New Jersey's Children's System of Care – Beginnings and Sustainability

Ruby Goyal-Carkeek
Deputy Commissioner, Children's System of Care
NJ Department of Children and Families
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System of Care

- Since the 1960s, repeated calls for reform in children's mental health have highlighted persistent issues: too few children receiving care, overly restrictive treatment settings, limited-service options, poor coordination across systems, lack of family involvement, and inadequate attention to cultural differences.*
- In response, the "System of Care" approach (SOC) was developed— emphasizing comprehensive, community-based, and coordinated services grounded in shared values, to address gaps in service delivery that reduce fragmentation and duplication and create shared accountability for quality and oversight of programs and services.**
- SOC is an organizing framework that ensures strategic, coordinated, and effective service delivery and is a responsive strategy to the growing public interest in diversion from deep-end systems like child welfare and juvenile justice, and for reducing health care costs- emergency department visits and inpatient treatment.
- **Core Values** - Youth and Family Driven - Community Based – Culturally and Linguistically Competent

* Stroul, Beth and Blau, Gary; The system of care handbook: Transforming Mental Health Services for Children, Youth and Families, 2008, Paul H. Brookes Publishing Co., Inc.

** https://www.casey.org/soc-issue-brief/

What is a System of Care?

"A system of care is a **comprehensive spectrum of effective services and supports** for children, youth, and young adults with or at risk for mental health or other challenges and their families that is organized into a **coordinated** network of care, builds meaningful **partnerships with families and youth**, and is **culturally and linguistically responsive** in order to help them to thrive **at home, in school, in the community,** and throughout life…"

-From the Evolution of the System of Care Approach

System of Care



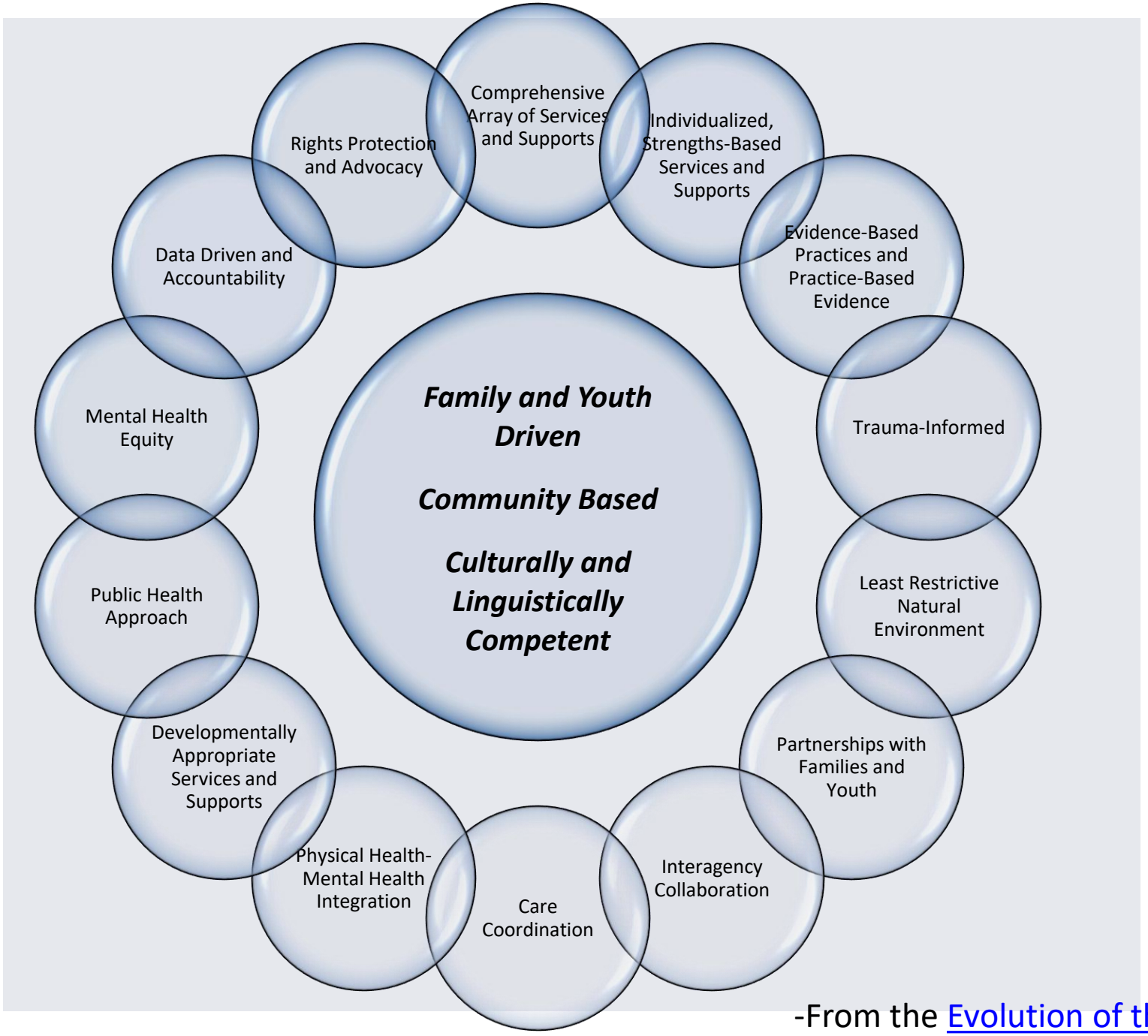
PHILOSOPHY



INFRASTRUCTURE



SERVICES AND SUPPORTS



System of Care Core Values and Guiding Principles

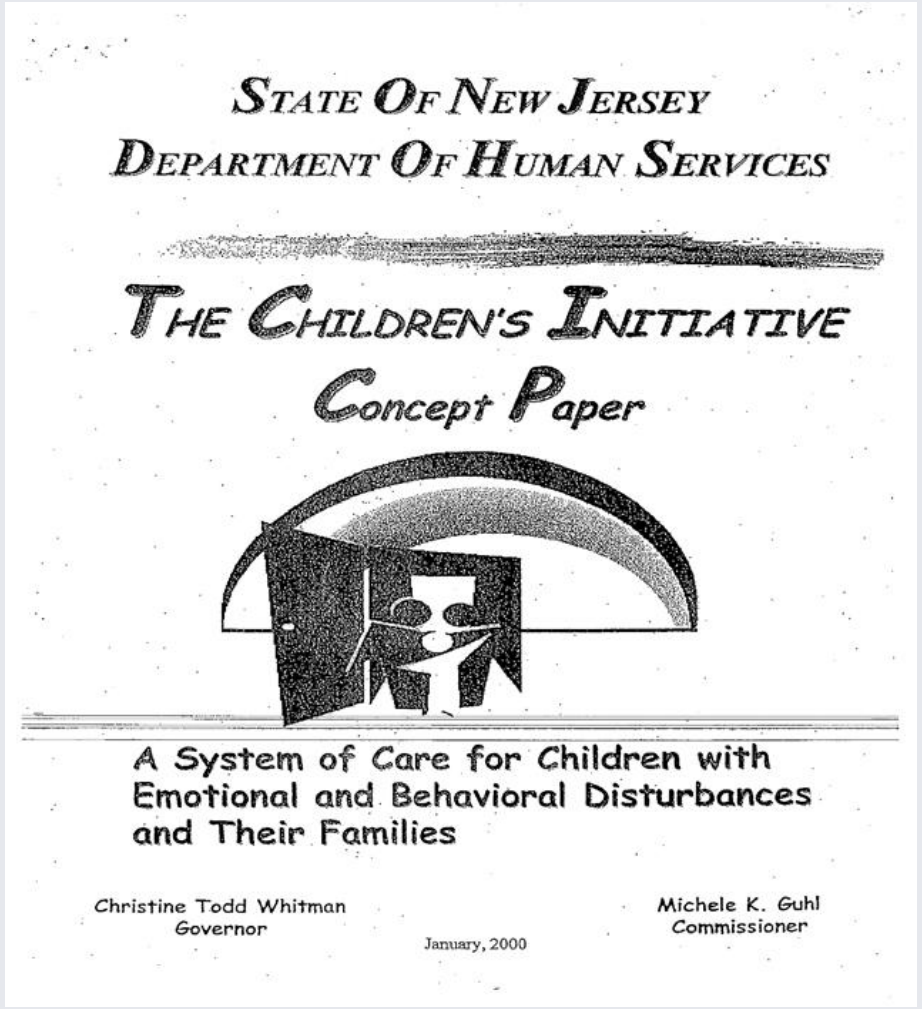
-From the Evolution of the System of Care Approach

