



UNIVERSITY OF  
SOUTH FLORIDA  
COLLEGE OF BEHAVIORAL  
& COMMUNITY SCIENCES

# Effective Financing Strategies for Systems of Care:

## Examples from the Field *Second Edition*

*A Resource Compendium for Developing a Comprehensive Financing Plan*

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The Research and  
Training Center for  
Children's Mental Health

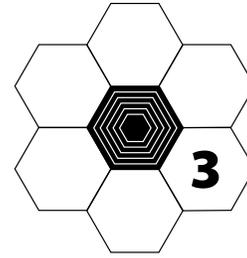
### **RTC Study 3**

Financing Structures and Strategies  
to Support Effective Systems of Care

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**Partial Contents:** RTC: Study 3 Background – Overview of Sites Studied – A Strategic Approach to Financing – How to Use this Book – Study Findings – Description of Sites Studied – Developing a Strategic Financing Plan for Systems of Care – Analyzing and Projecting Utilization, Costs and Resources – Core Financing Strategies – Realignment of Funding Streams and Structures – Braided Funding – Financing Services and Supports – Individualized, Wraparound Approach – Financing Key System of Care Features – Cross Agency Service – Family and Youth Partnerships – Improving Cultural and Linguistic Competence – Reducing Disparities in Care – Financing Mechanisms that Track and Manage Utilization, Quality, Costs, and Outcomes – Improving the Workforce and Provider Network – Financing Strategies for Tribal Systems of Care – Financing Behavioral Health Services – Conclusion

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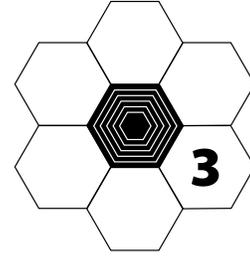
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Georgetown University Center for Child and Human Development  
Washington, DC

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Peoria, AZ



Research and Training Center  
For Children's Mental Health

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# Chapter 1. Background

## Research and Training Center Study 3

The Research and Training Center for Children’s Mental Health (RTC) at the University of South Florida conducted several five-year studies to identify critical implementation factors that support states, communities, tribes, and territories in their efforts to build effective systems of care to serve children and adolescents with or at risk for serious emotional disturbances and their families. One of these studies examined financing strategies used by states, communities, and tribes to support the infrastructure, services, and supports that comprise systems of care.

The study of effective financing practices for systems of care was initiated in October 2004 and was 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. of Arizona. The study was supported with federal funding from the National Institute on Disability and Rehabilitation Research of the Department of Education and the Substance Abuse and Mental Health Services Administration (SAMHSA).

### **The purposes of the study were to:**

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

The study of effective financing strategies for systems of care used a participatory action research approach, involving a continuous dialogue with key users on study methods, findings, and products. The study used a multiple case study design, and data collection and analysis included a mix of qualitative and quantitative methods.

Initial study tasks included convening a panel of financing experts, including state and county administrators, representatives of tribal organizations, providers, family members, and national financing consultants to develop a list of critical financing strategies and study questions. The critical financing strategies were used to create the first study product – A Self Assessment and Planning Guide: Developing a Comprehensive Financing Plan – that addressed important areas to assist service systems or sites (states, tribes, territories, regions, counties, cities, communities, or organizations) to develop and implement comprehensive and strategic financing plans for systems of care:

- Analyzing spending, utilization, and resources across agencies
- Realigning funding streams and structures
- Financing appropriate services and supports
- Financing to support youth and family partnerships

- Financing to improve cultural and linguistic competence and reduce disparities in care
- Financing to improve the workforce and provider network
- Financing for accountability

In each of these areas, critical financing strategies were developed and were used as the basis for developing site visit protocols to explore the implementation of these strategies in a purposively selected sample of states and communities. Study team members and members of the national expert panel nominated a number of states and communities as potential sites to study, based on their knowledge of effective financing strategies that supported systems of care at those sites. Telephone interviews with key informants knowledgeable about each of the sites nominated, along with review of documents and information from prior related studies, led to the identification of a sample of sites to include in two waves of site visits and interviews. As shown on **Table 1.1** below, four states and four regional or local areas were studied in the first wave; the second wave of sites included two additional states and three additional regional/local areas.

<b>Sites</b>	<b>First Wave</b>	<b>Second Wave</b>
<b>States</b>	<i>Arizona</i> and Maricopa County <i>Hawaii</i> <i>New Jersey</i> <i>Vermont</i>	<i>California</i> and Contra Costa County <i>Michigan</i> and Livingston and Ingham Counties
<b>Regional/ Local Areas</b>	Bethel, <i>Alaska</i> Central <i>Nebraska</i> Choices (based in Indianapolis, <i>Indiana</i> ) Wraparound Milwaukee	Cuyahoga County, <i>Ohio</i> Erie County, <i>New York</i> Project BLOOM, <i>Colorado</i>

The first wave of site visits was conducted from September 2006 to February 2007. Site visits involving in-depth interviews with key stakeholders about the various financing strategies in use were conducted in Arizona, Hawaii, Vermont, Bethel, and Central Nebraska. Abbreviated site visits and telephone interviews were used to gather updated data from New Jersey, Choices, and Wraparound Milwaukee, all of which had been studied previously by members of the study team. Examples of effective financing strategies used in each of these sites were reviewed and analyzed by the study team, and the first edition of a resource compendium detailing these approaches was published in 2008.

The second wave of site visits was conducted from January 2007 to November 2007, involving site visits with in-depth interviews of key stakeholders in five additional study sites. The financing strategies used in these sites were also reviewed and analyzed, and a second edition of the resource compendium was developed incorporating these additional examples of effective financing strategies and reorganizing the financing strategies into a refined framework.

This second edition of the resource compendium also includes a cross-site analysis of the financing strategies used in the 13 sites studied, which was undertaken to synthesize study findings on effective financing strategies for systems of care and to identify areas needing further exploration in the future.

## A Strategic Approach to Financing

A strategic approach to financing begins with system of care stakeholders answering two key questions: Financing for whom? And Financing for what? To answer these questions, system of care planners must achieve consensus on the following:

- The population(s) of focus, including the demographics, size, strengths and needs, current utilization patterns, and disparities and disproportionality in service use among the identified population(s)
- The underlying values and intended outcomes
- The services and supports and the desired practice model (for example, a strengths-based, individualized/wraparound, culturally competent, family-driven and youth-guided practice approach) to achieve outcomes
- How services and supports will be organized into a coherent system design
- The administrative infrastructure needed to support the delivery system

Once these issues are addressed, then system builders can undertake a process to develop a strategic financing plan for systems of care. The strategic plan involves undertaking analyses to project expected utilization and cost and to identify potential resources for systems of care. The process then involves designing a strategic plan that includes core financing strategies to realign financing streams in order to finance systems of care. The plan must include strategies for financing the broad array of services and supports that comprise systems of care and the adoption of an individualized or wraparound approach to service delivery. In addition, the plan must include strategies to finance key features of systems of care including care coordination, family and youth partnerships, cultural and linguistic competence, a diverse and qualified workforce, and accountability structures and processes. Specifically, the strategic planning process includes the following components:

- **Developing a Strategic Financing Plan for Systems of Care**
  - Analyze and Project Utilization, Cost, and Resources
  - Develop a Formal Strategic Financing Plan for Systems of Care
- **Core Financing Strategies: Realigning Financing Streams**
  - Utilize and Coordinate Multiple Funding Streams
  - Maximize Federal Entitlement Funding
  - Redirect Spending from “Deep-End” Placements to Home and Community- Based Services
  - Implement Financing Strategies for Youth with Intensive Service Needs and their Families
- **Financing Services and Supports and an Individualized, Wraparound Approach**
  - Finance a Broad Array of Services and Supports
  - Finance an Individualized, Flexible, Wraparound Approach to Service Delivery
  - Finance Evidence-Based and Promising Practices
  - Finance Early Childhood Mental Health Services
  - Finance Early Identification and Intervention
  - Finance Services for Uninsured/Underinsured Children
- **Financing Key System of Care Features**
  - Finance Cross-Agency Service Coordination
  - Finance Family and Youth Partnerships
  - Finance Improvements in Cultural and Linguistic Competence and Reduction of Disparities in Care
  - Finance Improvements in the Workforce and Provider Network
  - Finance Accountability Processes

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Strategic financing plans include both short and long-term financing strategies and delineate processes for evaluating financing strategies periodically to assess their effectiveness and to determine what refinements are needed to support system of care goals.

## How to Use this Document

This document presents examples of effective financing strategies in each of the components of a strategic financing plan for systems of care. It is intended as a technical assistance document to assist stakeholders to identify strategies that might be implemented or adapted in their own states, communities, tribes, and territories. The resource compendium is designed to serve as a reference and resource as states, communities, and tribes are designing and implementing strategic financing plans for systems of care.

The resource compendium can be used as a companion to the *Self-Assessment and Planning Guide* that provides states, communities, and tribes with a framework for developing a strategic financing plan for systems of care. As users move through the process of developing and implementing a financing plan, the resource compendium can be used to identify and learn the details about specific strategies that have been found to be effective in other states and communities. In many cases, web sites are provided to enable users to obtain additional information about the strategies that they may wish to replicate or adapt.

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## Chapter 2. Overview of Study Findings

This chapter presents an overview of the findings from the study and identifies areas needing further examination in the future. The strategies identified in the sites included in the study sample are summarized for each of the following major areas:

- **Developing a strategic financing plan for systems of care**
- **Core financing strategies: realigning financing streams**
- **Financing services and supports and an individualized, wraparound approach**
- **Financing key system of care features**

Information is provided both in a table displaying the sites in which each strategy and sub-strategy was found, as well as in narrative form providing brief examples of the types of financing strategies that were identified. It should be noted that the sample of sites included in this study is not representative of all states or regional/local areas. Rather, the sample was selected purposively based on nominations by key informants and a pre-screening process that confirmed that they had a critical mass of effective financing strategies in place. Thus, these sites are more likely to have financing strategies in these areas.

It should also be noted that Bethel, Alaska was selected for study based on its efforts to finance a system of care in a tribal community. Because of the significant differences in approach, Bethel's financing strategies are described in a separate chapter and are not included in the summary tables but are included in the text where appropriate.

### Developing a Strategic Financing Plan for Systems of Care

A strategic financing plan that establishes financing approaches for services and supports and for other key features of systems of care provides a road map for states, tribes, and communities as they build and expand the delivery system for children and youth with behavioral health challenges and their families. An important first step in the development of a strategic financing plan is identifying current spending and utilization patterns. This process enables a state, tribe, or community to understand how resources are currently being spent for behavioral health services – for which services and for which children and families. The identification of child behavioral health expenditures and utilization needs to occur across all child-serving systems as multiple systems – Medicaid, child welfare, juvenile justice, education, mental health and substance abuse, among others – finance child behavioral health services. Expenditure and utilization levels within individual child-serving systems vary from state to state. A second step is identifying the types and amounts of potential resources that can be allocated or redirected to systems of care. These often are dollars being spent on high-cost and/or poor outcome approaches, for example, on out-of-home placements. This type of analysis also can point to areas where federal financing, such as Medicaid and Title IV-E, may be under-utilized to support systems of care. Analysis of expenditures and utilization across child-serving systems also can shed light on disparities and disproportionalities in access and use based on race/ethnicity or geography. With the information learned through the analysis, strategic planning for financing systems of care can proceed. It is also important to undertake periodic assessment of financing policies and strategies to assess their effectiveness and to ensure their support for system of care goals. Strategies include: 1) analyzing and projecting utilization, cost, and resources and 2) developing a strategic financing plan.

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## I. Analyze and Project Utilization, Cost, and Resources

**Table 2.1** shows that all sites determine and track utilization and costs for a variety of planning, rate setting, and accountability purposes. For example, Cuyahoga County uses a web-based multipurpose management information system to collect data on utilization, costs, and cross-system involvement; one use of the information is to project future system of care costs. However, fewer than half of the sites did some type of analysis of utilization or of the amounts and types of funds spent for children’s behavioral health services across systems or identified potential financing streams for systems of care. An exception was found in Central Nebraska, which analyzed and “mapped” expenditures across child-serving systems to establish a case rate to support its system of care. Cuyahoga County and Project BLOOM developed a funding grid and a funding matrix respectively to identify all potential funding sources for their systems of care.

## II. Develop a Strategic Financing Plan for Systems of Care

**Table 2.1** also shows that some but not many sites have developed strategic plans for children’s mental health services, including a specific focus on financing. For example, Hawaii developed a strategic financing plan as part of its overall strategic plan for children’s mental health services that calls for strengthening Medicaid billing and braiding funds across agencies, among other strategies. Measurement of progress toward the financing goals established in strategic plans provides a framework for the periodic assessment of financing strategies and their effectiveness in achieving system of care goals. For example, Hawaii assesses the achievement of its financial targets, as does the Funders Group (an interagency body) in Cuyahoga County.

## Core Financing Strategies: Realigning Funding Streams

A multitude of funding streams at federal, state, and local levels can be drawn upon to support systems of care. However, the maze of funding streams that finance children’s behavioral health services must be better aligned, better coordinated, and, often, redirected to support individualized, flexible, home and community-based services and supports. Based on a careful analysis, a strategic financing plan “realigns” resources to develop a more coherent, effective, and efficient approach to financing the infrastructure and services that comprise systems of care. Such realignment involves: 1) utilizing and coordinating resources from multiple funding streams; 2) maximizing the use of entitlement programs (such as Medicaid); 3) redirecting and redeploying resources, often from more restrictive and expensive services such as out-of-home placements; and 4) financing strategies to manage services and create a “locus of accountability” for children with intensive service needs who are high utilizers of services and involved in multiple systems.

**Table 2.1**  
**Developing a Strategic Financing Plan for Systems of Care**

Sites	I. Analyze and Project Utilization, Cost and Resources		II. Develop a Strategic Financing Plan for SOCs	
	A. Analyze Utilization and Spending Patterns and Project Expected Utilization and Cost	B. Identify Types and Amounts of Funding for BH Services Across Systems and Potential Resources for SOCs	A. Develop a Formal Strategic Financing Plan	B. Evaluate and Refine the Strategic Financing Plan
<b>States</b>				
Arizona	X			
California	X			
Hawaii	X		X	X
Michigan	X		X	
New Jersey	X			
Vermont	X			
<b>Regional/ Local Areas</b>				
Central Nebraska	X	X		
Choices	X			
Cuyahoga County, OH	X	X	X	X
Erie County, NY	X	X		
Project BLOOM, CO	X	X	X	
Wraparound Milwaukee	X	X		
	<b>100%</b>	<b>42%</b>	<b>33%</b>	<b>17%</b>

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## I. Utilize and Coordinate Multiple Funding Streams

As shown on **Table 2.2**, all of the sites studied use resources from multiple child-serving systems to finance services and supports. Resources from mental health, Medicaid, child welfare, juvenile justice, and education are used by all of the sites. Resources from the substance abuse, developmental disabilities, and primary health systems are included in the financing mix less frequently, but are included in some of the sites. For example, Hawaii and California both combine resources such as: Medicaid; general revenue; federal block grants; special grants; special taxes; and child welfare, juvenile justice, and education funds for children’s mental health services.

A few sites also use special funding streams to finance children’s behavioral health services. For example, the Mental Health Services Act in California imposes a 1% tax on personal income over \$1 million, resulting in new funding for mental health. Cuyahoga County and Project BLOOM use local tax levies.

To coordinate funds across multiple funding streams, the sites studied use a number of strategies. Many of the sites pool, blend or braid funds across systems and utilize a case rate approach. For example, Central Nebraska, Choices, Erie County, Livingston County, and Wraparound Milwaukee blend funds from two or more child-serving systems to finance services and use case rates. Other sites describe their approach as “braided” funding from different sources which remain in separate strands administratively but are joined or “braided” to pay for a coordinated package of services and supports for individual children, such as in Cuyahoga County.

Most sites also share costs among partner agencies for specific services. For example, the mental health and child welfare systems co-finance therapeutic foster care in Arizona and Hawaii; education and mental health co-finance school-based wraparound in Central Nebraska; and child welfare, education, mental health and Medicaid co-finance crisis outreach services in Wraparound Milwaukee.

The sites use various mechanisms to coordinate funding across child-serving systems, including controlling and monitoring potential cost shifting. In Hawaii, memoranda of understanding have been negotiated between the mental health system and the Medicaid agency, as well as with the child welfare, education, and juvenile justice systems. Vermont enacted legislation mandating interagency coordination and establishing local and state interagency teams that address the coordination of resources and services. Other sites, such as Michigan, use local interagency structures for system-level coordination. Strategies for coordinating the procurement of services across agencies were found in several sites. For example, Hawaii developed uniform contracting protocols that include both performance standards and practice guidelines that are shared between the education and mental health systems. Wraparound Milwaukee has centralized the procurement of residential treatment services and has uniform rates for over 80 different home and community-based services and supports for utilization by wraparound teams. Erie County also has uniform rates for wraparound vendor services.

Flexible use of resources is an important element in financing systems of care and services, and increased flexibility in using funds was found in all of the sites. For example, in Hawaii, local lead agencies (Family Guidance Centers) have significant flexibility in the use of resources, and child and family (wraparound) teams determine how resources will be used for each individual child and family. Several sites use managed care approaches and managed care financing mechanisms (capitation and case rates) which allow for the flexible use of resources to meet individual needs.

**Table 2.2**  
**Core Financing Strategies: Realigning Financing Strategies**

Sites	I. Utilize and Coordinate Multiple Funding Streams						
	A. Utilize Multiple Funding Streams		B. Coordinate Funding Across Systems				
	1. Utilize Funding from Multiple Agencies	2. Utilize Special Funding Streams	1. Pool, Blend, or Braid Financing Across Systems	2. Share Costs for Specific Services and Supports	3. Coordinate Funding Across Systems at the System Level	4. Coordinate Procurement of Services and Supports Across Agencies	5. Increase Flexibility of State and/or Local Funds
<b>States</b>							
Arizona	X			X			X
California	X	X		X	X		X
Hawaii	X			X	X	X	X
Michigan	X		X		X		X
New Jersey	X		X			X	X
Vermont	X		X	X	X	X	X
<b>Regional/Local Areas</b>							
Central Nebraska	X		X	X		X	X
Choices	X		X				X
Cuyahoga County, OH	X	X	X	X	X	X	X
Erie County, NY	X		X			X	X
Project BLOOM, CO	X	X	X	X	X		X
Wraparound Milwaukee	X		X	X		X	X
	<b>100%</b>	<b>25%</b>	<b>75%</b>	<b>67%</b>	<b>50%</b>	<b>58%</b>	<b>100%</b>

## II. Maximize Federal Entitlement Funding

Another core financing strategy involves maximizing federal entitlement funding, including Medicaid, Title IV-E (child welfare), and special education. **Table 2.3** summarizes findings for each of these strategies.

With respect to Medicaid, strategies for maximizing eligibility and enrollment in Medicaid and SCHIP were found in all of the states that were visited. For example, *Hawaii* set eligibility at 300% of the federal poverty level for Medicaid and covers additional children through S-CHIP; individuals are allowed to buy into the Medicaid program. In *Colorado*, outreach and training are used in addition to a single streamlined application for both programs.

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All of the states represented in the sample cover a broad array of services and supports under their Medicaid programs. They include an extensive list of services in their state Medicaid plans in addition to traditional services, including services such as respite, family and peer support, supported employment, therapeutic foster care, one-to-one personal care, skills training, intensive in-home services, treatment planning, therapeutic camps, wraparound services, and many others. *Alaska* has developed a mechanism to cover traditional Native healing services under its state Medicaid program.

The sites studied have also maximized Medicaid financing of behavioral health services for children by taking advantage of the multiple options available to states under the Medicaid program, including the clinic and rehabilitation options, targeted case management, and several different types of waivers. For example, *Michigan* has four different types of waivers to maximize the ability to use Medicaid to finance children's behavioral health services and supports.

Some sites have implemented specific strategies for using Medicaid to finance services and supports instead of state-only funds. For example, *New Jersey* added services to its state Medicaid Plan that previously had been paid for with child welfare general revenue, and *Central Nebraska* redefined therapeutic group homes more accurately in order for them to be eligible for reimbursement, rather than using all general revenue funds. In addition, some of the sites reported that they have been successful in generating Medicaid match, typically using not only mental health dollars but funds from other child-serving programs and systems as well. For example, in *Vermont* the ability to secure Medicaid match from other systems has been a significant factor in the ability to maintain and expand services.

Few sites reported success in maximizing the use of Title IV-E. One example is provided by *Cuyahoga County*, which frees up child welfare dollars for the system of care by maximizing the use of IV-E within the child welfare system. In addition, few sites reported success in maximizing special education funding. However, an example of maximizing special education funds is provided by *Choices*, where the education system pays a case rate to obtain services to avert the need for an out-of-school or residential placement. Also, *California* has had legislation in place for many years (Assembly Bill [AB] 3632), which provides funding to county mental health agencies to provide mental health services to special education students (and requires the state Department of Social Services (DSS) to pay for out-of-home care for this population). Funds must be used to support mental health services that are included in Individual Education Plans (IEPs).

**Table 2.3**  
**Core Financing Strategies: Realigning Financing Streams**

Sites	II. Maximize Federal Entitlement Funding						
	A. Maximize Medicaid					B. Maximize Title IV-E Child Welfare Funds	C. Maximize Education/Special Education Funds
	1. Maximize Eligibility and/or Enrollment for Medicaid and SCHIP	2. Cover a Broad Array of Services Under Medicaid	3. Use Multiple Medicaid Options and Strategies	4. Maximize Medicaid in Lieu of Other State Funds	5. Generate Medicaid Match		
<b>States</b>							
Arizona	X	X	X	X		X	
California	X	X	X		X		X
Hawaii	X	X	X				
Michigan	X	X	X				
New Jersey	X	X	X	X	X		
Vermont	X	X	X		X		
<b>Regional/Local Areas</b>							
Central Nebraska	n/a	n/a		X			
Choices	n/a	n/a	X				X
Cuyahoga County, OH	n/a	n/a	X	X	X	X	
Erie County, NY	n/a	n/a	X				
Project BLOOM, CO	n/a	n/a	X				
Wraparound Milwaukee	n/a	n/a	X		X	X	
	<b>100% States</b>	<b>100% States</b>	<b>92%</b>	<b>33%</b>	<b>42%</b>	<b>25%</b>	<b>17%</b>

### III. Redirect Spending from “Deep-End” Placements

As shown on **Table 2.4**, all of the sites studied have implemented strategies to redirect resources from deep-end placements to home and community-based services and supports. This is a critical financing strategy as there are seldom new dollars for children’s services; expansion of home and community-based capacity must depend on redirected resources to a great extent. In most sites, significant reductions in the use of residential treatment have been achieved, and the practice approach has shifted to home and community-based services within systems of care. *Cuyahoga County* and *Wraparound Milwaukee* provide good examples of this strategy. In *Project BLOOM*, with the focus on the early childhood population, the rationale for the system of care is the concept of “cost of failure,” that is, with the failure to provide services in systems of care, significant future costs for deep-end services will be inevitable.

