The Affordable Care Act and Implications for Families Affected by Substance Use Disorders in the Child Welfare System

Suzanne Fields, Senior Consultant
The Technical Assistance Collaborative

Putting the Pieces Together for Children and Families: The National Conference on Substance Abuse, Child Welfare, and the Courts
September 16, 2011

1

Presentation Overview

- Affordable Care Act- areas to watch
- Implications for substance use disorder (SUD) treatment, child welfare systems and treatment providers
- Taking action
- Q & A

2

Areas to Attend to in the ACA

- Expansion of health insurance coverage
- Opportunities for SUD and mental health prevention and treatment
- Changing role of Medicaid

3

Expansion of health insurance coverage

4

Expansions

- By January 2014, Medicaid will cover adults under 65 with incomes up to 138% of the Federal poverty level (FPL).
  - Children who are in foster care at age 18 can continue to receive coverage until 26
  - Expansion also includes parents with children no longer Medicaid eligible under Section 1931 of the SSA
  - Moves youth between 100 and 133% of FPL from CHIP to Medicaid
- For adults over 138% FPL but do not have insurance (or part of small business) can enroll in Health Insurance Exchange

5

Implications

- More people with coverage means….
  - More people seeking care. Can the service system keep up with demand?
    - Impact on **workforce** that is already under pressure
    - How do we ensure **access to treatment?**
    - **Need for both best and evidenced-based practices-** peers/persons with lived experience, family treatment approaches, in-home and community engagement and treatment approaches, co-occurring treatment

6

Implications

- Opportunity to provide SUD, mental health and co-occurring treatment earlier and to a larger group of people then ever before.
  - Coverage for parents, particularly adult males
  - Most will be young with SUD issues

7

Action

- Eligibility does not equal enrollment.
  - **Learn** about your state's enrollment process
  - **Educate** others about enrollment changes resulting from ACA
  - **Advocate** for enrollment and outreach strategies that are uniquely tailored for people with mental health and SUD issues
  - Child welfare will continue to be an important portal to help parents get access - will necessitate new policies

8

Action

- Opportunity to impact SU workforce
  - **Identify** creative solutions to credentialing /licensing of SUD professionals
  - **Advocate** for the inclusion of peer services and the need for enhanced training for all persons who work in MH & SUD services
  - **Learn** about ACA workforce opportunities

9

Action

- Think about how to improve access/engagement
  - Developing relationships with FQHCs and other providers
  - What changes can be made to improve the "front door" to ensure access and engage families in treatment
- For young adults:
  - Ensure benefit plans cover **needs of transition age youth (TAY)**
  - Design **points of access** that are designed for youth and parents

10

Opportunities for substance use disorder (SUD) and mental health prevention and treatment

11

Prevention and Treatment Opportunities

- **Health homes** for individuals with chronic conditions
  - Health homes is a term to describe a multidisciplinary approach to delivering physical health, mental health and SUD care
  - Includes outcome measurement as a team
  - Funding for a team approach
  - Coordinated care through use of technology and/or use of data

12

Prevention and Treatment Opportunities

- Specifically identifies mental health and substance use disorders as "qualifying" chronic conditions
- Coordinate all physical and behavioral health care
- States have the opportunity to obtain increased federal matching dollars

13

Implications

- Affords the opportunity to better coordinate physical health, mental health, and substance use services for parents with substance use disorders involved in the child welfare system
  - 1/3 to 2/3 of families involved with child welfare services are affected by substance use
  - Children involved in child welfare have higher rates than their counterparts of acute and chronic illness, developmental delays, & educational challenges
    - 80% -chronic medical condition
    - 25% - 3 or more medical conditions
    - 30-70% serious emotional conditions

14

Action

- **Advocate** for states to amend their Medicaid program to include the health home option
  - **Participate** in public processes that will inform the design and development of the state's Medicaid program
- Be a **resource** to health home providers and primary care physicians
  - Don't assume that people understand the child welfare involved population
  - Understand the shifts happening in the physical health system so you know how to advocate