Partnership in a System of Care

Child welfare is **one of several** system partners at the table, along with behavioral health, Medicaid, juvenile justice, education, health systems, developmental disabilities, community providers, and families.

Concept Paper

"In January 2000, Governor Whitman unveiled a reform agenda to create a comprehensive system of care for children and families in New Jersey by committing to maintaining the integrity of family and community life for children while delivering effective clinical care and social supports services"



Behavioral Health Access

"Children's advocates have long identified a need for fundamental structural reform of [New Jersey's System of Care] for children with emotional and behavioral disturbances and their families. Like virtually every other state, a number of child-serving systems, each with its own mandates, perspective, and priorities, have responsibility to serve these children. Children and families **enter DHS services through many different doors (child welfare, mental health, juvenile justice, education and the courts), often with similar needs for behavioral health and other community support services.** The **access route generally defines the problem and the services available**. This, in turn, tends to define treatment goals and objectives based on the mandates and priorities of the specific child-serving system. The available services within these systems are then organized as programs, **requiring children to fit the program's structure rather than structured to meet the individual needs of the child and family**."

https://www.nj.gov/dcf/about/divisions/dcsc/Childrens.Initiative.Concept.Paper.pdf

Behavioral Health Access

Each child serving system has had ongoing difficulties accessing services from the others, and has developed separate, overlapping systems, offering **many parallel and duplicative services** they may or may not be based on good analytics or be adequate to **meet the needs**.

Efforts to **bridge these gaps** between parallel systems have been only partially successful. Services from parallel systems often lack inter-system coordination or care management on an ad hoc, case-by-case basis with mixed results that are highly dependent on the ability of individual case managers and families to overcome the inherent barriers of a segmented service system, and commonly come into the situation **too late**, with too little authority and **inadequate resources** to support needed levels of service intensity and integration.

Excerpted from NJ CSOC Concept Paper

Summary of Children's Initiative Concept Paper, January 2000

The Children's Initiative concept operates on the following abiding principles:

- The system for delivering care to children/youth must be restructured and expanded
- There should be a single point of entry and a common screening tool
- Greater emphasis must be placed on providing services to children in the most natural setting, at home or in their communities, if possible
- Families must play a more active role in planning for their children
- Non-risk-based care and utilization management methodologies must be used to coordinate financing and delivery of services



Financing Follows the Vision

Vision provides clarity and focus on resources needed or to be leveraged

Design and Implementation Focus

Essential Question to ask at every step:

Are we responding to the system or are we being responsive to the youth and family?

If we are satisfying the system needs (i.e. simplifying/addressing an internal process), then is it at the expense of youth and family needs?

In other words, the fundamental question that needs to be answered at every step of the design and implementation:

What/who are we trying to solve for?

Systems work better together when the 'simple' goal of keeping children, youth and their family are at the forefront

Structural Changes

- Moved the **front door to access**, responsibility and resources from child welfare and juvenile justice to the behavioral health system (which has grown to the system of care)
- Increase access and availability of in-home services and supports
- Prominent role of Medicaid and sustainable funding
- Created a Medicaid look alike number (all state funds)
- Focused on Clinical Necessity, not ability to pay
- Created strategies around both braided and blended funding
- Supported Family Support and Youth Partnerships
- Created both local and statewide feedback loops

A Brief History of New Jersey's System of Care

1999

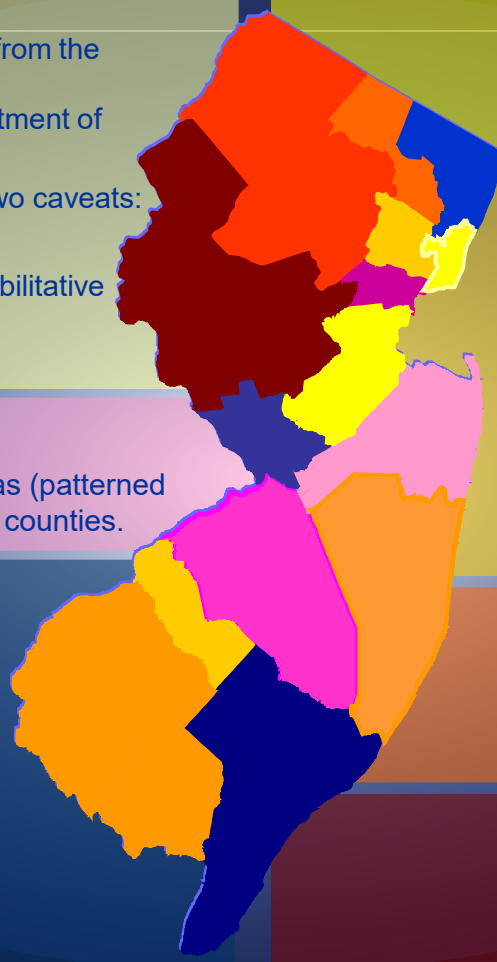
- New Jersey wins System of Care grant award from the Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal Department of Health and Human Services (USDHHS)
- Governor Whitman endorses the project with two caveats:
  1. It must be statewide,
  2. It must be funded through Medicaid "Rehabilitative Services."

2001

Local Systems of Care are initiated in three areas (patterned on vicinages): Burlington, Monmouth and Union counties.

2002

- Local Systems of Care are initiated in three additional areas: Atlantic/Cape May, Bergen, and Mercer counties
- Acting Governor DiFrancesco endorses the project with two caveats:
  1. The name must be changed to "the Partnership for Children", and
  2. The project must be expedited to initiate local Systems of Care in urban areas.



2003

Local Systems of Care are initiated in Hudson and Middlesex counties.

2004

- Local Systems of Care are initiated in Camden and Essex counties
- The Office of Children's Service (OCS) is created in response to the lawsuit against the Division of Youth and Family Services
- The Partnership for Children becomes the Division of Child Behavioral Health Services under OCS.