In addition to redirecting resources, most sites reported significant investments to develop home and community-based service capacity. For example, *California* invested state general revenue, special education funds, Mental Health Services Act (new tax dollars), and child welfare funds in expanding home and community-based services.

In addition, most of the states and communities studied have worked with residential treatment providers to encourage them to adopt the system of care philosophy and approach, to work in partnership with local systems of care, and to diversify by providing new types of services and supports. For example, *Cuyahoga County* held residential providers harmless for two years, allowing them to use excess dollars in their contracts resulting from reduced referrals to build home and community-based service capacity.

**Table 2.4**  
**Core Financing Strategies: Realigning Financing Streams**

Sites	III. Redirect Spending from Deep-End Placements to Home and Community-Based Services and Supports			IV. Implement Financing Strategies for Youth with Intensive Service Needs and their Families	
	A. Redirect Dollars from Deep-End Placements to Home and Community-Based Services and Supports	B. Invest Funds to Build Capacity for Home and Community-Based Services and Supports	C. Promote Diversification of RTC Providers to Provide Home and Community-Based Services	A. Finance Care Management Entities as a Locus of Accountability for Services, Cost, and Care Management	B. Use Risk-Based Financing Strategies for Populations with High Needs
<b>States</b>					
Arizona	X	X	X		X
California	X	X	X		
Hawaii	X	X	X	X	X
Michigan	X			X	X
New Jersey	X	X	X	X	
Vermont	X	X	X		
<b>Regional/Local Areas</b>					
Central Nebraska	X	X		X	X
Choices	X		X	X	X
Cuyahoga County, OH	X		X	X	X
Erie County, NY	X		X	X	X
Project BLOOM, CO	X	X		X	
Wraparound Milwaukee	X	X	X	X	X
	<b>100%</b>	<b>67%</b>	<b>75%</b>	<b>75%</b>	<b>67%</b>

## IV. Implement Financing Strategies for Children with Intensive Service Needs and Their Families

**Table 2.4** also shows that most of the sites finance some type of entity as a locus of accountability and care management for children with serious and complex challenges, who are involved in or at risk for involvement in multiple systems. These may be either a government entity or a private, nonprofit entity. For example, government entities are found in *Hawaii*, where the state children's mental health agency administers a carve-out under the state Medicaid program and utilizes seven public mental health agencies located throughout the state to coordinate service delivery. An example of private nonprofit entities is found in *New Jersey*, which contracts with nonprofit Care Management Organizations in each region of the state.

Further, many of the sites use some type of risk-based financing and various risk adjustment strategies for children and youth with complex needs. In *Arizona*, for example, the state contracts with four Regional Behavioral Health Authorities and finances them with capitation rates; higher, risk-adjusted rates are provided for children in state custody. Case rate financing is found in several sites. For example, *Central Nebraska* uses case rate financing, with differential case rates based on the target population and a risk pool to protect against higher than anticipated expenses; *Choices* has a case rate structure with four tiers, based on youth with different levels of need; and *Wraparound Milwaukee* also utilizes case rates for different high utilizing populations.

### Financing Services and Supports and an Individualized, Wraparound Approach

By definition, systems of care include a comprehensive array of services and supports to meet the multiple and changing needs of children and adolescents with emotional disorders and their families. Financing to cover this broad array of both clinical and supportive services is a fundamental requirement. The system of care philosophy and approach also emphasize an individualized approach to service delivery, such that the needs, strengths, and preferences of the youth and family dictate the types, mix, and duration of services and supports. Thus, in addition to financing that covers a broad service array, financing mechanisms must support and promote individualized, flexible service delivery. Financing strategies also are needed to support the incorporation of evidence-based and promising practices to improve the effectiveness of services, mental health services to young children and their families, early identification and intervention, and mechanisms to coordinate care across child-serving agencies at the service delivery level. The financing strategies assessed through the study include: 1) financing a broad array of services and supports, 2) financing individualized, flexible service delivery, 3) financing evidence-based and promising practices, 4) financing early childhood mental health services, 5) financing early identification and intervention, and 6) financing services for uninsured and underinsured children and their families.

## I. Finance a Broad Array of Services and Supports

The study examined coverage of the array of services and supports shown on **Table 2.5**.

<b>Nonresidential Services</b>	<b>Residential Services</b>	<b>Supportive Services</b>
• Assessment and diagnostic evaluation	• Therapeutic foster care	• Care management
• Outpatient therapy – individual, family, group	• Therapeutic group homes	• Respite services
• Medication management	• Residential treatment center services	• Wraparound process
• Home-based services	• Inpatient hospital services	• Family support/education
• School-based services		• Transportation
• Day treatment/partial hospitalization		• Mental health consultation
• Crisis services		
• Mobile crisis response		
• Behavioral aide services		
• Behavior management skills training		
• Therapeutic nursery/preschool		

**Table 2.6** shows that all of the sites studied cover virtually all of these services and supports. Often, additional services and supports are covered, such as supported employment, peer support, traditional healing, flexible funds, respite homes, respite therapeutic foster care, supported independent living services, intensive outpatient services, treatment/service planning, parent skills training, ancillary support services, family and individual education, consultation, peer support, emergency/hospital diversion beds, after school and summer programs, substance abuse prevention, youth development, and mentor services. These services and supports typically are covered using Medicaid and a variety of additional financing streams from mental health and other child-serving systems.

## II. Finance an Individualized/Wraparound Approach to Service Delivery

As shown on **Table 2.6**, nearly all of the sites incorporate flexible funds that can be used to pay for services and supports that are not covered by Medicaid or other sources. Typically, funds are designated for this purpose, and child and family teams can access these funds to provide these ancillary services and supports as needed. In some sites, such as *Central Nebraska* and *Wraparound Milwaukee*, the managed care financing approaches (e.g., case rates) make the resources within the system inherently flexible and available to meet individualized needs. *Choices* created categories of flexible funds and *Project BLOOM* developed detailed guidance for using flexible funds.

In addition to flexible funds, individualized care requires the convening of a child and family team that, in partnership with the youth and family, develops and implements an individualized service plan. Strategies to finance the participation of staff and providers in the individualized service planning process and on child and family teams have been implemented by all of the sites. In several sites, staff and providers can bill for time spent in child and family team processes as case management or service planning, and in some sites contract providers can bill the local lead agency for their time. *Hawaii*, for example, has a specific billing code for “treatment planning.”

Care authorization mechanisms that support individualized, flexible care were also found in most sites. For example, a number of the sites use child and family teams as the mechanism for authorizing services. The plan of care developed by the child and family team determines medical necessity and all or most services specified by the plan are considered to be authorized.

## III. Finance Evidence-Based, Evidence-Informed, and Promising Practices

**Table 2.6** also shows that all of the sites incorporate financing and/or financial incentives to promote the implementation of evidence-based, evidence-informed, and promising practices. Their strategies range from establishing billing codes for specific evidence-based practices to providing financial support for the initial training and start-up or developmental costs involved in adopting evidence-based practices, and, in some cases, providing resources for ongoing training and fidelity monitoring. A range of evidence-based approaches is supported in the sites, such as Multisystemic Therapy (MST), Functional Family Therapy (FFT), Multidimensional Treatment Foster Care (MDTFC), Dialectical Behavior Therapy, Cognitive Behavioral Therapy, Brief Strategic Family Therapy, Aggression Replacement Therapy, Integrated Co-Occurring Treatment, Parent-Child Interaction Therapy, the Incredible Years, and Touch Points, among others. Nearly all the sites use the wraparound process, which has been established as an evidence-based practice.

<b>Table 2.6 Financing Services and Supports and an Individualized, Wraparound Approach</b>					
<b>Sites</b>	<b>I. Finance a Broad Array of Services and Supports</b>	<b>II. Finance an Individualized, Flexible, Wraparound Approach to Service Delivery</b>			<b>III. Finance Evidence-Based, Evidence-Informed, and Promising Practices</b>
	<b>A. Finance a Broad Array of Services through Medicaid and Other Funding Streams</b>	<b>A. Incorporate Flexible Funds for Individualized Services and Supports</b>	<b>B. Finance the Functions of Child and Family Teams</b>	<b>C. Incorporate Care Authorization Mechanisms that Support Individualized Care</b>	<b>A. Incorporate Financing or Incentives for EBPs and Promising Practices and for Development, Training, and Fidelity Monitoring</b>
<b>States</b>					
Arizona	X	X	X	X	X
California	X	X	X	X	X
Hawaii	X	X	X	X	X
Michigan	X		X		X
New Jersey	X	X	X	X	X
Vermont	X	X	X	X	X
<b>Regional/Local Areas</b>					
Central Nebraska	X	X	X	X	X
Choices	X	X	X	X	X
Cuyahoga County, OH	X	X	X	X	X
Erie County, NY	X	X	X	X	X
Project BLOOM, CO	X	X	X		X
Wraparound Milwaukee	X	X	X	X	X
	<b>100%</b>	<b>92%</b>	<b>100%</b>	<b>83%</b>	<b>100%</b>

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## IV. Finance Early Childhood Mental Health Services

Five of the sites have paid particular attention to providing early childhood mental health services to young children and their families, as shown on **Table 2.7**. Several finance a broad array of services and supports for young children and their families. *Project BLOOM*, which is comprised of early childhood systems of care in four communities, provides a broad array of services and supports based on a “pyramid of needs and supports” that includes mental health promotion, prevention for at-risk groups of children, and intervention/treatment services for children with identified mental health problems.

Multiple sources of funding are utilized to finance early childhood mental health services in the sites, including Medicaid, general revenue, Part C of the Individuals with Disabilities Education Act (IDEA), Head Start, and a variety of other federal, state, and local funding streams. *Project BLOOM*, an early childhood system of care, demonstrates how multiple funding streams can be combined to fund early childhood mental health services, and developed a funding matrix to identify potential sources of financing.

In several sites, the children’s behavioral health system has worked with the Part C system to better identify and address the social and emotional needs of young children. For example, in *Arizona*, the behavioral health system has collaborated with Part C to develop workshops in early childhood mental health, to create an assessment tool for the 0 to 5 population and accompanying training for providers, and to build provider capacity for working with young children. In *Colorado*, considerable work was completed to determine how to better address social-emotional issues under Part C, resulting in delineation of responsibilities, development of a joint format for a service plan integrating wraparound into the individualized family service plans (IFSPs) and a funding hierarchy.

Mental health to early childhood settings (such as day care centers, Head Start, preschools, pediatricians’ offices, etc.) is an important component of the array of early childhood mental health services and supports. Several sites finance early childhood mental health consultation using Medicaid dollars, mental health general revenue funds, and others. *Project BLOOM* created a tool kit on early childhood mental health consultation with a financing section.

In addition, some sites finance services to families of young children, without the requirement of the child being present. These services are reimbursable as long as the services relate to the child’s behavioral health needs and are outlined in the individualized service plan. For example, in *California*, *Project BLOOM*, *Arizona*, and *Vermont*, Medicaid can be billed if the service is in relation to the identified child.

Sites	IV. Finance Early Childhood Mental Health Services				
	A. Finance a Broad Array of Services and Supports for Young Children and their Families	B. Use Multiple Funding Sources for Early Childhood MH Services	C. Maximize Part C and Child Find Financing	D. Finance Early Childhood Mental Health Consultation to Natural Settings	E. Finance Services to Families of Young Children
<b>States</b>					
Arizona	X	X	X	X	X
California	X	X		X	X
Hawaii					
Michigan	X		X		
New Jersey					
Vermont	X	X	X	X	X
<b>Regional/Local Areas</b>					
Central Nebraska					
Choices					
Cuyahoga County, OH			X		
Erie County, NY					
Project BLOOM, CO	X	X	X	X	X
Wraparound Milwaukee					
	42%	33%	42%	33%	33%

## V. Finance Early Identification and Intervention

As shown on **Table 2.8**, strategies for screening children and youth at high risk for behavioral health problems and linking youth to needed services were found in most of the sites. Typically, sites screen youth entering the child welfare or juvenile justice systems and make appropriate referrals for further evaluation or for services as indicated. *Arizona* screens youth within 48 hours of entering detention, using the Massachusetts Youth Screening Instrument, Version 2 – MAYSI-2. *California's Contra Costa County* screens all children entering non-relative child welfare placements. *New Jersey* has developed common screening tools to use across agencies, and *Project BLOOM* has recommended specific tools for screening young children in early care, education, and primary care settings.

In some sites, EPSDT screens, paid for by Medicaid, incorporate behavioral health screening components. In Vermont, mental health professionals are co-located in pediatric settings to improve access to behavioral health assessment and intervention. Project BLOOM has developed an EPSDT tool kit and has financed implementation strategies for early identification of behavioral health issues in pediatric settings.

Financing strategies to provide early intervention services for children at-risk were found in most sites, using various financing sources. For example, among other funding, state funds support school-based early intervention services in *California*, education funds are used in *Hawaii*, and child welfare funds are used in *Cuyahoga County*. In addition, several sites incorporate financing for linkages with primary care practitioners (PCPs) and training. For example, *Project BLOOM* has placed clinicians in primary care settings, used Part C and grant funds to train PCPs, and purchased behavioral health screening tools for use in pediatric practices. Flow charts and other materials for PCPs were developed to guide identification and referral for behavioral health problems.

## VI. Finance Services for Uninsured and Underinsured Children and Their Families

**Table 2.8** also demonstrates that all sites have implemented strategies to try to better finance services for uninsured and underinsured children and their families, often using state or local general revenue funds. For example, *New Jersey* established a classification of a “system of care child”, which allows non-Medicaid eligible children to receive services.

Several sites implemented specific financing strategies to ensure access to care without relinquishing custody. For example, *Vermont* enacted legislation that prohibits custody relinquishment for the purpose of obtaining needed mental health care. In *Central Nebraska*, a wraparound approach to services is used to work with youth and families to avoid placing youth in state custody; voluntary placement agreements are used when necessary.

A few sites have attempted to work with private insurers to cover a broader array of services. For example, *Hawaii* attempts to bill private insurers for covered services and, in addition, has had preliminary talks with Blue Cross about allowing their insured access to the service array in the system of care. *Vermont* and *Colorado* enacted parity laws requiring health plans to cover mental health and substance abuse services to the same extent as other health services.

Sites	V. Finance Early Identification and Intervention				VI. Finance Services for Uninsured/Underinsured Children and their Families		
	A. Finance BH Screening of High-Risk Populations and Linkages to Services	B. Incorporate BH Components in EPSDT-Funded Screens	C. Finance Early Intervention Services for At-Risk Populations	D. Finance Linkages with and Training of PCPs	A. Finance Services to Uninsured/Underinsured Children and Families	B. Incorporate Strategies to Access Services Without Custody Relinquishment	C. Encourage Private Insurers to Cover Broader Array of Services
<b>States</b>							
Arizona	X		X		X		
California	X	X	X	X	X		
Hawaii	X		X		X		X
Michigan	X				X		
New Jersey	X				X		
Vermont	X	X	X	X	X	X	X
<b>Regional/Local Areas</b>							
Central Nebraska	X		X		X	X	
Choices				X	X		
Cuyahoga County, OH			X		X	X	
Erie County, NY					X		
Project BLOOM, CO	X	X	X	X	X	X	X
Wraparound Milwaukee			X	X	X		
	67%	25%	67%	42%	100%	33%	25%

## Financing Key System of Care Features

In addition to a broad array of services and supports provided with an individualized approach, inherent in systems of care are core values and a set of principles that guide service delivery. These principles call for: coordination of service delivery across multiple agencies and programs; partnerships with families and youth to ensure family-driven, youth-guided services; culturally and linguistically competent services; a diverse and qualified provider network; and accountability mechanisms to ensure high quality services that are cost-effective and produce positive outcomes.

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The study examined the strategies used by sites to finance key features of systems of care including: 1) cross-agency service coordination, 2) family and youth partnerships, 3) cultural and linguistic competence and reduction of disparities in care, 4) development of a broad, diverse, and qualified workforce and provider network, and 5) accountability processes.

## I. Finance Cross-Agency Service Coordination

As shown on **Table 2.9**, cross-agency service coordination at the service delivery level is financed by nearly all of the sites, typically by financing dedicated care managers through various mechanisms. For example, in *Hawaii*, care coordinators are state employees, and in *Central Nebraska* several care coordination programs with wrap facilitators are financed through shared funding across agencies.

## II. Finance Family and Youth Partnerships

A central tenet of the systems of care philosophy is that families and youth are full partners in all aspects of the planning and delivery of services. The concept of family and youth involvement has been strengthened over time, and the new concept of *family-driven, youth-guided* care is achieving broad acceptance. Family-driven care means that families have a primary decision making role in the care of their own children, as well as in the policies and procedures governing care for all children in their community, state, tribe, and nation. Similarly, youth-guided care means that young people have the right to be empowered, educated, and given a decision-making role in their own care and in the policies and procedures governing care for all youth in their community, state, tribe, and nation. Financing strategies are needed to support partnerships with families and youth at the service delivery level in planning and delivering their own care and at the system level in designing, implementing, and evaluating systems of care. In addition, partnering with families and youth requires financing for services and supports not only for the identified child, but also for family members to support them in their caregiving role. Financing to fund program and staff roles for family members and youth also reflects a system of care that is committed to partnerships, as does financing for family- and youth-run organizations.

**Table 2.10** shows that all of the sites finance family and youth involvement and choice in service planning and delivery. The sites studied incorporate financing to support family and youth participation in service planning meetings and typically pay for such supports as transportation, child care, food, and interpretation on an as-needed basis. Most of the sites also provide financing for family and/or youth peer advocates. The role of these peer advocates typically includes working with families and youth to support them through the service planning and delivery process and providing a variety of types of direct assistance. Further, most of the sites finance an individualized care planning or wraparound process with child and family teams in which the youth and family are integral to decision making about the services and supports that will be provided. The sites also offer choices of providers to families and youth when possible.

Another strategy to support family and youth partnership in service delivery is to finance training for providers on how to partner with families and youth. The sites use various strategies to accomplish this, including providing training through a state mental health institute, contracting with a family organization to provide training, and incorporating this focus in all other training in the system of care approach and practice improvement.

<b>Table 2.9 Financing Key System of Care Features</b>	
<b>Sites</b>	<b>I. Finance Cross-Agency Service Coordination</b>
	<b>A. Finance Cross-Agency Service Coordination and Dedicated Care Managers at the Service Delivery Level</b>
<b>States</b>	
Arizona	
California	X
Hawaii	X
Michigan	
New Jersey	X
Vermont	X
<b>Regional/Local Areas</b>	
Central Nebraska	X
Choices	X
Cuyahoga County, OH	X
Erie County, NY	X
Project BLOOM, CO	X
Wraparound Milwaukee	X
	<b>83%</b>

Also shown on **Table 2.10** are the sites that have implemented strategies to finance family and youth involvement at the system level to participate in policy making and system management. All of the sites provide payments and/or other supports for family and youth participation at the policy level. The mechanism used most often in these sites is a contract with a family organization which, in turn, provides payments and supports to family members and youth. Typically, supports include stipends and, on an as-needed basis, may also include transportation, child care, and food.

Contracts with family organizations are the most frequent vehicle used to ensure family participation in policy making. Contracts are used to fulfill a wide variety of policy making and system management roles for families and often youth, including: serving on committees and advisory bodies; participating in evaluation activities; providing training; providing family advocates, peer mentors, and ombudspersons; developing and disseminating information; and organizing and facilitating youth groups and youth councils. Leadership development activities are financed in most of the sites to prepare families and youth for participation in policy making

and system management activities. *Hawaii*, *Project BLOOM*, and *Cuyahoga County*, for example, developed curricula for parent advocates, and the statewide family organization in *California* conducts peer-to-peer training.

In addition, all of the sites have incorporated strategies to ensure that services and supports can be provided to families and are not limited to the “identified child.” These include coverage under Medicaid, use of other agencies’ funds, use of flexible funds, and use of blended or braided funding structures supported by case rates. In most sites, family organizations can provide specific services and supports, with resources for these services included in contracts with these organizations or by allowing them to bill Medicaid. As an alternative approach to financing family organizations, *California’s Contra Costa County* hires family members as county employees to provide direct services, and *Cuyahoga County* uses family members employed by Neighborhood Collaboratives to provide services.

### III. Finance Improvements in Cultural and Linguistic Competence and Reduction of Disparities in Care

A core value of systems of care is that they are culturally and linguistically competent, with agencies, programs, and services that respect, understand, and are responsive to the cultural, racial, and ethnic differences of the populations they serve. In recognition of the unique cultural backgrounds of children and families served within systems of care, financing strategies are needed to incorporate specialized services, culturally and linguistically competent providers, and translation and interpretation. Financing strategies also are needed to support leadership capacity for cultural and linguistic competence at the system level and to allow for analysis of utilization and expenditure data by culturally and linguistically diverse populations, which contributes to the identification of disparities and disproportionalities in service delivery. Systems of care also must incorporate strategies to proactively address the disparities in access to care and in the quality of care experienced by culturally and linguistically diverse groups, as well as in underserved geographical areas.

**Table 2.11** shows that many of the sites cover “cultural” or culturally specific services, that is, specialized services that are specifically designed to respond to the ethnic and cultural characteristics of children and families served. For example, *Arizona* covers native traditional healing, and others sites use the wraparound child and family team process to identify and purchase culturally specific services. Most sites have incorporated financing and various types of incentives for culturally and linguistically competent providers, including natural helpers and traditional healers, and all of the sites finance translation and interpretation services either with Medicaid, managed care system resources, or with flexible funds.

Sites	II. Finance Family and Youth Partnerships								
	A. Finance Family and Youth Involvement and Choice in Service Planning and Delivery				B. Finance Family and Youth Involvement in Policy Making			C. Finance Services and Supports to Families and Other Caregivers	
	1. Finance Supports to Participate in Service Planning Meetings	2. Finance Family and Youth Peer Advocates	3. Incorporate Financing Policies that Provide Choices of Services and/or Providers	4. Finance Training for Providers on How to Partner with Families	1. Finance Payment and Supports Participation at the Policy Level	2. Finance Participation at the Policy Level, Including Contracts with Family Organizations	3. Finance Training and Leadership Development for Families and Youth	1. Finance Services and Supports to Families Under Medicaid and Other Financing Streams	2. Finance Families, Youth, or Family/Youth Orgs. To Provide Direct Services
<b>States</b>									
Arizona	X	X	X	X	X	X	X	X	X
California	X	X	X	X	X	X	X	X	X
Hawaii	X	X	X	X	X	X	X	X	X
Michigan	X		X		X	X		X	
New Jersey	X	X	X	X	X	X	X	X	X
Vermont	X	X	X	X	X	X	X	X	X
<b>Regional/Local Areas</b>									
Central Nebraska	X	X	X	X	X	X	X	X	X
Choices	X	X	X	X	X	X		X	X
Cuyahoga County, OH	X	X	X	X	X	X	X	X	X
Erie County, NY	X	X	X	X	X	X	X	X	X
Project BLOOM, CO	X	X	X	X	X	X	X	X	
Wraparound Milwaukee	X	X	X	X	X	X	X	X	X
	<b>100%</b>	<b>92%</b>	<b>100%</b>	<b>92%</b>	<b>100%</b>	<b>100%</b>	<b>83%</b>	<b>100%</b>	<b>83%</b>

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Analysis of utilization, expenditure, and outcome data by culturally and linguistically diverse populations allows systems of care to identify potential problems or disproportionalities in access to services, in service utilization, and in the quality and outcomes of care. Some of the sites have the capacity to analyze data by racial/ethnic groups (e.g., penetration rates), and *California* does special studies. Additionally, most of the sites finance leadership for cultural and linguistic competence – either cultural competence coordinators at state and/or local levels or various types of cultural competence advisory committees or teams.

