Planning Title IV-E Prevention Services: A Toolkit for States

Appendices

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CONTENTS

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Appendix A: Parameters for Title IV-E prevention services reimbursement

FFPSA and subsequent related guidance from the Administration for Children and Families (ACF) describe some key parameters of Title IV-E prevention services and the eligibility for federal reimbursement, including the following: [1]

Mechanism for obtaining Title IV-E reimbursement. Starting as soon as October 1, 2019, states may obtain Title IV-E reimbursement by submitting to and receiving approval from the ACF Children's Bureau Regional Office a five-year prevention program plan, including information such as how the state will provide, oversee, and evaluate services. Each child and/or associated family member (parent or kin caregiver) for whom reimbursement is received must also have a prevention plan that describes the foster care prevention strategy for the child and the services that will be provided to ensure the success of this strategy. With respect to eligible services for qualifying populations, states can receive 50 percent federal financial participation (FFP), or FFP at the state's federal medical assistance percentage (FMAP) starting in October 2026.

Types of services. States can use Title IV-E reimbursement for prevention services to receive FFP for mental health (MH) and substance use disorder (SUD) prevention and treatment services, in-home parent skill-based programs, and kinship navigator programs. The programs must be rated as promising, supported, or well-supported in the Title IV-E Prevention Services Clearinghouse. In addition, half of the total state spending for the Title IV-E prevention program in a fiscal year must go toward "well-supported" services. In July 2019, ACF issued guidance about how states can claim transitional payments for Title IV-E prevention services until the Clearinghouse is able to review and rate the program or service (ACYF-CB-PI-19-06).

Populations served. Reimbursable services are available for children who are "candidates for foster care" and for their families (parents or kin caregivers) if the children can remain safely in their home or in adoptive or kinship placement if they are provided with Title IV-E prevention services.[2] (A candidate for foster care is a child who is identified as being at "imminent risk" of foster care placement.) Title IV-E prevention services are also available for pregnant or parenting youth in foster care, and the parents and kin caregivers of pregnant or parenting foster youth. If a child who is a "candidate for foster care" enters foster care and is

[1] ACYF-CB-PI-18-09 describes requirements for states and ACYF-CB-PI-18-10 describes requirements for tribal agencies. This Appendix is intended to summarize existing ACF guidance to states and does not supersede ACF guidance.

[2] This also includes children whose adoption or guardianship arrangement is at risk of disruption or dissolution that would result in foster care placement. ACF guidance indicates that it will not further define "candidate for foster care" (as in section 475(13) of the Social Security Act) or further define "imminent risk".

therefore no longer considered a "candidate," reimbursement under the Title IV-E prevention program must end.

Duration of services. The state may provide Title IV-E prevention services for up to 12 months beginning on the date the state identifies the child as either a "candidate for foster care" or a pregnant or parenting foster youth in need of those services in their prevention plan. A state may provide Title IV-E prevention services to or on behalf of the same child for additional 12-month periods, provided that the state determines and documents in the child's prevention plan that the child meets prevention program requirements.

Restrictions and relation to other funding. Title IV-E reimbursement must supplement, not supplant, the total existing state foster care prevention funding based on a state's expenditures in fiscal year (FY) 2014.[3] In addition, Title IV-E is the "payer of last resort" for Title IV-E prevention services. If prevention services would have been paid for by another source (public or private) if not for Title IV-E, the state is not legally liable for providing the prevention services. An exception to this requirement is if a state uses Title IV-E to pay a provider for services in order to prevent a delay in the timely provision of services, pending reimbursement by the other funding source that is ultimately responsible.

[3] It may also be based on other years, depending on the population of the state.

Appendix B: Comprehensive arrays of SUD and MH services

1. Comprehensive array of SUD services

The American Society of Addiction Medicine (ASAM) criteria are the standard set of guidelines for assessing and making treatment decisions for adults and adolescents with SUD; Grogan et al. (2016) notes that the criteria are "the most widely used and evaluated set of guidelines for treating patients with SUD." Private and public payers rely on the criteria to define medically necessary treatment; they are also acceptable guidelines in applications for Medicaid SUD section 1115 demonstrations; and many states require providers that receive Substance Abuse and Mental Health Services Administration (SAMHSA) block grant funding to use the criteria in assessments and treatment decisions (Grogan et al. 2016; MACPAC 2018). In addition, many states use the criteria to describe services in their Medicaid state plan or in other documents (MACPAC 2018).

