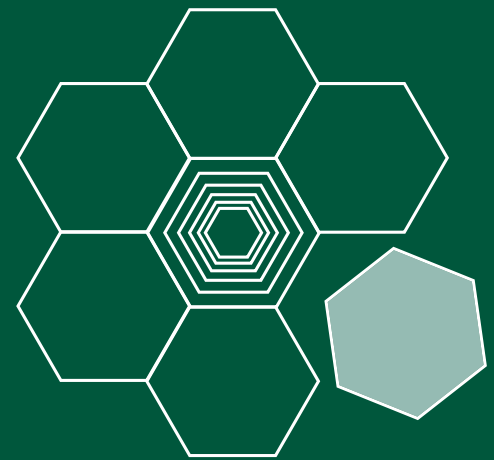


A Self-Assessment and Planning Guide:

Developing a Comprehensive Financing Plan

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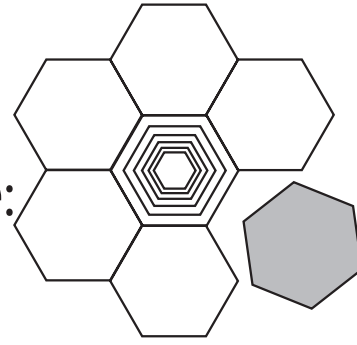
The Research and
Training Center for
Children's Mental Health

RTC Study 3

Financing Structures and Strategies
to Support Effective Systems of Care

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Partial Contents: Introduction to RTC: Study 3 – Study Background – How to Use the Self-Assessment and Planning Guide – Deciding Where to Begin – 1. Identification of Current Spending and Utilization Patterns Across Agencies with Outcomes and Strategies – 2. Realignment of funding streams and structures with Outcomes and Strategies – 3. Financing of appropriate services and supports with Outcomes and Strategies – 4. Financing to Support family and youth partnerships with Outcomes and Strategies – 5. Financing to improve cultural/linguistic competence and reduce disparities in care with Outcomes and Strategies – 6. Financing to improve the workforce and provider network for behavioral Health services for children and families with Outcomes and Strategies – 7. Financing for accountability with Outcomes and Strategies – Conclusions – Glossary – Appendix 1: Matrix 1—A Tool for Mapping Spending Across Child-Serving Systems – Appendix 2: Attachment A: Potential Funding Sources – Appendix 3: How are the Indian Health Service (IHS), Tribes and Urban Indian Programs Paid Under Medicaid? – Order Form for this publication and/or others in the series.

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Research and Training Center
For Children's Mental Health



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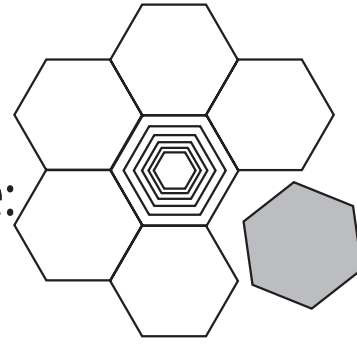
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Introduction

Study Background

The **Research and Training Center (RTC)** for Children’s Mental Health at the University of South Florida is conducting several five-year studies to identify critical implementation factors which support communities and states in their efforts to build effective systems of care to serve the needs of children and adolescents with, or at risk of, serious emotional disturbances and their families. One of these studies, conducted jointly by the RTC, the Human Service Collaborative of Washington, DC, the National Technical Assistance Center for Children’s Mental Health at Georgetown University, and Family Support Systems, Inc. examines financing plans, structures, and strategies that communities use to build systems of care.

The purposes of the study are to:

- Develop a better understanding of what are the critical financing structures and strategies to support systems of care for children and adolescents with behavioral health disorders and their families
- Examine how these financing components operate separately and collectively
- Promote policy change through dissemination of study findings and technical assistance to state and local policy makers and their partners.

The financing study uses a **participatory action research approach**, promoting a continuous dialogue with key users on study methods, findings and products. Data collection and analysis includes a mix of qualitative and quantitative methods. The study is using a multiple case study design and will include ten case study sites. Selection of study sites is guided by a national expert panel, document review, key informant telephone interviews, and prior related studies.

Products will include a series of technical assistance briefs with promising financing approaches; site-specific reports that will be shared with each site; and this Self-Assessment and Planning Guide.

During **Year One** of the study, the study team convened a panel of financing experts, including family members, state and county administrators, representatives of tribal organizations, providers, and national financing consultants to develop a list of critical financing strategies and study questions that form the basis for interviews to be conducted in the case study sites. These critical financing strategies were used to create this Self-Assessment and Planning Guide.

How to Use the Self-Assessment and Planning Guide

The **Self-Assessment and Planning Guide (Guide)** addresses seven important areas to assist systems/sites¹ to develop comprehensive and strategic financing plans for building effective systems of care:

1. Identification of current spending and utilization patterns across agencies
2. Realignment of funding streams and structures
3. Financing of appropriate services and supports
4. Financing to support family and youth partnerships
5. Financing to improve cultural/linguistic competence and reduce disproportionality in care
6. Financing to improve the workforce and provider network for behavioral health services for children and families
7. Financing for accountability

¹For brevity purposes, throughout the Guide, we use the term “system/site” to encompass any state, tribe, territory, region, county, city, community, or organization that is designing a comprehensive financing strategy to build a system of care.

For each of these seven areas, the Guide presents both outcomes that can be achieved and financing strategies that may help to achieve them. Systems/sites can use this Guide to assess their current financing structures and strategies and to prioritize how they want to move forward in developing a strategic financing plan. While all seven areas are important components of a comprehensive financing plan, it is not necessary to move sequentially through the seven areas. Your system/site already may address one or more of these areas. The Guide is intended to help you focus on those areas that your own system/site needs to address.

A **checklist format** is used for the outcomes and the strategies in each area. This will help your system/site conduct a self-assessment and identify which outcomes and strategies to pursue or explore. The questions in the box below may help you to decide where to begin the self-assessment process.

When you have reviewed all areas relevant to your system/site and have identified which outcomes and strategies to pursue, you should be in a position to begin developing a strategic financing plan to fund and support an effective system of care.

Deciding Where to Begin
<input type="checkbox"/> What do key stakeholders feel should be done first?
<input type="checkbox"/> Which financing strategies and structures to support effective systems of care are in place now in your system/site? Which ones need to be developed?
<input type="checkbox"/> Which financing strategies and/or structures may be difficult to accomplish but could have a major impact, i.e., which ones would need to be accomplished with a long-range strategy?
<input type="checkbox"/> What strategies may be relatively easy to achieve and viewed as short-term wins, i.e., which ones could be accomplished through immediate action?
<input type="checkbox"/> Which areas of the Guide might be most useful now?

We hope that planners, policy makers, advocates, family representatives, researchers, and others engaged in building systems of care for children and families will find the Guide useful.

The overall framework and financing strategies identified in this Guide have been reviewed by the study team and a national panel of financing experts. At this stage, the Guide is intended to serve as a road map, not as a “how to” manual. The study team will confirm these strategies over the next two years through site visits to a number of states, tribes and

communities with established financing strategies. Some of these strategies may prove to be more or less effective than others, and we may identify additional useful financing strategies and structures through the site visits. As more information is gathered, additional technical assistance tools will be developed and disseminated throughout the study. A series of technical assistance briefs based on findings from the site visits will provide more in-depth descriptions of **how** to implement some of the financing strategies included in this Guide.

I. Identification of Current Spending and Utilization Patterns Across Agencies

The identification of current spending and utilization patterns is an important first step in the development of a strategic financing plan. It enables a system/site to understand how its funds (across all child-serving systems) are currently being spent and for which children and families. It also assists in projecting expected utilization and costs and planning accordingly.

I. Outcomes

Instructions: Here are some possible outcomes that can be achieved by identifying spending and utilization patterns. Check the ones that your system/site might want to pursue.

I. Outcomes
<input type="checkbox"/> Knowledge of the amount and types of behavioral health services and support that families and children currently use.
<input type="checkbox"/> Knowledge of how much each child-serving system currently is spending on services and supports for these children and families.
<input type="checkbox"/> Identification of utilization patterns and expenditures by the demographics of children and youth served to identify disparities and disproportionality in access.
<input type="checkbox"/> Identification of utilization patterns and expenditures associated with high costs and/or poor outcomes.
<input type="checkbox"/> Identification of the funding sources for these expenditures.
<input type="checkbox"/> Projection of the amount and types of behavioral health services and supports that families and children will use in the future.
<input type="checkbox"/> Projection of how much each child serving system will potentially spend for these services and supports.