In comparison to financing strategies to improve cultural and linguistic competence, fewer sites finance specific strategies designed to reduce racial, ethnic, or geographic disparities in access and quality of care. Examples of financing strategies directed at reducing disparities in care can be found in *Arizona* where strategies include outreach, service provision in culturally appropriate sites, special studies to identify and elucidate disparities, and requirements for Regional Behavioral Health Authorities to serve under-served populations (such as the Latino population). *California* funds a Center for Reducing Health Disparities. Strategies to reduce geographic disparities were found in several sites. For example, *Hawaii* provides incentive pay for providers to work in underserved areas. Examples of financing the use of technology to address geographic disparities were found in more sites, such as telemedicine, videoconferencing, web-based technology, and teleconferencing for services including medication management, psychological and psychiatric evaluation, consultation, and education.

The sites finance outreach to culturally diverse populations and transportation to increase access to services and reduce disparities. For example, *Arizona's* managed care system included “structured outreach” to culturally diverse populations and using “promotores” (health promoters) to reach out to the Latino population.

#### **IV. Financing to Improve the Workforce and Provider Network**

Systematic attention is needed to develop a workforce with the attitudes, knowledge and skills needed to administer systems of care and to provide services within them. Financing strategies are needed to support a broad, diversified network of providers that is capable of providing the wide ranges of services and supports offered through systems of care and is committed to the system of care philosophy underlying service delivery, such as accepting and valuing the inclusion of families and youth as partners in service delivery and the shift from office and clinic-based practice to an individualized home and community-based service approach. In addition to supporting a broad provider network, workforce development strategies are needed to address pre-service training programs to prepare individuals for work within community-based systems of care, as well as to implement in-service training strategies to help the existing workforce to infuse the new philosophy, values, approaches, and evidence-based practices into their work. The payment rates established for providers must allow systems of care to attract and retain qualified providers within their provider networks and must create incentives for providers to develop and provide home and community-based services.

**Table 2.11**  
**Financing Improvements in Cultural and Linguistic Competence and Reduction of Disparities in Care**

Sites	A. Finance Culturally and Linguistically Competent Services and Supports					B. Finance Strategies to Reduce Disparities in Access to and Quality of Services and Supports			
	1. Finance Special Culturally Specific Services	2. Finance Culturally Competent Providers	3. Finance Translation and Interpretation	4. Analyze Utilization and Expenditures by Culturally Diverse Populations	5. Finance Cultural Competence Coordinators and Leadership Capacity	1. Finance Strategies for Reducing Racial and Ethnic Disparities	2. Finance Strategies to Reduce Geographic Disparities	3. Finance the Use of Technology to Reduce Disparities	4. Finance Outreach to Culturally Diverse Populations
<b>States</b>									
Arizona	X	X	X	X	X	X	X	X	X
California	X	X	X	X	X	X	X		X
Hawaii	X	X	X	X	X		X	X	X
Michigan		X	X					X	
New Jersey			X						
Vermont			X				X	X	
<b>Regional/Local Areas</b>									
Central Nebraska		X	X					X	
Choices	X	X	X		X				
Cuyahoga County, OH	X	X	X		X				X
Erie County, NY		X	X		X				X
Project BLOOM, CO	X	X	X	X	X	X		X	X
Wraparound Milwaukee	X	X	X	X	X	X			
	58%	83%	100%	42%	67%	33%	33%	50%	50%

As shown on **Table 2.12**, most sites have implemented strategies to finance a broad array of providers. *Arizona* created a new type of provider called a “community service agency” to offer a broader array of services. Other sites build extensive provider networks including agencies, individual practitioners, nontraditional providers, and specialty providers. A variety of workforce development activities is financed in the sites, including training, coaching, and learning communities on the system of care approach and on evidence-based and promising practices. Some sites have financed centers to provide training, such as the *California Institute of Mental Health* and the *New Jersey Behavioral Research and Training Institute*.

To create incentives for providers to develop and provide home and community-based services, sites have implemented strategies that establish higher rates for home and community-based services, as in *Arizona* and *Michigan*. Others, such as *Choices* and *Wraparound Milwaukee*, purchase primarily home and community-based services, in effect creating a strong market for these services and incentives for providers to develop home and community-based service capacity. Payment rates and policies to help recruit and retain qualified staff were found in a few sites. For example, *Arizona* pays off the college loans of some professionals entering the behavioral health system as an incentive.

## VII. Financing for Accountability

Systems of care need reliable, practical data and accountability mechanisms to guide decision-making and quality improvement in the provision of services to children and adolescents and their families. The development of strong accountability and continuous quality improvement procedures requires a financial investment in good information systems, as well as financing to support the collection, analysis, and use of data by administrators and other stakeholders to build on system strengths, remediate deficiencies, and make decisions about resource allocation. Accountability and quality improvement procedures require data on the populations being served, service utilization, service quality, cost, and outcomes at multiple levels (the system level, service level, and child and family level). Use of performance-based or outcomes-based contracting allows systems of care to incorporate accountability procedures in contracts with providers. In addition, financing is required for a focal point of accountability for systems of care, that is, an agency, office, or entity that is responsible for policy and management of the system of care.

**Table 2.13** shows that the sites studied make financial investments in mechanisms for tracking information related to service utilization, quality, cost, and outcomes and use this information for system improvement.

The use of data on cost-benefit, cost avoidance, or cost savings can provide powerful evidence of the efficacy of the services provided within a system of care approach. Several of the study sites collect these types of data. For example, *Hawaii* collects and uses cost-benefit data through a process referred to as Data Envelope Analysis (DEA), and *Wraparound Milwaukee* collects and uses data on cost savings for youth who would otherwise be in residential treatment or correctional facilities. *Project BLOOM* undertook an analysis to document the costs that could be avoided in the future by investing in the early childhood population.

Care managers play important roles in managing utilization, quality, cost, and outcomes in the sites. Some sites provide data on a regular basis to care managers to monitor their assigned children and families and to enable them to compare their practice patterns with those of other care managers. For example, *Choices* provides data to child and family teams, team leaders, and care managers enabling them to assess their approaches, costs, and outcomes and to make appropriate adjustments.

Some sites establish incentives or sanctions associated with utilization, quality, or cost. In *Arizona*, for example, incentives are included in contracts with Regional Behavioral Health Authorities related to standards for access, functional improvement, satisfaction, consumer and

family involvement, and others. In other sites, sanctions primarily involve discontinuing the participation of the provider if appropriate corrective actions are not taken in response to identified problems associated with utilization, quality, cost, or outcomes.

Sites	A. Finance a Broad, Diversified, Qualified Workforce and Provider Network		B. Provide Payment Rates that Incentivize Qualified Providers for Home and Community-Based Services	
	1. Finance a Broad Array of Providers	2. Finance Workforce Development Activities	1. Payment Rates and Policies that Incentivize Home and Community-Based Services	2. Payment Rates and Policies that Incentivize Recruitment and Retention of Qualified Staff
<b>States</b>				
Arizona	X	X	X	X
California	X	X	X	
Hawaii	X	X	X	
Michigan			X	
New Jersey	X	X	X	
Vermont			x	
<b>Regional/Local Areas</b>				
Central Nebraska				
Choices	X	X	X	X
Cuyahoga County, OH	X	X	X	
Erie County, NY	X	X	X	
Project BLOOM, CO	X	X		
Wraparound Milwaukee	X	X	X	X
	<b>75%</b>	<b>75%</b>	<b>83%</b>	<b>25%</b>

Electronic medical records will eventually be required through federal mandate, and most of the sites have begun preparing. In *Cuyahoga County*, *Wraparound Milwaukee*, and *Choices*, the electronic management information system includes electronic clinical records.

Sites	A. Finance Mechanisms to Track and Manage Utilization, Quality, Cost, and Outcomes					B. Utilize Performance-Based or Outcomes-Based Contracting	C. Finance a Leadership, Policy, and Management Infrastructure for Systems of Care	
	1. Finance Mechanisms to Track Utilization, Cost, Quality and Outcomes	2. Collect and Use Data on Cost Benefit, Cost Avoidance, and Cost Savings	3. Use Care Managers to Play Role in Accountability	4. Incorporate Financial Incentives and/or Sanctions Associated with Utilization, Quality, Cost, or Outcomes	5. Finance the Development of Electronic Medical Records		1. Finance a Focal Point for Policy Making and Management of SOCs	2. Finance Leadership Development for SOC Leaders
<b>States</b>								
Arizona	X		X	X	X	X	X	X
California	X		X		X* planned		X	X
Hawaii	X	X	X	X			X	X
Michigan	X				X		X	
New Jersey	X		X				X	X
Vermont	X			X			X	
<b>Regional/Local Areas</b>								
Central Nebraska	X	X	X				X	X
Choices	X	X	X	X	X	X	X	X
Cuyahoga County, OH	X				X		X	X
Erie County, NY	X	X		X	X	X	X	X
Project BLOOM, CO	X	X			X	X	X	X
Wraparound Milwaukee	X	X	X	X	X		X	X
	<b>100%</b>	<b>50%</b>	<b>58%</b>	<b>50%</b>	<b>67%</b>	<b>33%</b>	<b>100%</b>	<b>83%</b>

Performance or outcomes-based contracting is not utilized widely in the sites studied. However, some of the sites are working towards implementing performance-based contracting through a “score card,” pay for performance contracts, or financial incentives for fidelity to practice models and/or positive outcomes.

To ensure accountability, a designated focal point of responsibility for policy and management of systems of care is essential along with committed and skilled leaders. All of the sites finance some type of focal point for management of the system of care. In most cases, this involves a state-level focal point of responsibility, as well as a local agency or entity for local system management.

Most of the sites have implemented strategies to finance leadership development and training for systems of care, such as leadership academies, leadership development programs, training, and coaching.

## Areas for Additional Study

As the information derived from this study on effective financing strategies for systems of care was synthesized, the study team identified a number of areas requiring additional exploration in the future. Some of these areas represent aspects of financing that have not been sufficiently addressed by states and regional/local areas in the study sample. Others have emerged more recently as new directions, subsequent to the delineation of areas that would be explored through this study. Each is discussed briefly below.

### I. Under-Addressed Financing Strategies Requiring Further Attention

The following represent areas in which only half or fewer than half of the sites in the study sample were engaged in specific financing strategies.

#### **Identifying Behavioral Health Expenditures and Utilization Across Child-Serving Systems**

— Only 42% of sites in the study had engaged in a financing analysis that identified behavioral health expenditures and utilization across child-serving systems. This type of analysis is critical to ascertain, from a systemic standpoint, how much is being spent, by which systems, on which populations of children, on which types of services and with what types of dollars (e.g., Medicaid, general revenue, grant). This type of analysis also can identify disparities in service use by demographics, diagnosis, region, etc.; opportunities for redirection where dollars are being spent on restrictive levels of care; and clarify service shortage areas. It is a critical analysis for a state or community to undertake to get a clear sense of what is actually occurring in the delivery system.

**Developing and Updating a Strategic Financing Plan** — Only a third of the study sample has developed a specific strategic financing plan for its system of care, and even fewer (17%) review and update plans on an ongoing basis if they do have one. Without having a specific and dynamic strategic financing plan in place, state, local, and tribal systems of care are even more vulnerable to the sea changes that characterize public financing for children's systems.

**Utilizing Resources from State and Local Health, Substance Abuse, and Developmental Disabilities Systems** — Although all of the sites in the study draw on multiple funding streams from multiple state, local, and tribal agencies, few of them utilize funds from public health, substance abuse, and developmental disabilities systems. This may be because these systems have few resources available to support children and adolescents with behavioral health challenges, or they may be primarily adult-focused. However, given the prevalence of co-occurring substance abuse and mental health problems, and of developmental disabilities and mental health challenges, and the importance of integrating primary and specialty mental health care, this is a finding that warrants additional attention.

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**Generating New Revenue through Taxpayer Referenda or Local Tax Levies** — A quarter of the sites were using local levies for systems of care or were benefitting from taxpayer referenda that created a new source of funding for mental health services. In general, however, and particularly during periods of economic hardship, generation of new revenue sources is not a widely used strategy, leaving redirection of existing resources and/or maximizing federal match dollars as more viable strategies, which virtually all of the sites are employing.

**Coordinating Funding Across Child-Serving Systems** — Half of the sites systematically coordinate funding across child-serving systems, including tracking cost shifting. Given that multiple systems finance child behavioral health services, with multiple opportunities for duplication and fragmentation, the need for states, tribes, and communities to better coordinate funding strategies across systems remains high.

**Coordinating Procurement of Services Across Child-Serving Systems** — Half of the sites had put in place strategies to coordinate procurement of services across systems, such as developing uniform rates for services and a common contracting process or creation of a purchasing collaborative, in effect, by using case rates from multiple systems to purchase services. These strategies can create efficiencies in procurement and help to support more consistent and coordinated service delivery practices.

**Maximizing Medicaid in Lieu of 100% General Revenue and Generating Sufficient Medicaid Match** — While all of the sites in the sample try to maximize use of Medicaid in various ways, only a third of the sites in the sample systematically look for ways to utilize Medicaid in lieu of spending 100% state or local general revenue for Medicaid-eligible services and children. While a higher percentage (42%) report good success in generating Medicaid match, these findings also indicate opportunity for greater use of Medicaid, particularly for home and community-based services on which other systems, such as child welfare, spend significant amounts of general revenue dollars and are primarily serving Medicaid-eligible children.

**Maximizing Title IV-E and Special Education Funding** — Only a quarter of the sites engage in strategies to maximize use of Title IV-E, and only 17% maximize use of special education funding within the system of care. These are both federal entitlement dollars that could be used more creatively in systems of care. States and localities may need technical assistance, including peer technical assistance, on maximizing use of these dollars.

**Financing Strategies to Support Early Childhood Mental Health Services** — Forty-two to 33% of the sites in the study are implementing specific financing strategies related to early childhood mental health services. This is an area requiring further attention and one in which states and localities could benefit from the experience of sites that have a customized focus on infants and young children.

**Financing Behavioral Health Screens Through EPSDT** — Only 25% of the study sample reportedly incorporates financing strategies to ensure that behavioral health screens occur through the Early Periodic Screening, Diagnosis, and Treatment program in Medicaid. Given that behavioral health screens should be occurring through EPSDT and that certain subpopulations of Medicaid-eligible children, such as those in foster care, are at particularly high risk for behavioral health problems, this is an area that requires further attention.

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**Financing Linkages with Primary Care Providers** — Only 42% of the study sites are financing strategies to better integrate primary and behavioral health care. This is an issue that will be very much in the forefront in national health care reform discussions, with greater attention to integrated approaches.

**Strategies to Prevent Relinquishment of Custody to Access Services** — While all of the sites employ strategies to finance services and supports for non-Medicaid, non-SCHIP eligible families to help them access behavioral health services, funding is not sufficient in most cases, and families may still be faced with having to obtain services through the child welfare or juvenile justice system with a requirement for relinquishing custody to do so. Only a third of the study sample use specific strategies, such as legislation to allow voluntary access to services without relinquishing custody. The issue of an adequate benefit package for families who have children with serious disorders, who exhaust their private coverage or who are uninsured, is a critical one in the national health care reform debate, as well as for states.

**Strategies to Encourage Private Insurers to Cover a Broad Service Array** — Only a quarter of the study sites are working with private insurers to cover a broader service array for children with behavioral health challenges. This, too, is a critical issue for national health care reform and very much related to the issue of families having to relinquish custody to access services through child welfare or juvenile justice.

**Financing Support for Analyzing Utilization and Expenditures by Racially and Culturally Diverse Children** — Only 42% of the sites finance analysis of behavioral health utilization and expenditures by racially and culturally diverse children. National research (as well as given state studies) point to the disparities in access to behavioral health services by racially and culturally diverse children and the disproportionality in their use of more restrictive services. It is difficult to finance specific strategies to reduce disparities and disproportionality without analyzing one's own state or local data (as the following finding corroborates.)

**Financing Strategies to Reduce Racial Disparities** — Although half of the sites finance outreach to culturally diverse populations, only a third are employing specific financing strategies to reduce racial disparities. This is a critical national issue that requires greater attention.

**Financing Strategies to Reduce Geographic Disparities** — Only a third of the sites are utilizing specific strategies to reduce geographic disparities in access to children's behavioral health services. The lack of services in rural and frontier communities has been well documented. There remains a compelling need for specific financing approaches to reduce geographic disparities.

**Financing the Use of Technology to Reduce Disparities** — Half of the sites are using various telemedicine and related technology approaches in behavioral health care, though not necessarily targeted to children and adolescents. The use of technology to expand service access can be expected to grow and warrants further attention.

**Payment Rates and Policies to Incentivize Recruitment and Retention of Staff** — Only 25% of study sites were employing specific financing strategies to recruit and retain staff for systems of care. Staff recruitment and retention problems in children's behavioral health are well documented. This, too, is a critical national issue that requires greater attention.

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**Financing Cost Benefit, Cost Savings, and Cost Avoidance Analyses** — Half of the study sites have financed cost benefit, cost savings or cost avoidance analyses. Given that there is intense competition for limited children’s services and healthcare dollars, and given the focus of national health care reform on effective practices, including cost-effective practices, it is imperative that more comprehensive data are available supporting the value of systems of care.

**Incorporating Financial Incentives, Sanctions, and Performance Based-Contracting** — Half the study sites utilize financial incentives or sanctions tied to utilization, cost, or outcomes, but only a third utilize some type of performance-based contracting though virtually all expressed interest in doing so. This is an area where technical assistance, including peer technical assistance, would be helpful.

## II. New Directions Requiring Further Study

The following represent areas that were not a specific focus of the current study, but which have emerged as important aspects in the financing of systems of care.

**Relationship Between State and Local Financing** — The sample of sites in the current study included both states and regional/local areas to examine the financing approaches used to support systems of care from each of these perspectives. An area that has not yet been sufficiently investigated, however, is the relationship between state and local financing. Clearly, financing policies and strategies adopted at the state level have a dramatic impact in shaping the financing approaches that can be implemented at regional and local levels. It is also likely that financing strategies designed and tested locally can influence financing policy at the state level. Given the importance of state financing to take systems of care to scale on a statewide basis, the relationship between state and local financing and how both can be leveraged to promote broader implementation of systems of care is an area of interest.

**Financing Improvements at the Practice Level** – There is no disagreement in the field that the effectiveness of interventions provided to children and their families is the major determinant of clinical and functional outcomes that are achieved within systems of care. The disconnect between the growing evidence base on effective interventions and the approaches used by providers in the field has become increasingly apparent and underscores the need to improve practice. The study identified some financing strategies used by the sites to improve practice, however, additional study is needed to explore more fully the types of financing strategies that can be applied to provide incentives for improved practice. These may include enhanced payment rates for improved practice; financing the creation of specialty provider networks; and financing the adoption and provision of evidence-based, evidence-informed, and promising practices including funding development, training, coaching, fidelity monitoring, and other activities involved in improving practice.

**Financing Youth Partnerships** — The sites have implemented various strategies to finance partnerships with families and family organizations. However, the importance of partnerships with youth and youth organizations has more recently been recognized, and many states and communities are strengthening their efforts to support partnerships with youth. Future studies should explore effective financing strategies for partnerships with youth that support and strengthen youth-guided systems of care.

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**Financing a Public Health Approach**— Attention has increasingly been devoted to exploring the concept of a public health approach to children’s mental health services – an approach that would provide services to youth with serious emotional disorders and their families, as well as address mental health promotion activities and the prevention efforts directed at high-risk populations. Such an approach also would track incidence of child mental health problems. The implications for financing of adopting a public health approach warrants investigation, given the movement in this direction and the recognition that public mental health systems cannot limit their attention to only those children with already diagnosed disorders.

**Financing Workforce Development and Improvement Efforts**— Systems of care will not be developed or sustained without a workforce that is prepared to work with the system of care philosophy and approach. Some of the sites have implemented financing strategies to better prepare the workforce. Additional study in this area is needed to identify financing approaches that can support workforce development activities, including pre-service and in-service training, recruitment and retention of qualified staff, and incentivizing providers to deliver home and community-based services and evidence-informed interventions.

**Financing Children’s Behavioral Health Services Within the Context of National Health Care Reform**— National health care reform obviously has major implications for financing child behavioral health services. As options are debated related to coverage, quality, and efficiency particularly for high utilizing populations, use of electronic health records, the role of Medicaid and other publicly financed plans, and the like, there is a need to ensure that the unique financing issues related to children’s behavioral health care are part of the equation.

# Chapter 3. Description of Sites Studied

**Table 3.1  
Overview of Sites Studied**

States
<ul style="list-style-type: none"> <li>• <b>Arizona and Maricopa County:</b> A statewide behavioral health carve out operated under an 1115 waiver utilizing locally-based, capitated Regional Behavioral Health Authorities (i.e. behavioral health managed care organizations - BHOs); the BHO in Maricopa County (Phoenix) at the time of the site visit was Value Options</li> </ul>
<ul style="list-style-type: none"> <li>• <b>California and Contra Costa County:</b> California has a 1915 (b) freedom of choice waiver, which includes a behavioral health carve out for mental health specialty services that are administered by county mental health agencies and overseen by the state Department of Mental Health. Contra Costa County has had federal system of care grants from both SAMHSA and the Administration on Children and Families (ACF).</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Hawaii:</b> A statewide behavioral health system operated through the schools and managed care organizations for children needing short-term services and through the state Child and Adolescent Mental Health Division for children with serious emotional challenges and their families</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Michigan and Livingston and Ingham Counties:</b> A statewide system with 46 Community Mental Health Services Programs (CMHSPs) serving as a single point of access for publicly funded mental health services, including Medicaid and state-funded services. The state enters into managed care contracts with CMHSPs as health plans responsible for providing mental health services to Medicaid-eligible adults and children</li> </ul>
<ul style="list-style-type: none"> <li>• <b>New Jersey:</b> A behavioral health carve out utilizing a statewide Administrative Services Organization and locally-based Care Management Organizations and Family Support Organizations</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Vermont:</b> A statewide mental health system managed by the Department of Mental Health utilizing legislatively-mandated state and local interagency teams and designated provider agencies</li> </ul>
Regional/Local Areas
<ul style="list-style-type: none"> <li>• <b>Bethel, Alaska:</b> The administrative and transportation hub for the 56 villages in the Yukon-Kuskokwim Delta, with behavioral health services administered by the Yukon Kuskokwim Health Corporation (YKHC), a Tribal Organization, which administers a comprehensive health care delivery system for the rural communities in southwest Alaska</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Central Nebraska:</b> A 22-county partnership among Region 3 Behavioral Health Services, the Central Service Area of the Office of Protection and Safety, the State Department of Health and Human Services (DHHS), and Families CARE, a family-run organization, providing services and supports to several sub-populations of children with serious behavioral health challenges or at high risk</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Choices, Inc:</b> A nonprofit, community care management organization operating in Marion County, <b>Indiana</b>, Hamilton County, <b>Ohio</b>, Montgomery County, <b>Maryland</b> and Baltimore City, MD, which coordinates services for children and families with serious behavioral health challenges who are involved in one or more governmental systems</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Cuyahoga County, Ohio:</b> The Cuyahoga Tapestry System of Care (CTSOC) is a partnership of county child-serving systems and community and neighborhood provider organizations. Initiated with a federal system of care grant from SAMHSA, the system provides intensive, neighborhood-based services to at-risk children and families</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Erie County, New York:</b> A partnership among the county Departments of Mental Health and Social Services, Probation, and family members, called Family Voices Network of Erie County, to create a single point of access to a system of care for children and youth with serious and complex mental health challenges and their families</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Project BLOOM, Colorado:</b> A system of care serving young children ages 6 and under and their families, initiated with a federal system of care grant from SAMHSA and serving four counties in Colorado with Community Mental Health Centers as the locus of accountability. Early childhood mental health services are being expanded throughout the state</li> </ul>
<ul style="list-style-type: none"> <li>• <b>Wraparound Milwaukee:</b> A behavioral health population carve-out, operated by the Milwaukee County, <b>Wisconsin</b> Behavioral Health Division, serving several subsets of children and youth with serious behavioral health challenges and their families who also are involved in child welfare and juvenile justice systems</li> </ul>

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## Description of States in the Study Sample

### AZ Arizona and Maricopa County



**Arizona** provides behavioral health services to children and adolescents and their families through an 1115 Medicaid managed care research and demonstration waiver. The Arizona State Medicaid agency contracts with the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS), to manage a behavioral health carve-out. ADHS/BHS, in turn, contracts with four Regional Behavioral Health Authorities (RBHAs), covering six geographic areas throughout the state, and two Tribal Behavioral Health Authorities (TRBHAs). RBHAs receive a capitation for Medicaid and State Children’s Health Insurance (SCHIP) covered services; they also receive state general revenue dollars and federal mental health and substance abuse block grant monies to provide services to non-Medicaid/SCHIP populations and to pay for non-Medicaid-covered services.