2005

Local Systems of Care are initiated in three areas: Gloucester/ Cumberland/Salem, Ocean, and Passaic counties.

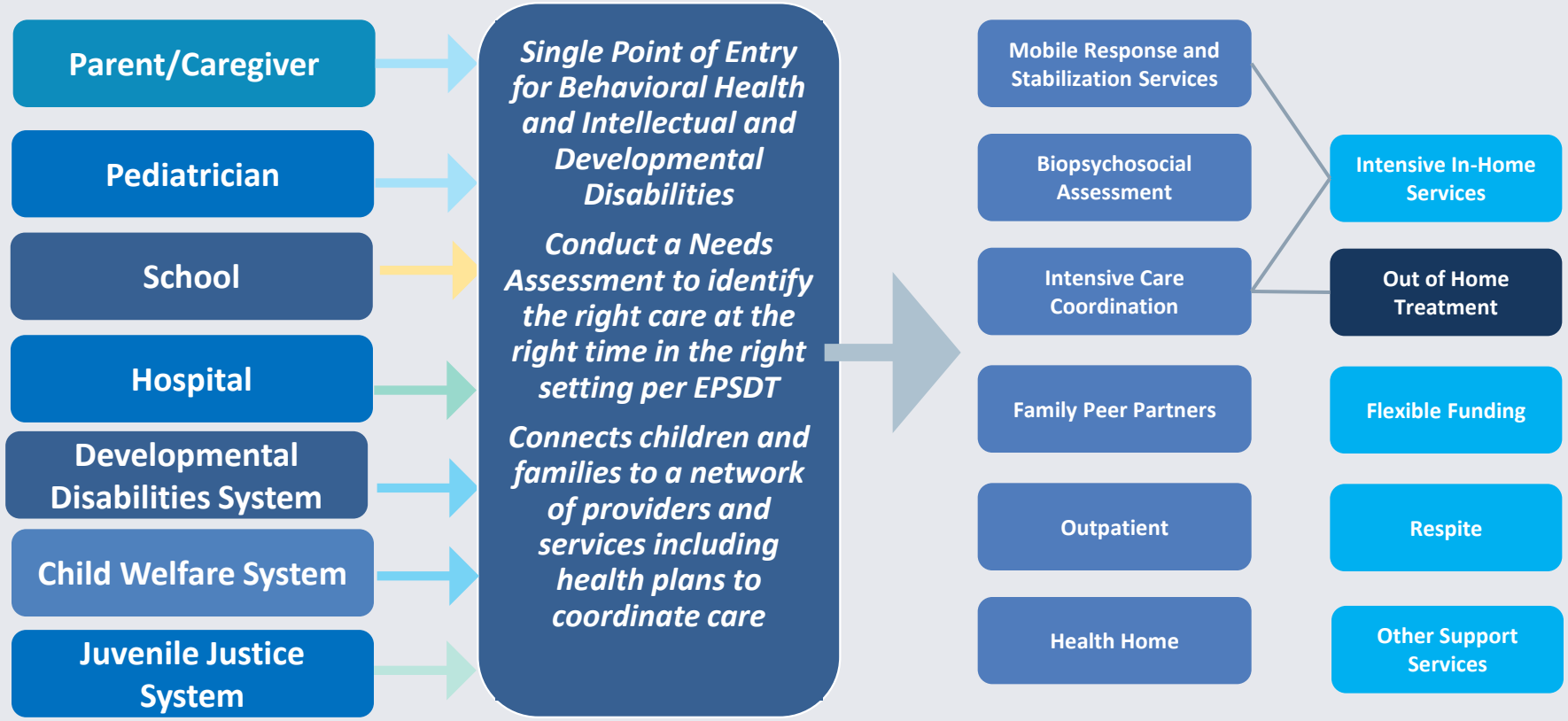
2006

Local Systems of Care have been initiated in the remaining two areas of the state: Sussex/Morris, and Hunterdon/ Somerset/Warren.

New Jersey Children's System of Care

- Serves children/youth under 21 with emotional and behavioral health care needs, intellectual/ developmental disabilities, Autism, and/or substance use challenges
- Commitment to provide these services based on the needs of the child, youth and their family in a family-centered, community-based environment
- Statewide services with access through **single point of entry**
- Voluntary
- Primarily funded with Medicaid, aligning with CMS' EPSDT requirements
- Local System partners are located in the community and **aligned** with Court Vicinages to assure seamless connections and coordination of care, particularly helpful when children and youth have multisystem involvement

Comprehensive Children's Behavioral Health and IDD System with a Single Point of Entry: *Investment in Infrastructure*



Children's System of Care Objectives

To Help Children and Youth Succeed…



At Home

Successfully living with their families and reducing the need for out-of-home treatment settings.



In School

Successfully attending the least restrictive and most appropriate school setting close to home.



In the Community

Successfully participating In the community and becoming independent, productive and law-abiding citizens.



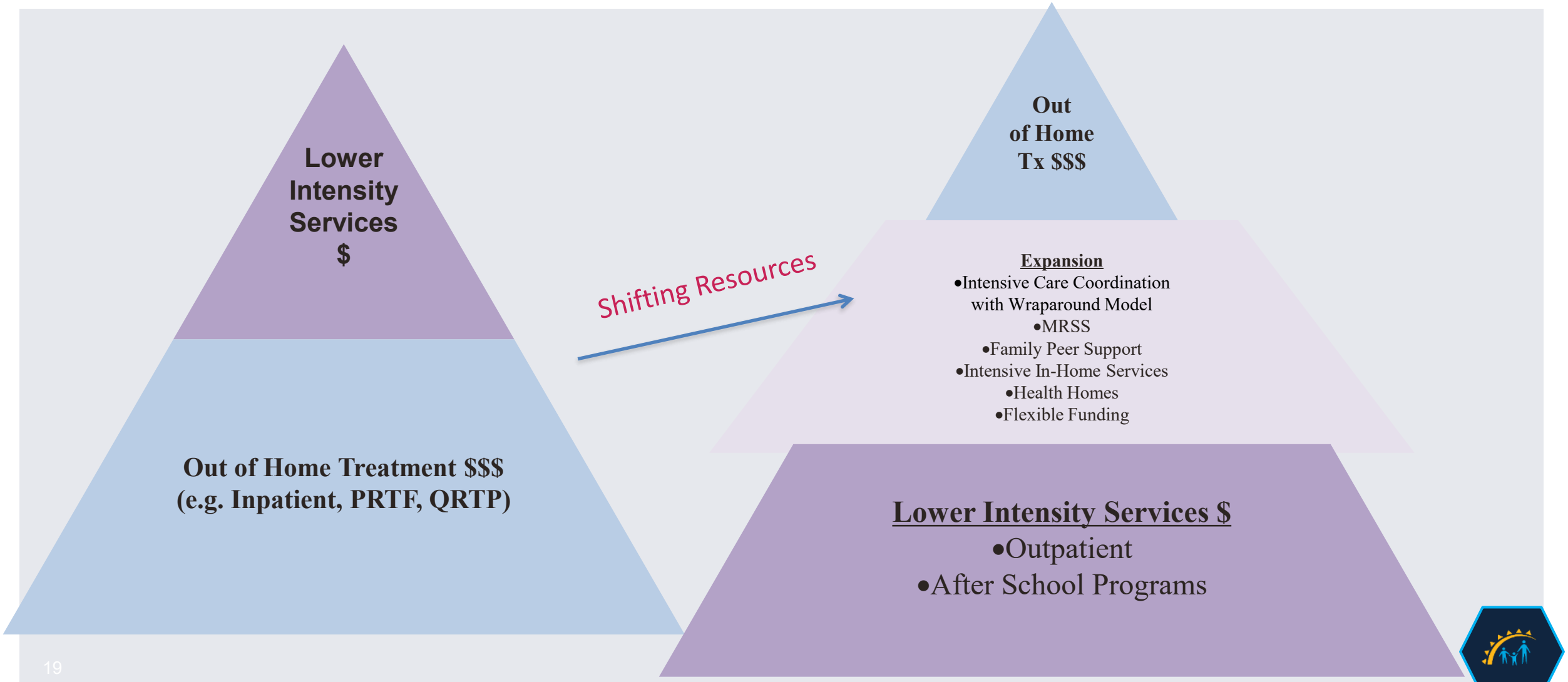
Out of home treatment is an intervention, not the final destination!