1. Strategies

Instructions: Here are some strategies that may help to identify spending and utilization patterns. Your system/site may already be using some of these strategies. Check those that you would like to explore further.

A. Determine and Track Utilization and Cost of Behavioral Health Services for a Defined Population

- 1. Conduct cross-system analysis of the amounts and types of behavioral health services and supports used by a defined population of children and families.
- 2. Identify disparities and disproportionality in access.
- 3. Identify utilization patterns and expenditures associated with high costs and/or poor outcomes.
- 4. Develop a data system for ongoing tracking of utilization and expenditures for these services and supports.

B. Map Cross-system Funding

- 1. Map current financing by:
 - Identifying the child-serving systems that contribute funding for system of care services and supports and the type of funding each system contributes.
 - Determining the actual expenditures by each child-serving system from each funding source.

(See **Appendix 1—Matrix 1** for a tool to assist in mapping spending across child-serving systems for behavioral health services/supports for children, youth and their families.

Appendix 2—Attachment A is provided as a tool to identify the potential funding sources for systems of care and to help you identify the types of dollars you are spending at state, local and tribal levels.)

- 2. Conduct a comprehensive scan of existing resources and untapped and/or under utilized sources of funding for services and supports.

- 3. Document the findings from the above strategies and use this information as the foundation to develop a clearly articulated plan for financing system of care services and supports.

II. Realignment of Funding Streams and Structures

When realigning funding streams and structures, a number of issues can be considered:

- Which funding streams to include and their flexibility
- Coordinating funds across systems
- Maximizing federal entitlement funding
- Redirecting spending from “deep-end” placements
- How to ensure a locus of accountability for services, cost, and care management for children/youth who utilize an extensive amount of services
- Paying for services for uninsured and under insured children and families
- Stopping the practice of families relinquishing custody to access intensive services
- What strategies will provide sustainable funding for tribal systems of care.

II. Outcomes

Instructions: Here are some possible outcomes that can be achieved when system/sites realign funding streams and structures. Check the ones that your system/site might want to explore further.

II. Outcomes
<input type="checkbox"/> An increase in the proportion of funding used for home and community-based services in relation to funding for more restrictive services.
<input type="checkbox"/> Maximization of the use of federal entitlement funding.
<input type="checkbox"/> Increased flexibility of funding sources and budget structures.
<input type="checkbox"/> Use of diverse funding sources.
<input type="checkbox"/> Reduced cost shifting and duplication or gaps in services.
<input type="checkbox"/> Coordination of funding across systems to ensure appropriate and integrated services for youth with co-occurring disorders and youth involved with multiple systems.
<input type="checkbox"/> Financing a locus of accountability for managing care and costs for youth with intensive needs (e.g., a care management entity).

II. Outcomes (continued)

- Use of risk adjustment mechanisms to appropriately serve youth with intensive needs.
- Financing for behavioral health services for uninsured and under insured children and their families.
- Maximization of funding streams and structures unique to tribal systems of care.
- Identification and use of new resources.

II. Strategies

Instructions: Here are some strategies that may help to realign funding streams and structures. Your system/site may already be using some of these strategies. Check those that you would like to explore further.

A. Utilize Diverse Funding Streams

- 1.** Explore the extent to which multiple child-serving systems can contribute new resources (staff and/or financing).
- 2.** Decide which type of coordinated funding mechanism is appropriate for your system/site (e.g., pooled, blended, or braided funding).
- 3.** Put into place a structure to manage and coordinate funding from multiple agencies and sources (e.g., mechanisms to track and meet reporting requirements for individual funding streams, even when they are combined with other funding streams).

B. Maximize Federal Entitlement Funding

- 1.** Explore all the ways Medicaid can be used to finance behavioral health (BH) services and supports for children and families, e.g.,
 - Expanding state plan to include a broad array of behavioral health (BH) services and supports.
 - Using all possible Medicaid options
 - Clinic Option
 - Rehab Option
 - Targeted Case Management
 - Psych Under 21
 - EPSDT
 - Katie Becket (TEFRA)
 - Home and Community Based Waiver (1915c)
 - Managed Care/Freedom of Choice Waiver (1915b)
 - Research and Demonstration Projects Waiver (1115)
 - Family of One
 - Securing a steady rate of state, tribal, and/or local match for Medicaid.
 - Exploring the potential of no match (100% FMAP) for services provided through Indian Health Services (IHS) and tribal facilities.
 - Using Medicaid to extent possible in lieu of 100% state and local general revenue funding.
- 2.** Address Medicaid eligibility issues by:
 - Increasing eligibility for Medicaid (age, income, disability criteria, presumptive eligibility, family of one, etc).
 - Conducting active outreach/enrollment and re-enrollment efforts for Medicaid.
- 3.** Increase eligibility and enrollment efforts for the State Child Health Insurance Program (SCHIP).
 - 12 months continuous coverage
 - Presumptive eligibility
- 4.** Explore expanded benefit package for SCHIP youth with serious behavioral health problems and ensure coverage of home and community based services in SCHIP plans

B. Maximize Federal Entitlement Funding (continued)

- 5.** Explore the use of a Title IV-E waiver to fund community-based services to prevent child placement.
- 6.** Maximize special education entitlement for and funding of behavioral health services and supports.

C. Redirect Spending from “Deep-End” Placements

- 1.** Explore strategies to finance a shift from residential and inpatient services to home and community-based services:
 - Medicaid home and community-based service waivers
 - Redirection of funds from bed closures and reduction in residential and other out-of-home placements to community-based services
 - Offer therapeutic foster care as an alternative to residential treatment
 - Offer TEFRA as Medicaid option
 - Direct new monies to home and community-based services
 - Define medical necessity criteria and level of care criteria to allow for diversion from residential and inpatient care to home and community based services
 - Include residential providers in discussions about the funding issues in moving to a community-based system
 - Develop partnerships with tribes in states with disproportionately high tribal out-of-state placements
 - Offer training and TA to residential providers about developing home and community-based services and short-term psychiatric stabilization
 - Involve families in identifying the community-based services that are needed and in advocating for the shift from residential to home and community-based services

D. Support a Locus of Accountability for Service, Cost, and Care Management for Children with Intensive Needs

- 1.** Identify and allocate funds to support a locus of accountability for managing care and costs, e.g., a care management entity.
- 2.** Identify and allocate funds to increase the infrastructure capability to develop a locus of accountability.
- 2.** Examine various risk adjustment strategies (e.g. differential case rates or capitation rates, risk pools, and other risk adjustment mechanisms).
- 3.** Gather fiscal data to support setting adequate rates
 - Track utilization and expenditures periodically to assist in determining the need for rate adjustments.

E. Increase Flexibility of State and/or Local Funding Streams and Budget Structures

- 1.** Redirect funds by moving dollars across budget categories, across child-serving systems, and across fiscal years. - (e.g., allow “savings” from reduced out of home expenditures to be used for increased home and community based services).
- 2.** Increase local control over funding for behavioral health services and supports for children and families.
- 3.** Provide flexible funds for child and family teams to use to fund services/supports that are not reimbursable.

F. Coordinate Cross-System Funding

- 1. Implement protocols to monitor and prevent cost shifting at state, tribal or local levels.
- 2. Set up a cross-agency system that ensures similar or consistent provider contracting mechanisms and rate structures for behavioral health services and supports. Consider joint or single certification of providers and joint training for providers serving multiple systems.
- 3. Create a cross-agency protocol for payment for services for children with co-occurring disorders or involved with multiple systems.
- 4. Implement mechanisms to coordinate funding across child-serving systems (e.g., interagency entities, interagency expenditure plan, memoranda of understanding/ agreements, legislation, funding for cross-agency training).
- 5. Ensure that services (not funding) drive the system
 - Use cross-agency mechanism to coordinate the procurement of services and supports (e.g., purchasing collaborative, joint cross-system procurement process)
 - Develop mechanisms to coordinate funding of services for individual children and families (e.g. child and family teams that authorize payment for services, single plans of care, cross-agency protocols for serving youth with co-occurring disorders, cross-agency assessment and service planning).