15

Action-con't

- Educate others about child welfare, MH and SUD services and resources and the needs of child welfare involved families
- Use facts and figures; and convey stories
- Child welfare agency policies to support people getting access to stable health care
- Establish agreements or MOU's with health homes/health providers

16

ACA and Benchmark Plans

- For the newly eligible "expansion population" states only have to offer a "benchmark" or equivalent plan
  - Expansion population means the new groups of people that state Medicaid programs will be required to cover
  - Benchmark plan means the same health benefit package offered to
    - the state's employees
    - standard Blue Cross Blue Shield Plan offered under the Federal Employee Health Benefits Plan
    - the state's largest commercial HMO, or
    - other models approved by the HHS Secretary

17

ACA and Benchmark Plans

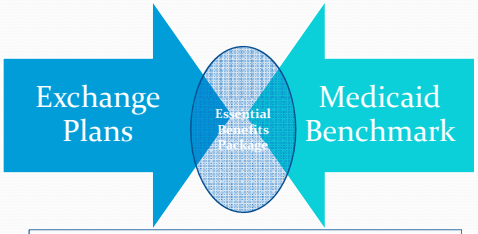
- Benchmark plans must provide:
  - Services are federally qualified health centers (FQHC) and rural health services
  - EPSDT services for youth under 21 (Early Periodic Screening , Diagnosis & Treatment)
  - Prescription drugs
  - Treatment for **MH/SUD at parity**

18

ACA and Benchmark Plans

- Certain groups of people, even though they are "the expansion population" cannot be required to enroll in a benchmark plan.
- These groups will have to be enrolled in the state's Medicaid program.
  - Pregnant women
  - Dually eligible (certain folks with both Medicare & Medicaid)
  - Aged, blind, disabled
  - Youth in foster care or those receiving adoption assistance
  - Medically frail and special medical needs individuals-- includes persons experiencing MI and children with SED
  - Individuals eligible for TANF

Benefit Continuity



35% of adults with family incomes less than 200% of FPL will experience a change in eligibility within a year

Source: Sommers, B.D. & Rosenbaum, S. (2011). Health Affairs.

Implications

- Many states have extremely limited SUD benefits – this changes with requirement for parity in benchmark plans
  - BUT parity does NOT necessarily equal good MH/SU coverage
- Benchmark benefit may offer less robust coverage than traditional / standard Medicaid benefit
- Essential benefit still not defined
  - Unknown whether SUD residential will be covered under essential benefit package
  - Inclusion of recovery support and other peer services

Action

- States only have to offer benchmark plan BUT can do more
  - **Advocate** for a good benefit package that includes continuum of SUD services
- Help **educate** people about the enrollment pathway that will lead them to the benefit package that will meet their needs
- Use data –tell the story

Implications

- Family Drug Courts and Child Welfare use residential programs that can admit a parent and child(ren) for treatment and early intervention services.
- Unknown whether SUD residential will be covered under essential benefit package – may not be covered
- Discharge planning from residential services will require coordination with Medicaid plans, health home teams, primary care, multiple providers to ensure continuity of community-based services

Implications

- Between a rock and a hard place …. everyone is confused….
- Medicaid programs are simultaneously cutting budgets , services, and numbers of enrollees while preparing for the largest expansion in health care since the inception of the program

Prevention Opportunities

- Section 4106 allows states to obtain a 1% increase in federal reimbursement (FMAP) for preventative services recommended by the USPSTF that have received a grade of A or B
  - Screening and Behavioral Counseling Interventions in Primary Care to Reduce Alcohol Misuse in Adults and Pregnant Women is one such service.

25

Prevention Opportunities

- Section 2951 provides states with funds to establish maternal, infant and early childhood visitation programs in communities that states identify as high risk.
- Assessment of risk includes substance use and the capacity for substance use disorder treatment.
- Those families with substance abuse treatment needs are among targeted groups for services.
- The State Substance Abuse Director is a required partner in the development of the State's MIECHV plan.

