them about their condition(s) and to support the individual in developing the knowledge and activities that support lifestyle changes, focusing on the goals of maintaining and protecting wellness. States with an approved health home state plan amendment receive 90 percent enhanced federal match for the first 8 quarters beginning from the effective date of the amendment. Section 1006(a) of the SUPPORT for Patients and Communities Act extends the enhanced federal matching rate for new Medicaid health home activities targeted to beneficiaries with SUD from 8 quarters to 10 quarters for SPAs approved on or after 10/1/18. Thereafter, the state's rate returns to their regular service match rate.

Home and Community Based Services (HCBS) Waiver Programs - Section 1915(c) of the Act

Home and community-based services waiver programs enable beneficiaries who would otherwise need an institutional level of care to receive long-term care services and supports in their home or community, rather than in an institutional setting. The 1915(c) HCBS waiver authority allows states to waive certain Medicaid requirements (statewide applicability of services, and/or income and resource rules applicable in the community) enabling them to target populations by age or diagnosis. A wide range of services may be provided under HCBS waiver programs, including personal care, respite care, and supported employment.

HCBS State Plan Option – Section 1915(i) of the Act

Like the section 1915(c) waiver authority, the 1915(i) state plan authority allows states to provide HCBS not already available under the state plan to individuals who meet state defined needs-based criteria. The 1915(i) authority allows states to provide HCBS to individuals who

¹⁵ These Medicaid authorities may also be used to cover some services offered by states participating in the Health Resources and Services Administration's (HRSA) Maternal, Infant, and Early Childhood Home Visiting (MIECHV) Program. (Additional information on home visiting services is available in the joint HRSA/CMS Informational Bulletin, [Coverage of Maternal, Infant, and Early Childhood Home Visiting Services](#), issued March 2, 2016.)

are at less than institutional level of care and not eligible for 1915(c) waiver services. The 1915(i) authority also enables states to establish additional needs-based criteria for specific 1915(i) services, establish a new Medicaid eligibility group for people to receive HCBS, and define the services included in the benefit, as set forth in 42 C.F.R. § 441.700. States could use the 1915(i) state plan authority to offer services that are not already available under the state plan to specific target populations by age, disability, diagnosis, and/or Medicaid eligibility group. The same services authorized under the 1915(c) waiver program may be provided under the 1915(i) state plan option.

Institution for Mental Diseases (IMD) Exclusion

Medicaid payment is generally not available for services provided to individuals' ages 21 through 64 who are patients in residential and inpatient treatment facilities that qualify as IMDs. An IMD is defined in section 1905(i) of the Act as a "hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."

Under section 1905(a) of the Act, there is a general prohibition on Medicaid payment for any services provided to any individual under age 65 who resides in an IMD.¹⁶ This is commonly known as the "IMD exclusion." The IMD exclusion applies to any care or services provided inside or outside of the facility to a Medicaid beneficiary residing in an IMD.

In accordance with longstanding, existing policy, State Medicaid agencies must review facilities over 16 beds, including family-focused residential treatment programs that provide diagnosis, treatment or care of persons with mental diseases, to determine if the facility meets the definition of an IMD according to Medicaid statute, regulation, and guidance in the State Medicaid Manual. The State Medicaid Manual indicates that an SUD is considered a "mental disease." Therefore, SUD residential treatment facilities with more than 16 beds could be IMDs. The State Medicaid Manual also clarifies that beds in an SUD treatment facility that are used solely to accommodate the children of individuals who are being treated there would not be counted as treatment beds. The children in beds that are not certified or used as treatment beds are not considered to be patients in the IMD and therefore are not subject to the IMD exclusion.¹⁷

¹⁶ Subdivision (B) following section 1905(a) of the Act.