Out of Home Care

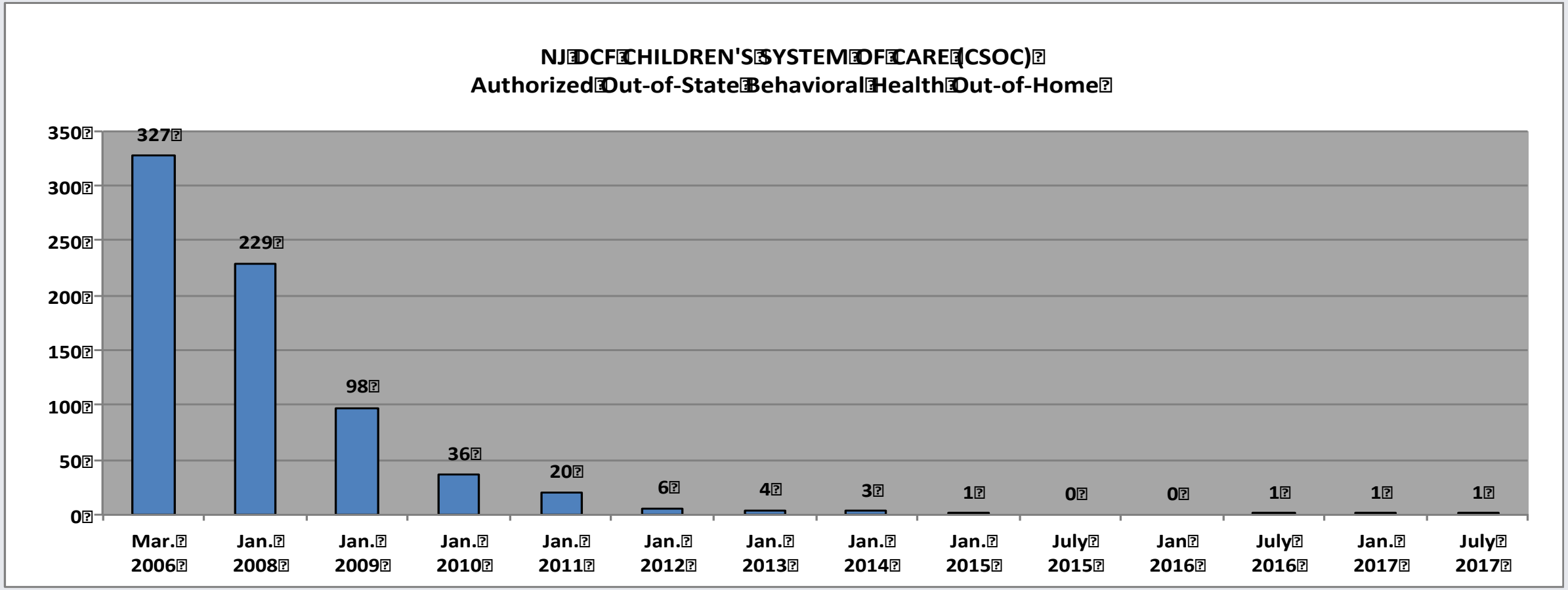
Key points to remember....

- ***Removing a child from their natural environment is a life altering decision***
- ***The pursuit of out of home treatment is a Child Family Team (CFT) decision that should be made with clear purpose AND expectations***

Service Array Expansion and Impact



Providing care for **children** closer to their families



1999

NJ is awarded a federal grant that allowed NJ to develop a system of care from the Substance Abuse and Mental Health Services Administration (SAMHSA) of the federal Department of Health and Human Services (USDHHS)
Governor Whitman endorses the project with two caveats:

1. It must be statewide,
2. It must be funded through Medicaid "Rehabilitative Services."

2006

The Department of Children and Families (DCF) becomes the first cabinet-level department exclusively dedicated to children and families
[P.L. 2006, Chapter 47].

January 2013

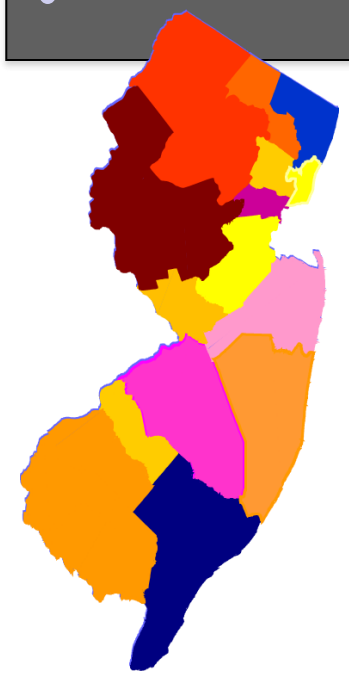
Intellectual/developmental disability (I/DD) services for youth and young adults under age 21 is transitioned from the Department of Human Services (DHS) Division of Developmental Disabilities to the DCF Children's System of Care (CSOC).**

July 2013

Substance use treatment services for youth under age 18 is transitioned from DHS, Division of Mental Health and Addiction Services, to DCF/CSOC.

July 2015

NJ wins a Federal SAMHSA Grant for System of Care - Expansion and Sustainability



2000 - 2001

NJ restructures the funding system that serves children. Through Medicaid and the contracted system administrator, children no longer need to enter the child welfare system to receive behavioral health care services.

2007 – 2012

The number of youth in out-of-state behavioral health care goes from more than 300 to three.*

May 2013

Unification of care management, under CMO, is completed statewide.

December 2014

Integration of Physical and Behavioral Health is initiated in two counties with expected Statewide rollout

*How did NJ DCF do this? Careful individualized planning and the development of in-state options (based on research about what youth need) using resources that were previously going out of state.