26

Implications

- Recent changes to Child Abuse Prevention and Treatment Act (CAPTA) provides opportunity to intervene with families and provide access to prevention and treatment services
- While preventative services may be covered under Medicaid, type of coverage across states varies greatly

27

Implications

- Creates new opportunities to focus on prevention and early intervention
- Enhances cross-system partnerships – Medicaid, early intervention, primary care, SUD and mental health – that can lead to other opportunities

28

Action

- **Work** with Medicaid to ensure they are taking advantage of all prevention opportunities
- **Review** your state's updated Medicaid coverage for a State Home Visiting Program
- Know your state's standards for pre-natal and post-birth screening, particularly for SUD screens

29

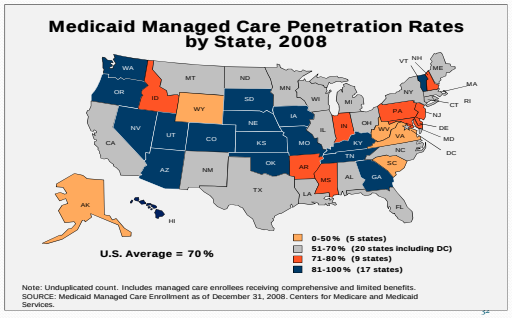
Changing role of Medicaid

30

Medicaid's expanded role

- Medicaid will now play a much larger role in SUD treatment because…
  - Expansion of Medicaid means 16-22 million more people will have access to Medicaid covered treatment services
  - Parity in benchmark plans means that state's cannot exclude treatment for SUD

Expansion of Medicaid Managed Care



Implications

- Medicaid becomes the most influential *purchaser* of MH/SUD services in your state
- "Safety-net" resources will be distributed differently – think changes to the SAPTBG and MHSBG
- Child welfare and SUD providers who have relied on grants and State contracts as primary source of funding will need to think about how to leverage insurance-based funding streams
- Medicaid and managed care will means changes to who can **provide** services, **how** services must be delivered, and **who** is eligible for the service(s)

Action

- **Get to know** your "Single State Medicaid Agency"
- Most Medicaid programs are not experienced in addressing SUD – **educate and inform** them about issues impacting this special population
- Encourage the **development of coalitions** between child welfare, SUD and mental health providers—strength in numbers
- **Identify** policy priorities at local, state and federal levels that align with your goals

Action

- **Develop** strategic partnerships with FQHCs and other Medicaid providers
- Support **strategic alliances** between agencies
- Learn which providers are already **billing insurance**
- **Learn** about managed care in your area
  - Who are the players?
  - What are the credentialing requirements?
  - What services are covered?
  - Rates?
  - Other infrastructure requirements?

Action

- Learn about agencies that are funded for **home visitation** services and how agencies are using that funding to support persons involved with child welfare and/or experiencing a SUD

Implications Summary

- Services and policies are needed to address the reality that many health conditions including MH/SUD require an ongoing chronic care management approach
- Without continuing care, child welfare involved families remain vulnerable to repeated involvement with the child welfare system due to the ongoing complexity of their needs.
- Achieving child welfare goals is dependent upon a strong community-based system that offers a continuum of treatment services.

37

Action Summary

- Partnering: Building a 2-Way Street
- Defining the issue and/or need
- Doing your homework
- Sharing in the responsibility and accountability

38

Q & A

39

Contact Information

Suzanne Fields, MSW, LICSW
Senior Consultant
sfields@tacinc.org

Technical Assistance Collaborative
31 St. James Avenue, Suite 710, Boston, MA 02116
www.tacinc.org

40

Parity and the Affordable Care Act: What are the effects on treatment for child welfare families?

Suzanne Fields, Senior Consultant
Kelly English, Senior Associate
The Technical Assistance Collaborative

Putting the Pieces Together for Children and Families: The National Conference on Substance Abuse, Child Welfare, and the Courts
September 15, 2011

1

Tell us about you…

- Consumer/Family
- Child welfare field
- Mental health (MH) and/or substance use disorder (SUD) fields
- Legal/court
- State/federal agency

2

Why do I need to know this?