¹⁷ Section 4390 of the State Medicaid Manual E. Chemical Dependency Treatment Facilities

Exceptions to the IMD Exclusion

Historically, there have been two exceptions to the IMD exclusion. First, Medicaid payment is permitted for inpatient hospital services, nursing facility services, and intermediate care facility services provided in IMDs to individuals age 65 and older.¹⁸ Second, Medicaid payment is permitted for inpatient psychiatric hospital services for individuals under age 21, sometimes referred to as the “psych under 21” benefit, furnished by a psychiatric hospital, a general hospital with a psychiatric program that meets the applicable Conditions of Participation, or an accredited psychiatric facility that meets certain requirements, commonly referred to as a “Psychiatric Residential Treatment Facility.”¹⁹ Other exceptions are described below.

- *Section 1012 of the SUPPORT for Patients and Communities Act* added a new limited exception to the IMD exclusion.²⁰ Section 1012(a) allows the state to claim federal financial participation (FFP) for medical assistance provided to a woman who is eligible on the basis of being pregnant (and up to 60-days postpartum), who is a patient in an IMD for purposes of receiving treatment for a SUD, and who was either enrolled under the state plan immediately before becoming a patient in the IMD, or who became eligible to enroll while a patient in an IMD. For such women, the IMD exclusion shall not be construed to prohibit FFP for medical assistance for items and services provided outside of the IMD.
- *Section 5052 of the SUPPORT for Patients and Communities Act* amended the IMD exclusion and established a new section 1915(l) of the Act to include a state plan option to provide services to Medicaid beneficiaries age 21 through 64 who have at least one SUD diagnosis and reside in an eligible IMD from October 1, 2019 through September 30, 2023.²¹
- *Section 1115 Demonstrations* authorized under section 1115 of the Act allow states to test innovative policy and delivery approaches that promote the objectives of the Medicaid program. On November 1, 2017, CMS announced a section 1115(a) demonstration initiative to improve access to and quality of SUD treatment for Medicaid beneficiaries as part of a Department-wide effort to combat the nation’s ongoing opioid crisis.²² This initiative aims to give states flexibility to design demonstrations that

¹⁸ 42 C.F.R. § 440.140.

¹⁹ 42 C.F.R. § 440.160.

²⁰ For more information about section 1012 of the SUPPORT for Patients and Communities Act, see <https://www.medicaid.gov/federal-policy-guidance/downloads/cib072619-1012.pdf>.

²¹ For more information see SMDL 19-003 dated November 6, 2019, *Implementation of Section 5052 of the SUPPORT for Patients and Communities Act – State Plan Option under Section 1915(l) of the Social Security Act*, available at: <https://www.medicaid.gov/federal-policy-guidance/downloads/smd19003.pdf>.

²² <https://www.medicaid.gov/federal-policy-guidance/downloads/smd17003.pdf>

improve access to high quality, clinically appropriate treatment for opioid use disorder (OUD) and other SUDs while incorporating metrics for demonstrating that outcomes for Medicaid beneficiaries are in fact improving. Through this section 1115 initiative, states can receive FFP for the continuum of services to treat addiction to opioids or other substances, including services provided to beneficiaries residing for short-term stays in residential and inpatient treatment facilities that qualify as IMDs. States with an approved 1115 SUD demonstration have authority to receive FFP for services delivered in a FFRTTP that is more than 16 beds, provided the program meets the requirements of the SUD demonstration.

- *Managed Care Authority:* In accordance with section 1903(m)(7) of the Act and 42 C.F.R. § 438.6(e), states may receive federal financial participation (FFP) for monthly capitation payments for beneficiaries age 21 through 64 receiving SUD treatment in an IMD for a short term stay of no more than 15 days during the period of the monthly capitation payment so long as criteria identified in the regulation are met. The IMD must be a hospital providing inpatient SUD treatment or a sub-acute facility providing SUD crisis residential services. In addition, the state must have determined that the IMD is medically appropriate and cost effective in lieu of covered settings for providing SUD treatment under the state plan. Further, the enrollee must not be required by the managed care plan to use or reside in the IMD and must have a choice of settings for the SUD treatment. Finally, the IMD services for treatment of SUD must be authorized and identified in the managed care contract between the state and the managed care plan, and offered to enrollees at the option of the managed care plan (i.e., coverage of the SUD treatment services in an IMD setting cannot be required of the Managed Care Organization, Pre-paid Inpatient Health Plan, or Pre-paid Ambulatory Health Plan).