The ASAM criteria classify the following five broad levels of care, which provide standard terminology for describing the continuum of recovery-oriented SUD services: early intervention, outpatient treatment, intensive outpatient services or partial hospitalization, residential inpatient services, and medically managed intensive inpatient services (MACPAC 2018). The levels of care are in Figure 1. The ASAM criteria also outline details about the settings, provider types, and therapies at each level of care. Each level can incorporate a range of specialized SUD services, such as medication-assisted treatment, withdrawal management services, case management, and peer recovery support, as appropriate. Related to the levels of care and the types of services, a joint Center for Medicaid and CHIP Services (CMCS) and SAMHSA bulletin (2015) discusses the following components of a continuum of services and supports for youth with SUD, which overlap with the ASAM criteria:

- Identification
- Outpatient treatment (such as individual, family, or group counseling; intensive outpatient treatment; and partial hospitalization)
- Medication-assisted treatment
- Case management/targeted case management
- Continuing care
- Recovery services and supports
- Residential treatment

Figure 1. American Society of Addiction Medicine (ASAM) Levels of Care

Source: Medicaid Innovation Accelerator Program (2017), based on the third edition of the ASAM criteria.

2. Comprehensive array of MH services

The literature presents several descriptions of arrays of comprehensive MH services, but does not identify a commonly accepted list of all types or levels of care for MH services. The most complete inventories of MH services in the literature, especially those coverable by Medicaid, include the following. The information below is divided by arrays that are not age-specific or are focused on adults, and arrays that are focused on services for children and youth.

Because the KFF (2019) and MACPAC (2016) arrays of services have the advantage of being used for analyses of Medicaid coverage across states, they may be a useful starting point for states that are considering Medicaid and other funding for MH services. However, the Certified Community Behavioral Health Clinic scope of services provides some additional nuance and detail on comprehensive outpatient services, which may also be useful for

states. Additional resources, including those based on relevant Substance Abuse and Mental Health Services Administration (SAMHSA) and Centers for Medicare & Medicaid Services (CMS) demonstration programs and from the Bazelon Center for Mental Health Law, add details about services that may be useful to consider for children/adolescents.

Specific demonstration programs are mentioned below for states to consider their comprehensive scopes of MH services. These scopes may be useful for stakeholders to consider, even if their state has not implemented or will not be implementing that particular demonstration program.

A. General or adult-focused arrays of MH services

1. **The Kaiser Family Foundation's Medicaid Behavioral Health Services Database (KFF 2019)** groups behavioral health services into categories and maps discrete services to these categories based on KFF's earlier study of specialty behavioral health service coverage, by state Medicaid programs and Marketplace qualified health plans in four states. KFF's analysis of MH services includes 5 services under institutional care and intensive services, 14 services under outpatient facility services and/or provider services, and 3 services under other behavioral health services, which are listed below:
   - **a.** Institutional care and intensive services
     - **i.** Inpatient psychiatric hospital
     - **ii.** 23-hour observation
     - **iii.** Psychiatric residential treatment
     - **iv.** Adult group homes
     - **v.** Crisis services
   - **b.** Outpatient facility services and/or provider services
     - **i.** Case management
     - **ii.** Day treatment
     - **iii.** Partial hospitalization
     - **iv.** Psychosocial rehabilitation (e.g., "Clubhouse model")
     - **v.** Intensive outpatient treatment
     - **vi.** Mental health rehabilitation
     - **vii.** ADL/skills training

viii. Assertive community treatment

ix. Psychiatric services-evaluation

x. Psychiatric services-testing

xi. Psychological testing

xii. Individual therapy

xiii. Group therapy

xiv. Family therapy

c. Other behavioral health services

i. Mental health clinic services

ii. Targeted case management for chronic mental illness

iii. Peer support services

2. **Medicaid and CHIP Payment and Access Commission's (MACPAC 2016) compendium of Medicaid state plan coverage of behavioral health services** groups many services to align with the home and community-based services (HCBS) taxonomy published by CMS. The taxonomy includes services such as case management, round-the-clock services, supported employment, day services, home-based services, and caregiver support (Peebles and Bohl 2014). MACPAC's analysis also includes additional services that are not within the HCBS taxonomy, inpatient services, partial hospitalization, peer support, and crisis intervention. Below are the categories of services, with definitions in parentheses:

