

# Frequently Asked Questions (FAQs)

## FY 2015 President's Budget Proposal

### ACF and CMS Demonstration to Address Over-Prescription of Psychotropic Medications for Children in Foster Care

#### 1. What is the purpose of the joint ACF and CMS demonstration?

The President's Budget proposes to authorize a five-year, Centers for Medicare & Medicaid (CMS) demonstration in partnership with the Administration for Children and Families (ACF) beginning in FY 2015 to address the over-prescription of psychotropic medications for children in foster care and to focus on implementing more effective courses of treatment including evidence-based therapies for children and youth.

#### 2. Why is this joint demonstration needed?

Vastly improved outcomes can be expected for children and youth in foster care if the child welfare system can accurately identify the social and emotional needs of the children and youth it serves, install and scale up evidence-based psychosocial interventions, and match young people with appropriate and effective treatments. These include a decreased reliance on psychotropic medications, a reduction in risky prescribing practices such as polypharmacy, and improved safety and social and emotional wellbeing of children and youth. Further, when children's emotional and behavioral health needs are met, it is reasonable to expect improvements in traditional child welfare outcomes as well as including decreased time to permanency, fewer disrupted adoptions, and, potentially, reductions in re-entry into foster care. We expect this new investment and continued collaboration between ACF and CMS in addressing the over-prescription of psychotropic medications will promote the wellbeing of and improve the social and emotional outcomes for some of America's most vulnerable children.

Given that evidence-based psychosocial interventions are not widely used in the child welfare system, and lack of systems capacity to implement such interventions, states rely predominately on generic psychotherapy and psychotropic medications to address complex emotional and behavioral disorders among the children and youth they serve. Usual care (i.e., traditional therapeutic interventions such as generic counseling) has been shown to have limited impacts on improving functioning and reducing the use of psychotropic medications.

The Government Accountability Office (GAO) estimates that 20 to 39 percent of young people in foster care are receiving psychotropic medications; they are between four and eight times more likely than their non-foster care peers to take these drugs. They are also more likely to receive two or more psychotropic medications (polypharmacy) and antipsychotics, often in dosages exceeding FDA guidelines.<sup>1</sup> While the extreme clinical complexity of this

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<sup>1</sup> <http://www.gao.gov/assets/660/650716.pdf>

population may be a factor, the risk of side effects is significant and the current level of use of psychotropic medications for this population suggests there may be an over-reliance on medication as a first-line treatment strategy. Additionally, children who come into foster care have often been exposed to multiple traumas, including abuse or neglect and subsequent removal from their homes. The impacts of these adverse experiences affect children in all domains: cognitive functioning, physical health and development, emotional/behavioral functioning, and social functioning. These children enter foster care with a complex array of symptoms, and the child welfare system currently struggles to fully address them all.

### **3. How much funding is requested for the ACF and CMS demonstration?**

Over five years demonstration states would receive \$250 million in funding through ACF to support state efforts to build provider and system capacity in screening, assessment and treatment to support the demonstration. This investment is paired with \$500 million in performance-based incentive payments administered by CMS for states to improve care coordination and service delivery for foster care children with the goal of reducing the over-prescription of psychotropic medications and improving outcomes for these young people.

### **4. What activities will the \$250 million in ACF funding for state infrastructure and capacity building support?**

ACF funding would support state infrastructure and capacity activities, including:

- Child Welfare Workforce: Help build a specialized workforce to recruit, train, and help retain resource families who are able to provide care for children while receiving alternative interventions. Staff will need smaller caseloads in order to provide intensive family support;
- Screening and assessment: Activities under this proposal would closely link findings from screenings and assessments with the selection of appropriate interventions, and ongoing assessments would be used to monitor children's progress with treatment;
- Coordination between child welfare case planning and management and Medicaid, especially Early and Periodic Screening, Diagnosis, and Treatment (EPSDT);
- Training: Training child welfare staff, foster parents, adoptive parents, guardians, judges and clinicians is an essential component of scaling up evidence-based interventions. Beyond initial training, some interventions require booster trainings to ensure that fidelity to the models does not erode. The child welfare workforce also should develop literacy in the area of evidence-based practice to support the transition to evidence-based service delivery;
- Fidelity Monitoring: Fidelity monitoring and ongoing coaching/supervision also are critical to the delivery of evidence-based interventions. Without them, the integrity of the intervention is compromised, and expected results may not be achieved. Funds would be used by states to support these activities to ensure interventions are being implemented with fidelity;
- Evaluation; and,
- Data collection and IT systems to support and improve coordination between state child welfare agencies, Medicaid and behavioral health services.

## **5. What will the \$500 million in CMS funding support?**

The \$500 million will provide incentive payments to participating states that demonstrate improvement. (A state that receives an incentive payment from this fund cannot use these funds to supplant other funds used by the state to carry out the Medicaid State plan, or IV-B or IV-E of the Social Security Act.)