Arizona has a population of about six million, with nearly two million children under 18 (about 32% of the overall state population). Maricopa County (Phoenix) has most of the state’s population, with over 3.5 million total and 1.2 million children under 18 (34%). The RBHA in Maricopa County at the time of the site visit was Value Options (VO), a commercial behavioral health managed care company. (Value Options was the BHO at the time of the site visit. Through a subsequent reprocurement, Magellan became the BHO in the county.) VO in Maricopa County contracted with seven Comprehensive Service Providers (CSPs), who receive a subcapitation (which excludes residential treatment facilities, which VO authorizes directly). The CSPs contract on a fee-for-service basis with many other providers, and VO also holds about 20 contracts with “niche” providers and Community Service Agencies (CSAs), which are community-based, often nontraditional providers that are not required to meet full licensure requirements as a behavioral health agency. These are a new type of provider developed by the state and they are paid on a fee-for-service basis.

In 1993, an EPSDT-related law suit, known as “Jason K” or “JK,” was filed in Arizona on behalf of the now 34,000 Medicaid-eligible class members under age 21 in need of behavioral health services. The JK suit was settled in 2001, and the JK settlement agreement forms the basis for the child/adolescent behavioral health system in the state. Technically, the agreement applies to the state Medicaid agency (i.e., the Medicaid managed care system) and ADHS/BHS; however, these systems work collaboratively across systems on implementation since the suit covers children in child welfare and juvenile justice, as well as Native American youth. What has come to be known as “the Arizona Vision” underpins the settlement agreement. The “vision” is a statement of 12 principles based on system of care values. The principles include: collaboration with the child and family, (priority on) functional outcomes, collaboration with others, accessible services, best practices, most appropriate setting, timeliness, services tailored to the child and family, stability, respect for the child’s and family’s cultural heritage, independence, and connection to natural supports.

The principles provide the philosophical foundation for reform of the system, including expansion of covered services, intake, assessment, and service planning processes, which involve a child and family team (or wraparound) approach. More information about the Arizona system can be found at:

<http://www.azdhs.gov/bhs>.

## CA California and Contra Costa County



**California** has a population of over 36.5 million people, with nearly 11 million children and adolescents. California's population is diverse, with about 44% of the population White, 35% Hispanic/Latino, 13% Asian/Pacific Islander, 7% Black/African American, and 1% American Indian/Alaskan Native. The poverty rate is approximately 13%. There were nearly 7 million individuals eligible for Medicaid (known as Medi-Cal in California) in FY 06.

Behavioral health services, for the most part, are administered through county mental health departments and overseen by the state Department of Mental Health (DMH). The state and counties share financial risk. Historically, counties were required to ensure delivery of mental health services through the Short-Doyle Program (SD), utilizing county-operated and contracted providers. For a number of years, the county SD program co-existed with the state Medi-Cal program, operated by the Dept. of Human Services (DHS), which administered the Clinic Option (essentially hospital and physician mental health services), referred to as Fee-for-Service Medi-Cal (FFS/MC). In 1971, legislation was enacted that added SD community mental health services into the scope of benefits of the Medi-Cal program, enabling counties to obtain federal Medicaid matching funds. California subsequently adopted the Rehabilitation Services and Targeted Case Management Options in Medicaid, thereby expanding the array of services that could be billed to Medicaid provided by county mental health departments.

In 1995, California implemented a 1915 (b) freedom of choice waiver, which includes a behavioral health carve out for specialty mental health services administered by DMH. However, general mental health care needs (defined as those that can be met by a general health care practitioner) remain under the purview of the state Medicaid agency (DHS) either through physical health managed care plans or FFS. There were 28 physical health Medicaid managed care organizations (MCOs) operating in the state at the time of the site visit. County mental health departments, under contract with DMH, operate as the single managed care plan for specialty mental health services, and are now called "mental health plans" (MHPs). MHPs select and credential their provider networks, negotiate rates, authorize services, and provide payment for services rendered.

Medi-Cal mental health services are financed approximately 50% with federal match dollars and the remaining 50% with state and county funds. Unlike physical health MCOs, the counties are not capitated. They receive a fixed annual allocation of state general funds based on historical utilization, and they receive uncapped state general funds for EPSDT services for children and adolescents above a baseline expenditure level. The MHPs also receive what are called "realignment funds," which are comprised of sales tax and vehicle licensure fees collected by the state. All of these funds may be used by the counties as state Medicaid match, in addition to county funds. These funds also may be used to provide mental health services to non Medi-Cal eligible persons.

An Early Periodic Screening, Diagnosis and Treatment (EPSDT) lawsuit in 1994 (TL vs. Belshe) resulted in expanded access to mental health services in 1995. In 1999, *Emily Q v. Belshe* resulted in the state's further expanding access to mental health services under EPSDT by adding a new service type, Therapeutic Behavioral Services (TBS). TBS is a behavioral aide service for children with serious emotional disturbance (SED), who are living in a group home, state psychiatric hospital or residential treatment facility, are at risk for these out-of-home placements, or have been hospitalized within the past two years for emergency mental health problems. County mental health plans are responsible for implementing the expanded

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EPSDT benefit under state DMH guidelines and pay the 50% match rate from the allocated state general revenue and county general revenue until they reach a baseline level of expenditures. More recently (2006), in another EPSDT lawsuit focusing on children in or at risk for child welfare involvement (known as Katie A.), the court ruled that the state must further expand EPSDT to ensure provision of therapeutic foster care and wraparound services.

The state Children's Health Insurance Program (SCHIP) operates as a separate program from Medi-Cal. It covers 30 days of inpatient or 20 office visits with an exchange rate between them. When a child exhausts the benefit, county mental health plans have the responsibility for additional care.

In addition to the funds described above, California voters approved Proposition 63 in 2004, creating the Mental Health Services Act (MHSA), a new and substantial source of financing that primarily goes to the counties for mental health services. It is estimated that the MHSA will generate \$2.1 billion for mental health funding over the next three years (\$690m. in FY 2006–07). Funding is derived from a 1% tax on taxable personal income over \$1 million. Funding must go to new or expanded programs that are based on models proven to be effective and includes both treatment and prevention services as well as infrastructure, technology and training needs. It includes a focus (though not exclusively) on individuals who are uninsured or under-insured. Funds cannot be used to supplant existing efforts. The MHSA specifies the percentage of funds to be allocated to each of six major components as follows (FY 06–7 percentages): 55% to community services and supports, of which 5% is devoted to development and implementation of promising practices; 20% to prevention and early intervention, of which 5% is devoted to development and implementation of promising practices; 10% to training; 10% to local planning; 10% to capital facilities and technology; and 5% to state-level implementation and administration. State-level funding is allocated to 8 state agencies and to the Mental Health Services Oversight and Accountability Commission created by the Act, with DMH receiving most of the state-level MHSA funding. The values underlying the MHSA resemble system of care values and include: community collaboration, cultural competence, consumer/family driven services, a wellness focus, and integrated services. The "Full Service Partnerships" required to implement the Community Services and Supports component of MHSA require the counties to implement wraparound for children and families.

California also has had in place for a number of years the Children's System of Care Initiative (CSOC), which provides incentives and financing to the counties to develop systems of care for children with serious behavioral health disorders and their families. CSOC was strengthened by Senate Bill 1452 to reinforce family partnerships, interagency collaborations, reduce ethnic and gender disparities in access to services, and to develop performance outcomes measures. Counties that receive CSOC funding, which is comprised of state general revenue and a supplemental mental health block grant allocation, have to meet certain performance measures established through annual performance contracts negotiated with DMH. At the time of the site visit, CSOC funding had been eliminated from the Governor's budget due to a state deficit. However, seven counties continued to receive funding for systems of care from the federal mental health block grant, and system of care principles still govern the children's mental health system in the state.

In addition to the funding streams discussed above, there are several other funding streams important to the financing of children's behavioral health services. These include:

- **Assembly Bill (AB) 3632**, which requires county mental health agencies to provide mental health services to special education students (and requires the state Department of Social Services (DSS) to pay for out-of-home care for this population). Funds must be used to support mental health services that are included in Individual Education Plans (IEPs).
- **Senate Bill 163**, which allows counties to develop wraparound models, using state and county Aid to Families with Dependent Children-Foster Care (AFDC-FC) dollars, to reduce out-of-home placements and lengths of stay. Counties must submit a Wraparound plan to DSS to access these funds and must

ensure that county staff and providers participate in state-approved Wraparound training. (Contra Costa County is one of 39 active Wraparound counties in the state.)

- **Assembly Bill (AB) 1650**, which authorizes DMH to award Early Mental Health Initiative (EMHI) matching grants to local education agencies to implement early mental health intervention and prevention programs targeted to children in kindergarten through third grade; services must be school-based. (Martinez Unified School District and San Ramon Valley School District in Contra Costa County have EMHI grants.)

For further information, see: <http://www.dmh.ca.gov>.

The study team also visited *Contra Costa County*, located in the San Francisco/Oakland/Fremont metropolitan statistical area. The county has a population of about 1 million, with about 270,000 children under 18. The population is diverse – about 53% White, 21% Latino/Hispanic, 14% Asian/Pacific Islander, 10% Black/African American, and 1% American Indian/Alaskan Native. The poverty rate is about 8% (compared to the overall state poverty rate of 13%). There were reportedly about 120,000 individuals eligible for Medi-Cal in the County in FY 06.

The Contra Costa Mental Health Division (CCMH) is located in the county health services agency. Children’s mental health services are provided through a network of three county regional mental health clinics, contracted providers, school-based services, and partnerships with probation and child welfare. The three regional community mental health centers function as a single point of access for children with serious behavioral health problems and those with multi-system involvement. In addition, county children have access to a “provider network”, which county mental health credentials, of 80 agencies and over 300 individual practitioners. Of the 6,000 children served per year, about 3200 are served through the county regional centers or county contracted providers of “specialty mental health services” (what is referred to as “the system of care side”); the rest are seen through individual providers or agencies in the larger network. About 125-150 children a year and their families receive services through a highly individualized, wraparound approach through the regional centers or contracted providers. The county employs or contracts for Wraparound Facilitators in each of the regions, within one of the school districts, and at juvenile justice screening.

Contra Costa utilizes all of the funding streams described above and, in addition, has had both a federal SAMSA system of care grant and a federal Children’s Bureau (child welfare) system of care grant, which, for implementation purposes, the county has treated as “one grant” for one system of care. It also has a Mentally Ill Offenders Criminal Reduction Act (MIOCR) grant from the state Department of Corrections and Rehabilitation Corrections Standards Authority to provide community-based mental health services to divert youth in juvenile justice with SED from group home placement. The County spends about \$35m. a year on children’s mental health services, \$25m. of which is Medi-Cal; the state match is comprised of 48% state funds and 5% county. The system served about 6,000 children a year at the time of the site visit.

For further information about the Contra Costa County system of care, go to:

[http://www.cchealth.org/services/mental\\_health/youth\\_families.php](http://www.cchealth.org/services/mental_health/youth_families.php).

## HI Hawaii



*Hawaii*, located 2,300 miles southwest of San Francisco, is a 1,523-mile chain of islets and eight main islands—Hawaii, Kahoolawe, Maui, Lanai, Molokai, Oahu, Kauai, and Niihau. The state’s population is approximately 1.3 million; 23.5% of the population is under age 18. The population is diverse, with more ethnic and cultural groups represented in Hawaii than in any other state. According to recent census data, 27% of the population is White, 41% Asian, 9% Native Hawaiian and

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other Pacific Islander, 8% Hispanic, 2% Black, and 20% reporting two or more races. Nearly 27% of households reported speaking a language other than English at home. Significant challenges to service delivery are presented by the state's island geography, as well as by its diverse population, and numerous cultures and languages.

Hawaii's children's mental health system is administered by the state government, specifically the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii Department of Health (DOH). CAMHD's mission is "to provide timely and effective mental health services to children and youth with emotional and behavioral challenges and their families...within a system of care that integrates [system of care] principles, evidence-based services, and continuous monitoring." A major system emphasis is on ensuring that all services and supports are individualized, youth-guided, and family-centered, as well as on services being locally available, community-based, and least restrictive.

Under the CAMHD structure are seven public Family Guidance Centers (community mental health centers) located throughout the state that are responsible for mental health service delivery to children and adolescents and their families. CAMHD also contracts with a range of private organizations to provide a full array of mental health services to children and adolescents and their families. Public employees within the Family Guidance Centers provide care coordination services, some assessment and outpatient services, and arrange for additional services with contracted provider agencies. Additionally, one branch (Family Court Liaison Branch) provides mental health assessments and treatment at the juvenile detention home and the youth correctional facility.

Over the past five years, CAMHD's system of care shifted from a comprehensive mental health service system for all children and youth to a system focused on providing more intensive mental health services to the population of youth with more serious and complex behavioral health disorders and their families. Beginning with fiscal year 2000-2001, the Department of Education took responsibility for serving students with less severe emotional and/or behavioral challenges through newly established school-based behavioral health services. Youth needing less intensive mental health services, such as outpatient counseling, now receive these services through school-based mental health (SBBH) services. The coordinated relationship between the education and mental health systems provides a system of care with the school as the central access point for mental health services for youth with educational disabilities. Youth with emotional challenges that are not impacting their education receive basic mental health services through their private insurance or through their Medicaid health plans which provide assessment and basic levels of outpatient treatment. More intensive services, if needed, for Medicaid-eligible youth, are then obtained through the CAMHD children's mental health system.

Through a Memorandum of Understanding (MOU) with the state Medicaid agency, CAMHD operates a carve-out under the state Medicaid program that serves youth with serious emotional and behavioral disorders (the Support for the Emotional and Behavioral Development of Youth or SEBD Program). CAMHD receives a case rate from Medicaid for each child in service and provides a comprehensive array of services and supports. At the time of the site visit, the case rate was \$542 per child per month. Operation as the prepaid mental health plan for Medicaid-eligible youth began in 2002.

In 1993, a class action lawsuit was filed alleging that the Hawaii Departments of Health and Education were failing to provide adequate and appropriate educational and mental health services to youth with emotional and/or behavioral challenges under the Individuals with Disabilities Education Act (IDEA) and Section 504 of the Rehabilitation Act of 1973. The following year, the state entered into what is referred to as the "Felix Consent Decree" in which it agreed to expand and improve services according to a detailed implementation plan, with the goal of creating a "system of care" that effectively integrates the activities of diverse service-providing agencies and provides a comprehensive array of services. As a result of the Felix

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Consent Decree in 1994, the legislature sharply increased appropriations for CAMHD and the Department of Education to expand and improve services. In 2004, the court ruled that the state had achieved substantial compliance with the Felix Consent Decree and that court monitoring would be continued for an additional period of time to ensure that progress is sustained. Court monitoring ended in June 2005. More information can be found at <http://www.hawaii.gov/health/mental-health/camhd/index.html>.

## **MI** Michigan and Livingston and Ingham Counties



According to a 2006 estimate, the total population of *Michigan* is 10,095,643; the percent of children under the age of 18 is estimated at 24.5% or 2.5 million children. The racial/ethnic breakdown of the total population is 81% Caucasian, 14% African American, 4% Hispanic, 2% Asian, and 0.6% American Indian and Alaska Native. In 2004, it was estimated that 12.5% of the population was below the poverty level.

Michigan is a decentralized state system with 46 Community Mental Health Service Programs (CMHSPs) that serve 83 counties and serve as Michigan's county-level community mental health providers. The CMHSPs are responsible for planning and implementing publicly funded services for people diagnosed with a mental illness, addiction disorders, and developmental disabilities, referred to as "specialty services." The CMHSPs serve as a single point of access in each respective locality for people seeking publicly funded specialty services, including Medicaid and other state-funded services.

The state developed a financing structure for the CMHSPs, with a funding formula of 95% state and federal dollars and 5% local match. With the goal of coordinating funds from several funding sources and facilitating the development of one person-centered plan for each recipient of services, the state combined several funding streams into one managed care contract. Accordingly, Michigan contracts with the 46 CMHSPs as health plans, referred to as Prepaid Inpatient Health Plans (PIHPs); each has at least 20,000 covered lives. A PIHP can either be a single CMHSP, or the lead agency in an affiliation of CMHSPs.

When an individual is enrolled in Medicaid, physical health care and a limited amount of mental health services (20 outpatient visits) are available through HMOs. The PIHPs are the managed care entity responsible for providing all mental health services for adults and children beyond the limited mental health benefit in HMOs. Services can be provided by the PIHPs through a subcontract with a managed behavioral health organization or through contracts with CMHSPs.

At the state level, the mental health authority is housed in the Michigan Department of Community Health (DCH). DCH also includes Medicaid, public health, substance abuse, and aging. DCH pays each PIHP a monthly capitated payment for each Medicaid participant in the service area based on an estimate of enrollees from the previous month. The amount of the capitation payment is determined by three variables; Medicaid eligibility category (e.g. Developmentally Disabled, TANF); the number of persons who are Medicaid eligible in each group in the PIHP's coverage area; and an intensity factor for each PIHP to account for regional variation in the historical utilization of mental health, developmental disabilities, and substance abuse services.

A separate state agency, the Department of Human Services, includes child welfare and some juvenile justice services, including the training schools. The remainder of juvenile justice services is controlled by local courts. Child protective services are state-operated; child welfare employees are state employees. Education is a separate state agency with a Board of Directors that sets policy. There are more than 500 local school districts.

The overall vision of the Department of Community Health (DCH) is to ensure that: “Michigan’s children, families and adults will have access to a public mental health and substance abuse service system that supports individuals with mental illness, emotional disturbance, developmental disabilities and substance use disorders by promoting good mental health, resiliency, recovery, and the right to control one’s life within the context of the benefits and responsibilities of community.”

DCH wants to continue to improve services and systems in the state and as a result has developed a Practice Improvement Committee. The committee’s plan for fiscal year 2008 was to continue to use the system of care planning process as an antecedent for the Children’s Block Grant application. In FY 08, the mental health capitation rate for children was increased, and PIHPs now have performance measures in place to increase the number of children served and the expenditures for both children with serious emotional disturbance and developmental disabilities with a special focus on children in the care of the child welfare system. Michigan has undertaken interagency initiatives that focus on children with serious mental health problems in the child welfare and juvenile justice systems.

The site visit also explored two Michigan counties:

- **Livingston County** is located in the south-central region of Michigan and is part of the Detroit-Warren-Livonia metropolitan area, with a population of 184,511 in 2006. Livingston County is the fastest-growing county in Michigan and is one of the highest income counties in the United States. About 2.40% of families and 3.40% of the population were below the poverty line. The racial makeup of the county in 2006 was: non-Hispanic whites 95.7%, Hispanics 1.6%, African-Americans 0.7%, Asians 0.8%, and Native Americans 0.4%. The county government oversees and operates the major local courts and the jail, administers public health regulations, and is a participant with the state in provision of assistance programs (such as TANF) and other services. The county board of commissioners controls the budget, but has only limited authority to make laws or ordinances. Most local government functions are the responsibility of individual townships and cities.
- **Ingham County** is located in the south-central portion of Michigan’s lower peninsula and is the capital county of the state; Lansing is its largest city. The county has a population of 276,898, according to the 2006 census. About 8.30% of families and 14.60% of the population were below the poverty level, including 14.60% of those under age 18. The population is 76.4% non-Hispanic whites, 11.0% African-American, 4.3% Asian, and 5.9% Latinos. Ingham County has a federal system of care grant.

## **NJ** New Jersey



**New Jersey** has a population of about 8.7 million people, with over 2 million children. It is one of the most densely populated states in the country. The New Jersey Children’s System of Care Initiative, which was begun in 2000, is a behavioral health carve out, serving a statewide, total population of children and adolescents with emotional and behavioral disturbances who depend on public systems of care and their families. The population includes both Medicaid and non-Medicaid-eligible children and includes both children with acute and extended service needs. The state describes the initiative as, “not a child welfare, mental health, Medicaid, or juvenile justice initiative, but one that crosses systems.” The initiative creates a single statewide integrated system of behavioral health care to replace the previous system in which each child-serving system provided its own

set of behavioral health services. The New Jersey Division of Child Behavioral Health Services, Department of Children and Families, oversees the initiative, the goals of which are to increase funding for children’s behavioral health care; provide a broader array of services; organize and manage services; and provide care that is based on the core system of care values of individualized service planning, family/professional partnerships; culturally competent services; and a strengths-based approach to care.

The New Jersey system of care uses a statewide Administrative Services Organization (ASO), called a Contracted Systems Administrator — CSA to coordinate, authorize, and track care for all children entering the system and to assist the state agency to manage the system of care and improve quality. A non risk-based contract was awarded to Value Options (VO), a commercial behavioral health managed care company, to perform this role. Newly formed nonprofit entities, called Care Management Organizations – CMOs, were created at the local level (one per region) that provide individualized service planning and care coordination for children with intensive, complex service needs. CMOs use child and family teams to develop individualized service plans which are required to be strengths-based and culturally relevant; the CMOs employ care managers who carry small caseloads. The system also incorporates partnerships with families by creating and funding Family Support Organizations (FSOs) in each region that fulfill a range of support and advocacy functions including Family Support Coordinators to provide peer support, informal community resources, and advocacy to families served by the CMOs.