   a. **Inpatient** (Includes psychiatric residential treatment facilities, inpatient hospital care, residential habilitation, and acute care facilities)

   b. **Partial hospitalization**

   c. **Case management/care coordination** (Includes case management, targeted case management, and care or service coordination)

   d. **Day services** (Includes day habilitation, day treatment, adult day health, adult day services, communication integration, and assertive community treatment)

   e. **Psychosocial rehabilitation** (Includes but not limited to pharmacotherapy, psychological treatment, psychological intervention, support to families of individuals with a mental disorder, and covering basic needs such as housing, employment, social network, and leisure)

f. **Psychotherapy** (Includes individual family, group, multiple family, or interactive groups involving talking with a psychiatrist, psychologist or other mental health provider)

g. **Other therapy** (Includes assisted outpatient treatment; individual, family, couple, and group counseling; multi-systemic therapy, adjunctive therapy, activity therapy, electroconvulsive therapy, maintenance therapy, dialectic behavior therapy, neurotherapy, illness management and recovery, rehabilitation therapy, and other behavioral health therapies)

h. **Peer support** (Includes individual or group services by trained peer support providers who listen to educate, and guide individuals)

i. **Crisis intervention** (Includes crisis intervention, crisis stabilization, psychotherapy for crisis, crisis residential treatment services, crisis intervention facilities, and crisis case management)

j. **Home-based services** (Includes home-based habilitation, personal care services, and other services that support beneficiaries living in their own homes)

k. **Round-the-clock services** (Includes group and shared living, as well as in-the-home round-the-clock services)

l. **Supported employment** (Includes job development, career planning, and ongoing supported employment services)

m. **Caregiver support** (Includes respite care, caregiver training and education, and other family supports)

n. **Telemedicine** (Includes use of telecommunication and information technologies to provide clinical health care at a distance)

o. **Other services**

3. **The Certified Community Behavioral Health Clinic (CCBHC) demonstration program** included a comprehensive scope of outpatient community-based behavioral health services, such as 24-hour crisis services, targeted case management, and family supports (SAMHSA 2017). CCBHCs must also coordinate care across settings, which they do, for example, by maintaining partnerships or contracts with other service providers or agencies (such as child welfare agencies). The scope of services from the CCBHC demonstration program included (SAMHSA 2017):

   a. Crisis mental health services, including 24-hour mobile crisis teams, emergency crisis intervention services, and crisis stabilization

   b. Screening, assessment, and diagnosis, including risk assessment

   c. Patient-centered treatment planning or similar processes, including risk assessment and crisis planning

   d. Outpatient mental health and substance use services

e. Outpatient clinic primary care screening and monitoring of key health indicators and health risk

f. Targeted case management

g. Psychiatric rehabilitation services

h. Peer support and counselor services and family supports

i. Intensive, community-based mental health care for members of the armed forces and veterans

B. Child- and youth-focused arrays of MH services

1. **SAMHSA's Children's Mental Health Initiative and CMS's Psychiatric Residential Treatment Facility demonstration programs** included traditional services, such as individual therapy, family therapy, and medication management**.** They also showed that including other home and community-based services significantly enhanced the positive outcomes for children and youth (CMCS/SAMHSA 2013). These services included:

   a. Intensive care coordination (wraparound)

   b. Family and youth peer support services

   c. Intensive in-home services

   d. Respite care

   e. Mobile crisis response and stabilization

   f. Flex funds (customized goods and services, such as rent and utilities).