- How is health care reform (HCR) and mental health and addictions parity relevant to families involved in the child welfare system?
- How will HCR and parity laws impact my work with families?

3

Relevance

- The Affordable Care Act (ACA) and the Mental Health Parity and Addictions Equity Act (MHPAEA)
  - Expand access to physical, mental health, and substance use prevention and treatment services that can…
    - Give you more tools to help you help families obtain treatment they need to successfully recover
    - Provide you with greater opportunities for prevention and treatment of substance use disorders and mental health issues that can reduce and potentially prevent child welfare involvement

4

One certainty is change

- Changes to…
  - Funding streams – role of insurance - both public and commercial - grows even larger
  - How providers collaborate and coordinate care especially for persons experiencing chronic health conditions

5

What does it all mean?

- Becoming knowledgeable and competent in working with Medicaid and managed care is critical
- Workforce challenges become every more acute
- More people seeking care (we hope) will require creativity to ensure people can actually access care when (and where) they want it
- Advocacy skills are key to ensuring opportunities are not missed and needs of child welfare families are not overlooked

6

Presentation Overview

- Expansion of health insurance coverage under health reform
- Mental Health Parity and Addictions Equity Act 101
  - What it is
  - What it means
  - What to look out for
- Q & A

7

Health insurance expansion

Improving access to physical health, mental health, and substance use disorder treatment through health insurance coverage

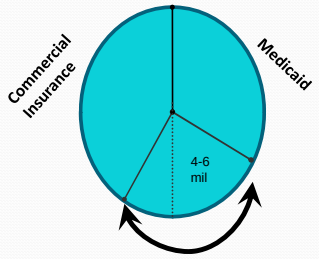
8

The Affordable Care Act…

- Expands access to health insurance
- Reduces barriers to health insurance enrollment
- Gives states more options for covering community-based long-term care services
- Improves access to MH and SUD services
- Authorizes funding for public health programs and mental health / physical health integration programs that will benefit families involved in child welfare who are impacted by SUD

9

BEGINNING IN 2014: 32 MILLION MORE AMERICANS WILL BE INSURED



6-10 Million have MH/SUD Needs

Source: SAMHSA

10

ACA Medicaid Eligibility Expansion

- Expands eligibility to single adults under 65 with incomes up to 138% of the Federal Poverty Level
  - Estimated that 16-22 million people will become eligible for Medicaid under the expansion
- States must enact these changes by 2014 but…..
  - States can enact these changes sooner
- States will receive a higher federal match to pay for the cost of this expansion
  - Federal match will be 100% of the costs associated with the expansion for the first three years, with the percentage gradually decreasing to 90% by 2020

11

Current Federal Medicaid Eligibility

Categorical Criteria

- Pregnant women
- Infants/Children
- Aged, Blind, Disabled
- Families with dependent children

Financial Criteria

- Income levels
- Assets and other income

12

New Eligibility Group Under ACA

Financial Criteria Only

- Single adults under 65
- Incomes up to 138% of the Federal Poverty Level

Single adults under 65 are eligible for Medicaid based on **income alone**

13

Medicaid Expansion cont.

- Children who are in foster care at age 18 can continue to receive coverage until age 26.
- Persons with low-income people and disabilities receiving SSDI (Social Security Disability Insurance) who are in the two year waiting period for Medicare will now have access to Medicaid
- Expansion includes parents and young adults who are not currently eligible under a State's existing Medicaid eligibility rules
- Moves youth on CHIP (Children's Health Insurance Program) between 100---133% of FPL (federal poverty level) from CHIP to Medicaid
- Permits enrollment of parents under Medicaid expansion only if their children have Medicaid or "other health insurance coverage"

14

Medicaid Eligibility Exclusions

- In general the following groups are INELIGBLE for Medicaid (and remain so under health reform):
  - Undocumented immigrants
  - Incarcerated adults and youth
    - **HOWEVER** ACA specifies that *pre-adjudicated* persons in jails are eligible for coverage in Medicaid or the new health insurance exchanges.