Room and Board

Except as noted below, Medicaid reimbursement is not available for the costs of room and board for Medicaid beneficiaries receiving SUD treatment in a residential substance use disorder treatment facility. However, as described in the sections II and III below, title IV-E foster care payments may include the cost of room and board for a child residing in a substance use disorder treatment facility. In addition, under the MaryLee Allen Promoting Safe and Stable Families Program described in section II, room and board for a parent in a residential treatment facility may also be reimbursed.

Under Medicaid law, “medical assistance” is available for care and services to Medicaid-eligible individuals. Title XIX specifies services in four types of inpatient settings, i.e., services in inpatient hospitals, services in nursing facilities, services in intermediate care facilities for individuals with intellectual disabilities, and services pursuant to the “psych under 21 benefit” as described above. As these are the only facility services expressly covered within the definition of “medical assistance” it is inferred that costs for room and board associated with inpatient care in other settings are not considered “medical assistance” and are therefore not eligible for federal matching funds. Room and board is also expressly prohibited under the section 1915(c) and (i)

HCBS programs.

While room and board is only available in the facilities mentioned above, Medicaid may reimburse for services delivered in many other settings. For example, if an infant receives treatment for NAS in a family-focused residential treatment program, Medicaid could reimburse for services delivered to the infant, but would not cover the costs of room and board. However, for an infant receiving treatment for NAS in an inpatient hospital or a nursing facility, Medicaid could provide reimbursement for room and board. (See the CMCS Informational Bulletin, [Neonatal Abstinence Syndrome: A Critical Role for Medicaid in the Care of Infants](#) for additional information).

Reimbursement

Federal funding is available for both services and administrative costs, though there are different flexibilities and requirements for each.

Payment Flexibilities

States may design payment methodologies for individual services, or may consider creating a bundled rate in which the state pays an all-inclusive rate for substance use disorder treatment services furnished to a Medicaid-eligible beneficiary in residential treatment. To assist states with bundled payment methodologies, CMS has issued [guidance](#) to states for designing and developing bundled payment methodologies under state plan authority.

Medicaid Administrative Costs

Medicaid administrative costs are allowable to the extent the expenditures directly benefit the Medicaid program and are claimed consistent with federal cost allocation principles at 2 C.F.R. Part 200. Allowable Medicaid administrative costs do not include the cost of activities related to the operation of a provider facility, such as the supervision and training of providers for medical purposes. Additional requirements for claiming federal match for Medicaid administrative expenditures may be found on the [CMS website](#).

Managed Care Strategies

States may provide services in either a fee-for-service or managed care delivery system. When states use a risk-based managed care delivery system, a managed care plan may voluntarily provide additional benefits that are not covered under the state plan, but the cost and utilization of such additional benefits may not be used in developing capitation rates for the managed care plan. A managed care plan may also provide services or use settings in lieu of services or settings covered under the state plan, so long as the state and the managed care plan meet the requirements for “in lieu of” services outlined in 42 C.F.R. § 438.3(e)(2) and if appropriate, 42 C.F.R. § 438.6(e). Services or settings provided in lieu of services or settings covered under the state plan may be taken into account when developing rates for the managed care plan if the

regulation requirements are met, including the requirement that the state determine that the alternative is a medically appropriate and cost effective substitute for the covered service or setting.

Demonstration Projects - Section 1115 of the Act

Section 1115 demonstration projects are intended to give states the flexibility to pilot new approaches that are likely to assist in promoting the objectives of the Medicaid program. This gives states a great deal of flexibility to design their demonstration projects to test new programs or delivery models, subject to CMS approval. States could, for example, elect to pilot a specific treatment option for a subset of the Medicaid population (e.g., pregnant women with SUD) or in a limited geographic area. Because section 1115 authority allows states to waive certain requirements, such as comparability or statewideness, states could utilize 1115 authority to offer enhanced services for beneficiaries in family-focused substance use disorder treatment facilities. As noted above, states can also utilize section 1115 authority to allow payment for SUD services delivered in an IMD pursuant to the [State Medicaid Director Letter 17-003](#) issued November 1, 2017. In addition, states have the option to utilize section 1115 authority to receive federal matching funds for short-term mental health treatment for adults with serious mental illness (SMI) and children with serious emotional disturbance (SED) delivered in an IMD, as established in the [State Medicaid Director Letter 18-011](#), *Opportunities to Design Innovative Service Delivery Systems for Adults with a Serious Mental Illness or Children with a Serious Emotional Disturbance* issued November 13, 2018.