2. **SAMHSA's System of Care Expansion and Sustainability Grants** require that a full array of mental health and support services be established in order to address the clinical and functional needs of children, youth and families. The array must include the following:[4]

   a. Diagnostic and evaluation services;

   b. Cross-system care management processes;

   c. Individualized service plan development inclusive of caregivers;

   d. Community-based services provided in a clinic, office, family's home, school, primary health or behavioral health clinic, or other appropriate location, including individual, group and family counseling services, professional consultation, and review and medication management;

[4] The Funding Opportunity Announcement (FOA) also includes a list of allowable/optional services, such as customized suicide prevention interventions. See FOA at https://www.samhsa.gov/grants/grant-announcements/sm-19-009

e. Emergency services, available 24 hours a day, seven days a week, including mobile crisis outreach and crisis intervention;

f. Intensive home-based services available 24 hours a day, seven days a week, for children and their families when the child is at imminent risk of out-of-home placement, or upon return from out-of-home placement;

g. Intensive day treatment services;

h. Respite care;

i. Therapeutic foster care;

j. Therapeutic group home services caring for not more than 10 children (that is, services in therapeutic foster family homes or individual therapeutic residential homes);

k. Assistance in making the transition from the services received as a child and youth to the services received as a young adult;

l. Family advocacy and peer support services delivered by trained parent/family advocates.

3. **Bazelon Center for Mental Health Law's 1999 analysis of Medicaid-funded services for children with serious emotional disturbance (SED)** categorized a comprehensive set of MH services for children under each of the following categories of care: community-based services, clinic services, and institutional care. The service array includes:

   a. **Community-based services** (Comprised of targeted case management, intensive home-based services, school-based day treatment, other day treatment, summer camps/summer programs, afterschool activities, family support/wraparound, child respite care, therapeutic foster care, therapeutic nurseries, therapeutic preschool, independent living skills training, other independent living programs, other psychosocial rehabilitation)

   b. **Clinic services** (Comprised of individual psychotherapy, family psychotherapy, group psychotherapy, family education regarding child disorder, substance abuse counseling, crisis intervention, partial hospitalization, medication management, other clinic services, psychologists: testing, psychologists: services, social workers, other psychology professionals, general hospital outpatient care, and physician services)

   c. **Institutional care** (Comprised of general hospital inpatient care, psychiatric hospital, residential treatment centers, group homes, and residential crisis intervention)

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Appendix C: Background on Medicaid

Medicaid, a program that provides health coverage for certain low-income individuals, financed services for about 75 million people in FY2018, including about 30 million children (Mitchell 2019). Within parameters set by the federal government, states administer the program and thus the landscape of Medicaid coverage (in terms of factors such as eligibility, services covered, and delivery systems) varies by state. Below is basic background information about Medicaid, and references for additional background information. More information about Medicaid is in companion documents in this toolkit ("Assessing population, service needs, and service coverage" [Section C] and "Understanding roles of funding and decision points").

Who is eligible for Medicaid?

- Medicaid provides coverage for low-income individuals, including children, pregnant women, parents of dependent children, individuals age 65 and older, and individuals with disabilities; most states have also expanded Medicaid to cover other low-income nonelderly adults. While federal standards set minimum mandatory eligibility criteria, states have flexibility to expand eligibility to some additional optional population groups. For example, states' Medicaid programs must provide coverage to children with family income at or below 133 percent of the federal poverty level, but states can also elect to extend eligibility to children with higher incomes (Mitchell 2019). See Brooks et al. 2019, CMS data on Medicaid and CHIP income eligibility levels, and KFF's "State Health Facts" for state-specific information about eligibility and enrollment policies.

A. Which services does Medicaid cover?

- Medicaid can cover a wide range of services, such as preventive care, primary care, acute care, behavioral health care, and long-term services and supports. While federal rules indicate which benefits are mandatory or optional for states to cover (as in section 1905(a) of the Social Security Act), some of the benefit categories are broad and allow states to define specifics and establish limits on services. The Early and Periodic Screening, Diagnostic, and Treatment benefit provides comprehensive and preventive health care services for children under age 21 who are enrolled in Medicaid. (See Section A.1 of the "Understanding roles of funding and decision points" companion document in this toolkit for more information.) For information about resources regarding which services states cover in Medicaid, see Section C of the "Assessing population, service needs, and service coverage" companion document in this toolkit.
- Federal guidelines also indicate that Medicaid services must be sufficient in amount, duration, and scope; provided with comparability between population groups; provided statewide; and that enrollees must have freedom of choice among health care providers. However, there are some exceptions to these rules, and states can apply for waivers of

some of these requirements (see Mitchell 2019 for details). For individuals with other health insurance coverage (such as private insurance or Medicare), Medicaid is generally the payer of last resort.