15

ACA and Benchmark Plans

- For the newly eligible "expansion population" states only have to offer a "benchmark" or equivalent plan
- Benchmark coverage means the same health benefit package offered by:
  - (a) the state for state employees
  - (b) standard Blue Cross Blue Shield Plan offered under the Federal Employee Health Benefits Plan (FEHBP)
  - (c) the states largest commercial HMO, or
  - (d) other models approved by the HHS Secretary

16

Benchmark Enrollment Exceptions

- Certain individuals cannot be required to enroll in a benchmark plan including:
  - Medically frail and special medical needs individuals--includes persons experiencing MI and children with SED
  - Pregnant women
  - Dually eligible
  - Aged, blind, disabled
  - Youth in foster care or those receiving adoption assistance
  - Individuals eligible for TANF

17

Affordable Insurance Exchanges

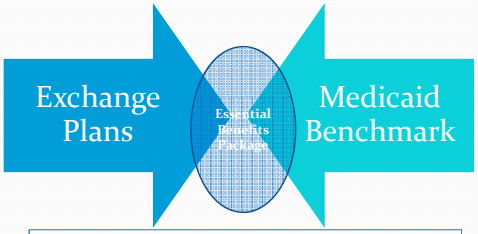
- Exchanges are another pathway to health insurance coverage under the ACA
- What are they?
  - Virtual marketplace where individuals and small business can go to shop for low-cost health insurance from *qualified* health plans
- Allow people to see if they are eligible (and apply for) other health insurance programs including Medicaid and CHIP

18

Affordable Insurance Exchanges

- Data sharing between public agencies (e.g. Social Security) to reduce paperwork burden and redundancies
- Responsible for consumer outreach and education
  - Navigator grants to qualified entities to assist in this effort
- Intended to make enrollment in health insurance easier, faster, and more efficient

Benefit Continuity



35% of adults with family incomes less than 200% of FPL will experience a change in eligibility within a year

Source: Sommers, B.D. & Rosenbaum, S. (2011). Health Affairs.

Essential Health Benefits

- Ambulatory and Emergency Services
- Hospitalization
- Maternity & newborn care
- **Mental health & substance abuse (at parity)**
- Prescription drugs
- Rehabilitation and devices
- Lab
- Preventive and wellness
- Pediatric (oral and vision)

Implications

- States only have to offer the benchmark plan BUT they can do more
  - Important to advocate for a good mental health and SUD treatment benefit that includes:
    - Peer and family partner services
    - Evidence-based and promising practices such as:
      - Functional Family Therapy, Multi-Systemic Therapy, Integrated Dual Disorder Treatment, Assertive Community Treatment
    - Prevention services including pre-natal and post-birth screening for substance use
    - Therapeutic foster care

Implications

- Family Drug Courts and Child Welfare use residential programs that can admit a parent and child(ren) for treatment and early intervention services.
- Unknown whether SUD residential will be covered under essential benefit package – may not be covered
- Opportunities do exist under ACA for expansion of home and community-based outpatient services
- Discharge planning from residential services will require coordination with Medicaid plans, health home teams, primary care, multiple providers to ensure continuity of community-based services

Health care reform in Massachusetts

HCR in Massachusetts

- Mass residents required to have health insurance as of June 2007 or risk tax penalty
  - Federal waiver expanded MassHealth (Medicaid) to people not traditionally covered
  - Commonwealth Care – subsidized insurance program for people who do not qualify for MassHealth
  - Commonwealth Connector – the State's Health Insurance Exchange program facilitates access to both MassHealth and Commonwealth Care plans
    - Grants to community-based organizations to help facilitate enrollment and outreach to underserved populations
    - Minimum creditable coverage standard