II. Coordinating Funding under Title IV-E, Medicaid, and other programs for SUD and Other Treatment Services provided by a Family-Focused Residential Treatment Program

The title IV-E Prevention Services Program, the title IV-B, subpart 2 MaryLee Allen Promoting Safe and Stable Families Program (42 U.S.C. § 629 et seq.), child welfare discretionary grants, and grants issued by SAMHSA may provide funding for SUDs and other treatment services provided by family-focused residential treatment facilities.

Title IV-E Prevention Services Program

Beginning October 1, 2019²³, title IV-E agencies may claim optional title IV-E funding for time-

²³ The title IV-E Prevention Services Program was authorized by the Family First Prevention Services Act enacted

limited (one year) prevention services for mental health/substance use disorder and in-home parent skill-based programs for: 1) a child who is a candidate for foster care²⁴, 2) pregnant/parenting foster youth²⁵, and 3) the parents/kin caregivers of those children and youth (sections 471(e), 474(a)(6), and 475(13) of the Act (42 U.S.C. §§ 671(e), 674(a)(6), 675(13))). Detailed program requirements are provided in [ACYF-CB-PI-18-09](#), [ACYF-CB-PI-18-10](#) and [ACYF-CB-IM-20-01](#) remain official ACF guidance regarding the title IV-E prevention service program.²⁶ Section 8082(b) of the SUPPORT for Patients and Communities Act amended section 471(e)(10) of title IV-E to make title IV-E programs the payer of last resort for title IV-E prevention services that are both coverable under Medicaid and allowable under section 471(e) of title IV-E.²⁷ For the substance use disorder and mental health services and in-home parent skill-based program described in this section, title IV-E may pay for allowable services not covered under the Medicaid program.

Title IV-E agencies with an approved title IV-E Prevention Service Program Five-Year Plan may claim reimbursement for mental health and substance use prevention and treatment services²⁸ that are provided by qualified clinicians and in-home parent skill-based programs. The in-home parent skill-based program must include parenting skills training, parent education, and individual and family counseling. ACF interprets the term “in-home” broadly, in that it does not

February 9, 2018.

²⁴ A “child who is a candidate for foster care” is defined as a child who is identified in a title IV-E prevention plan as being at imminent risk of entering foster care (without regard to whether the child would be eligible for title IV-E FCMPs, title IV-E adoption assistance or title IV-E kinship guardianship assistance payments), but who can remain safely in the child’s home or in a kinship placement as long as the title IV-E prevention services that are necessary to prevent the entry of the child into foster care are provided. A “child who is a candidate for foster care” includes a child whose adoption or guardianship arrangement is at risk of a disruption or dissolution that would result in a foster care placement (section 475(13) of the Act). A child who is not under the placement and care of the state title IV-E agency and is in a kinship placement could be considered a “child who is a candidate for foster care” as defined in section 475(13) of the Act.

²⁵ A pregnant/parenting foster youth may receive prevention services to ensure that the youth is prepared (in the case of a pregnant foster youth) or able (in the case of a parenting foster youth) to be a parent; and to prevent any child born to the youth from entering foster care.

²⁶ See also the Children’s Bureau’s website at: <https://www.acf.hhs.gov/cb/title-iv-e-prevention-program>.

²⁷ Title IV-E is the payer of last resort for title IV-E prevention services that are Medicaid-coverable provided to a pregnant or parenting youth in foster care, but Medicaid remains the payer of last resort for services provided to most youth in foster care, including in a family-based residential treatment facility for substance abuse. The title IV-E Prevention Program does not provide federal funding for room and board, however, room and board is an eligible expense under the title IV-E foster care program for eligible children placed in a licensed residential family-based treatment facility for substance abuse. See Section III for further detail.