**Youth with I/DD in OOH programs or at risk of OOH, are transitioned July 2012

NJ Childrem's System of Care Integration

Reasons for Integration of services for children and youth with Intellectual/Developmental disabilities and youth with Substance Use challenges

- **Enhancing care through promoting an Integrated Approach to Care**
- Synchronized service coordination and elimination of potentially duplicated services
- Support sustainable communities and balanced resource coordination
- Bring all children's services into a single child serving department
- Further current progress and achievement of strategic objectives of the Department of Children and Families

NJ Children's Physical/Behavioral Health Care Integration

Reasons for Integration of Physical Healthcare

- Holistic view of youth needs
- Focus on wellness, prevention, disease management,
- Avoids fragmented care;
- Decreases acute services such as ER and inpatient care;
- Earlier intervention improves mental health outcomes and reduces cost driver for adults

Core health home services:

- Comprehensive care management and care coordination including transitional care between settings and systems e.g. pediatric and adult;
- Health promotion;
- Individual and family support;
- Referral to community and social support services; and
- The use of health information technology to link services



The Role of Assessment within CSOC

The *vision* of CSOC is to create positive outcomes by:

- **Identifying the child/youth and family's strengths & needs**
- Determining the **most appropriate Intensity of Service**
- Delivering the **most appropriate services**

  for the **most appropriate length of time**
- Using **standardized assessment** tool that provides common language that is clear for families – the foundation of the Children's System of Care-and aligned with **SOC core value**



CANS Assessment Tools – SNA and CAT

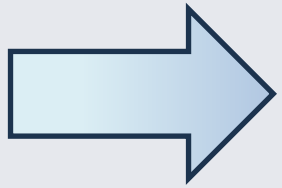
- Life Domain Functioning
- Child Strengths
- Child Behavioral/ Emotional Needs
- Child Risk Behaviors
- Caregiver Needs & Strengths

Trauma, Developmental, Medical, Substance Use and Other Specialty Need Modules

Communication and Paradigm Shift: Language is Important

Not System of Care Language

- Clients, cases, consumer, patient
- Mom and dad
- Placement
- Motivated
- Close, terminate
- Runaway
- Home visit



System of Care Language

- Children, youth, families
- Parents / caregivers
- Treatment / Out of Home Care
- Engagement
- Transition
- Missing
- Family time

Training and Technical Assistance

Rutgers University-Center for Excellence

- Training to all system partners and families
- Certification on CANS
- Certification for service lines
- DD/SU and Behavioral Health training
- *Biennial Conference*
- *Annual CQI Fair*
- Consultants
- Coaching

NJ MRSS Program Structure

24/7 Community Response – Where You Are, Anywhere in NJ in 1 Hour, *Family Defined Crisis*

72 Hour Intervention

Up to 8 Week Stabilization Period

Provider Network

Community, locally based Organization within System of Care Structure

Training, certification and supervision

CANS-Crisis assessment tool (CAT)

Local system collaboration

System Collaboration

Initiative with child welfare system: MRSS for every child/youth removed from the family to help stabilize them and provide support for child/youth. Foster parent can access MRSS directly

Can provide services as part of Station House Adjustment, divert from justice system

Resource for schools and pediatricians, requires parental consent

Screening Centers can call CSA to request MRSS if child or youth is not hospitalized

MRSS Data

Since its inception in 2004, MRSS has consistently **maintained** at least **95 % of children in their current living situation at the time of service, including children who are involved with the child welfare system.**

Family Support Organization

Support, Education and Advocacy for Families and Youth

- **Individual family peer support**
  - CFT co-facilitator
  - FANS
  - Family Action Plan
- **Youth Partnerships**
  - Youth voice, building leadership, advocacy and life skills
  - Youth Conference
- **Community Supports**
  - Warmline Support
  - Support Groups
  - Advocacy and Outreach

Care Management Organizations (CMO)

- CMOs are agencies that provide **intensive care coordination using Wraparound model** in care planning for children and youth with moderate and high needs, and their families
- Responsible for facilitating access to a full range of treatment and support services
- They facilitate and work within **child-family teams** to develop individualized plans of care based on assessment
- Responsible for facilitating access to a full range of treatment and support services

Intensive Care Coordination – What Success Looks Like

Wraparound practitioners, community partners, and team members must:

- create a climate that moves beyond the walls of a single organization/system
- embrace a shared responsibility to provide necessary treatment and support
- empower youth and their families to be successful in their homes and communities

"Effective and lasting support of youth with complex needs and their families requires a whole system response that extends beyond care coordination to include a comprehensive service array and robust provider network (inclusive of mobile response and stabilization services, peer support, evidence-based and promising practices, and non-traditional services), trauma-responsive and evidence-supported, appropriate cross-system assessment tools, and focused workforce development and outcomes monitoring activities."

Source: https://store.samhsa.gov/sites/default/files/d7/priv/samhsa-state-community-profiles-05222019-redact.pdf

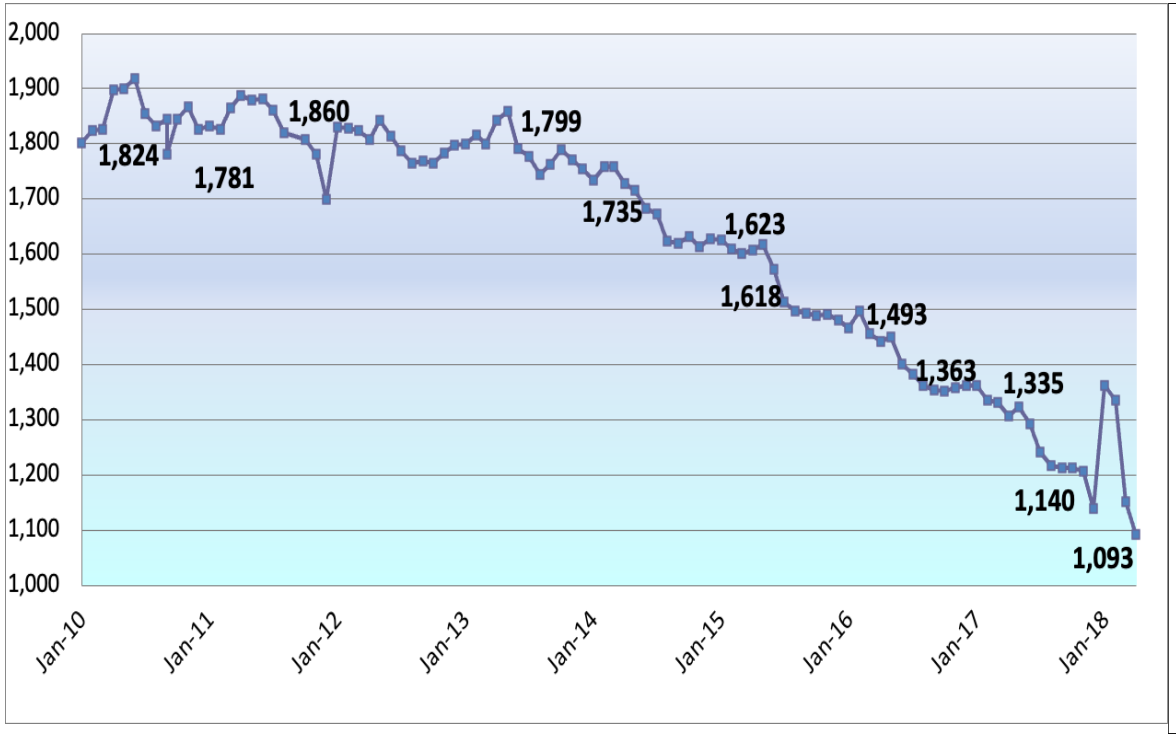
Child Family Team (CFT)