G. Incorporate Mechanisms to Finance Services for Uninsured and Under Insured Children and their Families

- 1.** Consider the following mechanisms for financing behavioral health services and supports for uninsured/under insured children and their families:
 - Offering sliding fee scales
 - Allowing families to buy into Medicaid
 - Using Medicaid family of one and/or TEFRA options (Tax Equity and Fiscal Responsibility Act, a.k.a. Katie Beckett Option)
 - Using home and community-based waivers that cover uninsured and under insured children
 - Pooling, blending, or braiding funds to serve uninsured and under insured children
- 2.** Encourage private insurers to cover a broader array of behavioral health services and supports for children and their families.
- 3.** Assist families to evaluate their child for IDEA.
- 4.** Link schools and community mental health services to facilitate appropriate services for children with emotional disabilities under IDEA.

H. Incorporate Effective Financing Strategies for Tribal Systems of Care*

- 1.** Engage in state/tribal agreements to develop financing mechanisms for tribal systems of care.
- 2.** Identify state and federal funds that can be transferred to tribes for the development of tribal behavioral health services.

* See **Appendix 3** for additional information on how the Indian Health Service, Tribes and Urban Indian Programs are paid under Medicaid.

III. Financing of Appropriate Services and Supports

When considering how and what services and supports to finance, it is helpful to keep in mind a broad array of services and supports, as well as how to pay for individualized and flexible services and supports, evidence-based and promising practices, early identification and intervention activities, early childhood mental health services, and cross-agency service coordination.

III. Outcomes

Instructions: Here are some possible outcomes related to services and supports that can be achieved with appropriate financing mechanisms. Check the ones that are most important for your system/site.

III. Outcomes
<input type="checkbox"/> A broad array of services and supports.
<input type="checkbox"/> Individualized and flexible services and supports.
<input type="checkbox"/> Community and neighborhood-based services and supports.
<input type="checkbox"/> Culturally diverse services and supports.
<input type="checkbox"/> Evidence-based and promising practices in the service array.
<input type="checkbox"/> Early identification of behavioral health needs.
<input type="checkbox"/> Early intervention and prevention activities.
<input type="checkbox"/> Early childhood mental health services and supports.
<input type="checkbox"/> Services and supports for transition-age youth (e.g., 18–24).
<input type="checkbox"/> Cross-agency service coordination.
<input type="checkbox"/> Billing codes that facilitate reimbursement of appropriate services and supports.

III. Strategies

Instructions: Here are some financing strategies that may help to build community-based services and supports. Your system/site may already be using some of these strategies. Check those that you would like to explore further.

A. Provide a Broad Array of Services and Supports

- 1. Identify how the services and supports in your system/site are funded. (Complete **Matrix 2** at the end of this section)

B. Promote Individualized, Flexible Service Delivery

- 1. For individualized services and supports identified in **Matrix 2** that are not currently funded, explore whether other flexible monies could be used to cover these services and supports. Identify the sources for these funds.
- 2. Identify whether your state's Medicaid plan includes intensive individualized services needed to keep in their homes and communities, youth who would otherwise be hospitalized or placed in residential treatment.
- 3. Explore whether a Medicaid home and community-based waiver (1915c) would promote individualized services for children and families in your system/site.
 - Whom does your system/site want to include in the target population?
 - Do you have data to support the number of children in your state who might qualify for a waiver?
 - How would your state ensure cost neutrality?
 - Identify the pros and cons of applying for a 1915c waiver.

B. Promote Individualized, Flexible Service Delivery (continued)

- 4.** Explore whether a Title IV-E waiver would promote individualized services for children and families in your state
- Whom does your state want to include in the target population and what services would be offered?
 - How would your state ensure cost neutrality?
 - How would your state carry out the required evaluation?

- 5.** Finance family vouchers or monthly budgets for families to purchase services

C. Support and Provide Incentives for Evidence-Based and Promising Practices

- 1.** Seek funding to determine the evidence for promising practices that exist in your system/site (e.g. foundations, community/agency/university partnerships).
- 2.** Create fiscal incentives to promote and provide evidence-based and promising practices (e.g., paying providers for the time and effort required to develop a practice before implementation).
- 3.** Finance practice based evidence - credible practices in the community (often specific cultural practices) that may never reach the level of evidenced-based practice (EBP).
- 4.** Provide funding for the ongoing training, supervision, and fidelity monitoring of evidence-based and promising practices (public-private partnerships to share the cost).

D. Promote and Support Early Childhood Mental Health Services

- 1. Because there is no one funding stream targeted to young children facing social and emotional difficulties, mix and match multiple funding streams, eligibility requirements, and administrative requirements.
- 2. Use IDEA to:
 - Ensure that children eligible for Section 619 [Part C (0 to 3) and Part B (3 to 5)] are assessed for behavioral health needs and referred for behavioral health services.
 - Ensure that Child Find (0 to 21) screens and assesses for social, emotional and developmental status.
- 3. Use block grants and smaller grant programs:
 - To provide flexible funding to fill gaps left by Medicaid, Part C and other core funding streams (e.g., Foundations for Learning; Safe and Drug Free Schools; Early Learning Opportunities; and Good Start, Grow Smart)
 - To cover services/supports for families and other caregivers not provided through Medicaid (Title V Maternal and Child Health State Block Grant (MCHSBG) flexible funding)
 - For center-level awards to start early childhood MH projects with parent-child assessment, intervention and/or consultation services (MCHSBG)
- 4. For Medicaid strategies:
 - Use EPSDT to provide a broad array of child development and mental health services for young children.
 - Adopt policy and billing mechanisms/codes that encourage providers to perform developmental screening with age-appropriate tools and to offer follow-up referrals and treatment.
 - Denote parent-child treatment coverage for children younger than 6 in state Medicaid plan
 - Use billing codes tailored to young children's conditions (create a cross-walk from the Diagnostic Classification of Mental Health and Developmental Disorders of Infancy and Early Childhood [DC: 0-3]) to DSM IV.
- 5. Finance screening for and treating maternal depression through Title V MCHBG.

D. Promote and Support Early Childhood Mental Health Services (continued)

- 6.** Finance two-generation strategies and parent-child therapeutic interventions using Title V or Title IV-B (Part 1 — child welfare services program and Part 2 — promoting safe and stable families [for families with young children in or at-risk for foster care]).
- 7.** Finance early childhood Mental Health (MH) consultation with Child Care and Development Fund (CCDF) funds (thru the quality set-aside), by transferring TANF funds to the CCDF or the Social Services Block Grant (SSBG); with Medicaid/EPSDT (for individual children); or with state and/or local general revenue. See potential funding sources.
- 8.** Require that all children birth to age 3 entering the foster care system be assessed thru IDEA Part C Early Intervention program.

E. Promote and Support Early Identification and Intervention

- 1.** Identify funding sources for behavioral health screening for children/youth at risk (children in child welfare and/or juvenile justice) and linkage to appropriate services (e.g. using Medicaid to fund a comprehensive assessment for all children who enter out-of-home care.)
- 2.** Offer adequate reimbursement to providers to conduct comprehensive EPSDT exams that include a behavioral health screening, and recommend appropriate screening tools.
- 3.** Explore funding sources that support primary care practitioners in making referrals and coordinating with behavioral health providers (e.g. Skilled Professional Medical Personnel administrative medical case management funded by Medicaid).

F. Support Cross-Agency Service Coordination

- 1.** Explore financing mechanisms to pay for service coordination activities at the service delivery level, such as care management, child and family teams (e.g., Medicaid Targeted Case Management, Part C for young children).
- 2.** Provide funding to support cross system child and family teams that create individualized service plans for children and their families (e.g. ensure that providers are reimbursed for the time that they spend in child and family team meetings; provide transportation and child care so that family members can participate).

G. Support Cross-Agency Service Coordination

- 1.** Explore financing mechanisms to pay for service coordination activities at the service delivery level, such as care management, child and family teams (e.g., Medicaid Targeted Case Management, Part C for young children).
- 2.** Provide funding to support cross system child and family teams that create individualized service plans for children and their families (e.g. ensure that providers are reimbursed for the time that they spend in child and family team meetings; provide transportation and child care so that family members can participate).