²⁸ For additional five-year state plan requirements, see ACYF-CB-18-09 Attachment B.

necessarily refer to the location in which the services are provided. The needs of the child, parent, or caregiver for the services must be directly related to the safety, permanence, or wellbeing of the child or to preventing the child from entering foster care. For state title IV-E agencies, mental health and substance use disorder treatment services and in-home parent skill based programs must be rated and approved by the title IV-E Prevention Services Clearinghouse (Clearinghouse) (or approved for a transitional payment).^{29, 30} Eligible services must be identified in the title IV-E agency's five-year title IV-E prevention program plan (section 471(e)(1)(A) of the Act (42 U.S.C. § 671(e)(1)(A))).

The Clearinghouse approves programs and services on an on-going basis. An updated list of services and programs approved by the Title IV-E Prevention Services Clearinghouse may be found at: <https://preventionservices.abtsites.com/>. It is possible that some of these services could be provided in a residential treatment facility.

Title IV-E is the payer of last resort for title IV-E prevention services that are Medicaid-coverable. However, since Medicaid covers discrete services, not programs, states will need to determine what individual service components in a program may be coverable (see section I for general guidelines on the services/providers that are generally coverable under Medicaid).

States should also assess whether a state plan change is necessary to align Medicaid benefits with eligible title IV-E prevention program services. The Medicaid state plan language may limit a service so it precludes fidelity to the program. For example, if the Medicaid state plan limits coverage to individual counseling, and the Clearinghouse-approved program calls for family counseling, the state may need to submit a state plan amendment (SPA) to accommodate the change. The state should also identify the practitioners who provide the service to determine if the current state plan lists those practitioners as qualified to perform the specific service. The state should determine if changes to the Medicaid provider manual or state legislation action is needed to provide coverage for the service as called for in the Clearinghouse-approved program. CMS encourages states to seek technical assistance if there are questions about how to facilitate Medicaid coverage of services in a Clearinghouse-approved program. States may access technical assistance through the CMCS Medicaid and CHIP Operations Group (MCOG).

Prevention Program Administrative Funding

Beginning in FY 2020, costs for the proper and efficient administration of the title IV-E

²⁹ [ACYF-CB-PI-19-06](#)

³⁰ Tribal title IV-E agencies are not required to use the services and programs approved by the title IV-E Prevention Services Clearinghouse. Instead, the agency may determine the practice criteria for services that are adapted to the culture and context of the tribal communities served and must describe the practice criteria in the five-year title IV-E prevention program plan. [See ACYF-CB-PI-18-10.](#)

prevention services program are reimbursable at 50 percent FFP. These include activities to develop necessary processes and procedures to establish and implement the provision of prevention services for eligible individuals, policy development, program management, and data collection and reporting. The title IV-E agency may claim for allowable activities that comport with or are closely related to one of the listed activities at 45 C.F.R. § 1356.60(c)(2). Note that performance of investigations, physical or mental examinations or evaluations are not allowable administrative costs for the title IV-E prevention services program ([ACYF-CB-PI-18-09](#) page 9). The Children’s Bureau provides additional guidance on claiming under the title IV-E prevention services program in [ACYF-CB-PI-18-12](#). See also “Medicaid Administrative Claiming” in section I above.

Title IV-B, Subpart 2, MaryLee Allen Promoting Safe and Stable Families (PSSF) Program

Federal funding is available under the PSSF program for four categories of services: family preservation, family support, family reunification, and adoption promotion and support services.