## **6. Who will administer the joint demonstration?**

The demonstration would be managed collaboratively by ACF and CMS.

## **7. What are the goals of the demonstration?**

- Reduction in prescriptions of psychotropic medications, including the elimination of prescribing practices that do not conform to best practice guidelines for children and youth;
- Increased use of evidence-based/evidence-informed, trauma-informed, screening, assessment, and psychosocial interventions as first-line treatments for emotional and behavioral health needs;
- Improved child welfare outcomes including increased child safety, decreased time to permanency, fewer disrupted adoptions, and fewer entries and re-entries into foster care; and,
- Improved functioning across physical, social-emotional, cognitive, and developmental domains.

## **8. What outcomes can we expect from the joint demonstration?**

Through the collaborative demonstration we expect that child welfare agencies working in partnership with their state Medicaid agencies will have an increased ability to appropriately identify the root causes of emotional and behavioral health challenges, provide appropriate interventions, decrease over-prescription of psychotropic medications, enhance child safety, increase the use of community and family based care and increase timely permanence, including adoption.

Improvement on specific, targeted outcomes can be expected. These include reducing reliance on psychotropic medications and in risky prescribing practices such as polypharmacy, and improving safety and social and emotional wellbeing of children and youth. Further, when children's emotional and behavioral health needs are met, it is reasonable to expect improvements in traditional child welfare outcomes as well including increased safety, decreased time to permanency, fewer disrupted adoptions, and fewer entries and re-entries into foster care.

For example, children who have experienced abuse and neglect often have significant trauma related emotional and behavioral health needs, which can drive their health care costs, can lead to instability in care and delay or disrupt permanency. The Academy of Child and

Adolescent Psychiatrists recommends psychotherapy as the first-line treatment for Post-Traumatic Stress Disorder (PTSD); yet children across all age groups often receive medication first, without evidence-based psychosocial interventions. As a result, many children in care are over-medicated, under-treated, and have poor safety, permanency, education and health outcomes. A trial of Cognitive Behavioral Therapy (CBT) with 3-6 year-old children with PTSD demonstrated improved outcomes across symptom categories.

**9. What types of evidence-based interventions might states include in a demonstration of this kind?**

There are several types of evidence-based interventions that address psychotropic over-prescription and could be among those offered through the demonstration including but not limited to:

- Multidimensional Treatment Foster Care (MTFC);
- Parent-Child Interaction Therapy (PCIT);
- Multi-systemic Therapy (MST);
- Functional Family Therapy (FFT);
- Triple P;
- Parenting Wisely;
- Trauma-Focused Cognitive Behavioral Therapy (CBT); and,
- Incredible Years (IY).

**10. What have states done to reduce over-prescription on psychotropic medications or increase state child welfare use of evidence-based psychosocial interventions?**

Title IV-B child welfare plan requirements include identifying protocols for the appropriate use and monitoring of psychotropic medications. Six states (IL, NJ, NY, OR, VT, and RI), with the Center for Healthcare Strategies have engaged in a three year quality improvement collaborative to improve systems for oversight and monitoring of psychotropic medications.

**11. Would states be interested in applying for a demonstration that seeks to address the over-prescription of psychotropic medications for children in foster care?**

There is significant interest among states: 27 of 46 state child welfare agencies responding to a 2010 survey considered high levels of psychotropic drug prescriptions for children in foster care to be a topic of “high” level concern (Leslie, et al, Multi-State Study on Psychotropic Medication Oversight in Foster Care, 2010). There are 12 states in which at least 15 percent of children in foster care were prescribed second-generation antipsychotic drugs in 2007, with a median rate among all states at 12.8 percent. In 11 of those 12 states, such prescriptions increased between 2002 and 2007. While Texas, the remaining State, saw a decreased rate, it had the highest rates both initially (23.7 percent) and at the end of the period (21.7 percent).

**12. How long will it take to demonstrate results?**

It will depend based on the state. We may see some states in year two have improvements relative to their baseline and receive incentive payments. Other states may need until year four or five to fully qualify for incentive payments.

**13. How many children will be served by the joint ACF and CMS demonstration?**

The CMS Office of the Actuary (OACT) estimates that this demonstration would serve at least 400,000 children through the end of the demonstration.

**14. Will CMS impose penalties on providers that do not demonstrate improvement in “risky prescribing practices” such as polypharmacy?**

The purpose of the demonstration is not to penalize providers, but to encourage the use of best practices in providing care to vulnerable children and youth.

**15. How will states qualify for the demonstration?**

The Secretary of Health and Human Services (HHS) would define criteria for qualifying states, qualifying foster children, and recommend models to test. Through a competitive grant process, qualifying states would apply for (1) ACF infrastructure grant funding, (2) incentive payments if the state qualifies based on the Secretarially defined criteria, or (3) both. State applications would include an assessment of need, the types of interventions they would provide, and demonstrate that they have a state Medicaid plan that allows them to use Medicaid dollars to pay for these services.