Matrix 2

Complete this Matrix to identify how the services and supports in your system/site are funded. For each service identify all funding sources.

Matrix 2 Services and Supports Covered by Medicaid and Other Funding Sources			
Service	Medicaid	Other Funding Sources	If Other, Specify Sources
Screening			
Assessment and diagnostic evaluation			
Outpatient psychotherapy (individual, family, and group)			
Medical management			
Home-based services			
Day treatment/partial hospitalization			
Crisis services			
Mobile crisis response and stabilization services			
Behavioral aide services			
Behavioral management skills training			
Substance abuse treatment services			
Therapeutic foster care			
Therapeutic group homes			
Residential treatment centers			
Crisis residential services			
Inpatient hospital services			
Case management services			
School-based services			
Special services for youth in juvenile justice system			
Special services for children/youth in child welfare system			
After school and summer programs			
Youth development activities			
Respite services			
Wraparound services/process			
Family support/education			
Transportation			

Matrix 2 (Continued)
Services and Supports Covered by Medicaid and Other Funding Sources

Service	Medicaid	Other Funding Sources	If Other, Specify Sources
Mental health consultation (for early childhood and other programs)			
Therapeutic nursery/preschool			
Supported independent living services			
Other, Specify			

IV. Financing to Support Family and Youth Partnerships

Supporting family and youth partnerships involves strategies at several levels. At the service level, it means families have a decision-making role in the care of their own child and that youth have a role in guiding their own care. For older youth, it may mean directing their own care. It also means parents should never need to relinquish custody of their children to access behavioral health services and supports. At the system level, it is important for families and youth to have decision-making power in designing, implementing and evaluating policies and procedures governing care for all children and youth in the community. In addition, partnering with families and youth means that the system provides services and supports, not only for the identified child, but also for family members to support them in their care giving role. In true family/systems partnerships financing is available to fund program and staff roles for family members and youth to be fully involved in helping professionals establish youth-guided and family driven systems of care².

IV. Outcomes

Instructions: Here are some possible outcomes related to supporting family and youth partnerships that can be achieved with appropriate financing mechanisms. Check the ones that are most important for your system/site.

IV. Outcomes

- Youth and their families are trusted and respected as experts on their family needs, individual needs and their cultural needs. They:
 - Have the lead roles in directing the treatment plan and configuring the service planning team
 - Are provided an opportunity to discuss their needs and strengths
 - Are offered a choice in types of services, supports and providers
 - Share with providers the responsibility for identifying and achieving outcome indicators

²These concepts are reflected in the definition of *family-driven care* found in the Substance Abuse and Mental Health Services Administration's Federal Agenda for Children's Services. Presentation by Sybil Goldman, August 8, 2005, at the 2005 Policy Academy for Transforming Mental Health Care for Children and Families, Albuquerque, NM. For more information, see http://www.tapartnership.org/advisors/family/the_family_page.asp

IV. Outcomes (continued)

- Youth and their families are offered services and supports to meet the needs of families/ caregivers, in addition to services for the identified youth. They are:
 - Afforded the opportunity to receive support related to the stress of living with behavioral health challenges
 - Afforded the opportunity to receive education that will allow for informed decisions about their care.
- Youth and their families develop skills to help them establish youth-guided and family driven systems of care.
- Active involvement of culturally diverse families and youth.
- Mutual respect and shared decision-making between providers and families.

IV. Strategies

Instructions: Here are some possible strategies that may help to support family and youth partnerships. Your system/site may already be using some of these strategies. Check those that you would like to explore further.

A. Support Family and Youth Involvement and Choice in Service Planning and Delivery

- 1.** Finance supports for families and youth to participate in service planning teams, such as childcare, transportation, food, family and youth peer advocates.
- 2.** Provide funds for service planning teams to use flexibly in supporting individualized services and supports.
- 3.** Finance family vouchers or monthly budgets for families to purchase services.
- 4.** Finance training for providers (residential and community-based) on a strengths-based/ family partnership approach.

B. Finance Family and Youth Involvement in Policy Making

- 1.** Provide payments, stipends, or other types of support for family and youth leadership development and family and youth participation in policy-making activities, including developing financing strategies.
- 2.** Contract with or fund a family organization to mobilize and prepare families for participation in policy-making activities.
 - Explore potential funding sources such as Community Mental Health Block Grant, Medicaid administrative claiming, federal transformation planning funds
- 3.** Fund orientation, training, education, and leadership development to prepare families and youth for participation in policy-making and system management.

C. Offer Services and Supports for Families/Caregivers

- 1.** Use mechanisms, such as case rates or capitation rates, to provide services to families in addition to the identified child.
- 2.** Explore Medicaid options available to assist family members of the identified child, such as targeted case management and/or the rehabilitation option.
- 3.** Collaborate with other systems, including child welfare, substance abuse, and adult mental health to address the needs of family members and share the cost of services to meet those needs.
- 4.** Establish and fund, or support existing, family organizations to provide services such as peer support, education, information, respite, advocacy.

V. Financing to Improve Cultural/Linguistic Competence and Reduce Disproportionality in Care

It is important to recognize the value of cultural and linguistic competence in service delivery and commit the necessary resources in your financial planning. Effective financing plans address disparities and disproportionality in access to care, including geographic and cultural/racial/ethnic factors.

V. Outcomes

Instructions: Here are some possible outcomes related to improving cultural and linguistic competence and to reducing disparities and disproportionality in care that can be achieved with appropriate financing mechanisms. Check the ones that are most important for your system/site.

V. Outcomes
<input type="checkbox"/> Culturally and linguistically competent services.
<input type="checkbox"/> Equal access to services and supports for families and children of diverse cultural/racial/ethnic backgrounds.
<input type="checkbox"/> Equal access to services and supports for families and children from under served geographic areas, e.g. rural and frontier.
<input type="checkbox"/> Reduction in disparities (e.g. in access to cover utilization of services, and family outcomes) for children and families from diverse cultures.
<input type="checkbox"/> Increased effectiveness of services for children and families of diverse cultures.

V. Strategies

Instructions: Here are some possible strategies that may help to support cultural/linguistic competence and equal access to care. Your system/site may already be using some of these strategies. Check those that you would like to explore further.

A. Provide Culturally and Linguistically Competent Services and Supports	
<input type="checkbox"/>	1. Explore and advocate for funding sources to pay for culturally-specific specialized services, nontraditional services, indigenous providers, and natural helpers (e.g. some states have revised their Medicaid plans or service definitions or provider network requirements to include these services and providers).
<input type="checkbox"/>	2. Include translation and interpretation as fundable services.
<input type="checkbox"/>	3. Offer fiscal incentives for providers who demonstrate cultural and linguistic competence (e.g. an annual cultural competence plan, increases in the proportion of services to culturally diverse populations).
<input type="checkbox"/>	4. Offer fiscal incentives that will result in more providers from diverse cultures becoming members of the provider network (e.g., pay existing providers to mentor smaller organizations regarding administrative requirements, offer TA on how to become a Medicaid provider).
<input type="checkbox"/>	5. Set contract standards for having providers who represent the cultures of the service population (e.g., require MCOs to include a certain proportion of diverse providers).
<input type="checkbox"/>	6. Fund outreach activities to culturally and linguistically diverse populations.
<input type="checkbox"/>	7. Fund a cultural competence coordinator at state, tribal, and/or local levels.

B. Reduce Disparities and Disproportionality in Access to Services and Supports

- 1.** Analyze service utilization, expenditures, and outcomes by culture, race, and ethnicity. Explore financing strategies to address inequities described in the findings.
- 2.** Analyze service utilization, expenditures, and outcomes by geographic area. Explore financing strategies to address inequities described in the findings.
- 3.** Offer fiscal incentives to attract providers to locate in underserved geographic areas.
- 4.** Explore the use of technology to reach underserved areas and fund effective approaches for your system/site, e.g., telehealth.
- 5.** Offer rewards, bonuses or other fiscal incentives to providers that show a reduction in disparities.
- 6.** Explore and fund the types of transportation arrangements that are needed for access to services and supports in your system/site.