PSSF program funds designated for family reunification services and activities may pay for substance use disorder day-treatment and room/board for a parent involved in the child welfare system. Section 431(a)(7)(B) of the Act specifies that such services can include “inpatient, residential, or outpatient substance abuse treatment services.” Such services may be provided to the parent of a child placed in foster care to facilitate the reunification of the child safely and appropriately within a timely fashion, and to ensure the strength and stability of the reunification. While programs other than PSSF might be available to assist with costs for housing, PSSF can also support housing for a parent(s) with children involved in the child welfare system. As specified at section 431(a)(1) of the Act, the term “family preservation services” means services for children and families designed to help families (including adoptive and extended families) at risk or in crisis, including service programs designed to help children³¹ where safe and appropriate, return to families from which they have been removed.³²

Consistent with the agency’s title IV-B child and family services plan requirement to coordinate services in 45 CFR 1357.15(m) (See [ACYF-CB-PI-19-02](#) page 29), we encourage title IV-B agencies and Medicaid agencies to discuss the involvement between their programs for funding SUD and other treatment services that may be provided by residential treatment facilities.

Child Welfare Discretionary Grants

ACF administers competitive Regional Partnership Grants (RPG) to Increase the Well-Being of, and to Improve the Permanency Outcomes for, Children Affected by Opioids and Other

³¹ Section 431(a)(1)(A) of the Act

³² Section 431(a)(1)(A)(i) of the Act

Substance Abuse. These grants fund specific services and activities that increase child well-being, improve permanency outcomes, and enhance safety of children who are in or at risk of being placed in an out-of-home placement as a result of a parent's or caretaker's substance abuse. Services and activities under the grant may include quality SUD treatment for parents and families that include access to comprehensive substance use disorder treatment programs where children can live on-site with their parents. Many RPG grants provide services and interventions to improve family functioning that are provided for all family members, including access to family-based and individual care plans for the adult and child members of the family and intensive out-patient treatment with or without a housing component (i.e., sober living homes). In addition, many of these programs work to meet the needs of the entire family by providing access to MAT, trauma-specific services, and continuing care and recovery support. For additional information, see [the National Center on Substance Abuse and Child Welfare](#).

SAMHSA Programs

SAMHSA offers several grant programs that specifically target residential substance use disorder treatment programs for pregnant and postpartum women and their children.

Services Grant Program for Residential Treatment for Pregnant and Postpartum Women

This grant program expands comprehensive treatment, prevention and recovery support services for women and their children in residential substance use treatment facilities, including services for family members of both the women and children not residing in the facility. The program targets low-income women, age 18 and over, who are pregnant, postpartum (the period after childbirth up to 12 months), and their minor children, age 17 and under, who have limited access to quality health services. Domestic public and private nonprofit entities, including state and local governments, are eligible for the award. Additional information is available [here](#).

State Pilot Grant Program for Treatment for Pregnant and Postpartum Women

The State Pilot Grant Program for Treatment for Pregnant and Postpartum Women enhances flexibility to: 1) support family-based services for pregnant and postpartum women with a primary diagnosis of a substance use disorder, including opioid disorders; 2) help state substance use disorder treatment agencies address the continuum of care, including services provided to women in nonresidential-based settings; and 3) promote a coordinated, effective and efficient state system managed by state substance use agencies by encouraging new approaches and models of service delivery. Additional information is available [here](#).

III. State Coordination of Funds Between Medicaid and the Title IV-E Foster Care Program for Children and Youth Placed with Parents Residing in a Residential Treatment Facility

This section provides general guidance for coordinating funds between Medicaid and title IV-E foster care for children and youth placed with parents residing in a licensed residential family-

based treatment facility for substance use disorder.³³ The table below provides a broad overview of what might be coverable under Medicaid and the title IV-E foster care program for children and youth placed with parents residing in a licensed residential family-based treatment facility for substance use disorder. Of note, this list is not comprehensive, and to be eligible for reimbursement, the services must comport with the requirements of the specific Medicaid benefit, or the title IV-E foster care program for children placed in a licensed residential family-based treatment facility for substance use disorder. Subsequent sections explain components of licensed residential family-based treatment facilities for substance use disorder.

³³ Section 472(j) of the Act defines a licensed residential family-based treatment facility for substance abuse.