**16. How will states qualify for ACF infrastructure funding?**

These requirements will be further specified through the competitive grant process.

**17. How will states qualify for performance payments?**

States would have to meet targets each year in order to qualify for incentive payments. States would have to ensure coordination between the state Medicaid and child welfare agencies. These requirements will be further specified through the competitive grant process.

**18. In addition to states, will tribes be eligible to apply?**

Yes, tribes may participate in the demonstration. These requirements will be further specified through the competitive grant process.

**19. How will providers be paid?**

Providers would be reimbursed for any Medicaid services through normal Medicaid reimbursement procedures, not through these funds. States would be required to reimburse

the evidence-based therapies through Medicaid as a condition of participation in the demonstration.

**20. How will incentive payments be made to states and tribes?**

Incentive payments would be paid annually during the five-year demonstration period, and would be tied to process metrics, quality metrics, and milestones. These requirements will be further specified through the competitive grant process.

**21. Will there be a cost to the Medicaid program from induced utilization of services?**

OACT has estimated that the costs from utilization of Medicaid services from the \$500 million in new incentive payments would be approximately \$665 million over the life of the demonstration.

**22. If this demonstration will reduce the use of psychotropic medications among children in foster care, why doesn't this proposal save money?**

Currently psychotropic medications are utilized more frequently than therapy for behavioral health disorders among the foster care population. Evidence-based psychosocial interventions are often more costly than the current treatment provided, thus this proposal has a cost. However, this demonstration will provide important data on how costs may compare over a longer period of time. The estimated cost reflects the impact to the Medicaid baseline and not impacts to other government programs or short- and long-term benefits to the children themselves.

**23. How much does Medicaid spend on psychotropic medications for the foster care population?**

Children in foster care receive a disproportionate level of psychotropic medication compared to other children on Medicaid. A recent GAO report using Medicaid claims from five states found that 20 percent to 39 percent of children in foster care received a prescription for psychotropic medication in 2008, compared with 5 percent to 10 percent of children not in foster care. The CMS Office of the Actuary found that in CY 2008, \$532 million was claimed for psychotropic drugs for Medicaid children in foster care. Other studies have found that among children enrolled in Medicaid in 2011, children in foster care were prescribed psychotropic medications at rates from 3 to 11 times higher than non-foster children. Moreover as many as 41 percent of children in foster care who took any psychotropic medication received three or more psychotropic medications within the same month.<sup>2</sup> Of course, this does not include the cost of generic psychotherapy or more intensive treatments provided to children and youth in foster care.

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<sup>2</sup> [http://www.acf.hhs.gov/sites/default/files/opre/psych\\_med.pdf](http://www.acf.hhs.gov/sites/default/files/opre/psych_med.pdf)

## **24. Will there be an evaluation of the demonstration?**

The Secretary would be required to evaluate the demonstration in order to understand the changes put in place by states, determine whether children in fact receive a more appropriate service mix, and whether children's social and emotional functioning, as well as broader health and child safety, permanency, and wellbeing outcomes improve as a result of the demonstration. The evaluation of this demonstration will include three components: a process evaluation, an outcome evaluation, and a cost analysis. Each of the demonstration sites will be evaluated individually; in addition, a cross-site component will seek to examine outcomes and issues common to all the sites.

## **25. What have drug companies said about over-prescription of psychotropic medications by children, particularly those in foster care?**

In a recent *Wall Street Journal* article a statement from one manufacturer was quoted as saying, "Because children in foster care are particularly vulnerable to mental health problems, we support the creation of policies to protect their interests."<sup>3</sup>

## **26. Doesn't Medicaid already cover these services?**

A state may, but is not required to, offer these services as part of their state plan. State Medicaid agencies are often reluctant to cover these services without the necessary infrastructure to ensure they are provided with the intended fidelity or there may not be providers available to provide the service. Thus, drugs are being used in place of evidence-based treatments, which has led to the over-prescription of children in foster care being addressed in this demonstration.

## **27. How does exposure to traumatic events in a child's life impact the likely use of psychotropic medications and outcomes for children?**

Complex trauma is a common yet serious concern for children especially for those referred to child welfare services. Rates of trauma exposure are approximately 90 percent among children in foster care.<sup>4</sup> The landmark Adverse Childhood Experiences (ACE) Study demonstrated long-term consequences in adulthood of multiple adverse experiences that occur in childhood, including increased likelihood of stroke, diabetes, cardiovascular disease, cancer, and early death, as well as lower job performance and levels of employment. Children and youth in foster care are far more likely than their peers to receive psychotropic medications, including atypical antipsychotic medications, which carry a high risk of both physical and behavioral side effects including weight gain or movement disorders, elevated blood sugars, and possible increased risk for diabetes. There is reason to believe that such widespread and sometimes problematic use of these drugs is a reaction to the clinical complexity of symptoms among children exposed to complex trauma and the lack of appropriate screening, assessment and treatment.