VI. Financing to Improve the Workforce and Provider Network

The ability to provide adequate services and supports for children with behavioral health needs and their families depends upon having a broad, diversified, and qualified workforce and provider network.

VI. Outcomes

Instructions: Here are some possible outcomes related to having in place a broad, diversified, and qualified workforce and provider network. Check the ones that are most important for your system/site.

VI. Outcomes
<input type="checkbox"/> A sufficient number and types of providers to offer a broad array of quality services and supports.
<input type="checkbox"/> Geographically desirable distribution of traditional and non-traditional providers and natural helpers.
<input type="checkbox"/> A competent workforce — broad, diversified, qualified workforce with traditional and non-traditional providers/natural helpers that reflects the demographics of the service population.
<input type="checkbox"/> Adequate provider payment rates.

VI. Strategies

Instructions: Here are some financing strategies that may improve the work force and provider network for behavioral health services for children and their families. Your system/site may already be using some of these strategies. Check those that you would like to explore further.

A. Support a Broad, Diversified, Qualified Workforce and Provider Network

- 1. Certify and reimburse diverse types of providers and programs (including non-traditional providers, family organizations, paraprofessionals and natural helpers who have access to clinical consultation/supervision).
- 2. Enable these providers to be reimbursed with diverse funding streams, including billing of Medicaid.
- 3. Fund workforce development activities such as workforce analyses, recruitment and retention activities, pre- and in-service training and coaching.
- 4. Address professional shortages in public sector by funding scholarship and internship opportunities, educational loan and loan repayment programs.
- 5. Offer financial incentives to attract providers to under served geographic areas.
- 6. Offer financial incentives to attract providers that reflect the racial/ethnic/linguistic composition of the target population.
- 7. Fund advances in information technology to improve services, e.g., telehealth and web-based learning strategies.
- 8. Reimburse providers in a timely manner so that smaller providers can participate in the service system.

B. Provide Adequate Provider Payment Rates

- 1.** Provide payment rates and policies that will:
 - Encourage provision of evidenced-based/promising practices
 - Allow providers to participate in child/family team meetings
 - Coordinate services with other agencies
 - Support work with family members in addition to the identified child
 - Allow providers to serve children and families at home, school and in the community
 - Pay for mental health consultation with other settings
 - Assist families with transportation and child care
 - Create a system in which providers document the cost of care/services and can request amended rates as needed.

- 2.** Use a rate methodology that reflects actual market rates to establish service reimbursement rates.

VII. Financing for Accountability

Accountability is a hallmark of every strategic financing plan. It is important that financing strategies and decisions should be data driven, e.g., provider arrangements should use performance-based or outcomes-based contracts. Service utilization and costs need to be monitored and managed, and financing policies should support and promote continuous quality improvement and system of care goals. Family, youth, and consumer involvement is important in evaluating service and system performance. Finally, financing strategies should support effective leadership capacity, and a governance and management infrastructure for systems of care.

VII. Outcomes

Instructions: Here are some outcomes related to accountability that can be achieved with effective financing mechanisms. Check the ones that are most important for your system/site.

VII. Outcomes
<input type="checkbox"/> Service utilization and system costs are monitored and managed.
<input type="checkbox"/> The performance of providers and system managers is evaluated against outcomes at the system, program, and child and family levels.
<input type="checkbox"/> The performance of providers and system managers is evaluated against child and family outcomes for different cultural and ethnic groups.
<input type="checkbox"/> Financing policies and strategies are evaluated on a regular basis to ensure that they support a continuous quality improvement system.
<input type="checkbox"/> Financing policies and strategies are evaluated on a regular basis to ensure that they support and promote system of care goals.
<input type="checkbox"/> Quality, outcome, and cost-benefit data are used to monitor the effectiveness of financing strategies.
<input type="checkbox"/> A leadership, policy and management infrastructure exists at state, tribal, and local levels to support systems of care.

VII. Strategies

Instructions: Here are some strategies that may help to support and promote accountability. Your system/site may already be using some of these strategies. Check those that you would like to explore further.

A. Incorporate Utilization and Cost Management Mechanisms	
<input type="checkbox"/>	1. Make sure that timely and accurate service utilization and cost data are available and used by system managers and policy makers for making fiscal and funding decisions. These data may include: <ul style="list-style-type: none">• Total costs of child behavioral health services,• Costs of services by child served,• Information on outliers (e.g., those using too much or too little service compared to expected use),• Utilization and cost by type of population served.
<input type="checkbox"/>	2. Allocate adequate funds for the development and maintenance of the management information system so that it has the capacity to track service utilization and costs by population (e.g., children in the child welfare and juvenile justice systems).
<input type="checkbox"/>	3. Develop a series of fiscal incentives and/or sanctions associated with service utilization and cost management.
<input type="checkbox"/>	4. Make sure that timely and accurate service utilization and cost data are available and used by case managers and child and family teams.
<input type="checkbox"/>	5. Develop mechanisms so that case managers are accountable for utilization and cost management.

B. Support Leadership, Policy, and Management Infrastructure for Systems of Care

- 1.** Identify funding mechanisms to support interagency entities for policy making and system management at state, tribal, and community levels.
- 2.** Develop adequate compensation packages and performance incentives for leaders at the state, tribal, and local levels who have designated responsibilities for building and sustaining systems of care.
- 3.** Explore funding opportunities for ongoing leadership development in systems of care, including family organizations and family and youth leaders.

C. Utilize Performance-Based or Outcomes-Based Contracting

- 1.** Implement performance or outcomes-based contracts with providers, system managers, case managers, and administrative service vendors.
- 2.** Include in contracts financial incentives and/or sanctions based on quality of care indicators, and specified outcomes at the system, program, and child and family levels.
- 2.** Include in contracts financial incentives and/or sanctions based on achieving outcomes for child and family from different cultural and ethnic groups.
- 3.** Provide funds to carry out contract monitoring activities and reporting.
- 4.** Use public (internal or external) disclosure of performance, as appropriate, to push the quality improvement agenda.

D. Evaluate Financing Policies to Ensure that They Support and Promote System of Care Goals and Continuous Quality Improvement

- 1.** Develop a system for ongoing monitoring of financing policies and strategies to ensure that they support system of care goals.
- 2.** Identify funds that can be used to support family and youth involvement in the ongoing monitoring of financing policies and strategies.
- 3.** Develop a system for ongoing monitoring of financing policies and strategies to ensure that they support and are responsive to a continuous quality improvement process.
- 4.** Collect and analyze cost-benefit data on the performance of systems of care.
- 5.** Use child and family outcome data in the monitoring and revision of financing policies and strategies.
- 6.** Provide funding for the regular dissemination of quality, outcome, and cost-benefit data.
- 7.** Produce quality, cost, outcomes and cost/benefit data about your system of care.

Conclusion

Now that you have completed the Self-Assessment and Planning Guide, we hope that you are prepared to develop a strategic financing plan that will assist your system/site to fund and sustain an effective system of care for children and families.

As your community uses this tool, give us feedback on its usefulness and what revisions might be helpful. For example, you may identify additional financing strategies and structures that are important for your community in the development of an effective system of care. If one or more of the strategies in this tool did not work in your community, let us know and tell us why.

You may have information that would be useful for other states and communities. Your response to any of the following questions will contribute to the study:

1. What technical assistance has been helpful to your state/tribe/community in developing and implementing your financing policies/strategies for systems of care (i.e., TA focus and TA methods)?
2. What technical assistance could be helpful as you continue to evolve and improve your financing policies/strategies for systems of care?
3. What changes do you anticipate in your financing policies and strategies for systems of care in the next several years?
4. What contextual, environmental, fiscal, or other factors do you think will influence your financing policies and strategies for systems of care in the next several years?

Your feedback will assist us to adapt this Guide and to develop additional technical assistance tools as we move forward in this study. Please send your feedback to: **armstron@fmhi.usf.edu**.

Glossary

Administrative Services Organization

(ASO): A contractual arrangement whereby a Managed Care Organization provides only the administrative services required by a health plan or payer.