Examples of title IV-E foster care maintenance payments or administrative costs, including for children placed in a licensed residential family-based treatment facility for substance use disorder³⁴

Allowable	Unallowable
cost of providing food for the child clothing for the child room and board for the child daily supervision for the child personal incidentals for the child liability insurance certain reasonable travel costs case management referral to services preparation for/participation in judicial determinations placement of the child	homemaker or housing services family reunification services health care services substance use disorder treatment services mental health services facility operating costs

Examples of Medicaid Coverable and Not Coverable Services

Coverable	Not Coverable
mental health services substance use disorder treatment services case management care coordination	room and board in a residential treatment facility clothing food ³⁵ housing costs in the community child placement personal incidentals daily supervision preparation for/participation in judicial proceedings

³⁴ This table provides some, but not all, examples of allowable costs in a licensed residential family-based treatment center for substance abuse, but is not meant to include examples of costs for family-focused residential treatment centers. For more information on allowable title IV-E FCMP program costs, see the Child Welfare Policy Manual, sections 8.1B and 8.3B.1.

³⁵ Food that does not constitute a full nutritional regimen can be covered under 1915(c) waivers, 1915(i) or 1915(k) state plan options.

Room and Board

Title IV-E agencies may make title IV-E FCMPs for a youth in title IV-E foster care who is placed with a parent in a licensed residential family-based treatment facility for substance use disorder for up to 12 months in accordance with requirements in sections 472(a)(2)(C) and (j) of the Act. FCMPs include the cost of providing food, clothing, shelter, and daily supervision, personal incidentals, liability insurance and certain reasonable travel costs, among other things. (See section 475(4)(A) of the Act; [ACYF-CB-PI-18-07](#) page 4). However, Medicaid reimbursement is not available for the costs of room and board for any Medicaid beneficiaries receiving SUD treatment in a residential treatment facility, except under the circumstances discussed previously in this guidance.

Services

A title IV-E agency may not claim federal reimbursement under the title IV-E Foster Care program for social services provided to a youth or his or her parent (section 475(4)(A) of the Act). Examples of such services include counseling or other treatment to the child, his family, or foster family to remedy home conditions, personal problems or behaviors; homemaker or housing services and assisting in reuniting families ([CWPM 8.1B #1](#)). In addition, the provision of health care services is not an allowable cost item under title IV-E ([CWPM 8.1B #4](#)). However, Medicaid reimbursement may be available for services provided in a licensed residential family-based treatment facility for substance use disorder as explained in section I of this guidance.

Facility Requirements

A licensed residential family-based treatment facility for substance use disorder is not a child care institution (CCI) as defined in section 472(c) of the Act. This means that the facility must be licensed, but there is no requirement that it meet the title IV-E licensing and background check requirements for a CCI. The treatment facility must provide parenting skills training, parent education, and individual and family counseling under an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma and in accordance with recognized principles of a trauma-informed approach and trauma-specific interventions to address the consequences of trauma and facilitate healing (section 472(a)(2)(C) and (j) of the Act). However, the title IV-E foster care program does not pay for these or any other services. [ACYF-CB-PI-18-07](#) provides additional guidance for youth in foster care who are placed in a licensed residential family based treatment facility for substance use disorder with his/her parent authorized under section 472 of the Act.

Child Eligibility

The child or youth placed in a licensed residential family-based treatment facility for substance use disorder must meet all the title IV-E foster care eligibility requirements except the Aid to Families of Dependent Children (AFDC) eligibility requirements in sections 472(a)(1)(B) and

(3) of the Act. State Medicaid agencies and title IV-E agencies should be aware that although a child or youth may be receiving a title IV-E FCMP in this type of placement, a child who does not meet the AFDC requirements is not categorically eligible for Medicaid under section 472(h) of the Act. The requirement that the child is under the placement and care responsibility of the title IV-E agency, e.g., in foster care, while placed with the parent in the facility remains in effect. Although the child is in foster care while placed with the parent, only the child is eligible for FCMP in this setting. The recommendation for the placement in a licensed residential family-based treatment facility for substance abuse must be specified in the child's case plan before the placement.