25

HCR Impacts

- Uninsured rates go down
  - Mass has the lowest uninsured rate in the country at 4.2% (Source: U.S. Census Bureau, 2009 American Community Survey)
  - Number of calls requesting access to a state-funded SUD residential tx bed for people lacking coverage decreases more than 50% between 2004 and 2007
- Numbers of people accessing treatment rises
  - Admissions to SUD tx rose almost 20% between 2006 and 2008
  - MassHealth Members admitted to SUD tx rose by more than 300% between 2005 and 2009

26

HCR Impacts

- Reductions in out-of-pocket costs and problems paying medical bills
- Access to services improves
  - Level IIIB residential detox funding restored
  - CommCare covers methadone maintenance and Buprenorphine

27

Issues remain

- People lacking insurance remain especially amongst young adults 19 to 24 with disparities in coverage for people of color
- Gap between enrollment and when coverage takes effect
- MassHealth does not cover the cost of room and board for SU residential tx
- Navigating managed care plans with different rules and rates
- Coverage transitions and "churning" leading to breaks in treatment

28

Issues remain

- People lacking insurance remain especially amongst young adults 19 to 24; disparities in coverage for people of color
- Gap between enrollment and when coverage takes effect
- MassHealth does not cover the cost of room and board for SU residential tx
- Navigating managed care plans with different rules and rates
- Coverage transitions and "churning" leading to breaks in treatment

29

What can we learn?

- Outreach especially for underserved populations is critical to ensuring enrollment
  - Child welfare agencies can be an important portal to facilitating access to health insurance under HCR especially for transition age youth and young parents
- Advocacy around benefit design and inclusion of MH/SUD treatment services is crucial
- Managed care savvy becomes even more important

30

What can we learn?

- Safety-net resources remain an important part of the service continuum
  - Gap coverage
  - Prevention services
  - Provider capacity building
    - Infrastructure development
    - Training/workforce development
  - Flexible funding for "non-medical" services (e.g. childcare)
  - Development of emerging treatments

To learn more….

- The National Association of State Alcohol and Drug Abuse Directors (NASADAD). *The Effects of Health Care Reform on Access to, and Funding of, Substance Abuse Services in Maine, Massachusetts, and Vermont.* http://nasadad.org/resources/Final%20revisions%20HCR%20508%20compliant.pdf
- BlueCross/Blue Shield Foundation. *Lessons from the implementation of Massachusetts health reform.* https://www.mahealthconnector.org/portal/binary/com.epicentric.contentmanagement.servlet.ContentDeliveryServlet/Health%2520Care%2520Reform/Overview/LessonsFromtheImplementationofMAHealthReform.pdf
- *Commonwealth of Massachusetts health reform webpage* http://www.mass.gov/?pageID=mg2subtopic&L=4&L0=Home&L1=Resident&L2=Health&L3=Health+Care+Reform&sid=massgov2

Mental Health Parity and Addictions Equity Act (MHPAEA)

AKA: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008

Federal Parity Law

- Separate law from ACA but connected
- Signed into law in 2008
- Regulations effective January 2011
- Requires group health insurance plans with 50 or more insured employees that offer coverage for mental illness and SUD to provide for MH/SUD benefits in a way that is no more restrictive than medical and surgical benefits
- Does not preempt stricter state parity laws

Federal Parity Law

- Parity applies to….
  - Financial requirements (deductibles, co-pays, annual/lifetime limits)
  - Both quantitative (e.g. limit of 15 visits) and non-quantitative (e.g. step-therapy protocols, prescription drug formulary design) treatment limitations
- If the plan covers out-of-network medical/surgical providers, they must also cover out-of-network MH/SUD providers

Federal Parity Law

- Applies to six classifications of benefits:
  1. In-network inpatient
  2. Out-of-network inpatient
  3. In-network outpatient
  4. Out-of-network outpatient
  5. Emergency care
  6. Prescription drugs

Requirements and Exemptions

- Applies to Medicaid managed care plans
- Health insurance offered through Exchanges
- Medicaid benchmark plans

- Does NOT apply to Medicaid fee-for-service, Veteran's Administration , Medicare, or Tri-care
- Plans with fewer than 50 employees
- State /local govt. employer group health plans can opt-out
- Cost-exemption
  - If costs increase 2% or more greater in first year due to parity employer can request exemption for next year.
  - If cost in subsequent year is 1% greater due to parity employer can request exemption for further year.