Assessment: Assessment services, sometimes referred to as diagnostic and evaluation services, involve a professional determination of the nature of an individual's problem, the factors contributing to the problem and the strengths and resources of the individual and family. Recommendations for treatment and services are based on this information. It is important for the provider and family together to decide what kind of treatment and supports, if any, are needed. Comprehensive assessments focus on the child, family and the environment in which they live. They address each child's individual culture and physical, mental/emotional and developmental condition. Assessment plays a particularly important role for children and youth with serious emotional disturbances because their problems are complex and do not fit established diagnostic categories.

Behavioral Health Services and Supports:

Coordinated and integrated healthcare with the goal of restoring optimal behavioral health through the treatment of mental health and substance abuse disorders. Includes a broad array of mental health, chemical dependency, forensic, mental retardation, developmental disability, and cognitive rehabilitation services that are not limited to any setting or facility. Incorporates a full continuum of treatment intensities (from emergency and acute care to rehabilitation to stabilization) as well as prevention interventions at individual, family and community levels.

Blended Funding: The process of combining categorical funds from different sources and agencies into a single funding stream or "pool" to gain more flexibility in how these funds can be spent on individualized services. Once blended these funding sources are indistinguishable from

each other. Blended funding can allow systems to fund activities that are not reimbursable through specific categorical programs. Systems must track, document and account for the funds they spend, whether using a blended or braided approach.

Braided Funding: Funds from various sources are used to pay for a coordinated package of services for individual children, but tracking and accountability for each pot of money is maintained at the administrative level. The funds remain in separate strands but are joined or "braided" for the individual child and family. Systems must track, document and account for the funds they spend, whether using a blended or braided approach.

Capitation Rate: A fixed amount of money paid for every person enrolled in a health plan whether or not they present for services during a specific time. Usually expressed in units of per member per month.

Care Management: A process to facilitate individual child and family care at critical treatment junctures to assure their care is coordinated, received when they need it, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. This process establishes an identifiable point of accountability between the child and family and all helping systems.

Case Rate: A fixed amount of money paid for each person who presents for covered services. May be expressed differently in different programs, e.g., per child per month or per child per episode of care.

Case Manager: An individual who organizes and coordinates services and supports for children with mental health problems and their families, also, referred to as a care manager.

Child and Family Outcome Data: Data used for determining the impact of programs on the children and families served.

Child and Family Teams: Teams of children, families, providers and others who come together to develop individualized service plans. The team is usually made up of the providers and other agency representatives who work with the family, extended family members, and other support persons, such as neighbors or ministers. The family approves all team members. The team reviews each family's strengths and needs, identifies and plans for needed services and supports.

Child Find: A component of the Individuals with Disabilities Education Act (IDEA) that requires states to identify, locate, and evaluate all children with disabilities, aged birth to 21, who are in need of early intervention or special education services.

Clinic Option: A Medicaid optional benefit that allows for outpatient services to be provided through a wide variety of health care clinics including community mental health agencies. Services must be based at the clinic (except for services to homeless people) and supervised by a physician.

Co-Occurring Disorder: A term referring to co-occurring substance-related, mental health or developmental disorders. At the individual level, a co-occurring disorder exists when at least one disorder of two types can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder.

Cost Benefit Data: Data on child/family outcomes and on system performance to use in weighing the cost of a service, policy, or procedure against the benefits achieved for children and families.

Cost Neutrality: Refers to the requirement that States applying for Medicaid waivers under sections 1115, 1915(b) and/or 1915(c) must demonstrate that the program does not exceed what the federal government would have spent without approving the waiver. States can do this by showing that the average per capita expenditure estimated by the State in any fiscal

year for medical assistance provided with respect to the group affected by the waiver does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the state plan for such individuals if the waiver had not been granted. The concept of cost neutrality applies to other federal waivers also, e.g., Title IV-E.

Cost Shifting: The practice of one agency or system obtaining care for a child at the expense of another agency or system, i.e. shifting the cost of care from one agency to another.

Cross-System: Implies that more than one child-serving agency or system participates in a service, a program, a training event, etc.

Cultural Competence: Cultural competence is a developmental process that evolves over an extended period. It requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally
- Have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, adapt to diversity and the cultural contexts of the communities they serve
- Incorporate the above in all aspects of policymaking, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

Disparities: Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States. Research on health disparities related to socioeconomic status is also encompassed in the definition.

Disproportionality: A situation in which a particular racial/ethnic group of children is represented at a higher percentage than other racial/ethnic groups.

Early Childhood Mental Health: The social, emotional, and behavioral well-being of children birth through five and their families, including the developing capacity to: experience, regulate, and express emotion; form close, secure relationships; and explore the environment and learn.

EPSDT (Early and Periodic Screening, Diagnostic, and Treatment): A Medicaid program that is designed to improve primary health benefits for children with an emphasis on preventive care. States must cover regular and periodic exams for all eligible children under the age of 21; and must provide any medically necessary services prescribed by the exams, even those not covered in a state's Medicaid plan.

Evidence-Based Practice: The provision of services in a manner that is: consistent with current professional knowledge; supported by careful, systematic, and rigorous research and evaluation; based on best clinical experience; and consistent with child/family values.

Family-Driven: A term meaning families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes: choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; partnering in funding decisions; and determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

Family of One: The "family of one" option is a basic Medicaid rule (optional for states) that allows children who have been in an out-of-home placement for 30 days or longer (e.g., residential treatment or therapeutic foster care) to become eligible for Medicaid, regardless of their family's income, while they need and remain in the placement. It does not allow eligibility during the first 30 days in placement and does not allow the use of Medicaid to cover

costs during that time. When the child returns home, he/she is no longer eligible as a "family of one."

Family Organization: An organization with the explicit purpose to serve families who have a child, youth, or adolescent with special physical, mental, emotional, behavioral, developmental or educational needs. It is governed by a board of directors comprised of a majority of individuals who are family members; gives preference to family members in hiring practices; and is incorporated in a State as a private non-profit entity.

Individualized Service Plans (ISP): The written procedures and activities that are appropriately scheduled and used to deliver services, treatments, and supports to a child and the child's family. Families help create these plans which guide the work of the care manager. The ISP is created uniquely for each child and family and changed as often as necessary to reflect changes in the child, the family, and/or their circumstances. Such plans treat the family as a unit and seek to coordinate service efforts across all family members.

Level of Care Criteria: Guidelines employed to assist in the determination of the appropriate setting and intensity of behavioral health treatment.

Linguistic Competence: The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures and dedicated resources to support this capacity.

Managed Care Organization: An organization that either directly provides or arranges managed health care by applying various

strategies designed to optimize the value of provided services by controlling their cost and utilization, promoting their quality and measuring performance to ensure cost-effective outcomes.

Management Information System (MIS):

A system (almost universally automated or computer based), which collects the necessary information in proper form and at appropriate intervals for managing a program or other activities. The system shall afford indicators, which measure program progress toward objectives, identify discrete costs, and facilitate identifying problems that need attention.

Medicaid Options: Options granted by the federal government to states through which they can provide an expanded range of services to a target group of children.

Medical Necessity Criteria: Criteria used by the managed care entity to determine if requested interventions or services are medically appropriate and necessary to meet the needs for a particular individual.

Part C: The Early Intervention Program of the Individuals with Disability in Education Act (IDEA) that focuses on infants and toddlers and requires a range of early intervention services needed as a result of developmental delays affecting cognitive development, physical development, language and speech, or psychological development.

Performance-Based or Outcomes-Based Contracts: Emphasizes that all aspects of an acquisition be structured around the purpose of the work to be performed as opposed to the manner in which the work is to be performed or broad, imprecise statements of work which preclude an objective assessment of contractor performance. It is designed to ensure that contractors are given freedom to determine how to meet performance objectives, that appropriate performance quality levels are achieved, and that payment is made only for services that meet these levels.

Pooled Funding: See definition for Blended Funding.

Practice Based Evidence: A range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. Practice based evidence services are known to be effective by the local community, through community consensus. They address the therapeutic and healing needs of individuals and families from a culturally specific framework. Practitioners of practice based evidence models draw upon cultural knowledge and traditions for the treatment and are respectfully responsive to the local definition of wellness and dysfunction.

Practice Based Evidence/Promising Practices: Practice knowledge supported by evidence of effectiveness through the experiences of key stakeholders, such as families and direct-care providers and usually outcome data.