- A team of family members, professionals, and significant community identified by the family and organized by the care management organization to design and oversee implementation of the individualized care plan
- CFT members should include, but are not limited to, the following individuals:
  - Child/Youth/Young Adult
  - Parent(s)/Legal Guardian
  - Intensive Care Coordination Provider
  - Peer Partner
  - Informal supports as identified and selected by child, youth and family
  - Treating Providers (in-home, out-of-home, etc.)
  - Education Professionals
  - Physical Health Provider (pediatrician, specialist)
  - Probation Officer (if applicable)
  - Child Welfare Caseworker, if applicable

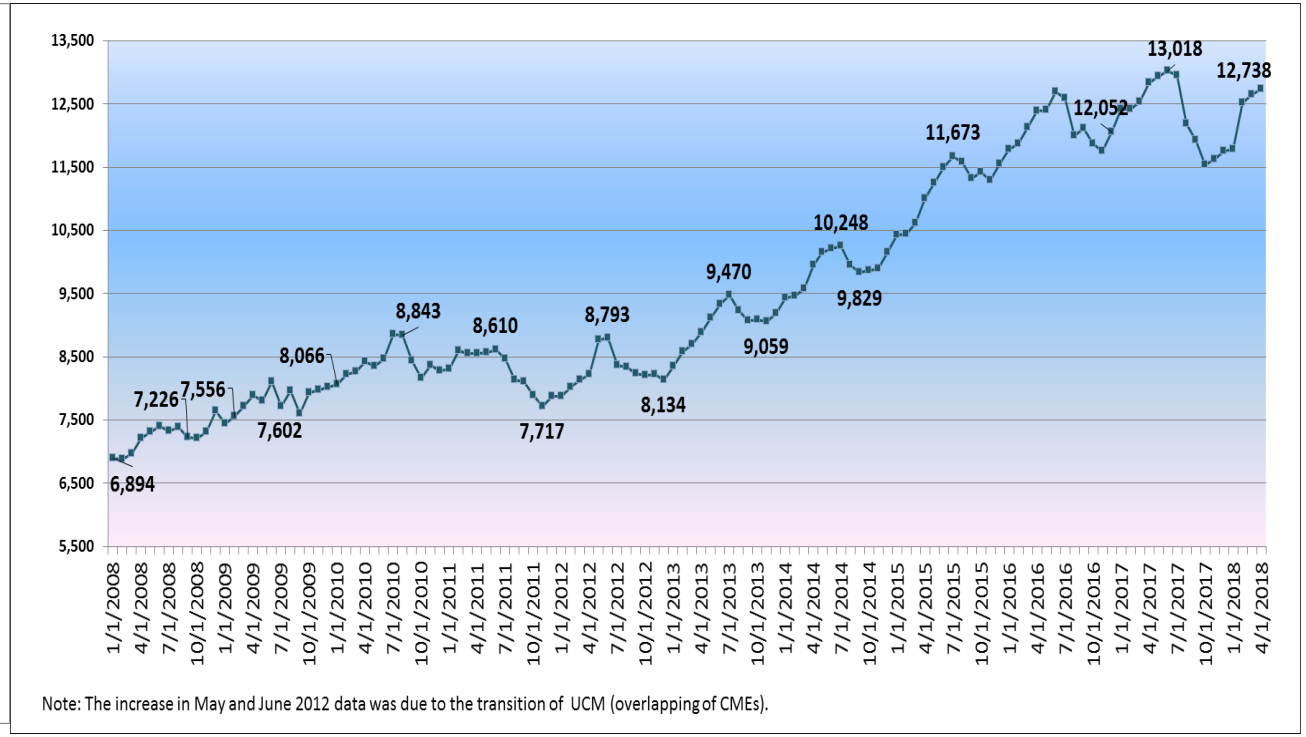


Children and Youth Served Over Time

Youth in Behavioral Health Out of Home



Youth in Intensive Care Coordination

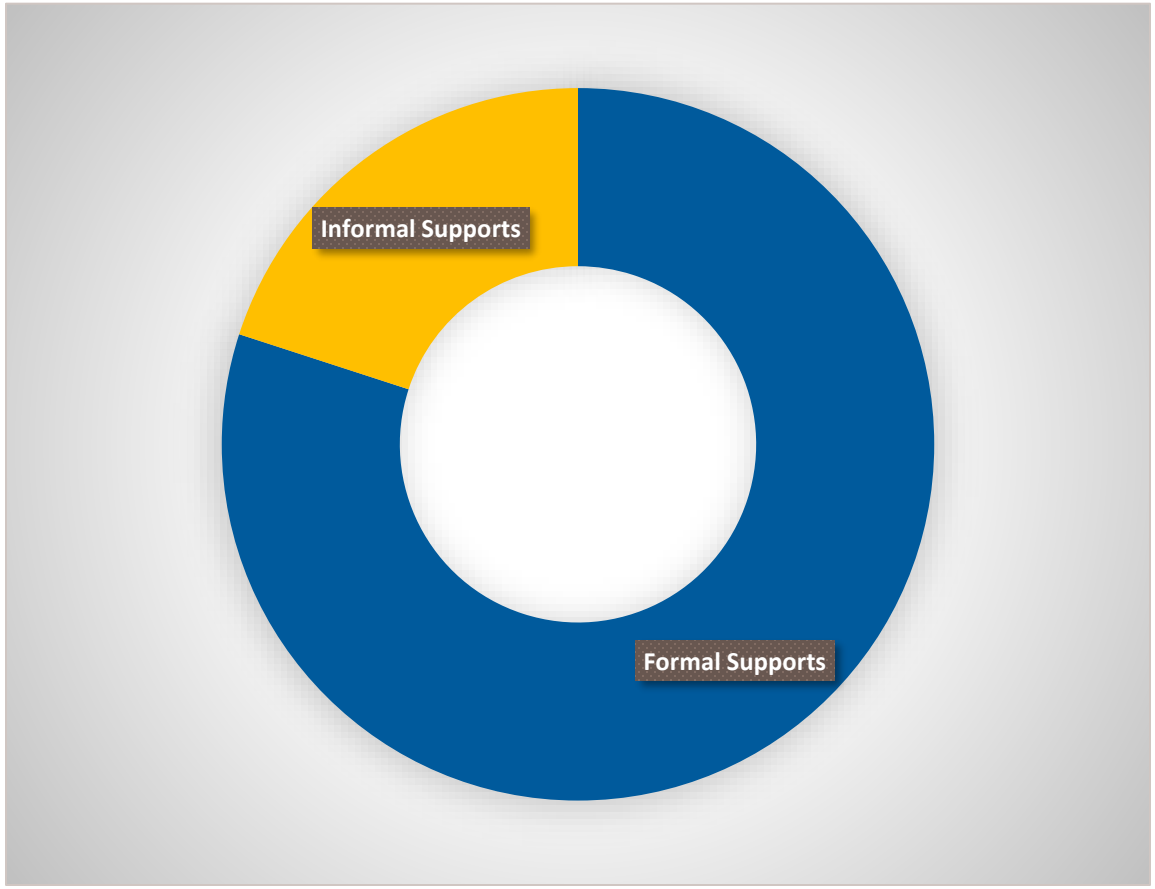


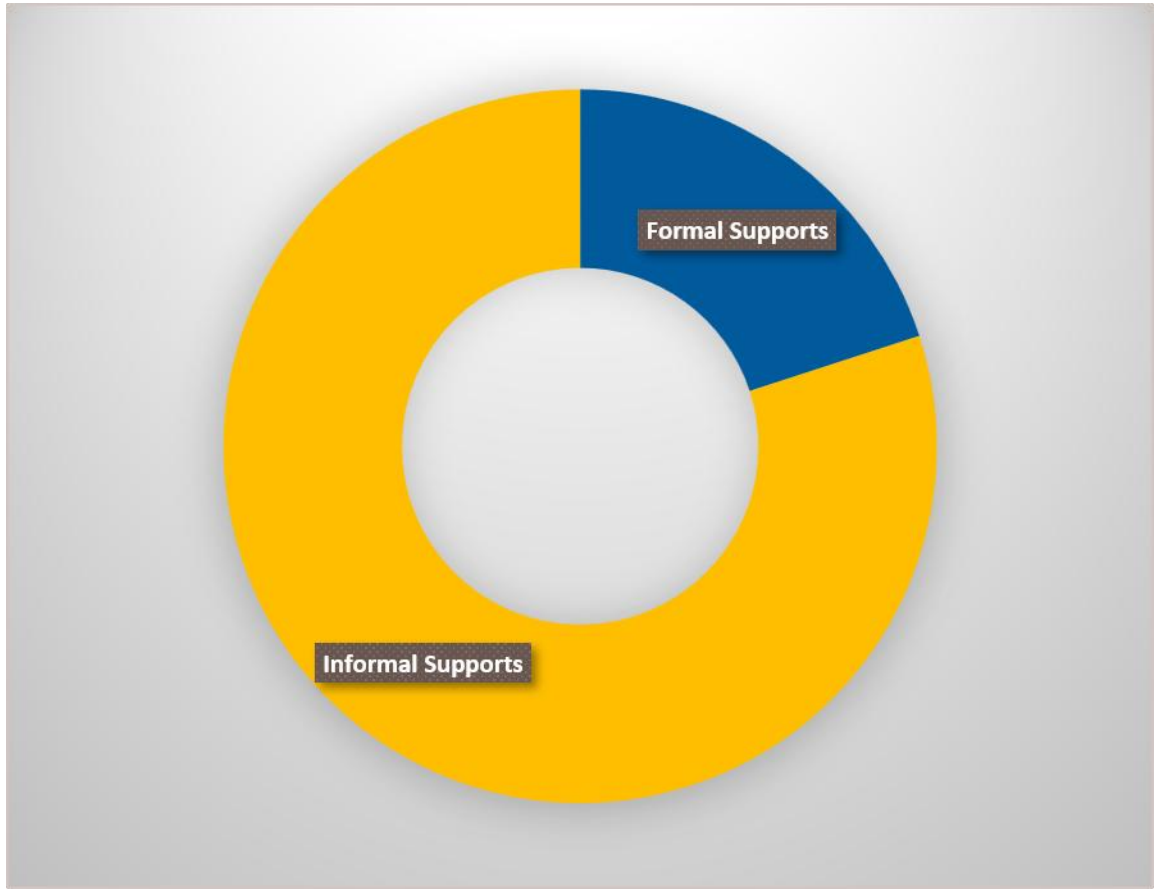
Note: The increase in May and June 2012 data was due to the transition of UCM (overlapping of CMEs).

Individualized Planning

- Child, youth and family vision
- Functional strengths of the children, youth and family
- Primary presenting needs
- Strength-based strategies
- Barriers to implementing strategies
- Additional unmet needs
- Youth diagnosis and medication, if needed
- Services to be requested, if any
- Resource/Support people and their roles

Sustainability For Families





CSOC and Courts

- Ongoing formal and informal training to the judiciary, prosecutor's office, public defender, probation, law guardians, mental health attorneys, hospital staff and all local CSOC system partners.

- Ongoing training to CSOC System Partners by CSOC staff, Rutgers University Behavioral HealthCare and local court partners.

- Co-Development of the cross-training materials, such as the JJC Informational Packet, Glossary and Evaluation and Assessment Guide.

Services for Youth Involved with Juvenile Court

- Biopsychosocial Assessment through Juvenile Detention Centers
- 14 Day Plan (N.J.S.A. 2A:4A-43)
- Legal Guardian can request services directly through CSA
- Mobile Response and Stabilization Services (MRSS) through Station House Adjustment Program
- Some county specific services to reduce reliance on out of home treatment services (MST, FFT)

NJ'S Children's System of Care Impact

- ✓ *Less children in institutional care*