Administrative Costs

Title IV-E agencies may claim administrative costs during the 12-month period consistent with 45 C.F.R. 1356.60(c) for the administration of the title IV-E program, which includes such things as case management, referral to services, preparation for and participation in judicial determinations, and placement of the child. ACF does not define the term "case management" and states and tribes define "case management" differently due to varying laws, policies, and practices. "Case management" activities must be necessary for the administration of the title IV-E prevention program, and may include collecting information such as child and family histories, assessments, the authorization and issuance of appropriate payments, the preparation of service plans, authorizing services and managing the delivery of services, and ongoing case monitoring (see section 474(a)(6)(B) of the Act). For additional information on claiming case management under Medicaid, please see "Managed Care Strategies" in section I.

A state title IV-E agency's public assistance cost allocation plan must identify the costs that are allocated and claimed under the program in accordance with the cost principles of 45 CFR Part 75 Subpart E. For guidance on Medicaid administrative costs, see "Administrative Costs" in section II above.

Health Care Oversight and Coordination Plan for Children and Youth in Foster Care

Section 422(b)(15)(A) of the Act requires the title IV-B agency to develop a plan for the ongoing oversight and coordination of health care services for children and youth in foster care (Health Care Oversight and Coordination Plan). The plan must be developed in coordination with the state Medicaid agency, and in consultation with pediatricians and other experts in health care, such as behavioral health providers, and experts in and recipients of child welfare services. The title IV-E agency's Health Care Oversight and Coordination Plan must include the following, per section 422(b)(15)(A)(i)-(vii) of the Act:

- A schedule for initial and follow-up health screenings that meet reasonable standards of medical practice, and how health needs identified through screenings will be monitored and treated, including emotional trauma associated with a child's maltreatment and removal from home. Note that state Medicaid agencies must provide EPSDT services that include a comprehensive array of prevention, diagnostic, and treatment services for low-

income infants, children and adolescents under age 21, as specified in Section 1905(r) of the Act. Section I of this guidance for additional information. We encourage state Medicaid agencies and title IV-E agencies to coordinate the use of EPSDT services for youth in foster care and/or participating in other title IV-E programs;

- How medical information for children and youth in foster care will be updated and appropriately shared, which may include developing and implementing an electronic health record;
- Steps to ensure continuity of health care services, which may include establishing a medical home for every child in care; through the Medicaid Health Home optional state plan benefit, states can establish Health Homes to coordinate care for Medicaid beneficiaries' chronic conditions (including SUD) as set forth in Section 1945 of the Act. See "Health Home Benefit - Section 1945 of the Act" in section I of this guidance for additional information on Medicaid Health Home benefits;
- The oversight of prescription medicines, including protocols for the appropriate use and monitoring of psychotropic medications;
- How the agency actively consults with and involves physicians or other appropriate medical or non-medical professionals in assessing the health and well-being of children and youth in foster care and in determining appropriate medical treatment for the children and youth;
- The procedures and protocols the agency has established to ensure that children and youth in foster care placements are not inappropriately diagnosed with mental illness, other emotional or behavioral disorders, medically fragile conditions, or developmental disabilities, and placed in settings that are not foster family homes as a result of the inappropriate diagnoses; and
- Steps to ensure that the components of the transition plan development process required under section 475(5)(H) of the Act relate to the health care needs of youth aging out of foster care are met, including the requirements to include options for health insurance, information about a health care power of attorney, health care proxy, or other similar document recognized under state law, and to provide the child with the option to execute such a document. Note: [ACYF-CB-PI-19-02](#) and [ACYF-CB-PI-19-04](#) provide guidance for developing a Health Care Oversight and Coordination Plan.

Additional Information

This document seeks to provide information to states but does not establish requirements or supersede existing laws or official guidance. Specific scenarios and questions should be directed to [Children's Bureau regional offices within ACF](#). Additional related information can be found [here](#).

Additional information about the Medicaid program is available at [Medicaid.gov](#). Questions regarding Medicaid should be directed to Kirsten Jensen, Director of the Division of Benefits and Coverage, at kirsten.jensen@cms.hhs.gov.