The NJ system of care incorporates a broad, flexible benefit design that includes a range of traditional clinical services, as well as nontraditional services and supports. To achieve this, the initiative expanded services covered under Medicaid through the Rehabilitation Services Option and covers other services through non-Medicaid dollars. The initiative uses a “single payer system” through the state Medicaid agency for both Medicaid and non-Medicaid eligible children served in the system. More information can be found at <http://www.nj.gov/dcf/behavioral>.

## **VT** Vermont



U.S. census data estimate **Vermont's** population at 623,000 persons in 2005; slightly more than 135,000 – about 22 percent – were children under age 18. In the late 1990s, it was estimated that about 12% of Vermont's children and youth (16,200 children and adolescents) experience serious or severe emotional disturbance each year. The number of children who received public children's mental health services increased from about 3,750 in 1989 to slightly more than 10,000 in 2005.

Vermont's system of care for children and adolescents with severe emotional disturbance and their families took shape in the 1980s. In 1982, Vermont was the first state to secure and implement a Medicaid home and community-based services waiver for children with serious emotional disorders. In 1985, Vermont received a National Institute of Mental Health (NIMH)-funded Child and Adolescent Service System Program (CASSP) planning grant that provided the means to develop the vision and values necessary to create and sustain a system of care. In 1988, Vermont enacted Act 264, which codified its vision and structure for a coordinated system of care for this population. Act 264 articulated system of care values and principles and established an infrastructure to advance the system of care approach statewide. The law institutionalizes interagency cooperation and coordination at the state and local levels by: establishing a definition of severe emotional disturbance for all agencies to use; mandating state and local interagency teams; creating an advisory board appointed by the governor to advise the partnering state agencies on the development and operation of the system of care; entitling eligible children and youth to a coordinated services plan; and mandating and setting forth a structure for family involvement.

Vermont's Department of Mental Health is the lead state office for children's mental health. It is closely aligned with the state's Department of Health due to a recent reorganization within the umbrella Agency of Human Services. A Designated Agency within each region (e.g., a community mental health center) serves as the local focal point for management and coordination of the system of care. Five core services are available within each geographic area of the state. Additional services and support are provided under contract with the designated agency, as well as several statewide services. The core services are categorized

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as: immediate crisis response; clinic-based and outreach treatment; family support; and prevention, screening, referral and community consultation. Statewide services are emergency/hospital diversion, intensive residential services, and hospital inpatient services.

Operationally, an interagency treatment team of family members and service providers that is led by a care coordinator develops the individualized coordinated service plan for each child. One agency has legal responsibility for ensuring that a coordinated service plan is in place. If the child is in the custody of the state's child welfare agency, the Department for Children and Families, that agency is responsible. If the issues are primarily associated with the child's educational environment and functioning and the child is not in state custody, then the local school district is responsible. In all other cases, the mental health system's Designated Agency (e.g., community mental health center) is responsible for developing the coordinated services plan that outlines goals and needed supports and services. If problems or issues arise that the individual treatment team cannot resolve, the team or any member may initiate a referral to the Local Interagency Team (LIT) in the region for help. The State Interagency Team is a state-level forum for the next round of consideration or assistance should issues not be resolved locally.

The Agency for Human Services and the Department of Education signed a new agreement in 2006 that broadened the scope of eligible youth and the group of providers who participate in and contribute to service planning for them. With the new interagency agreement, eligibility expanded from the original single disability of severe emotional disturbance to include youth with any of the 14 disabilities in state and federal special education law. These children and their families can access coordinated plans that "include but are not limited to developmental services, alcohol and drug abuse programs, traumatic brain injury programs and pre and post adoption services."

Vermont's children's mental health partners also are exploring new approaches to financing services for children with multiple, severe needs. Under the authority of the state's Global Commitment Medicaid waiver received in 2005, the state is working to establish a mental health funding resource that would create a pool of resources funded by several agencies for services and supports for children with multiple and serious needs. More information can be found at <http://healthvermont.gov/mh/programs/cafu/child-services.aspx>.

## Description of Regional/Local Areas in the Study Sample

### **AK** Bethel, Alaska



Bethel is a city located 340 miles west of Anchorage. According to 2005 Census Bureau estimates, the population of the city is 6,262. Bethel is the largest community in western *Alaska* and the 9th largest municipality in the state. It lies inside the largest wildlife refuge in the United States. It is an administrative and transportation hub for the 56 villages in the Yukon-Kuskokwim Delta, one of the biggest river deltas in the world, roughly the size of Oregon.

The Delta has approximately 20,000 residents; 85% of these are Alaska Natives, both Yup'ik Eskimos and Athabaskan Indians. Nearly half of the region's population is children due to the high birth rate and young median age. The main population center and service hub is the city of Bethel; each of the 56 villages within the Delta has up to 850 people. Most residents live a traditional subsistence lifestyle of hunting, fishing, and gathering, and over 30 % have cash incomes well below the federal poverty threshold.

Precipitation averages 16 inches a year in this area, and the average snowfall is 50 inches. The average low temperature in July is 49 °F and the average high is 63 °F, although temperatures as low as 32 °F or as high as 87 °F have been recorded in July. In January, the average low is 1 °F and the average high is 12 °F, while extremes of -49 to 49 °F have been recorded.

Health and behavioral health services in this region are the responsibility of the Yukon Kuskokwim Health Corporation (YKHC), which administers a comprehensive health care delivery system for the 56 rural communities in southwest Alaska. The system includes community clinics, sub-regional clinics, a regional hospital, dental services, behavioral health services, including substance abuse counseling and treatment, health promotion and disease prevention programs, and environmental health services.

YKHC is a Tribal Organization authorized by each the 58 federally recognized tribes in its service area to negotiate with the Federal Indian Health Service to provide health care services under Title III of the Indian Self-Determination and Education Assistance Act of 1975.

YKHC, along with 12 other Tribal Organizations, is a co-signer to the All-Alaska Tribal Health Compact, a consortium which negotiates annual funding agreements with the federal government to provide health care services to Alaska Natives and Native Americans throughout the state.

Community health aides provide village-based primary health care in 47 village clinics in the Yukon-Kuskokwim Delta. Health aides receive extensive training in acute, chronic and emergency care, have a five-tiered career ladder and are certified by a board operated by the Alaska Native Tribal Health Consortium. Health aides are nominated for training by their local village councils, and usually serve the villages where they grew up. The village health clinic is typically the first point of access to the YKHC health and behavioral health care system. Health aides consult with family medicine providers or specialists in Bethel and either treat patients locally or make referrals for individuals needing more comprehensive care.

The programmatic approach for children's mental health services is core teams of licensed mental health professionals and behavioral health aides who are responsible for the provision of children's mental health services in the rural villages of the Delta area. The core teams are modeled on the Community Health Aide Program, the rural health care program that uses indigenous community health aides (CHAs) and community health practitioners (CHPs), specially trained and certified individuals who offer health services, including preventive care and health screening services to small groups of individuals living in widely scattered villages in bush Alaska. More information about YKHC can be found at <http://www.ykhc.org>.

## NE Central Nebraska



Region 3 Behavioral Health Services (BHS) serves 22 counties in Central and South **Central Nebraska**. The service area covers 15,000 square miles and has a population of 223,000. Approximately half of the population in the Region 3 service area lives in three urban centers (Grand Island, Kearney, and Hastings). The remainder of Region 3 is rural.

With the support of the partners listed below and a federal grant, an effective service system, guided by system of care values and principles, has been created and sustained in Central Nebraska. These partners include:

- Region 3 BHS, one of six regional behavioral health authorities in Nebraska, governed by a board consisting of elected officials from the 22 counties served
- Nebraska Department of Health and Human Services (DHHS), Division of Behavioral Health Services (DBHS), the state mental health authority that contracts with each regional behavioral health authority and has been actively engaged in the work in Region 3

- Nebraska Department of Health and Human Services (DHHS), Central Service Area, Office of Protection and Safety, a state-administered agency that provides services in child welfare, juvenile justice, and developmental disabilities for 21 of the 22 counties in Region 3
- Families CARE, the family support and advocacy organization in Central Nebraska
- School districts and educational cooperatives including Grand Island Public Schools, Kearney Public Schools, and Educational Service Units 9 and 10.

Efforts to build a strong behavioral health service system for children and families in Central Nebraska began in 1989 when Region 3 hired a Child and Adolescent Services System Program (CASSP) Coordinator. Central Nebraska had the benefit of a five-year system of care grant from the federal Center for Mental Health Services, beginning in 1997. Prior to implementing a system of care in Central Nebraska, only 10% of the Region 3 BHS annual budget was allocated to children's services, and four children's services staff were employed. After receipt of the federal grant, the staff increased to approximately 48 FTEs related to child/family services. In fiscal year 2005, almost 50% of the Region 3 BHS budget was allocated for children's services.

Within the system of care in Central Nebraska, there are several programs, designed to serve children with differing needs, which are funded through collaborative financing strategies. These include:

- *Professional Partners (PP)* — Wraparound process for children who meet the definition for serious emotional disturbance and have other risk factors (implemented statewide)
- *Integrated Care Coordination (ICCU)* — Intensive care management based on principles of the wraparound process and family-centered practice, for children in state custody who have complex behavioral health needs and multiple agency involvement
- *Early Intensive Care Coordination (EICC)* — Similar to ICCU, but works with families in the child welfare system earlier, to prevent children from entering state custody
- *Family Advocacy/Support/Education and Youth Encouraging Support* — Both programs are offered by Central Nebraska's family organization, Families CARE
- *Multisystemic Therapy (MST)* — Intensive, time-limited home-based treatment to help families of children with behavioral health needs make changes in their child's environment
- *School Wraparound* — School-based wraparound approach to stabilize and maintain in the most normalized environment students who are experiencing emotional and behavioral challenges.

In fiscal year 2005, these six programs together served approximately 1,000 children and their families.

A case rate methodology, created in Central Nebraska by blending funding sources, serves as a primary funding strategy to support and sustain an intensive care management model, the work of Families CARE, a number of the services described above, and the system of care. Use of case rates has provided the flexibility to offer individualized care and develop new services. Cost savings have been reinvested in the child-serving system by providing technical assistance to replicate the program in other areas of the state and by expanding the population of children and families served in Central Nebraska. This case rate methodology is now used by five of the six regional behavioral health authorities in Nebraska.

Medicaid funds are not included in the case rate. The Nebraska DHHS/DBHS funds the public, *non-Medicaid* state mental health system. Region 3 BHS does not receive or manage Medicaid funds. Behavioral health services reimbursed by Medicaid are authorized by Magellan Behavioral Health Care, Inc., Nebraska's statewide managed care administrative services organization (ASO), and reimbursements are made on a fee-for-services basis to providers. More information can be found at <http://www.region3.net>.

## Choices (IN Marion County, Indiana; OH Hamilton County, Ohio; MD Montgomery County and Baltimore City, Maryland)



Choices, Inc. is a nonprofit, community care management organization that coordinates services for individuals and families involved in one or more governmental systems. Choices uses the system of care philosophy and approach with wraparound values and blends them with managed care technologies to provide a wide range of services and supports to high-risk populations with multiple and complex service needs. Choices programs serve both children and adults; the core of each program is that services are family centered, community based, culturally competent, outcome driven, and fiscally accountable.



Choices, Inc. was incorporated in 1997 as a private, nonprofit entity in Marion County, *Indiana*, of which Indianapolis is the county seat. It was created by four Marion County community mental health centers to coordinate the Dawn Project, a collaborative effort among child welfare, education, juvenile justice and mental health agencies to serve youth with severe emotional disturbances and their families the county. Dawn began as a pilot and served its first 10 youth in 1997. In 1999, a five-year federal grant from the Comprehensive Community Mental Health Services for Children and Their Families Program was awarded to the Dawn Project, enabling an increase in the number of children and families served, including an expansion in the target

population to serve children at risk for out-of-home care, as well as support for the development of a family support and advocacy organization (*Families Reaching for Rainbows*) and evaluation activities.

Choices was conceived as a separate and independent entity to manage the Dawn system of care. Fulfilling the role of a “care management organization,” Choices provides the necessary administrative, financial, clinical, and technical support structure to support service delivery and manages the contracts with the provider network that serves youth and their families. The responsibilities of Choices include: providing financial and clinical structure; providing training; organizing and maintaining a comprehensive provider network (including private providers); providing system accountability to the interagency consortium; managing community resources; creating community collaboration and partnerships; and collecting data on service utilization, outcomes, and costs. Choices now operates programs in several states that serve youth with serious emotional disorders – the Dawn Project in Marion County (Indianapolis), Indiana; Hamilton Choices in Hamilton County (Cincinnati), *Ohio*; and Maryland Choices in Montgomery County and Baltimore City, *Maryland*.

The goal of Dawn (and Choices programs for youth and families in Ohio and Maryland) is to improve services for youth with serious emotional disorders and to enable them to remain in their homes and communities by providing a system of care comprised of a network of individualized, coordinated, community-based services and supports, using managed care technologies. The managed care system is designed to serve youngsters with the most serious and complex disorders and needs across child-serving systems, those who typically are the most costly to serve and who are in residential care or at risk for residential placement. In essence, the design creates a separate “system of care carve-out” for this population. Dawn and the Choices Ohio program are funded by case rates provided by the participating child-serving systems. The recently initiated program in Maryland is in the developmental stages; it is not as yet risk based and is not using the case rate approach at this time.

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Over time, Choices has developed other services for high-need, complex populations, filling particular high-priority service gaps in the community. The Action Coalition to Ensure Stability (ACES) program serves adults who are homeless and who have co-occurring mental health and substance abuse disorders; Youth Emergency Services (YES) is a 24-hour mobile crisis service for abused and neglected children; and Back to Home serves runaway youth in the county. The common threads in all the programs operated by Choices include the use of managed care approaches, blended funding from participating agencies, individualized and flexible services, and care management.

In addition to its direct services, Choices has become a resource for technical assistance in Indiana. The Indiana Divisions of Mental Health and Family and Children began providing start-up resources in 2000 for the development of systems of care, based on Dawn's experience, in other areas of the state. Choices has been a key technical assistance resource for these sites and, in 2002, was officially funded by the state as a technical assistance center (Technical Assistance Center for Systems of Care and Evidence-Based Practices for Children and Families) to provide assistance in developing similar community based systems of care throughout the state. More information about Choices can be found at: <http://www.choicesteam.org>.

## **OH** Cuyahoga County, Ohio



*Ohio's* Cuyahoga Tapestry System of Care (CTSOC) is a partnership of the county child-serving systems and community and neighborhood provider organizations. CTSOC provides intensive, neighborhood-based services (both formal and informal) to at-risk children and families. It blends formal Medicaid billable mental health services with informal supports facilitated by Care Coordinators, Parent Support Partners, and Parent Advocates via a network of public and private agencies that are called "Neighborhood Collaboratives". High-fidelity wraparound is the practice model used by all the components of the system of care. Each family has a Child and Family Team and an individualized service plan that is driven by the needs of the child and family. CTSOC merges the wraparound model with the Family-to-Family Model, a child welfare reform initiative in the tradition of neighborhood settlement houses. This integration has occurred in 14 Neighborhood Collaboratives that have Family-to-Family contracts with the county Department of Children and Family Services (DCFS — child welfare agency).

Cuyahoga County, which encompasses Cleveland and surrounding areas, has a population of 1.3 million, with 24% under the age of 18, about 300,000 children. Cleveland is the largest city in the county and has one of the highest poverty rates among America's big cities. CTSOC serves the most economically challenged families in the most economically depressed city in the country — 47.6% of children under eighteen and 53.3% of children under age five live in poverty. Nearly 80% of families enrolled in CTSOC live at or below the poverty level. The racial/ethnic breakdown of the county population is: 63% White, 29.2% African American, 3.8% Hispanic or Latino Origin, 1.2% Multi-racial, and .2% American Indian-Alaskan Native.

The CTSOC is composed of a number of individual components, each with its own funding sources. A single funding source may support several of these components, and each component is supported by more than one funding source. However, the funds are not actually blended or pooled. Instead the county refers to its funding process as braiding and defines it as strands of money from the various public partners, which are separately tracked by the ASO, and joined to pay for a seamless service package for an individual child and family.

CTSOC began with a \$9.5 million grant from SAMHSA for a six-year period from 2003 to 2009, with the Board of County Commissioners (BOCC) required to provide matching funds. The original goal of CTSOC was to adopt the nationally recognized wraparound approach, to increase access to services, as well as increase the capacity and integration of mental health services to help an additional 1,200 children and

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youth. DCFS (the county child welfare agency) played a significant role in the development of the system of care by redirecting its placement funds to support 14 Neighborhood Collaboratives (\$4.2 million), eight Care Coordination Partnerships and two Residential Step-Down contracts (\$3 million). A reduction in placement costs and residential treatment costs enabled DCFS to redirect its spending and contribute significantly to the system of care. The county's Office of Health and Human Services contributed \$6M to the SAMHSA match.

During its initial phase, Cuyahoga County created a System of Care Oversight Committee to provide the governance of CTSOC and to approve its budget. By Year 4, decision making (i.e., budget approval and program recommendations) came under the purview of a Funder's Group comprised of the directors of the county's public child-serving systems and juvenile court. The SOC Oversight Committee remains an advisory partner and includes a broad stakeholder group, representing the major child-serving systems, families and youth representing Neighborhood Collaboratives, providers, university partners, etc. It has five subcommittees, including the Parent Advisory Council (also a Youth Advisory Board), Training and Coaching, Cultural and Linguistic Competence, Evaluation, and Social Marketing.

In order to manage the system of care, the BOCC established the CTSOC office as a public administrative services organization (ASO) which reports to the Deputy County Administrator for HHS and to the Funder's Group. The ASO manages multiple braided funding streams; provides planning, communications, operational and fiscal management for the initiative; manages the Continuous Quality Improvement (CQI) initiative; and tracks outcomes (through a web-based multipurpose management information system called "Synthesis" (which Cuyahoga County leases from Wraparound Milwaukee). The ASO handles care authorization and enrollment for the 900 children and families served by the eight Care Coordination Partnerships. The CTSOC office (the ASO) has developed a Provider Services Network (PSN) which consists of community agencies and individual providers that offer informal and formal services to children and families enrolled in CTSOC. The ASO develops service descriptions, standards for all services, and approves unit rates, within the parameters of existing statutes and regulations

Criteria for youth acceptance into the SAMHSA funded aspects of CTSOC includes, among others, a diagnosis of serious emotional disturbance, major impairments in several life domains, involvement with (or at risk for involvement with) more than one public child-serving system, and a need for multiple sources of support to address problems across life domains. Funding from the SAMHSA grant, with two local tax levies providing the match, enabled the county to initially serve 240 youth and their families. The county then merged a smaller SAMHSA grant (SCY — Services for Community Youth) which provides substance abuse services for 60 youth and their families) into the system of care, thus serving 300 children and families. Enthusiasm about the system of care concept and the desire to serve a greater number of children and families has led the county to expand the target population. Through contributions to the system of care from the BOCC (\$6 million) and from DCFS (\$3 million from savings achieved by reducing residential care), the system of care now has the capacity to serve an additional 600 children. Two populations of children are targeted for services with this additional funding. The first population is comprised of 300 children referred by DCFS, and the goals are to divert 100 children from residential care and serve them in the community through the Care Coordination Partnerships and to serve 200 children/youth who have behavioral health problems and who are in kinship care or in placements at risk for disruption. The second population comprises 300 youth referred by the court system, with goals to divert 100 children from residential care and serve them in the community through the Care Coordination Partnerships and to serve 200 who have domestic violence convictions or status offenses.

The 600 children in the expanded service population above will be served by Care Coordination Partnerships (CCPs). Each of the eight care management entities (CCPs) is a formal, contractual partnership between at least one DCFS contracted Neighborhood Collaborative and one lead provider agency that provides Medicaid treatment services and has a residential services capacity. The CCPs, based in different

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county neighborhoods, provide care management and wraparound plans for the total 900 children and families in the target populations.

In 2006, the county was able to serve an additional 2500 + families annually who were at risk of involvement in child welfare and mental health, using funds from DCFS (approximately \$4 million) and from SAMHSA (\$1.1 million). These families are served by Family-to-Family “wrap specialists” in the 14 Neighborhood Collaboratives.

Parent advocates, funded by CTSOC (primarily through the SAMHSA grant), offer support for families and ensure that the parent voice is heard in the child and family team meetings. Currently, 15 parent advocates are available to families involved in the county’s system of care. They are funded by CTSOC and housed in each of the 14 Neighborhood Collaboratives. All are parents of children with special needs and come from the communities that they serve.

The Care Coordination Partnerships operating at the neighborhood level also are linked to PEP Connections, established in Cleveland in the late 1980’s as an intensive service resource for youth at risk of placement. PEP Connections is financed through 1915 (a) of the federal Medicaid statute (Social Security Act) to provide intensive care coordination, and it utilizes a \$1,602/mo/child case rate.

For additional information, see [www.CuyahogaTapestry.org](http://www.CuyahogaTapestry.org).

## **NY** Erie County, New York



**New York** State is a state-administered, county operated system. Each county is a Local Governmental Unit (LGU) with delegated responsibility from the New York State Office of Mental Health (OMH) for meeting the mental health needs of individuals in their respective geographic areas. In Erie County is a metropolitan center located on the western border of the state; the city of Buffalo serves as the county seat. The Erie County Department of Mental Health (ECDMH) is responsible for mental health, substance abuse, and developmental disabilities.

The Erie County Department of Social Services (DSS) is responsible for child welfare services, TANF, child care services, adult protective services, and detention services. DSS has also been designated as the lead agency for the County’s Persons in Need of Supervision (PINS) Diversion Initiative, and the Erie County Department of Probation is responsible for juvenile justice.

In New York State, Medicaid eligible individuals are enrolled in Health Maintenance Organizations (HMOs) that are responsible for primary health care, a limited number of days of psychiatric inpatient care, and a limited number of mental health outpatient visits. Pharmacy, including psychotropic medications, is not included in the HMO capitation and remains fee-for-service. Specially designated clinic treatment services for children with serious emotional disturbance (SED) are also not included in the managed care system, and billing for these services remains fee-for-service.

Family Voices Network (FVN) of Erie County is the system of care for children with serious mental health problems that was created through a partnership among the county ECDMH, DSS, Probation, and family members. Family Voices also has a federal system of care grant that was funded in 2004. The applicant was ECDMH on behalf of the partnership. FVN has an Executive Committee with representation from mental health, social services, probation, family court and public school systems, in addition to family and youth membership. The Director of DSS chairs the executive committee. The target population is comprised of high-need, high-risk youth between the ages of 5 and 17. The value base of the system of care calls for family driven, youth guided, community based, and culturally sensitive services; the primary practice model is the wraparound approach.

Prior to submitting its federal system of care application, Erie County contracted with the State University of New York at Buffalo, Department of Family Medicine, to identify the service needs of the county's high-risk youth and their families. The assessment found that many of the youth in the target population and their families had been engaged in more than one of the county's service systems for youth and that regardless of which service system was primary at the time of system penetration, there was significant consistency in the needs, risks, and level of functioning for the sampled youth and their families. This important finding resulted in the development of a shared enterprise partnership between the Erie County Departments of Mental Health, Probation and Social Services, as well as family members, in the planning, governance, funding and implementation of the children's system of care reform.