- ✓ *Less children accessing inpatient treatment*
- ✓ *Closure of state child psychiatric hospital (Arthur Brisbane) and state operated institutional RTC's (Woodbridge, Ewing and Vineland)*
- ✓ *Reduction from over 350 + youth in out-of-state facilities to 0 youth in BH out of home setting*
- ✓ *Children in out of home care have more intense needs than prior to the system of care development*
- ✓ *Less youth in detention centers (11 closed)*
- ✓ *Wraparound model works!!*

Nationally recognized model for a System of Care!

New Jersey Financing Structure and Support

- **Delivery System- Behavioral Health Carve Out, Fee for Service, non-risk based ASO**
- **1115 Waiver**-Children's Supports Waiver, I/DD and SED
- **State Plan Amendment**
  - **Targeted Case Management** -Intensive Care Coordination using Wraparound model
  - **Psych under 21 Benefit** -OOH Treatment Programs, aka PRTF
  - **Rehabilitation Option-**MRSS, IIC/BA, Out of Home Treatment Programs
  - **State Option to Provide Health Homes- ACA Section 2703 Health Homes**
- **State General Funds**
  - Some I/DD services, i.e. respite
  - Flex funds
  - Rutgers Training and Technical Assistance contract
  - NJ CSOC funds conveners for CIACCs-local planning bodies that foster cross system collaboration and partnership re: children's services-1 per county, CIACCs are also feedback loop to the State;
  - Education partnerships-liaison to school district
- **Mental Health Block Grant (**MBHG) and **Substance Use Prevention, Treatment, and Recovery Services Block Grant (SUBG)**
- **SAMHSA grants** (time-limited i.e. for SU prevention activities, system improvement initiatives -Promising Path to Success)
- Child Welfare **(IV-E)** is accessed to fund R&B for eligible youth in CSOC OOH programs that are under Rehab option)
- Juvenile Justice-some funds to support MRSS
- **Medicaid Administrative Claiming** -for the ASO (aka CSA) and Family Support Organizations (peer partners)

New Jersey-Seamless Access and Funding

Title XXI (CHIP) benefit mirrors Title XIX

All services are billed to a single platform (MMIS) with some exceptions

- Utilization and expenditure data is available in one place
- Understand trends
- Determine gaps and needs
- Determine where Medicaid can be leveraged

Algorithms are built in the MMIS system so charges are appropriately directed to federal and state.