B. How is Medicaid financed?

- Medicaid is financed jointly by federal and state governments, meaning states and the federal government each pay a share of the costs of providing services to enrollees. The federal share of most Medicaid expenditures is based on a state-specific regular federal medical assistance percentage (FMAP) rate, with some exceptions (for example, the federal share for expenditures on some services, populations, or administrative activities can vary). States' FMAP rates through FY2019 range from 50 to 76 percent (see Mitchell 2018 for details and exceptions).

C. How are Medicaid services delivered?

Medicaid enrollees generally receive covered services through a fee-for-service (FFS) or managed care delivery system, or a combination of both. Under FFS, the state Medicaid program contracts directly with providers and pays them for each service they provide to enrollees. Under managed care, the state contracts with a managed care entity (often paying them a per member per month fee), which then generally contracts with providers to deliver services to enrollees. There are a few types of Medicaid managed care entities (as defined in 42 CFR 438.2):

- Managed care organizations (MCOs), which cover a comprehensive array of benefits;
- Prepaid inpatient health plans (PIHPs) and prepaid ambulatory health plans (PAHPs), which cover only some types of services, such as inpatient or outpatient behavioral health services; and
- Primary case management (PCCM) or PCCM entities (PCCMe), which involves states contracting with primary care providers or organizations to provide case management services to enrollees, and, in some cases, coordination and administrative functions. Other services are then generally delivered on a FFS basis.

States can "carve out" some services from MCO contracts (such as MH or SUD services, dental services, or pharmacy services), and then cover these services under FFS or a different type of managed care entity. States may also "carve out" certain populations from MCO contracts—for example, children who are in foster care.

In 2017, about 82 percent of Medicaid enrollees were enrolled in some form of managed care. 69 percent were enrolled in comprehensive MCOs, and about 13 percent were enrolled in behavioral health organizations (PIHPs and PAHPs) (CMS 2019). (See Section C of the "Assessing population, service needs, and service coverage" companion document in this toolkit for information about how the service delivery system is important to understand, and for resources about state-specific information.)

Additional resources for further information:

Kaiser Family Foundation. "Medicaid Pocket Primer." Menlo Park CA: KFF, June 2017. Available at http://files.kff.org/attachment/Fact-Sheet-Medicaid-Pocket-Primer

Mitchell, A. "Medicaid: An Overview." Report R43357. Washington, DC: Congressional Research Service, June 24, 2019. Available at https://fas.org/sgp/crs/misc/R43357.pdf

Casey Family Programs. Medicaid webinar series. 2019. Slides and recordings available at https://www.casey.org/medicaid-webinar-series/.

Appendix D: Text from Title IV-E prevention program five-year plan pre-print (without attachments) [a]

Federal Regulatory/ Statutory References[b]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
Section 1. Services Description and Oversight		
471(e)(1)	**A. SERVICES.** The state agency provides the following services or programs for a child and the parents or kin caregivers of the child when the need of the child, such a parent, or such a caregiver for the services or programs are directly related to the safety, permanence, or well-being of the child or to preventing the child from entering foster care: 1. MENTAL HEALTH AND SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES.—Mental health and substance abuse prevention and treatment services provided by a qualified clinician for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child. 2. IN-HOME PARENT SKILL-BASED PROGRAMS.—In-home parent skill-based programs for not more than a 12-month period that begins on any date described in paragraph (3) of Section 471(e) with respect to the child and that include parenting skills training, parent education, and individual and family counseling.	
471(e)(5)(B)(i)	B. OUTCOMES. The state agency provides services and programs specified in paragraph 471(e)(1) is expected to improve specific outcomes for children and families.	