Provider Network: Group of agencies and/or individual providers that agree to provide and are reimbursed for services to members of a managed care plan or an organized system of care.

Psychiatric Rehabilitation Options

(Rehabilitation Option): An option in Medicaid services that incorporates rehabilitative, community-based services to persons with psychiatric and co-occurring psychiatric-substance abuse diagnosis. This category is known as the Medicaid Rehabilitation Option or MRO. Medicaid also pays for behavioral health services through the Clinic Option and through Targeted Case Management (TCM).

Psych Under 21: An optional benefit under section 1905(a)(16) of the Social Security Act that covers inpatient hospitalization of children under age 21. The benefit must provide any services listed in section 1905(a) that is needed to correct or ameliorate defects and physical and mental conditions discovered by EPSDT screening, whether or not the service is covered under the State plan.

Purchasing Collaborative: A collaborative behavioral health services model that brings all agencies tasked with the delivery, funding or oversight of behavioral healthcare services together to create a single behavioral health service delivery system in a state.

Quality Assurance: An approach to improving the quality and appropriateness of medical care and other services. Includes a formal set of activities to review, assess, and monitor care to ensure that identified problems are addressed.

Quality Improvement/Continuous Quality Improvement: A process that continually monitors program performance. When a quality problem is identified, CQI develops a revised approach to that problem and monitors implementation and success of the revised approach. The process includes involvement at all stages by all organizations, and stake holders that are affected by the problem and/or involved in implementing the revised approach.

Risk Adjustment Mechanisms: Various methods that can be used to level the playing field prospectively or retrospectively for at-risk provider systems under situations where voluntary or mandatory enrollees may choose among competing providers. Adjust rates paid to managed care organizations or providers for the cost of caring for populations with known high service costs.

Risk Pool: A grouping of enrollees or contracts by some common factor, (e.g., contract, size, geographic location, services utilization pattern) that allows all revenue and expenses for that group to be aggregated and to distribute risk among participants and thus insure that the losses faced by any one participant are minimized. Used to spread risk for low incident, high cost conditions or to buffer a risk bearing managed care organization or provider from catastrophic cost that are outside provider's control.

Screening: A guideline that recommends periodic interventions be performed for the early detection of behavioral health problems so that appropriate care can be provided early on.

Section 1115 Research & Demonstration Projects: This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.

Section 1915 (b) Managed Care/Freedom of Choice Waivers: This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

Section 1915 (c) Home and Community-Based Services Waivers: This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

Service Utilization: A description, usually statistical, of the level, frequency, and necessity of services actually used by consumers. Generally aggregated into population measures, rather than individual consumer measures.

Single Plan of Care: A single care plan developed among all agencies serving the family. There should be no separate education plans, child welfare plans, mental health agency plans, etc.

Skilled Professional Medical Personnel/ Administrative Medical Case Management: Medicaid funding may be used to reimburse for administrative case management when the case management is provided by Skilled Professional Medical Personnel (SPMP). SPMP may provide services such as administrative medical case management, intra/interagency coordination, collaboration and administration, training, program planning and policy development, and quality management.

State Children's Health Insurance Plan

(SCHIP): Under Title XXI of the Balanced Budget Act of 1997, the availability of health insurance for children with no insurance or for children from low-income families was expanded by the creation of SCHIP. SCHIPs operate as part of a State's Medicaid program.

System/Site: Any state, tribe, territory, region, county, city, community, or organization that is designing a comprehensive financing strategy to build a system of care.

Systems of Care: A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.

Target Population: The specific population of people a particular program or practice is designed to serve or reach.

Targeted Case Management: Medicaid term for case management services covered under Title XIX of the Social Security Act (as of November 1995). Federal law defines Targeted Case Management as services that will assist individuals eligible under the state Medicaid plan in gaining access to needed medical, social, educational and other services.

Intensive Care Management: intensive community services for individuals with severe and persistent mental illness designed to improve planning for their service needs. Intensive care management includes outreach, evaluation and support services. Case managers are generally advocates and arrangers of services and supports, but also provide teaching of community-living and problem-solving skills; modeling productive behaviors and helping individuals help themselves.

Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA): TEFRA is a specific Medicaid eligibility option available to states that allows the provision of home and community-based services for children who meet SSI disability criteria and who, without the home and

community-based services, would require institutional placement. Parental income is not considered in determining the child's eligibility. If a state uses this option, there is no limit on the number of children who can be served, and it creates an entitlement for all children who qualify based on their disability and care needs. It is also known as the Katie Beckett option in some states.

Telehealth (Telemedicine): Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site.

Title IV-E Demonstration Waiver (Child Welfare Demonstration Projects): Provides States with an opportunity to design and test a wide range of cost-neutral approaches to improve and reform child welfare by waiving certain requirements of Title IV-E. The general objectives of the waivers include the development of family-focused, strengths-based, community-based service delivery networks that enhance the child-rearing abilities of families, to enable them to remain safely together when possible, or to move children quickly to permanency; and development of better results for children and families.

Utilization Management: A system of procedures designed to ensure that the services provided to a specific individual at a given time are cost-effective, appropriate, and least restrictive.

Utilization Review: Retrospective analysis of the patterns of service usage in order to determine means for optimizing the value of services provided (e.g. minimize cost and maximize effectiveness/appropriateness).

Youth-guided: A term meaning youth having a role in guiding their own care. For older youth, it may mean directing their own care.

Appendix 1

Matrix 1: A Tool for Mapping Spending Across Child-Serving Systems

This matrix is intended to be used as a tool to map spending on behavioral health services and supports for children, adolescents and their families across child-serving systems at state, local, and tribal levels.

The vertical column of **Matrix 1** includes a fairly thorough, but not necessarily complete, listing of the child-serving systems that tend to spend dollars for behavioral health services/supports for children and youth. You may have to adapt the list for your given state, tribal authority or locality.

The horizontal row creates a high-level grouping of the major types or sources of dollars for behavioral health services/supports for children and adolescents and their families. As you analyze each source of funding, you will want to specify the exact type. For example, under “Federal Block Grant,” you will want to specify the type of federal block (e.g., Mental Health Block Grant, Social Services Block Grants, etc.). As another example, under “Local General Revenue,” you will want to specify the type or source of local revenue (e.g., special county levy, local tax dollar match for child welfare, etc.). In addition to identifying the type of funding under each heading in the horizontal row, you will want to identify the amount being spent under each type.

Attachment A is intended to assist you in completing **Matrix 1**. It provides a comprehensive (though, again, not necessarily complete) listing of potential sources of funds for systems of care. You can use **Attachment A** to guide you in identifying the specific types of dollars you are spending at state, local and tribal levels in each of the funding categories listed in the horizontal row.

The purpose of this mapping exercise is to give you a fuller picture of the extent of spending for behavioral health services and supports for children and youth, which systems are controlling this spending, and the amount and types of dollars being spent. Completing this type of mapping exercise will provide a full understanding of the totality of resources in your system, opportunities for maximizing some spending, and opportunities for redirection, for braiding funds and the like.

Matrix 1 A Tool for Mapping Spending Across Child- Serving Systems										
Agencies/Systems that Contribute Funds	Funding Categories									
	State General Revenue	Local General Revenue	Tribal Authority Revenue	Medicaid Match (i.e. state and/or local revenue used as Medicaid match)	Federal Medicaid Revenue	Other Federal Entitlement Funding (e.g., Title IV-E)	Federal Block Grants	Federal Formula Grants	Other Federal Funding (e.g., federal discretionary grants)	Non-governmental (e.g., foundation funding, grants, fees, donations*)
Mental Health										
Medicaid										
Child Welfare										
Juvenile Justice										
Education										
Substance Abuse										
Primary Health/ Public Health										
Developmental Disabilities										
TANF										
Tribal Organizations (BIA, HIS, Tribal Government)										
Child Care										
Housing										
Labor										
Family Organizations										
Non-government Organizations										

*NOTE: You may also wish to include and estimate the value of in-kind contributions and their source.