Funding is braided (blended in some situations)

Seamless Billing for providers

- Medicaid Look-alike number
- All youth are treated the same

Sustaining a System of Care

- Develop cross-system partnerships to improve access to behavioral health services that are outside of the child welfare or juvenile justice systems.
- Involve the experts — children/youth and families — in the system re-design and throughout their care.
- Expand the availability of home and community-based services array.
- Increase the behavioral health workforce capacity to support the unique needs of children and youth with behavioral health needs, including children with intellectual and developmental disabilities (i.e., increasing knowledge and skills of the workforce).
- Develop sustainable financing strategies to prevent multi-system involvement as defined by child welfare and juvenile justice involvement.

Lessons Learned for Sustainability



Staying on mission and vision



It takes time and persistence



In spite of leadership changes (changes at all levels-governor, cabinet, division (11+ division leadership changes in its first 15 years); system can be successful and still transform lives of children, youth and families

Comprehensive Behavioral Health System - *Key Components and Infrastructure*

Key Components

- **Single Point of Access for All,** seamless access to care
- Use of **Standardized Screening and Assessment** Tool
- **Mobile Response & Stabilization Services-a** best practice and service design that has an emphasis on family defined crisis, 24-7.
- **Intensive Care Coordination,** through Care Management Entities (CME), using a consistent practice model such as Wraparound
- **Family Peer Support** Partners that provide education and advocacy
- **In Community Treatment,** Services and Supports (service providers that meet families where they are and feel most comfortable, in their homes and communities)

Infrastructure, Oversight, Quality

- Careful Oversight of Out of Home Treatment ***(OOH Treatment programs are also small home-like setting with short lengths of stay)***
- Uniform Electronic Health Record
- Strong public-private partnerships
- Community liaisons and feedback loop
- Public facing data, modeling and committing to shared responsibility, transparency, and accountability
- Robust training entity (e.g. Centers for Excellence), partnership with a university, providing consistent Training and Support for workforce

State	Child Population	Counties	Administration of CW System	SOC Lead Agency	SOC Reach	SOC Initiated by	Population Served by SOC
Ohio	2,578,254*	88	County	Department of **Medicaid**	Statewide by 2022 37,748 youth served**	Medicaid	☒Under 21 ☒Behavioral Health ☒Intellectual & Developmental Disability (IDD) ☒Child Welfare Involved ☒Justice Involved
Oklahoma	966,607*	77	State	Department of **Mental Health and Substance Use** Services	Statewide by 2014 18,447 youth served***	Legislature	☒Under 21 ☒Behavioral Health ☐ IDD ☒Child Welfare Involved ☒Justice Involved
New Hampshire	252,050*	10	State	Bureau for Children's **Behavioral Health**, under the Department of Health and Human Services	Statewide by 2012 69,141 youth served****	Legislature	☒Under 21 ☒Behavioral Health ☐ IDD ☒Child Welfare Involved ☒Justice Involved
New Jersey	2,010,290*	21	State	Division of **Children's System of Care**, under the Department of Children and Families	Statewide by 2006 36,547 youth served*****	Parent Advocacy	☒Under 21 ☒Behavioral Health ☒ IDD ☒Child Welfare Involved ☒Justice Involved

**Although the approaches listed above support youth under 21, available population estimates are provided for up to age 18. Source: https://datacenter.aecf.org/*
*** As of August 2024. Source: https://medicaid.ohio.gov/news/press-release/ohiorise-2years*
****As of January 2025. Data provided by Oklahoma Department of Mental Health and Substance Abuse Services.*
*****Youth served from 2019-2024 in community mental health centers, residential treatment settings, or care management entities. Data provided by NH DHHS, BCBH.*
******As of August 2024. Source: https://www.nj.gov/dcf/childdata/continuous/Commissioners.Monthly.Report_10.24.pdf*

System of Care Results

From		To
Fragmented service delivery	→	Coordinated service delivery
Categorical programs/funding	→	Multidisciplinary teams and blended sources
Limited services	→	Comprehensive service array
Reactive, crisis-oriented approach	→	Focus on prevention/early intervention
Focus on "deep end," restrictive settings	→	Least restrictive settings
Children out of home	→	Children within families
Centralized authority	→	Community-based ownership
Creation of "dependency"	→	Creation of "self-help" and active participation
Child- or youth-only focus	→	Family as focus
Needs/deficit assessments	→	Strengths-based assessments
Families as "problems"	→	Families as "partners" and therapeutic allies
Youth as "problems"	→	Youth as partners
Cultural blindness	→	Cultural and linguistic competence
Highly professionalized	→	Coordination with informal, natural supports
Child and family must "fit" services	→	Individualized/Wraparound approach
Input-focused accountability	→	Outcome/results-oriented accountability
Funding tied to programs	→	Funding tied to populations

Source: Adapted from https://gucchd.georgetown.edu/products/PRIMER2ndEd_FullVersion.pdf

Early and Periodic Screening, Diagnostic, and Treatment EPSDT

- Federally mandated benefit for Medicaid-eligible children and youth (under 21), providing comprehensive preventative and developmental health services.
- A “cornerstone of the Medicaid program,” aimed at “ensur[ing] robust health coverage for children.”
- The goal of EPSDT is to assure that individual children get the health care they need when they need it — “the right care to the right child at the right time in the right setting.”

Centers for Medicare & Medicaid Services. (2024, September 26). *SHO #24-005: Best practices for adhering to Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) requirements*. U.S. Department of Health & Human Services. https://www.medicaid.gov/federal-policy-guidance/downloads/sho24005.pdf; Centers for Medicare & Medicaid Services. (2014, June). *EPSDT - A guide for states: Coverage in the Medicaid benefit for children and adolescents*. U.S. Department of Health & Human Services. https://www.medicaid.gov/medicaid/benefits/downloads/epsdt-coverage-guide.pdf

CMS Guidance - Leveraging Medicaid, CHIP, and Other Federal Programs in the Delivery of Behavioral Health Services for Children and Youth

- **Early and Periodic Screening, Diagnostic and Treatment-** Goal is to assure that individual children get the health care they need when they need it – **the right care to the right child at the right time in the right setting.**

- **Health Services Initiative-** Several states have used HSIs for behavioral health initiatives, including to provide opioid overdose reversal kits, train public school employees to administer opioid overdose reversal drugs, and support consultation and collaboration between pediatric primary care and mental health specialists

- **Home and Community-Based Services** - As states consider the unique needs of their children and youth, they are encouraged to think strategically about how home- and community-based services (HCBS) can meet and wrap around EPSDT-required behavioral health services.

- **Improve Prevention, Early Identification and Engagement in Treatment** - **Avoid requiring a behavioral health diagnosis** for the provision of EPSDT services. States can determine that some services are medically necessary for children and youth without a diagnosed behavioral health condition.

- CMS released Children's Behavioral Health Toolkit released in February 2026
  https://www.medicaid.gov/federal-policy-guidance/downloads/bhccib08182022.pdf



Thank You!

Email: Ruby.Goyal-Carkeek@dcf.nj.gov