Consistent with its approved application, the system of care sought to reduce utilization of residential treatment and reinvest savings in the development of community-based services in the evolving system of care. The county began to develop operational partnerships, a Wraparound approach, and a blended funding strategy even before approval of its federal system of care grant. During the first year of the grant, the following framework connecting the reform of practice with the allocation of resources was articulated:

- Partnering and the resulting reforms must be supported by fundamental changes in practice and relationship
- Wraparound values and culture provide the underpinnings of all collaboration and change
- Learning communities supported by empirical data drive policy and operational reform and changes in practice
- Ongoing quality improvement focusing on the relationship between practice and the achievement of family valued and system reform outcomes reshapes management, supervision and learning at all operational levels of the reform
- Changes in culture, practice and the achievement of valued outcomes can be reinforced and sustained through the implementation of incentives

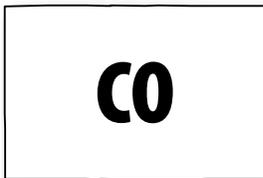
An additional impetus that has provided urgency and an operational platform for sustaining the financing and policy reform that is being achieved in Erie County's system of care was an overall county government fiscal crisis. In January 2005, the Erie County legislature did not approve a one-cent increase in the county sales tax included in the county executive's recommended budget. This action resulted in a large budget deficit; the legislature and county executive were not able to reach consensus on an approach to resolution of this crisis. Ultimately, New York State imposed a fiscal stability authority to provide oversight to the county budgeting and finance functions.

While the crisis resulted in an overall significant reduction in the county workforce and cutbacks in some targeted services provided to county residents, it also provided leadership in the three participating county departments to support the development and maintenance of a system of care. During formal deficit reduction planning activities sponsored by the fiscal stability authority, the Departments of Social Services and Mental Health submitted a joint cost savings initiative that was approved for inclusion in the county's Four Year Fiscal Stability Plan. Based on the system of care reform agenda, but with an additional pre-investment of resources from the two partnering departments and the SAMHSA system of care grant, the jointly sponsored cost savings initiative projected a cumulative 60% reduction in residential treatment center bed day utilization over four years. The cost saving initiative included each of the following elements:

- The capacity to identify, using objective criteria, individuals at risk of significant system penetration and/or high utilization of institutional care
- Utilizing virtual single points of entry to ensure that the youth at greatest risk of system penetration gain priority access to critical community alternatives to institutional care

- The development of expanded capacity for Wraparound Services and other evidence based/ emerging service models to interrupt system penetration and/or provide effective service alternatives to institutional placement
  - A shortened length of stay initiative for residential treatment that integrates practice reform while in residential services with linkage to Wraparound services designed to reduce length of stay from its pre-reform average 11 months to a normative stay of 4 to 5 months for referred youth
  - Real time data and management structures that support ongoing goal setting and monitoring of performance milestone achievement, learning opportunities for improvements in the efficacy of practice, and the identification of and adjustment to emerging challenges
  - A reinvestment methodology that invests a portion of achieved targeted reductions in residential treatment expenditures in expanded community system of care services in order to achieve and sustain future savings targets associated with additional decreases in institutional care utilization
- For additional information, see: [www.familyvoicesnetwork.org](http://www.familyvoicesnetwork.org)

## CO Project BLOOM, Colorado



**Colorado** is structured into 64 counties, with a high degree of control vested in these local communities. Colorado’s public mental health system is administered by the Division of Mental Health (DMH), within the Department of Human Services (DHS), and serves individuals who do not have mental health insurance coverage or who have Medicaid. Mental health services are primarily delivered through contracts with 17 nonprofit community mental health centers (CMHCs) and 7 specialty clinics.

DMH serves as the state authority for behavioral health. However, responsibility for the Medicaid program was transferred to the Department of Health Care Policy and Financing in 2003. The Medicaid managed care program operates under a 1915(b) waiver first implemented in 1995. Five behavioral health organizations (BHOs) manage Medicaid behavioral health services in the state, each serving an assigned geographic area. These BHOs are nonprofit entities that contract with CMHCs and other entities to provide behavioral health services. Three of the BHOs are jointly owned by CMHCs, although they are separate nonprofit entities. The majority of Medicaid behavioral health dollars flow to the 17 CMHCs in Colorado, several specialty clinics (for example, for Asian Pacific clients), and private providers. The BHOs subcontract with the CMHCs, but the centers are still required to do “shadow billing” for services provided under Medicaid, demonstrating the units of care provided.

Project BLOOM is a system of care serving young children ages six and under. The system of care received federal funding from the Comprehensive Mental Health Services for Children and their Families Program (Children’s Mental Health Initiative or CMHI) in 2002 for a six-year duration; at the time of the site visit, the system of care was in its fifth year of funding. Its vision is to ensure the mental health and social-emotional well being of Colorado’s young children, and its goals are to: 1) reduce expulsions from early childhood care and education programs by providing timely, high-quality treatment services, 2) increase family access to culturally competent resources and develop model family involvement practices, 3) expand capacity and competency of the early childhood workforce to address mental and behavioral health needs by increasing the depth and breadth of training, 4) maximize limited resources for behavioral health care for young children, increasing the number of health providers and building community support for mental health services, and 5) address fragmentation in the current health/mental healthcare systems.

Project BLOOM serves four communities, including frontier, rural, urban, and suburban areas (three counties and one city). The communities include:

- Mesa County — A large rural area with some frontier areas. Mesa County has a population of approximately 116,000, with 18% of the children under age 18 living in poverty and the highest rate of child abuse and neglect in Colorado counties.
- Fremont County — A rural area with some frontier areas. Fremont County has about 46,000 residents.
- City of Aurora — A large metropolitan area that is urban with some suburban area. Arapahoe County is located in metropolitan Denver and includes the City of Aurora with a population of 297,235.
- El Paso County — An urban area with some suburban areas that includes Colorado Springs and surrounding areas, with a population of 576,884.

The Project is administered through the Colorado DMH by a staff person in the Program Quality Unit who serves as the Principal Investigator (PI) and as the early childhood specialist within the Division. There is also a Child and Adolescent Specialist within the Division of Mental Health who, with the Project BLOOM PI, is part of the “Children’s Team.” The Children’s Team is a formal structure within DMH. The team has responsibility for children’s mental health services and fulfills a number of functions, including responding to legislative requests, providing technical assistance to community mental health centers and other mental health facilities, and conducting site visits to mental health centers where it reviews child and adolescent charts.

A subcontract from the Division of Mental Health with JFK Partners at the University of Colorado at Denver and Health Sciences Center is used to provide much of the support for the system of care in the four Project BLOOM communities. The decision to subcontract with JFK Partners was based on its extensive history, expertise, curricula and other resources and products in the early childhood area. JFK Partners contracts with the community mental health centers to provide services and supports in each of the four communities, as well as contracting with the Colorado chapter of the Federation of Families for Children’s Mental Health for a wide range of family involvement and family advocacy activities and the Colorado Children’s Campaign primarily for social marketing activities. JFK Partners is responsible for administering these subcontracts and providing technical assistance to the subcontracts. It is at the community level that decisions are made regarding the constellation of services and supports to be provided. The communities have considerable autonomy and decision making authority regarding how the resources will be used to serve the target population. In addition, the mental health center in each of the communities is responsible for developing and operating a local governance structure for the system of care.

The Request for Applications (RFA) for the federal system of care grant was not originally geared to an early childhood population, and some of the required goals and activities for funded systems of care require adaptation to fit with system of care development activities and services for this group. For example, the population eligibility criterion related to “duration” of emotional problems does not fit for an early childhood population, and, thus, is not considered. For the criterion “multi-agency involvement,” the types of agencies involved with the early childhood population differ from those often involved with older children, such as juvenile justice. Rather, a different constellation of agencies and resources are involved with young children, including early care agencies and early education settings, pediatrics and primary health care, and child welfare.

Across all four of the Project BLOOM systems of care, the population of children served includes about 70% males, with an average age of 3.6. The population served through Project BLOOM is diverse, with consistent findings that approximately 30% of the children and families served is Hispanic and another 25% is multi-racial. The primary presenting problems of the children enrolled in Project BLOOM systems of care include anxiety, hyperactivity and attention, conduct, and adjustment disorders. Depression, specific developmental disabilities, and school (i.e., child care or early education) problems are the next most frequent presenting problems.

Several critical partnerships support the activities of the Project BLOOM systems of care. The state Division of Child Care and the Department of Education’s early childhood initiatives are critical partners as they have a significant impact on the lives of young children and their families.

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The work of Project BLOOM was not intended to result in a short-term “project” per se, but to strategically build the foundation for early childhood mental health services to be incorporated into mental health and early childhood service systems on a statewide basis. Weaving and integrating early childhood mental health services into the services, funding, and operations of other existing systems is one of the major vehicles being used to accomplish this statewide expansion. A primary strategy is to use state funds to support an early childhood specialist position at each of the 17 CMHCs in the state. This approach has brought the CMHCs “to the table,” bringing an early childhood focus to their agendas and requiring linkages with the Early Childhood Councils in their respective communities. The early childhood mental health specialist position is conceptualized as a combination of direct services, consultation services to families and early care and education providers, and cross-system program development.

More information about Project BLOOM can be found at [www.projectBLOOM.org](http://www.projectBLOOM.org) and about the Colorado Division of Mental Health at [www.cdhs.state.co.us/dmh/programs\\_early-childhood.htm](http://www.cdhs.state.co.us/dmh/programs_early-childhood.htm)

### Wraparound Milwaukee

## Wraparound Milwaukee



Wraparound Milwaukee is a behavioral health carve-out, serving several subsets of children and youth with serious behavioral health challenges and their families in Milwaukee County, *Wisconsin*. Milwaukee County has a population of about 240,000 children under age 18. The primary focus of Wraparound Milwaukee is on children who have serious emotional disorders and who are identified by the child welfare or juvenile justice system as being at risk for residential or correctional placement. Wraparound Milwaukee serves about 1,000 children a year over age 5. (It does not serve the 0-5 population in general.) A combination of several state and county agencies, including child welfare, Medicaid, juvenile probation services, and the county mental health agency, finance the system. Their dollars create, in effect, a pooled fund that supports Wraparound Milwaukee, which is a system of care administered by the Milwaukee County Behavioral Health Division in the County Department of Health and Human Services. Wraparound Milwaukee organizes an extensive provider network and utilizes intensive care coordinators, who work within a wraparound, strengths-based approach. Wraparound Milwaukee involves families at all levels of the system and aggressively monitors quality and outcomes. It has an articulated values base that emphasizes: building on strengths to meet needs; one family-one plan of care; cost-effective community alternatives to residential placements and psychiatric hospitalization; increased parent choice and family independence; care for children in the context of their families; and unconditional care.

Wraparound Milwaukee operates as a special managed care entity under its contract with the state Medicaid program. It operates under 1915 (a) of the federal Medicaid statute (Social Security Act) and a sole source contract between the state Medicaid agency and Milwaukee County, which allows it to blend funds from multiple child-serving systems. Governance is through the Milwaukee County Board of Supervisors.

Wraparound Milwaukee prefers to designate itself a “care management,” rather than managed care, entity, emphasizing a values base which it feels is more consistent with its public sector responsibilities than the term “managed care” may connote. The program, however, utilizes managed care technologies, including a management information system designed specifically for Wraparound Milwaukee, called *Synthesis*, capitation and case rate financing, service authorization mechanisms, provider network development and management, accountability mechanisms, and utilization management, in addition to care management. More information about Wraparound Milwaukee can be found at: <http://www.milwaukeecounty.org/wraparoundmilwaukee>.

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# Chapter 4. Developing a Strategic Financing Plan for Systems of Care

## I. Analyze and Project Utilization, Cost, and Resources

A strategic financing plan that establishes financing approaches for services and supports and for other key features of systems of care provides a roadmap for states, tribes, and communities as they build and expand the delivery system for children and youth with behavioral health challenges and their families. An important first step in the development of a strategic financing plan is identifying current spending and utilization patterns. This process enables a state, community, tribe, or territory to understand how resources are currently being spent for behavioral health services – for which services and for which children and families. The identification of child behavioral health expenditures and utilization needs to occur across all child-serving systems because multiple systems – Medicaid, child welfare, juvenile justice, education, mental health and substance abuse, among others – finance child behavioral health services. Expenditure and utilization levels within individual child-serving systems vary from state to state.

A second step is identifying the types and amounts of potential resources that can be allocated or redirected to systems of care. These often are dollars being spent on high-cost and/or poor outcome approaches, for example, on out-of-home placements. This type of analysis also can point to areas where federal financing, such as Medicaid and Title IV-E, may be under-utilized to support systems of care. Analysis of expenditures and utilization across child-serving systems also can shed light on disparities and disproportionalities in access and use based on race/ethnicity or geography. With the information learned through the analysis, strategic planning for financing systems of care can proceed. It is also important to undertake periodic assessment of financing policies and strategies to assess their effectiveness and to ensure their support for system of care goals.

### **Financing strategies include:**

- A. Analyze Spending and Utilization Patterns and Project Expected Utilization and Cost**
- B. Identify the Types and Amounts of Funding for Behavioral Health Services Across Systems and Potential Resources for Systems of Care**

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## A. Analyze Utilization and Spending Patterns and Project Expected Utilization and Cost

All sites determine and track utilization and costs for a variety of planning, rate setting, and accountability purposes. For example, **Cuyahoga County** uses a web-based multipurpose management information system to collect data on utilization, costs, and cross-system involvement; one use of the information is to project future system of care costs.

### **AZ** Arizona

#### ***Tracking Utilization and Cost for the Child Welfare Population***

The **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), has worked with the state child welfare agency to identify utilization and costs associated with behavioral health services financed by the child welfare system that were being provided to Medicaid-eligible children and which could be covered by Medicaid instead of using all state general revenue dollars. This was part of a revenue maximization strategy. ADHS/BHS worked with child welfare and Medicaid actuaries to determine the cost of services to child welfare-involved children in licensed Level I out-of-home placements (i.e., secure and non-secure residential treatment centers and acute inpatient hospital care). The assumptions reflected that not all children would meet Medicaid criteria for placement (i.e., medical necessity criteria). The prior authorization criteria were expanded to allow for a decision to place or maintain a child in an out-of-home treatment setting if the child, along with having a mental health diagnosis, did not have a home to go to or the opportunity to obtain community-based services to maintain functioning. Specific dollars were allocated to Value Options (VO), the contracted managed care organization in Maricopa County, to begin funding these out-of-home treatment services (as well as alternatives to out of home placement). Subsequently, additional funds were earmarked for child welfare-involved children to support their involvement in Level II and III placements (i.e., out of home placements less restrictive than residential treatment centers and inpatient hospital care, such as therapeutic foster care), as well as outpatient programs. As a result of this effort, the agencies identified a number of child welfare-involved children whom they felt should be in Medicaid-financed therapeutic foster care or in Medicaid-financed counseling services. The numbers of children were arrived at based on actual services provided by child welfare for children eligible for Medicaid services.

The analyses undertaken with child welfare led to a revision upward in the capitation rate for child welfare-involved children (i.e., development of a risk-adjusted rate). Dollars were not shifted from child welfare as part of this process due to that system's experiencing an increase in children coming into custody; however, behavioral health received additional resources through the state budget process. Following these analyses, ADHS/BHS also expanded the definition of "urgent" as it relates to provision of crisis services. In the new definition, children who are removed from home by child welfare are considered to have "urgent behavioral health needs," requiring a 24-hour response by the behavioral health system to conduct an initial assessment. This expansion was made both to ensure timely response to children removed from home and to intervene early to prevent the need for out-of-home therapeutic placements further down the road. While most of these children become state wards and thus eligible for Medicaid, at the time of the "urgent care" response, financial eligibility verification is not required.

Both statewide and in Maricopa County, about 60% of the foster care population was receiving behavioral health services through the managed care system at the time of the site visit. (That is now reportedly up to 75%.) In Maricopa, this is a sizeable increase over what had historically been a 30% foster care involvement rate. Increased access for children in child welfare is a goal of the AZ reform.

The state develops a yearly utilization management report for children, ages 18 and under (and for 21 and under), that looks at units of service and financial expenditures. The largest percentage of dollars (36.4%) for children and youth is spent on what Arizona calls “support services,” which includes case management, therapeutic foster care, respite care, family support, transportation, personal assistance, flex fund services, peer support, housing support services, and interpreter services.

## **CA** **California**

### ***Using State Data Systems to Determine and Track Utilization and Costs***

The **California** Department of Mental Health (DMH) maintains a number of county mental health data systems. The Client and Service Information System (CSI) tracks the following by county and statewide:

1. Client records, including client characteristics such as age, race/ethnicity and language
2. Service records, including date of service, type of service and diagnosis
3. Periodic records, such as living arrangements and employment status.

Data are reported monthly by the counties via the Information Technology Web Server (ITWS). Summary statewide and county reports are also sent back to the counties via ITWS. The state indicated that in FY 04–05, 246,000 children received mental health services, about a 2% penetration rate for all children and about a 5% penetration rate for children at or below 200% of poverty. Data provided by the state for FY 02–03 indicated that **Contra Costa** County served over 5,000 children, about a 2% penetration rate for all children and a 10% penetration rate for children at or below 200% of the poverty level (about twice the statewide penetration rate of 5%).

DMH data systems also include Medi-Cal eligibility and claims files for specialty mental health services, a separate file mandated by the Emily Q. EPSDT lawsuit that tracks utilization and costs related to Therapeutic Behavioral Services, a performance outcomes data system that tracks consumer perception of the system (discussed more fully under Accountability), and a cost and financial reporting system. All legal entities furnishing local community mental health (Medi-Cal and non Medi-Cal) services must complete an annual Cost Report. The report is used for several purposes:

- To compute the cost per unit for each service
- To determine the estimated net Medi-Cal entitlement (Federal Financial Participation-FFP) for each legal entity
- To identify the sources of funds
- To serve as the basis for the local county year-end cost settlement, and
- To provide a source for other data requests.

DMH data systems allow the state to track the percent of Medi-Cal eligible persons receiving mental health services by aid group, by age and by county. The FY 02–03 data indicate that Contra Costa provided services to about 60% of the foster care population (compared to 48% statewide). The data systems also can track high-cost clients by diagnosis.

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The state does not do “caseload estimates” by county; it does an annual estimate of utilization looking at historical utilization by county, for example past use of EPSDT with a 36-month look-back. The state expressed interest in refining their methods to estimate/predict utilization but indicated that the flexibility provided to counties makes this difficult. The state also noted that the diversity of their counties makes it difficult to set benchmarks around utilization or penetration. The state is conducting prevalence studies, however, which are looking at prevalence by age, race/ethnicity, and poverty level. They are using data from the California Health Interview Study.

## **HI** Hawaii

### ***Regular Tracking and Reporting of Utilization and Cost Trends***

Since 1997–98, the state children’s mental health system has systematically tracked mental health service utilization to determine the amount of services to purchase from provider agencies. The Child and Adolescent Mental Health Division (CAMHD) produces a financial report on a regular basis (monthly and quarterly) that analyzes information regarding financial resources and expenditures. For example, the quarterly report specifies:

- How much Medicaid (Title XIX) revenue CAMHD receives per client/per month
- How much Special Fund revenue CAMHD received in the fiscal year and how much money remained in the Special Fund accounts (Medicaid capitation and fee for service, investment pool, Title IV-E)
- How much Title IV-E revenue CAMHD received
- Utilization trends for CAMHD emergency services, including 24 hour crisis telephone consultation, 24 hour mobile outreach, and crisis stabilization (average monthly cost per registered client)
- Utilization trends for CAMHD intensive services, including intensive in-home and Multisystemic Therapy – MST (average cost per client per month)
- Utilization trend for CAMHD residential services (average cost per registered client per month)
- Utilization trend for hospital-based residential care (average cost per registered client per month)
- Comparison of expenses from authorizations per unduplicated client among Family Guidance Centers
- How CAMHD operational expenses compare to quarterly allocations

Included in the financial report are charts showing operational expenses per month within General Funds, Special Fund (Title XIX), and federal and interdepartmental transfers (such as federal grants and Title IV-E funds). These expenses are broken down by service within categories including emergency services, intensive services, residential services, and other services (such as ancillary/flex services and respite services).

**MI Michigan*****Determining and Tracking Utilization and Cost***

The Department of Community Health (DCH) pays each Prepaid Inpatient Health Plan (PIHP) a monthly capitated payment for each Medicaid participant in their service area based on an estimate of enrollees from the prior month. The amount of the capitation payment is determined by three variables; Medicaid eligibility category (e.g., Developmentally Disabled, TANF); the number of persons who are Medicaid eligible in each group in the PIHP's coverage area; and an intensity factor for each PIHP to account for regional variation in the historical utilization of mental health, developmental disabilities, and substance abuse services.

The capitation amount is calculated based on the historical costs for services. The rate setting process involves evaluating administrative and service costs separately; they are then combined to create a single capitated rate. To maintain simplicity and uniformity, DCH uses the same process for separating administrative and service costs in the Indigent ("General Fund") programs. This creates a single method for identifying costs throughout the public mental health system.

In order to establish the costs of providing treatment, supports and services, the state requires each PIHP network to submit financial information related to each service encounter delivered regardless of funding source in the form of an "aggregate net cost per unit." This aggregate net cost per unit is calculated by the PIHP by dividing the sum of the Medicaid costs in the PIHP's service area (including affiliates) for a procedure by the total units of the procedure delivered to Medicaid beneficiaries in the PIHP's service area (including the affiliates). This provides a single uniform system for identifying the costs of Medicaid treatment, supports and services. The total Medicaid expenditures and total units are reported on the PIHP's Medicaid Utilization and Net Cost Report at six and twelve months. The total Community Mental Health Service Programs (CMHSP) expenditures and total units are reported on the CMHSP total Sub-Element Cost Report at twelve months.