Federal Regulatory/ Statutory References[b]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
471(e)(5)(B)(iii)(I)(IV) **471(e)(4)(B)**	1. the services or programs selected by the state, and whether the practices used are promising, supported, or well supported; 2. how the state plans to implement the services or programs, including how implementation of the services or programs will be continuously monitored to ensure fidelity to the practice model and to determine outcomes achieved and how information learned from the monitoring will be used to refine and improve practices; 3. how the state selected the services or programs; 4. the target population for the services or programs; 5. an assurance that each prevention or family service or program provided by the state meets the requirements at section 471(e)(4)(B) of the Act related to trauma-informed service-delivery (states must submit Attachment III for each prevention or family service or program); and 6. how each service or program provided will be evaluated.	Attachment III
Section 2. Evaluation strategy and waiver request		
471(e)(5)(B)(iii)(V)	A. PRACTICES. With respect to the prevention family services and programs specified in subparagraphs (A) and (B) of paragraph 471(e)(1), information on the specific practices state plans to use to provide the services or programs, including a description of how each service or program provided will be evaluated through a well-designed and rigorous process, which may consist of an ongoing, cross-site evaluation approved by the Secretary, unless a waiver is approved for a well-supported practice; and	
471(e)(5)(C)(ii)	B. REQUEST FOR WAIVER OF WELL DESIGNED, RIGOROUS EVALUATION OF SERVICES AND PROGRAMS FOR A WELL-SUPPORTED PRACTICE. The state must provide evidence of the effectiveness of the practice to be compelling and the state meets the continuous quality improvement requirements included in subparagraph 471(e)(5)(B)(iii)(II) with regard to the practice.	Attachment II
Section 3. Monitoring child safety		
471(e)(5)(B)(ii)	The state agency monitors and oversees the safety of children who receive services and programs specified in paragraph 471(e)(1), including through periodic risk assessments throughout the 12-month period in which the services and programs are provided on behalf of a child and reexamination of the prevention plan maintained for the child under paragraph 471(e)(4) for the provision of the services or programs if the state determines the risk of the child entering foster care remains high despite the provision of the services or programs.	

Federal Regulatory/ Statutory References[b]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
Section 4. Consultation and coordination		
471(e)(5)(B)(iv) and (vi)	A. The state must: 1. engage in consultation with other state agencies responsible for administering health programs, including mental health and substance abuse prevention and treatment services, and with other public and private agencies with experience in administering child and family services, including community-based organizations, in order to foster a continuum of care for children described in paragraph 471(e)(2) and their parents or kin caregivers and 2. describe how the services or programs specified in paragraph (1) of section 471(e) provided for or on behalf of a child and the parents or kin caregivers of the child will be coordinated with other child and family services provided to the child and the parents or kin caregivers of the child under the state plans in effect under subparts 1 and 2 of part B.	
Section 5. Child welfare workforce support		
471(e)(5)(B)(vii)	The state agency supports and enhances a competent, skilled, and professional child welfare workforce to deliver trauma-informed and evidence-based services, including— A. ensuring that staff is qualified to provide services or programs that are consistent with the promising, supported, or well supported practice models selected; and B. developing appropriate prevention plans, and conducting the risk assessments required under clause (iii) of section 471(e)(5)(B).	
Section 6. Child welfare workforce training		
471(e)(5)(B)(viii)	The state provides training and support for caseworkers in assessing what children and their families need, connecting to the families served, knowing how to access and deliver the needed trauma informed and evidence-based services, and overseeing and evaluating the continuing appropriateness of the services.	
Section 7. Prevention caseloads		
471(e)(5)(B)(ix)	The state must describe how caseload size and type for prevention caseworkers will be determined, managed, and overseen.	
Section 8. Assurance on prevention program reporting		
471(e)(5)(B)(x)	The state provides an assurance in Attachment I that it will report to the Secretary such information and data as the Secretary may require with respect to the provision of services and programs specified in paragraph 471(e)(1), including information and data necessary to determine the performance measures for the state under paragraph 471(e)(6) and compliance with paragraph 471(e)(7).	Attachment I

Federal Regulatory/ Statutory References[b]	Requirement	State Regulatory, Statutory, and Policy References and Citations for Each
Section 9. Child and family eligibility for the title IV-E prevention program		
471(e)(2)	A. CHILD DESCRIBED.—For purposes of the title IV-E prevention services program, a child is: 1. A child who is a candidate for foster care (as defined in section 475(13)) but can remain safely at home or in a kinship placement with receipt of services or programs specified in paragraph (1) of 471(e). 2. A child in foster care who is a pregnant or parenting foster youth.	

[a] From Attachment B of ACYF-CB-PI-18-09. Pre-print and additional attachments can be accessed at: https://www.acf.hhs.gov/cb/resource/pi1809

[b] Statutory references refer to the Social Security Act. Regulatory references refer to Title 45 of the Code of Federal Regulations (CFR).

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