Appendix 2

Attachment A Potential Funding Sources

Federal
Department of Health and Human Services
Social Security Act
Temporary Assistance for Needy Families (TANF) –Title IV-A
Child Welfare – Title IV-B, Part 1-Child Welfare Services Program
Child Welfare – Title IV-B, Part 2-Promoting Safe and Stable Families
Child Welfare – Title IV-E-Foster Care and Adoption Assistance
Juvenile Justice—Title IV-E
Maternal and Child Health Block Grant – Title V
Healthy Start Initiative
Medicaid – Title XIX
Early and Periodic Screening, Diagnostic, and Treatment Services (EPSDT)
Rehabilitation Option
Targeted Case Management (TCM)
Fee for Service
Waivers:
Section 1915 (b)
1915 (b) (3)
Section 1915 (c) (Home and Community-Based Waiver)
Section 1115
Health Insurance Flexibility and Accountability (HIFA) Waiver
Social Services Block Grants –Title XX
State Children’s Health Insurance Program (SCHIP) – Title XXI
Administration for Children and Families
System of Care Grants
Head Start
Early Head Start
Child Care Development Fund
Family Resource Support

Developmental Disabilities
John H. Chafee Foster Care Independence Program
Indian Health Service
Substance Abuse and Mental Health Services Administration
Substance Abuse Prevention Block Grant
Substance Abuse Treatment Block Grant
Mental Health Block Grant
CMHS Local Services Grant
Child State Incentive Grant
Mental Health Transformation State Incentive Grant
Co-Occurring State Incentive Grant
Other
Department of Education
Title I-Improving the Academic Achievement of the Disadvantaged
Individuals with Disabilities Education Act (IDEA)
Part B: Preschool
Part B: State Grants
Part C: Infants and Toddlers
Even Start--Family Literacy
Even Start – Migrant Education
Even Start – Indian Tribes
Other
Other Federal Agencies
Department of Justice
Violence Against Women Act
Office of Juvenile Justice Delinquency Prevention
Department of Transportation—DUI/DWI
Department of Agriculture
Food Stamps
Women Infants and Children (WIC)
Housing and Urban Development Department
Community Development Block Grant
Housing

Department of the Interior
Bureau of Indian Affairs (BIA)
Social Services
Child Welfare
Department of Homeland Security
Infrastructure Development Grant
Underage Drinking (SAMHSA, OJJDP, NIAAA, NHTSA, CDC funds)
Corporation for National and Community Service --AmeriCorps
Job Training
Department of Labor
Housing
Public Welfare
Other
State, Tribal, and Local
Non-Medicaid State Matching Funds
State General Revenue Flexible Dollars
Other State General Funds
Local Tax Funds
Local Levies
Gaming/Casinos
Tobacco Settlement
Non-Government
Private Insurance
Foundation Funding
Corporate Giving
Social/Volunteer/Faith Organization Donations
Other
Other Funding Strategies
In Kind Donations
Source: Attachment A is adapted from <i>System of Care Communities Regional Meetings – 2006 Funding Source Matrix</i> , created by the Technical Assistance Partnership for Child and Family Mental Health at the American Institutes for Research, Washington, DC, 1/06.

Appendix 3

How are the Indian Health Service (IHS), Tribes and Urban Indian Programs Paid Under Medicaid?

February 2006

Prepared for National Indian Child Welfare Association (NICWA) by Nancy Weller

Following the adoption of the Indian Health Care Improvement Act in 1976, it became apparent that even though the IHS and tribes were authorized to bill Medicaid, Medicare and other third parties they did not have the capacity to bill for the services they rendered. In order to facilitate payment, the federal government negotiated rates to purchase inpatient and outpatient services from Medicare and Medicaid. This rate was based on the Medicare deductible at the time for outpatient services and was multiplied by 5 for inpatient services. The rates, called the IHS Published Rate or All-Inclusive Rate is published annually in the Federal Register by the Indian Health Service and is applicable to that calendar year. Payment of these rates is made by states using all federal funds since the match rate for IHS and tribal facilities is 100% Federal Medical Assistance Percentages (FMAP).

During the mid 1990's the Office of Management and Budget (OMB) expressed increasing concerns about the basis of the IHS rates so the IHS contracted for the services of an agent to develop cost reports for IHS hospitals across the country called the Method E. Rates are now published based on the cost reports developed for both IHS and tribally operated hospitals. These rates are still annually negotiated between IHS and OMB before being published.

Beginning in 1997, the Federal Register notice also permitted physician services to inpatients to be reimbursed at the state fee schedule for Medicaid, and in 2005 the language was further expanded to include undefined health professionals.

The IHS Published rates are used by about 23 states. Because the rate has never been defined, the use of the outpatient rate is as varied as the Medicaid Program itself. Each state determines what services are covered by the outpatient IHS Published Rate as well as the types and number of encounters that will be paid with the rate. Both states and tribes have requested federal guidance regarding the use of the IHS Published Rates, but that guidance has not been forthcoming. Indeed, states are generally wary of discussing the IHS rates because the little federal guidance regarding the use of the rates and claiming of the 100% FMAP has been contradictory. The only specific federal policy issued on the issue prohibits the 100% FMAP reimbursement for non-emergency transportation provided by tribes. States generally claim 100% FMAP for any services provided by and IHS or 638 tribe or tribal organization regardless of the payment methodology used to reimburse the services. A number of state lawsuits are in progress with regards to claiming of the 100% FMAP, and language has been included in various versions of the bills reauthorizing the Indian Health Care Improvement Act to clarify the use of the 100% FMAP (including extending it to Urban Indian Organizations). The State of Alaska won a federal appeal in 2004 regarding claiming of 100% FMAP for tribally operated air ambulance services.

In order to receive payment at the IHS Published Rates, a facility of the IHS or a 638 tribe or tribal organization must be included on the IHS Facility List. This is in accordance with the 1996 Memorandum of Agreement between the IHS and the Health Care Financing Administration (the federal agency overseeing Medicare and Medicaid prior to being named CMS). Unfortunately, the IHS facility list has not been distributed to states since 1997; many states make their own efforts to access the IHS facility list from their local areas offices of the IHS.

Urban Indian Programs, except for those in Oklahoma, are not eligible to receive the IHS Published Rates, and payments made to Urban Indian Programs (except for Oklahoma) are not reimbursed to states with the 100% FMAP. An Urban Indian Programs may enroll with Medicaid under any methodology for which they qualify. The most common provider type used by Urban Indian Programs is the FQHC (federally qualified health center) since this provider type must be reimbursed at cost under federal law. An FQHC is a program that may offer Physician, Physician assistant, Nurse Practitioner, Psychologist and Licensed Clinical Social Worker Services as well as other ambulatory services included in the State Plan. An FQHC may also offer visiting nurse services in areas underserved by home health agencies. States are free to allow FQHCs to provide any range of services covered in their State Plan, such as Perinatal Services, case management and a wide array of behavioral health services. An FQHC must provide an annual cost report upon which their rates are based, and are typically paid an encounter rate for all services provided to a patient on a given day with an annual cost settlement.

Many states with a significant American Indian/Alaska Native population will dedicate resources to work with the IHS, tribes and Urban Indian Programs. In some states this is due to the encouragement of Tribal Consultation by the federal government; tribal consultation is required when the state enters into Waivers or renews waivers. Obviously some states devote more resources than others depending on a number of factors, and it is in the best interest of the I/T/U to develop relationships with the state Medicaid Program in order to receive adequate training, claims support and an ongoing dialog about important issues to their people. The I/T/U should negotiate with the state on important issues such as the services covered by the IHS Published Rate and administrative matching funds for outreach and enrollment activities, as states may be agreeable to making policy changes when approached.

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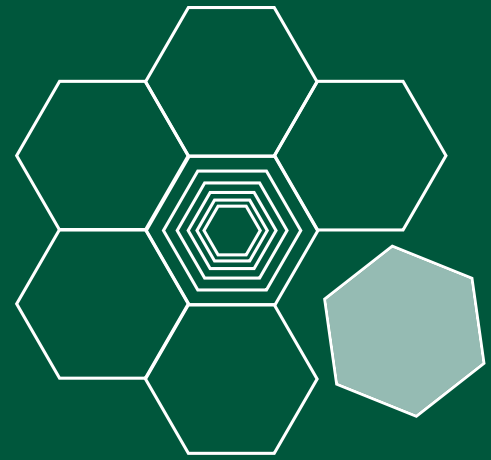
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