**NJ New Jersey*****Regular Tracking of Utilization and Cost Data***

**New Jersey's** Administrative Services Organization, called the Contracted Systems Administrator (CSA), authorizes, coordinates and tracks care for all children entering the system. Providers are paid using a single method and this allows for the maintenance of one electronic record of behavioral health care across systems that serve children. The CSA's ABSOLUTE Information System has the capacity to produce reliable cost and utilization data. Examples of the types of data that are tracked include:

- Number of referrals by source, location (county or CMO area), age, ethnicity and sex.
- Number of referrals screened (EPSDT), assessed, multi-system assessed by diagnosis, location, age, ethnicity, and sex.
- Number of referrals assigned to the CMOs statewide and by diagnosis, location, age, ethnicity, sex and referral source.
- Number of referrals and accepted children eligible for Medicaid, NJ Kidcare/Family care

- Number/Percent of children accepted in the Children's Initiative with service plan completed within required timeframe by diagnosis, location, age, ethnicity and sex.
- Amount of dollars spent for children in the Children's Initiative by child, diagnosis, eligibility type (CMO, CSA care coordination) location, age, ethnicity, sex, service type
- Amount and type of service used (hours, days) per child by diagnosis, eligibility group, location, age, ethnicity, sex
- Timeliness of service authorization - % of service authorization decisions for continued stay in inpatient services made within 24 hours after receiving assessment information from a clinical provider or screening team (CSA UM system)
- Timeliness of service authorization - % of admission and continuation of care decisions for routine care for non-CMO children made within 5 working days after receiving a service request with all of the clinical information required by, and stated in, written CSA policy (CSA UM system)
- FSO involvement - % of CMO families referred to FSOs; % of families in crisis referred to FSO (CSA UM system)
- Restrictiveness of living environment - % and # of children who moved to a less restrictive living environment from entry to exit
- Readmission rate - % of children discharged from an inpatient facility readmitted within 7, 30, 90, and 180 days after discharge, stratified by age
- Functioning - % change in Strength and Needs Assessment scores (entry score, score at review period, exit score)
- Placement stability - # of children unable to be maintained in current placement for emotional or behavioral reasons from ISP
- RTC length of stay - % change in RTC lengths of stay: Per child· Per 100 children
- Adequacy of crisis management -# of crisis screenings reported to the CSA: Per child· Per 100 children
- Timeliness of crisis management follow-up -% of children discharged from crisis management that receive a service within 3 days
- Timely outpatient or community-based services follow-up to inpatient treatment - % of children discharged from inpatient care who receive outpatient or community-based services within 7 days
- Coordination with the primary care Medicaid HMO physician (PCP) -% of children receiving psychotropic medications whose provider is actively coordinating with the Medicaid HMO PCP, excluding children without an assigned PCP.

## **VT** Vermont

### ***Tracking Utilization and Costs for Planning and Accountability***

**Vermont** routinely tracks utilization and costs associated with mental health and system of care services. The data are used for accountability functions and to document ongoing and changing needs in the community. They also provide basic information (presented to and reviewed by the legislature) that influences program and policy directions for children's behavioral health services. In addition to providing information for required fiscal reporting and monitoring by the state and local agencies, university partnerships also exist that utilize the data in special studies.

The designated community provider agencies report client and service information to the state Department of Mental Health on a monthly basis. These provider agencies have the responsibility for the development and maintenance of their respective management information systems. The data collected populate the state's mental health database that is used by the Department of Mental Health's research and statistics staff for tracking, analyzing, and reporting mental health information. A state-level, multi-stakeholder advisory group developed recommendations that guide these efforts.

An annual statistical report provides data on all aspects of mental health services in the state by various categories, including children's services. Regularly reported data on children's services cover, in the aggregate and by community service provider: age and gender; financial responsibility for service; diagnosis of clients served; length of stay; clinical intervention; individual, family, and group therapy; medication and medical support and consultation services; clinical assessment services; service planning and coordination; community supports; emergency/crisis assessment, support and referral; emergency/crisis beds; housing and home supports; and respite services.

The state also has reporting through the Vermont Performance Indicator Project (PIP) that issues brief reports on a weekly basis that provide information about different aspects of the behavioral healthcare system (<http://healthvermont.gov/mh/docs/pips/pip-reports.aspx>). These reports (PIPs) are available on the state's site and investigate indicators such as:

- Access to care
- Practice patterns
- Treatment outcomes
- Concerns of criminal justice involvement
- Employment
- Hospitalization

These reviews often examine the relationship of mental health services with other programs and state agencies. Cross-agency data analysis is facilitated by the use of a statistical methodology that provides unduplicated counts of the number of individuals served by multiple agencies, without reference to personally identifying information, thus protecting confidentiality and complying with HIPAA.

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## **NE** *Central Nebraska*

### ***Tracking Utilization and Expenditures for Case Rates***

The monthly case rate for children served by the Integrated Care Coordination Unit (ICCU) is \$2136/month. To track utilization and account for how these funds are spent, Region 3 Behavioral Health Services (BHS) prepares a monthly report that identifies, by child, direct service costs (including services provided, flex funds spent, and concrete expenditures such as transportation or rent) and non-direct service costs. This monthly report shows the extent to which the case rate was under-spent or over-spent for each child. From these reports on individual children/families, Region 3 BHS is able to track trends, such as: average cost per family, average cost of direct services, costs for youth who are in placement compared to costs for youth who are not in out-of-home placements, average monthly costs for different types of placements, and monthly associated non-service costs (including staff personnel costs). Yearly and monthly increases and decreases in expenditures by placement type also are tracked.

## **Choices** *Choices*

### ***Tracking Utilization and Cost for Case Rates***

**Choices** uses a method to determine utilization and cost for a defined population in order to develop their case rate and to determine and document the need for case rate adjustments. At present, Choices has an actuarial database on 1200 children. Data are analyzed by grouping children according to level of service need in order to correctly estimate utilization and costs for populations of youth from different referral sources and at different levels of need. The analytic process looks at cost of care, regardless of funding sources. It allows for utilization targets to be established for the various types and units of care within the case rate structure. Children are coded by referral source (such as child welfare or juvenile justice), and data are analyzed to determine what each population group would cost. The method involves computing the cost of particular services, the utilization of those services, plus the expected volume of services to be provided through Choices. This analysis determines if it is fiscally feasible to use a case rate approach or if fee-for-service must be used. Data are primarily from Choices utilization and cost data. Choices has had varying success obtaining utilization and cost data from the various agencies referring youth for services, but its own database produces reliable cost estimates.

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**OH** **Cuyahoga County, Ohio**  
**Tracking Utilization and Costs and Projecting System of Care Costs**

**Cuyahoga County** leased *Synthesis*, a web-based multipurpose case management information system, from Wraparound Milwaukee. The county gained access to *Synthesis* in 2006 and began its real time use in 2007. *Synthesis* allows public and private Cuyahoga Tapestry System of Care (CTSOC) partners to input and access both case management and fiscal data in real-time, on a need to know basis. *Synthesis* can create 400 reports including a Utilization Report (cost/child, types of services authorized and delivered, service billings). All providers must use *Synthesis* unless prior approval of another billing method is granted. CTSOC provides required training on *Synthesis* for all approved service providers. The county uses SAMHSA grant funds to lease *Synthesis* and to cover the necessary consulting fees.

System of Care evaluators track the involvement of youth served by CTSOC with the child welfare system (Dept. of Child and Family Services, DCFS). Data from 2005 show that 61% (104 children served by CTSOC) matched the DCFS data system and 57% (96) had a history of maltreatment allegations. Another SAMHSA grant that has been incorporated into the CTSOC, Services for Community Youth (SCY), serves 60 youth with substance use problems and their families at any point in time. Between April 2003 and March 2007, SCY enrolled 232 youth. The grant has tracked cross-system involvement of these youth and found “lifetime cross-system involvement” to be high – 55% of the youth were involved with four or more child-serving systems.

The county undertook a study of Medicaid expenditures that compared the utilization and cost figures for mental health services used by youth who were in the Department of Child and Family Services (DCFS child welfare) placements at Levels 3–6 (Therapeutic foster care – residential treatment center) to the costs for youth under 18 who were in the county mental health data base (Multi-Agency Community Services Information System - MACSIS). The purpose of this comparison was to determine a baseline for the cost of mental health services before the system of care was implemented and to ensure availability of this amount of funding in the future. The county also wanted to gauge the impact of the Cuyahoga Tapestry System of Care (CTSOC) from 2005 forward. Children and families were first enrolled in Tapestry in January 2005.

The 2004 Medicaid data showed that 853 of the 1,200 youth in DCFS Level 3-6 placements received Medicaid billable mental health services. These 853 youth made up only 7% of the total 12,150 youth under 18 receiving mental health services; however, these 853 youth accounted for 23.1% (\$8,757,824) of the Medicaid funds expended (\$37,930,374) for mental health services for children and youth. The average cost of mental health services for the Level 3-6 youth was \$10,269 while the average cost for other children (non-DCFS) receiving mental health services was \$2,582. The county concluded that the needs of children in the child welfare system were driving the mental health system costs and that mental health care for children in Levels 3-6 is expensive.

The findings noted the need for continued research to quantify the complex nature of youth served by multiple systems, their service needs, and the cost of their care. At the time of the site visit, the county indicated that a similar examination of juvenile justice costs for the youth in Level 3-6 placements was forthcoming and that perhaps they would address drug and alcohol and special education for a subset of the 1,200 youth. The county also is collecting lifetime longitudinal data across each of the child-serving systems for the 1,200 youth in Level 3 – 6 placements to analyze life course multi-system involvement.

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## **NY** Erie County, New York

### ***Tracking Utilization and Cost and Projecting Changes***

**Erie County** uses *Care Manager* (a software system for clinical care management) to track utilization and cost for children enrolled in Care Coordination. The software developer is working with Erie County to evolve the management functions of *Care Manager*. The county has recently gained access to Medicaid claims data through a data sharing agreement with NYS Department of Health, and has developed the capacity to retrieve and use data from the New York State Office of Child and Family Services (OCFS) data warehouse which includes child welfare funding streams.

Erie County's projected changes in utilization and cost were established from historical trends and the emerging capacity of different departments to divert youth of different subpopulations from placement. The projected changes in utilization were monitored utilizing data retrieved in several ways:

- Regarding utilization of Residential Treatment Center (RTC) bed days in any time period, the county has established monthly and year to date reports that retrieve utilization data directly from the New York State OCFS Data Warehouse. Provider specific and total county cost is computed within the retrieval program by inputting current provider specific rates that are matched with the utilization for each provider. The retrieval program also computes lengths of stay by agency and total and identifies trends in this critical area. In addition, reports allow comparison by reference time frame (e.g., 2005 base year) to monitor progress against utilization and cost targets. This database tracks utilization of RTCs regardless of the whether the youth is referred by mental health, juvenile justice or child welfare systems.
- Regarding Medicaid, Erie County has recently developed similar retrieval and report generation capacity of Medicaid Adjudicated Claims Data. This capacity can also organize Utilization and Cost summaries by subpopulation, service type, and provider.
- The county tracks utilization of non-Medicaid system of care services through its use of the *Care Manager* database. Projections have been updated and revised utilizing actual data from each of the above databases. In the last year, *Care Manager* has been upgraded in its capacity to monitor the achievement of performance milestones utilizing Dashboard Reports that reflect individual practitioner, program, Contract Agency and Initiative-wide monthly and year-to-date performance.

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**CO** **Project BLOOM, Colorado**  
***Tracking Services and Costs and Fiscal Mapping to Estimate Costs of Early Childhood Mental Health Services***

**Project BLOOM** is involved with the Services and Cost study that is part of the national evaluation of the federal Children’s Mental Health Initiative (CMHI). At the time of the site visit, discussions were underway as to how to track the costs of services provided, separating out the costs of infrastructure, training, and other system-level functions of the system of care so as not to artificially inflate the costs of specific services but, at the same time, account for the full cost of services. One approach is to assess how much providers are paid for a particular service, although there is variance in this across the counties served. A draft form assesses: each service provided by each participating agency, the cost of each service, the unit of measure for the services, whether the agency is reimbursed for the service, and who reimburses for the services (can be multiple sources). At the time of the site visit, this protocol for tracking services and costs was still under development.

In addition, a web-based tracking system was under development for two years; communities began to use the data system starting in January 2007. The system (*Tracking System of Care* or *TSOC*) tracks demographics, referral information, service utilization, wraparound process, flexible funding requests/use, child care and placement information, and acuity assessments (monthly assessments of level of need). It also tracks system information including training that has occurred and match funds. Service utilization is tracked through the “services screen” of *TSOC*, which tracks utilization and cost. The system tracks the services and supports that are specified on the child and family’s wraparound plan and what services are utilized, allowing for a comparison of what is planned and what is provided, alerting the system of care to underutilization. The system can capture reasons for non-provision of services, such as no provider available, no funding, or the service is not available. Child and family teams are encouraged to put all needed services and supports in the wraparound plan, even if the service does not exist.

The “wraparound page” tracks who attended child and family team meetings, the facilitator, family participation, the goals established, and services planned. The tracking system was based on the database created by a previously funded system of care in Colorado (Cornerstone). The PROJECT BLOOM system of care communities had input as to what they wanted to include in the database and what outcomes they wanted to measure in addition to what is required by the national CMHI evaluation. For example, some measures specific to early childhood were added, such as expulsions from child care.

Specifically focused on determining the cost of early childhood mental health services, a fiscal mapping project (also referred to as a financial modeling project) is being conducted as part of Smart Start to project the costs of services based on various scenarios. Smart Start, housed in the Lt. Governor’s office, is an integral part of the strategy to integrate early childhood services into existing early care, education, and mental health systems. It is a statewide alliance of early childhood partnerships working together to create a comprehensive system for young children birth to age 8 and their families that has developed a strategic plan for early childhood services. In addition, Smart Start local councils coordinate early childhood activities throughout the state.

One component of the four areas being explored through the fiscal mapping project is the cost of early childhood mental health services. The project involves identifying the service components and costing out service delivery based on different scenarios, for example, providing services to a total population of children or serving children up to a certain level of poverty. The information developed through this financial modeling project will ultimately be incorporated into the work of the Blue Ribbon

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Policy Council to support the creation of a strategic plan. (The Blue Ribbon Policy Council was formed in 2003 to provide a high-level policy council to support the early childhood efforts in Colorado.)

Conducted by the Colorado Children’s Campaign, the fiscal mapping project called for the development of an interactive tool using Microsoft Excel that incorporates a wide range of data on components of early childhood services. The tool allows users to change a range of variables and assumptions to determine the effects of these changes on cost estimates. The fiscal mapping project specified that stakeholders would define the range of elements that should be included in a comprehensive early childhood system and a cost model would be generated. The intended products were an interactive model, a technical report, and presentation materials. Examples of best practices and their associated costs were expected to inform the cost of providing particular services or creating a particular type of infrastructure.

**WI** ***Wraparound Milwaukee  
Tracking Utilization and Cost to Inform Planning and Quality Improvement***

Specifically to support the system of care, the Milwaukee County child behavioral health division developed a web-based management information system, called *Synthesis*, to provide real time data to care managers and administrators and to support a wide array of utilization and cost analyses. For example, utilization and cost analyses can be stratified for particular subpopulations of youth by age, child welfare or juvenile justice involvement, diagnosis, etc., by type of service received, by cost and so on. All providers in the Wraparound Milwaukee network must use *Synthesis*. The system supports ongoing planning and quality improvement (QI) activities at several levels: at an individual child and family level by providing care managers and wraparound teams with real time data on the type, volume and cost of services being provided to a given child/family and whether outcomes are being achieved; at a program level, for example, by identifying particular providers in need of technical assistance or by identifying subpopulations of youth for whom outcomes could be enhanced; and at a systems level by identifying utilization and cost trends for different child welfare-involved youth versus youth involved in juvenile corrections, tracking out of home placement costs, and the like. *Synthesis* is able to interact with State Medicaid and county child welfare data systems to ensure that utilization and costs associated with particular auditable funding streams, such as Medicaid and Title IV-E, are identifiable and specifically tracked.

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## B. Identify the Types and Amounts of Funding for Behavioral Health Services across Systems and Potential Resources for Systems of Care

Several sites did some type of analysis of the amounts and types of funds spent for children's behavioral health services across systems and identified potential financing streams for systems of care. For example, **Central Nebraska** analyzed and "mapped" expenditures across child-serving systems to establish a case rate to support its system of care. **Cuyahoga County** and **Project BLOOM in Colorado** developed a funding grid and a funding matrix respectively to identify all potential funding sources for their systems of care.

### **NE** Central Nebraska

#### ***Mapping Cross-System Funding to Establish a Case Rate***

When **Nebraska** proposed in 2000 to develop an individualized system of care for approximately 200 youth and their families in Central Nebraska, it had to identify funding sources for behavioral health services across child-serving systems. The target population was youth in state custody with intensive behavioral health needs who were placed in Agency-Based Foster Care and higher levels of care such as group homes, treatment foster care, and residential treatment. The state and the region believed that through partnering across systems and with the regional family organization, they could provide more appropriate care with better outcomes for families and youth at a lower cost. Nebraska used a case rate methodology as the financing structure to fund this system of care. To establish the case rate amount, the current cost of care (both the types and amounts of funding) for 201 youth was analyzed. This included all the child *placement* costs for each of the 201 children over a six-month period (1/00–6/00). It did not include treatment services that were funded by Medicaid. These treatment services remained available to the youth as needed, outside of the case rate. In 2000, the primary funding sources identified for the case rate for the cost of care for these 200 children were state child welfare funds, juvenile services funds, and Title IV-E (federal). A small amount of "other" funds came from block grant funds, child care funds, reunification funds, and state-only funds.

### **OH** Cuyahoga County, Ohio

#### ***Developing Funding Grid***

The Funders Group, the collaborative leadership and governance structure for the Cuyahoga Tapestry System of Care (CTSOC), is charged with the ongoing responsibility of determining the funding levels needed to sustain an effective system of care and with seeking those funds. At the request of the Funders Group, a fiscal work group completed a funding grid in 2005 that identified all funding sources for services to children and families, the annual amount each source provided, and the cross-system agencies where these funds are expended. Medicaid funds were not included in the grid. The purpose of the grid was to determine where to find funding within the county's jurisdiction that could support the system of care. The grid showed total current expenditures at \$607,423,918. The majority of funds were located in the child welfare system (\$156,000,000) and in the mental health system (\$118,000,000).

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The county used the funding grid to identify funds that might have enough flexibility to be used in the system of care. The deputy county administrator indicated that the county currently is leveraging all the funds that could potentially fund the system of care, including the two Health and Human Services tax levies which provided (\$6 million), the two SAMHSA grants (the federal system of care grant and the Strengthening Communities for Youth grant from the Center for Substance Abuse Treatment to create a system of care for youth with substance abuse problems) and Department of Child and Family Services (DCFS) dollars that became available due to a reduction in residential treatment center (RTC) placements (\$3 million). In the future, the county hopes to establish a broader funding framework that will include the mental health and the alcohol and drug addiction services boards, developmental disabilities, and juvenile justice/courts. Medicaid helps to finance the system of care through services billed to Medicaid by Medicaid providers in the system of care network.

**NY** **Erie County, New York**  
***Identifying Sources of Financing for the System of Care***

A partnership between **Erie County** Department of Mental Health and the Erie County Department of Social Services has strategically identified various types of funding that can be used to support the system of care. Contracts utilizing blended funding streams from each child serving system have been centralized within the County Department of Mental Health. In several cases, this was achieved through interdepartmental transfers within the overall county budget. During the annual County budget development process, representatives from each participating department identify emerging funding streams available for system of care development.

**CO** **Project BLOOM, Colorado**  
***Developing a Funding Matrix***

**Project BLOOM** took the funding matrix for early childhood mental health services created by the National Technical Assistance Center for Children’s Mental Health at Georgetown University and explored the various funding streams that come into the state. More than 50 funding sources were researched, and information on 45 was included in the materials developed for Project BLOOM communities and other Colorado communities on financing streams for early childhood services. This information was provided to the four Project BLOOM communities so that they could assess potential funding streams to finance services and supports and the potential applicability and use of the financing streams locally.

The information in this funding matrix recently has been updated. The packet is part of a workshop conducted with each of the four Project BLOOM local communities to assist them in considering all potential sources of financing for early childhood mental health services. Information on the funding streams and worksheets for planning are included. The training is conducted with

an interagency group of participants and family members. Family participants pushed the agency representatives to look at possibilities and not to discount possible financing options. Many individuals, even at the state level, are not aware of the possible financing options that exist to fund early childhood mental health services. The funding matrix information includes the following funding sources:

State Funds	Federal Funds Entitlements	Federal Discretionary Grants
<ul style="list-style-type: none"> <li>• Developmental Disabilities Early Intervention</li> <li>• Exceptional Children’s Education Act</li> <li>• Colorado Preschool Program</li> <li>• Core Services (Child Welfare)</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid</li> <li>• Title IV-E</li> <li>• Social Security Income</li> <li>• IDEA Part C and Part B sec. 611 and 619</li> <li>• ECEA</li> </ul>	<ul style="list-style-type: none"> <li>• Community Based Grants for the Prevention of Child Abuse and Neglect</li> <li>• Family Violence Prevention and Services</li> <li>• Headstart</li> <li>• Juvenile Justice Formula Grants</li> <li>• Indian Health Care Improvement Act</li> <li>• Promoting Safe and Stable Families</li> <li>• TANF</li> <li>• Title 1</li> <li>• Title-IV-B</li> <li>• Title V Incentive Grants for Local Delinquency Prevention</li> <li>• WIC</li> <li>• Workforce Investment Act</li> </ul>
Other Sources	Block Grants	
<ul style="list-style-type: none"> <li>• Lottery Funds</li> <li>• Tax Check Off</li> <li>• Tobacco Funds</li> <li>• Gaming-Casino Tax</li> <li>• Divorce Fees</li> <li>• Fees on Speeding Tickets</li> <li>• Local Taxes</li> <li>• Tax Credit</li> <li>• Mental Health Districts</li> <li>• Children’s Health Plan</li> </ul>	<ul style="list-style-type: none"> <li>• Child Care Development</li> <li>• Community Mental Health</li> <li>• Substance Abuse Prevention and Treatment</li> <li>• Social Services</li> <li>• Maternal and Child Health</li> <li>• Community Services</li> </ul>	

At the time of the site visit, this information was being put into a searchable database and also on a CD for use by communities statewide. The information was also being folded into the Smart Start Financial Mapping process. Additional information is available at <http://infosys.omni.org/matrix>

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## II. Develop a Strategic Financing Plan for Systems of Care

With the information learned through a financing analysis, strategic planning for financing systems of care can proceed. It is also important to undertake periodic assessment of financing policies and strategies to assess their effectiveness and to ensure their consistency and support for system of care goals.

### Financing strategies include:

- A. Develop a Formal Strategic Financing Plan
- B. Evaluate and Refine the Strategic Financing Plan

### A. Develop a Formal Strategic Financing Plan

Several sites have developed strategic plans for children’s mental health services, including a specific focus on financing. For example, Hawaii developed a strategic financing plan as part of its overall strategic plan for children’s mental health services that calls for strengthening Medicaid billing and braiding funds across agencies, among other strategies.

#### **HI** *Hawaii*

#### ***Developing a Strategic Financing Plan***

The legislature requires a four-year strategic plan for children’s mental health services. A new plan was completed for the period 2007–2010, with seven priority areas:

- Decrease stigma and increase access to care
- Implement and monitor effectiveness of a comprehensive resource management program
- Implement a publicly accountable performance management program
- Implement and monitor a comprehensive practice development program
- Implement and monitor a strategic personnel management plan
- *Implement and monitor a strategic financial plan*
- Implement and monitor a strategic information technology program

Development of the strategic financing plan involved collection of information, including obtaining input from stakeholders, partner agencies, and others through meetings. The financing plan, as part of the larger strategic plan, builds on what is already in place and includes specification of thresholds/benchmarks and an emphasis on linking utilization, costs, outcomes, and financing incentives to drive system of care principles in provider agencies and cost/quality efficiencies.

The broad goals of the financing plan are to demonstrate a diversity of sustainable funding

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streams, strengthen the expertise of the children’s mental health branch (Child and Adolescent Mental Health Division – CAMHD) in financial operations, achieve established thresholds for each funding source, demonstrate braided and blended funding programs with all child-serving agencies, and demonstrate routine financial reporting to the management team and community stakeholders.