37

Appeals/Grievances/ Enforcement

- Medical necessity criteria used to make coverage decisions must be made available to beneficiaries upon request
- Reasons for denials of MH/SUD benefits must be disclosed

38

Appeals/Grievances/ Enforcement (con't)

- Enforcement depends on plan type
  - Individual and small employer plans: State Insurance Commissioner
    - http://www.naic.org/state_web_map.htm
  - Self-funded employer plans: Department of Labor
    - http://www.dol.gov/ebsa
    - Call toll- free 1-866-444-EBSA (3272).
  - Large group self-funded plans provided by State and local govt. and churches: HHS
    - http://www.sms.hhs.gov/HealthInsReformfor Consume/01_Overview.asp
    - Call 877-267-2323 ext 6-5511

39

The Meaning of Parity

- It DOES NOT....
  - Mean access to good MH & SUD benefits; it only means that MH & SUD are treated similarly to physical health (PH) benefits
  - Mean that managed care companies have to end utilization management practices such as prior authorization, application of medical necessity criteria
  - Require health plans to cover MH/SUD services if they did not already cover them

40

The Meaning of Parity

- It means...
  - Improved access to coverage of MH/SUD treatment services
  - That MH & SUD should be treated equally to medical/surgical care – attempts to end unequal treatment and discrimination
  - Any use of non-quantitative limitations must be, comparable to, and applied no more stringently than, the processes,& standards, applied to limiting medical/surgical benefits (with variation to the extent that, "recognized clinically appropriate standards of care may permit a difference.")

41

Where can I find out more about parity?

- SAMHSA website: http://www.samhsa.gov/healthreform/parity/
- National Council for Community Behavioral Healthcare: http://www.thenationalcouncil.org/galleries/policy-file/Parity%20Fact%20Sheet_National%20Council.pdf
- Regulations in the Federal Register: http://edocket.access.gpo.gov/2010/pdf/2010-2167.pdf
- Parity Implementation Coalition: http://www.mentalhealthparitywatch.org

42

Putting the pieces together

What does this all mean?

To recap…

- More people will have access to health insurance coverage and therefore access to treatment for physical health, mental health, and substance use disorders
- Fewer uninsured coupled with improvement in coverage of MH/SUD (i.e. parity) means safety-net resources will be distributed differently

To recap…

- Insurance, both commercial and public, will play an even bigger role in funding MH/SUD treatment
- Managed care will play a key role in all aspects of the health delivery system
- Expectation for coordination of care across physical health, MH and SUD

To recap…

- Essential Benefits Package defined by HHS will clarify the required services that have to be covered
- States have to offer at least a benchmark plan BUT they can offer more
- Parity is a good thing BUT does not mean access to a good MH/SU benefit
- Important to advocate for a good benefit package and services

What do you think should be included in the essential benefits package and why?

Engaging policy leaders

- Know your "ask"– have only 2-3 items for discussion
- Have data and personal stories
- Prepare for all sides of the issue
- Power of coalition—who else shares your perspective?
- What if the answer is "no"
- Ask how you can help make "the ask" a reality
- Identify next steps, including whom on their staff you can work with

Taking Action

- Get to know your "Single State Medicaid Agency"
- Encourage the development of cross-disability coalitions between child welfare, mental health, and substance use advocates and providers—strength in numbers
- Identify policy priorities at local, state and federal levels that align with goals of reducing child welfare involvement
- Encourage cross-system partnerships at state and federal levels

49

Q & A

50

Contact Information

Suzanne Fields, MSW, LICSW
Senior Consultant
sfields@tacinc.org

Kelly English, MSW, Ph.D.
Senior Associate
kenglish@tacinc.org

Technical Assistance Collaborative
31 St. James Avenue, Suite 710, Boston, MA 02116
www.tacinc.org

51