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<sup>3</sup> <http://online.wsj.com/news/articles/SB10001424052702303442704579361333470749104>

<sup>4</sup> Stein, B., Zima, B., Elliott, M., Burnam, M., Shahinfar, A., Fox, N., et al. (2001). Violence exposure among school-age children in foster care: Relationship to distress symptoms. *Journal of the American Academy of Child and Adolescent Psychiatry*, 40(5), 588–594.

## 28. Are there authoritative sources that can provide more context for this issue?

HHS, Congress, external researchers and others have all explored the issue of over-prescription of psychotropic medication for children in foster care. Some resources include:

- HHS Tri-Director Letters from CMS, ACF, and SAMHSA:
  - 2011 Tri-Director Letter on Psychotropic Medication: <http://www.medicare.gov/Federal-Policy-Guidance/downloads/SMD-11-23-11.pdf>
  - 2013 Tri-Directory Letter on Trauma: <http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf>
- External Research:
  - 2012 journal article by Rubin et al: *Interstate variation in trends of psychotropic medication use among Medicaid-enrolled children in foster care* (full study from which the maps above are derived) <http://www.sciencedirect.com/science/article/pii/S0190740912001648>
  - Children in Foster Care: PolyPharmacy Medication Use 2002-2009 (Map graphic on use rates state-by-state from a Children's Hospital of Philadelphia study): <http://policylab.chop.edu/data-visualization/children-foster-care-polypharmacy-medication-use-2002-2009>
  - 2010 study by Leslie et al: *Multi-State Study on Psychotropic Medication Oversight in Foster Care*: <http://www.tuftsctsi.org/About-Us/News/Archive/~media/23549A0AA4DE4763ADE445802B3F8D6F.aspx>
- GAO Report:
  - 2012 GAO study: *Children's Mental Health: Concerns Remain about Appropriate Services for Children in Medicaid and Foster Care*; <http://www.gao.gov/assets/660/650716.pdf>
  - 2011 GAO study: *Foster Children: HHS Guidance Could Help States Improve Oversight of Psychotropic Prescriptions*: <http://www.gao.gov/products/GAO-12-270T>
- Congressional Hearings:
  - 2008 Ways and Means subcommittee hearing on Prescription Psychotropic Drug Use among Children in Foster Care: <http://www.gpo.gov/fdsys/pkg/CHRG-110hrg45553/pdf/CHRG-110hrg45553.pdf>
  - 2011 Senate Government Affairs subcommittee hearing on The Financial And Societal Costs Of Medicating Americas Foster Children: <http://www.gpo.gov/fdsys/pkg/CHRG-112shrg72558/pdf/CHRG-112shrg72558.pdf>
- Other Organizations:
  - The American Academy of Child & Adolescent Psychiatrists (AACAP):

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- [https://www.aacap.org/App\\_Themes/AACAP/docs/member\\_resources/practice\\_information/foster\\_care/FosterCare\\_BestPrinciples\\_FINAL.pdf](https://www.aacap.org/App_Themes/AACAP/docs/member_resources/practice_information/foster_care/FosterCare_BestPrinciples_FINAL.pdf)
- [http://www.aacap.org/App\\_Themes/AACAP/docs/press/guide\\_for\\_community\\_child\\_serving\\_agencies\\_on\\_psychotropic\\_medications\\_for\\_children\\_and\\_adolescents\\_2012.pdf](http://www.aacap.org/App_Themes/AACAP/docs/press/guide_for_community_child_serving_agencies_on_psychotropic_medications_for_children_and_adolescents_2012.pdf)

## 29. Who has written about this issue?

A number of journalists and others have addressed the issue including:

- *The Wall Street Journal*
  - <http://online.wsj.com/news/articles/SB10001424052702303442704579361333470749104>
- David Brooks
  - [http://www.nytimes.com/2012/09/28/opinion/brooks-the-psych-approach.html?\\_r=1](http://www.nytimes.com/2012/09/28/opinion/brooks-the-psych-approach.html?_r=1)
- Nicholas Kristof
  - [http://www.nytimes.com/2012/01/08/opinion/sunday/kristof-a-poverty-solution-that-starts-with-a-hug.html?\\_r=1&ref=nicholasdkristof](http://www.nytimes.com/2012/01/08/opinion/sunday/kristof-a-poverty-solution-that-starts-with-a-hug.html?_r=1&ref=nicholasdkristof)
- Diane Sawyer
  - <http://abcnews.go.com/US/story-shows-foster-children-high-rates-prescription-psychiatric/story?id=15058380>