Specific goals are to:

- Strengthen Title XIX Medicaid billing practices
- Strengthen the Random Moments Studies billing
- Strengthen Title IV-E billing
- Strengthen braided and blended funding
- Maximize funding opportunities by pursuing federal and community grants
- Develop third-party billing agreements
- Implement routine financial reporting.

For each goal, the plan delineates specific “initiatives,” deliverable products, units responsible, and due dates. For example, for the goal on strengthening braided and blended funding, the plan specifies completing a review of all CAMHD agreements on joint funding, identifying possible options for other joint funding opportunities, and expanding the number of agreements for joint funding. The final product, a listing of joint funding MOAs, was to be completed by June 2008.

## **MI** Michigan

### ***Developing a Local Strategic Financing Plan for the System of Care***

**Ingham County** has a theory of change that includes a financing strategy for the IMPACT system of care. IMPACT is a partnership among various child serving systems working together to provide coordinated services for children with serious emotional disturbance and their families. The plan includes the following financing strategies:

#### **IMPACT Year Two Implementation Work Plan to Align Funding Streams and Structures**

Every family, regardless of formation or agency of initial contact, will obtain the resources necessary to provide for their child with a severe emotional disorder (SED).

##### **1. Create finance and sustainability policies**

The community aims to create policies that will help coordinate funding across-systems and create a locus of accountability that will shift services from deep-end placements to home and community-based services. These policies should achieve the following:

- County government support for a community-based system of care, as well as interagency agreements committing community partners to the system of care
- Broadening of eligible populations as resources allow
- Funding for the system of care that is sustainable and funding from the county for youth and families that is stable
  - a) Develop a strategic information plan (continuous reporting) that will be implemented to inform the community of the progress in development of the system of care
  - b) Develop financing policies around the sustainability and expansion of funding for the system of care
  - c) Secure supports for existing partnerships, such as the United Way, and form relationships with other new community partners for investments in the system of care

##### **2. Design mechanisms to implement finance and sustainability policies**

The aim is to design and implement mechanisms that help manage care and cost by:

- a) Providing comprehensive home-based services to children and youth with SED through service agreements between Ingham County, the county Department of Human Services, and the Family Division of the Circuit Court (as payers), and CMH (as provider). The agreement will include a cross-agency procedure for payment for services for children and youth involved with multiple system partners and mechanisms to coordinate procurement of services and supports
- b) Redirecting funds from out-of-home expenditures to home and community-based services
- c) Increasing local control over funds for behavioral health services and supports so the child and family teams are able to use flexible funds for services and supports that are not reimbursable
- d) Utilizing mechanisms for coordinated funding of services for individual children and families
- e) Contracting mechanisms for providers that are consistent, with rate structures for behavioral health services and supports
- f) Designing protocols to monitor and prevent cost shifting
- g) Tracking the amount of funding by source that support services for children and families
- h) Developing a manual or a “play book,” with a key role for the System of Care Coordinator that will provide the Team with a guide for assessing eligibility and best funding sources for services and supports
- i) Developing and establishing mechanisms that sustain funding to assess, design, implement, and evaluate home and community-based services

**OH Cuyahoga County, Ohio*****Developing a Strategic Financing Plan to Sustain the System of Care***

County administrators, agency heads, system of care partners, providers, parent advocates, etc. continuously discuss and plan for sustainability. They also are engaged in a formal strategic planning process. The Funders Group contracted with a consultant to assist them in updating the Cuyahoga Tapestry System of Care strategic plan, considering a different fiscal construct, and making any necessary adjustments to a new way of doing business. The consultant was charged with doing an organizational assessment that would include, among other activities, a look at financing mechanisms and whether they support a wraparound model effort going forward and growing to scale. The services of the consultant were funded by the Cuyahoga County Department of Health and Human Services (DHHS).

**Some of the key questions related to financing being discussed in this strategic planning process include:**

- What portion of savings from reduced out-of-home and residential placement costs can be redirected to CTSOC?
- Are potential Medicaid Options being fully explored?
- Is it viable for all child-serving systems to contribute some level of financial support to CTSOC? What would make it viable?
- Are we paying more for informal services that prior to CTSOC were already being received at lower prices?
- Can the program support some level of block grant type funding to the neighborhood centers?

**Some fiscal issues identified by stakeholders during the strategic planning process:**

- How can we swap direct service funding for care management funding? Need evaluation results that show cost-effective outcomes.
- Medicaid in Ohio pays for services only for the identified child, which is a critical issue in a family-centered system. State limitations on Medicaid services complicate Tapestry funding sustainability
- Partners appreciate the support of other non-paying systems, but want to see financial investment which would be a sign of sustainable buy-in.  
Next steps in the strategic planning process:
- Establish a more balanced investment to help sustain funding and institutionalize a new system of care
- Consider some negotiated ratio or other formula with the county Office of Budget and Management for how child-serving agencies may re-invest savings realized by the reduction in the length of stay in out-of-home or residential placements with Tapestry.
- Explore future Medicaid options with the state, utilizing the leadership of the Mental Health Board (MHB) and the Alcohol and Drug Addiction Services Board (ADASB)
- Explore future financial support from the state as a demonstration project that can impact state policy or as an area of concentrated need.

**Other meetings have been held with financial consultants to discuss issues such as:**

- Fiscal architecture for children' systems for the county
- Most rational way to fund CTSOC
- Opportunities for revenue maximization

- Developing a braided funding agreement for multi-system involved children and their families
- Backroom reimbursement processes to reduce hindrances to access to care
- Feasibility of expanding use of 1915 (a) in Medicaid beyond current geographic and SED definitions
- Feasibility of a statewide child welfare Medicaid plan
- Maximizing flexibility of funds and revenue.

## **CO** Project BLOOM, Colorado

### ***Financing Component of Strategic Plan for Early Childhood Mental Health Services and Project BLOOM Sustainability Plan***

At the time of the site visit, the Blue Ribbon Policy Council (formed in 2003 to provide a high-level policy council to support the early childhood efforts in the state) was developing a strategic plan with a financing component to address financing of the early childhood mental health system. Strategies and recommendations were under development. The sustainability plan for the **Project BLOOM** systems of care is a strategic plan with a strong focus on financing. The plan will be brought to the Blue Ribbon Policy Council to be used as one of the conceptual documents that will help to develop the strategic financing plan for early childhood mental health statewide.

The Sustainability Matrix prepared by Project BLOOM identifies potential ongoing financing sources for each of the elements of the system of care. Examples of potential long-term funding sources identified in the sustainability plan include the following:

- Mental health consultation to primary care, home visitation, early intervention/special education and child care — Medicaid
- Flexible funding and collaborative service coordination — Community organizations, local Project BLOOM partners
- Wraparound — Medicaid, local early childhood providers, participating agencies from Early Childhood Partnership
- DC 0-3 diagnostic system for young children – Medicaid, Behavioral Health Organizations
- Service array — State mental health services, Medicaid, private insurance

Project BLOOM also identified activities and strategies needed to sustain its various elements, as well as partners and allies. Efforts will be directed at pursuing these financing sources.

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## B. Evaluate and Refine Strategic Financing Plan

Measurement of progress toward the financing goals established in strategic plans provides a framework for the periodic assessment of financing strategies and their effectiveness in achieving system of care goals. For example, **Hawaii** assesses the achievement of its financial targets, as does the Funders Group (an interagency body) in **Cuyahoga County**.

### **HI** Hawaii

#### ***Using Strategic Plan Goals and Progress Assessment***

The new strategic plan specifies financing policies and strategies to promote the system's goals. This has set the stage for assessment of the effectiveness of these financing strategies during the course of implementing the strategic plan for the next period. In addition, cost is examined as a part of assessing quality. Financial targets are set by the system, and financial reports are reviewed as a component of performance monitoring.

### **OH** Cuyahoga County, Ohio

#### ***Using System of Care Governance and Management Structures to Assess Financing Policies***

The system of care governance and management structure created by the county ensures ongoing attention to financing policies and strategies. The Funders Group, which is chaired by the Deputy County Administrator for Human Services, has six strategic subcommittees, including one on sustainability. The purpose of the sustainability subcommittee is to develop a plan to ensure that the system of care will continue beyond the scope of the current grant funding. This includes focusing on community support, transformational leadership and financial viability. The Sustainability Committee has two subcommittees – the fiscal subcommittee and the MIS subcommittee. The fiscal subcommittee is charged with ongoing review of current funding streams to ensure financial viability.

The county also contracted with a consulting group to do an organizational assessment and assist in developing a strategic plan for phase II of the Cuyahoga Tapestry System of Care (CTSOC). This organizational assessment is to ensure that the strategic plan, structure, operating model, and financing mechanisms support a wraparound model – going forward and growing to scale. This plan is funded by the county Department of Health and Human Services. Another charge for this group is to determine how CTSOC can establish and maintain a sustainable funding base for the future. One of the recommendations being considered as a result of this strategic planning process is the “creation of a financial structure that permits flexible funding.”

## Chapter 5. Core Financing Strategies: Realigning Funding Streams

A multitude of funding streams at federal, state, and local levels can be drawn upon to support systems of care. However, the maze of funding streams that finance children’s behavioral health services must be better aligned, better coordinated, and, often, redirected to support individualized, flexible, home and community-based services and supports. Based on a careful analysis, a strategic financing plan “realigns” resources to develop a more coherent, effective, and efficient approach to financing the infrastructure and services that comprise systems of care. Such realignment involves: 1) using and coordinating resources from multiple funding streams, 2) maximizing the use of entitlement programs (such as Medicaid), 3) redirecting and redeploying resources, often from more restrictive and expensive services such as out-of-home placements, and 4) financing strategies to manage services and create a “locus of accountability” for children with intensive service needs who are high utilizers of services.

### **Financing strategies include:**

- I. Utilize and Coordinate Multiple Funding Streams**
- II. Maximize Federal Entitlement Funding**
- III. Redirect Spending from “Deep-End” Placements to Home and Community-Based Services**
- IV. Implement Financing Strategies for Children with Intensive Service Needs and Their Families**

### **I. Utilize and Coordinate Multiple Funding Streams**

#### **Financing strategies include:**

- A. Utilize Multiple Funding Streams**
- B. Coordinate Funding Across Systems**

## A. Utilize Multiple Funding Streams

### Financing strategies include:

1. Utilize funding from multiple agencies
2. Utilize special funding streams

### 1. Utilize Funding from Multiple Agencies

The sites studied use resources from multiple child-serving systems to finance services and supports. Resources from mental health, Medicaid, child welfare, juvenile justice, and education are used by all of the sites. Resources from the substance abuse, developmental disabilities, and primary health systems are included in the financing mix less frequently, but are included in some of the sites. For example, *Hawaii* and *California* both combine resources such as Medicaid; general revenue; federal block grants; special grants; special taxes; and child welfare, juvenile justice, and education funds for children’s mental health services. **Table 5.1** shows the extensive use of cross-system funding to contribute to financing a broad array of services and supports. **Table 5.2** provides an example of how multiple and diverse resources are used in *California* to finance children’s behavioral health services.

States												
Source	AZ	CA	HI	NJ	VT	MI	Central NE	Choices	Cuyahoga	Erie	Project BLOOM	Wraparound Milwaukee
Mental Health	X	X	X	X	X	X	X	X	X	X	X	X
Medicaid	X	X	X	X	X	X	X	X	X	X	X	X
Child Welfare	X	X	X	X	X	X	X	X	X	X	X	X
Juvenile Justice	X	X	X	X	X		X	X	X	X		X
Education	X	X	X		X		X	X				X
Substance Abuse	X	X		X			X					
Developmental Disabled.	X	X	X					X				X
Primary Health		X			X							

**Table 5.2**  
**Use of Multiple System Resources in California**

Agencies/Systems that Contribute Funds	Types of Funds	Purpose (e.g., for a range of services or for specific services or programs)
<b>Mental Health</b>	<p>Medi-Cal</p> <p>Federal Mental Health Bock Grant</p> <p>Prop 63 - Mental Health Services Act</p> <p>Sales tax and vehicle licensure fees ("realignment" funds)</p> <p>Other state general revenue (e.g., Senate Bill 90)</p> <p>Assembly Bill 1650 – Early Mental Health Initiative</p> <p>Children’s System of Care funds (now eliminated)</p> <p>County general revenue (no specific county, mental health levy)</p>	<p>“Specialty” mental health services, including Rehab Option, TCM, &amp; EPSDT)</p> <p>Range of services and support for systems of care in 7 counties</p> <p>Treatment, early intervention, prevention, and certain infrastructure, technology, training costs, and innovation</p> <p>For health, social services and mental health trust funds</p> <p>State reimburses counties for costs of state-mandated mental health services</p> <p>Early intervention services for kindergarten through 3<sup>rd</sup> grade</p> <p>Home and community-based, wraparound services</p> <p>Any mental health purpose</p>
<b>Medicaid</b>	<p>Fee for service and managed care hospital and physician and drugs</p>	<p>Mental health services that can be provided by a primary care doctor</p>
<b>Child Welfare</b>	<p>Senate Bill 163 – Aid to Families with Dependent Children-Foster Care</p> <p>At Contra Costa level, Medi-Cal and emergency foster care dollars</p> <p>At Contra Costa level, Title XIX Medicaid Administrative Claiming through Child Welfare</p>	<p>Home and community based, wraparound services as alternative to out of home placement</p> <p>MH assessments for children entering non-relative placements</p> <p>Consultation and linkage to mental health services and providers for child welfare-involved children</p>
<b>Juvenile Justice</b>	<p>Mentally Ill Offenders Criminal Reduction Act (MIOCR) grant from the state Department of Corrections and Rehabilitation Corrections Standards Authority to Contra Costa</p> <p>County general revenue</p>	<p>Community-based mental health services to improve responses to youth from law enforcement and improve access to mental health services; also funds mental health courts. Used in Contra Costa to divert youth in juvenile justice with SED from group home placement.</p> <p>Chris Adams Girls Center (jointly funded by county MH and county JJ)</p>

**Table 5.2 (continued)**  
**Use of Multiple System Resources in California**

Agencies/Systems that Contribute Funds	Types of Funds	Purpose (e.g., for a range of services or for specific services or programs)
<b>Education</b>	Assembly Bill 3632 (special ed) funds  Medi-Cal school-based clinic in one school district in Contra Costa	Related MH services in IEPs  School-based MH services
<b>Substance Abuse</b>	Medi-Cal (EPSDT)	If co-occurring with SED
<b>Primary Health/ Public Health</b>	In Contra Costa, Children’s Medical Services – Title V Public health nurses	MH consultation to in-home caregivers PH nurses integrated into wraparound teams
<b>Developmental Disabilities</b>	In Contra Costa, DD funds	Co-fund with mental health a residential program for youth 12-18 with dual diagnoses of developmental disabilities and emotional disorders
<b>TANF</b>	In Contra Costa, TANF	Program for women with substance abuse who have babies
<b>Part C Early Intervention Program</b>		
<b>Tribal Orgs. (BIA, HIS, Tribal Govt.)</b>		
<b>Child Care</b>		
<b>Housing</b>	At Contra Costa level, housing funds and Mental Health Services Act	Transition age housing for 16-25 year olds; housing vouchers for families for temporary housing; master lease agreements for young adults placed with a family with a care manager
<b>Labor</b>		
<b>Family Organizations</b>		
<b>Non-government Organizations</b>	Foundations (e.g., Kaiser)	Small grants
<b>Other – In Contra Costa, Community Services Agency Also, 1<sup>st</sup> Five Commission</b>	County general revenue  Cigarette tax monies	Piloting “Incredible Years” for MH Services for 0–5

**CA California*****Using Multiple Financing Streams***

As **Table 5.2** demonstrates, California draws on a multitude of funding streams to finance child behavioral health services. California counties, such as Contra Costa, augment State funding to varying degrees. Children’s mental health services in California are financed primarily utilizing the following funding streams:

- Medi-Cal (Rehab Option, TCM, EPSDT, Clinic) — freedom of choice waiver (1915 b) and fee-for-service Medi-Cal finances about 80% of the cost of mental health services in California for adults and children)
- Federal mental health block grant
- State mental health general revenue
- Sales tax and vehicle licensure fees collected by the state (called “realignment funds”)
- Proposition 63 funds (now known as Mental Health Services Act funds)
- AB 3632 (special education) funds – IDEA and state general fund
- SB 163 – State AFDC-FC (wraparound) funds
- AB 1650 EMHI State general revenue grant funds
- SB 90 reimbursement process, which requires the state to reimburse local governments for the costs of new programs or increased levels of service mandated by the state
- County general revenue

**HI Hawaii*****Utilizing Resources from Multiple Systems***

Resources from multiple agencies/sources include:

- *Mental health general revenue* — Funds staff, services and supports not covered by Medicaid, payments to providers above the Medicaid rate (which “makes it or breaks it” for providers)
- *Medicaid* — through a carve-out operated by the Child and Adolescent Mental Health Division (CAMHD)’s children’s mental health system
- *Block Grant* — Funds screening and assessment of children in family court, screening and assessment of children in the child welfare system, statewide family organization, young adult support organization, early intervention and prevention, services for homeless children, etc.
- *Title IV-E* — Funds training, administrative costs, some costs for treatment of children in foster care system
- *SAMHSA Grant* — Funds system of care development, alternatives to seclusion and restraint, data infrastructure development. A grant from the Comprehensive Community Mental Health Services for Children and their Families Program funded system of care development in two areas on Oahu; a new grant from SAMHSA is financing system of care development for youth in transition to adulthood in one area of the state.

- *Education System* — Funds the cost of education in residential treatment programs
- *Office of Youth Services* — Funds an array of community-based services for children at risk for incarceration, including some community gang interventions, substance abuse services, sex offender services, sex abuse services, youth development, and some cost sharing on an individual case basis
- *Developmental Disabilities* — Provides cost sharing as needed on an individual case basis

## **MI** Michigan

### ***Using Multiple and Diverse Funding Streams***

Michigan has a state general fund called the Child Care Fund (CCF) which was established for the purpose of the state and counties sharing the cost of court-ordered services for children who are court wards. The state reimburses 50% of eligible county funds spent for services when the county bills the state under the CCF. The CCF serves as a cost sharing between the state and the counties. The fund is used to fund in-home and community based care, as well as out-of-home placement costs. More than half of the children served under the CCF (54%) are neglected or abused. It is the largest funding source for children involved in child welfare, though a large part of the fund is also for children in the juvenile justice system. The CCF has no cap, it is open ended, but it is supposed to be the payer of last resort. Counties can narrow or widen the criteria for services covered under the CCF. It can be used for wraparound services, and it is used to provide match to draw down Medicaid dollars. Seventy of the 83 counties are doing wraparound in both mental health and child welfare. The other funding streams that are used in Michigan for children's behavioral health services include Medicaid, state mental health general revenue funds, mental health block grant funds, education, and TANF funds.

## **VT** Vermont

### ***Utilizing Resources from Multiple Systems***

The Department of Mental Health, the Department of Education, and the Department for Children and Families are the principal partners and funding sources, with Medicaid making the largest contribution. Vermont Health Department data show that Medicaid had responsibility for at least some of the cost for 77% of the children's behavioral health services provided in 2005. In Chittenden County, for example, (Vermont's most populous county), Howard Center (the designated local service agency) estimated that Medicaid would contribute about 45% to the agency's total budget for children's services funding in 2007. This does not include mental health services to children in residential care, which is listed separately and covered by a per diem that includes but does not break out mental health services. Education contributes funding in several ways, including support for an approved Vermont Department of Education school under the auspices of the local designated agency that provides a therapeutic, regional educational program to meet the needs of junior and early high school age students experiencing serious emotional, social, behavioral, and academic

problems. Referring school districts pay tuition for students placed in the program directly to the agency operating the school. The school utilizes a portion of this revenue as match to bill Medicaid for treatment-related services.

In financing early childhood mental health services, funding streams come from Part C of IDEA, Medicaid/SCHIP, mental health grants, maternal and child health, child and family services funding (Head Start), private insurance, and family contributions. Funding from these resources finance a mix of services through a variety of providers and programs, including early intervention centers, shelters with child care, substance abuse treatment programs, etc.

State agency partners contribute some of their general fund allotment to the mental health agency in order to draw down federal Medicaid funds to pay for services. This approach can be seen in schools with school-based services, as well as with mental health services provided in homes and at community agencies. School-based services use Medicaid, education dollars, and other grant and discretionary funds for behavioral health screenings, counseling services, and training. EPSDT is administered through the health department, which contracts with school districts. Schools pay nurses and guidance counselors for the work, which allows the early detection of behavioral health issues.

Funding is also shared between mental health, the Division of Vocational Rehabilitation (in the Department for Children and Families) and the Department of Corrections to fund the JOBS program for youth at high risk as they transition to adult life.

In addition, the creation of a child's Coordinated Services Plan under Vermont's Act 264 pulls together whatever public and private providers and supportive individuals are relevant to a specific child and family to assess needs, to determine desired goals, and to plan who can provide those services and supports as well as who can pay for them.

### **OH** Cuyahoga County, Ohio *Using Multiple Funding Sources*

The county has two Health and Human Services levies. The total received for the two is \$225 million/year. The levies underwrite the county Department of Health and Human Services, they provide local match, subsidize the Mental Health Board and the Alcohol and Drug Addiction Services Board, subsidize the public county hospital and are used as match to leverage child welfare dollars. Funding from the levies provided the original local match (about \$9 million) for the SAMHSA system of care grant which serves 240 youth and their families. The county also merged a smaller SAMHSA grant (Services for Community Youth [SCY] which provides substance abuse services for 60 youth and their families) into the system of care. This enabled the system of care to serve 300 children and families.

The county wanted to expand and serve more families in the system of care. Discussions were held with DCFS, the juvenile court, and the behavioral health boards about how to serve more than 300 children and their families. All were enthusiastic about the system of care concept, and DCFS was willing to contribute \$3 million to serve additional children from DCFS and from the court system. The \$3 million was available due to a reduction in residential placements. The Board of County Commissioners contributed another \$6 million from levy funds (HHS), creating the capacity to serve 600 additional children and their families.

At the time of the site visit, the Funders Group was in discussion with the county Mental Health Board about expanding the use of 1915 (a) in Medicaid, which currently funds the original PEP Connections program (i.e., intensive care coordination) (\$1,602 case rate) in Cleveland to cover more of the SOC children. They plan to look at whether Title IV E and TANF could serve as non-local resources for the SOC over the long term.

In its strategic planning efforts and in developing its braided funding approach, the county hopes to gain a financial commitment from the juvenile court, the two behavioral health boards, and mental retardation and developmental disabilities. To do so, the SOC acknowledges the need to demonstrate its effectiveness, show public system leaders how the funds would be used, and establish performance benchmarks. One county administrator indicated that they are building the on-ramps to the highway funding streams that will later allow them to blend funds from different streams/systems.

Eight Care Coordination Partnerships (CCP) represent a critical component of the CTSOC. The monthly billing process used by the eight lead agencies in the CCPs demonstrates how the county taps into different funding sources for each individual child and family's care. While the lead agency bills the CTSOC office at an established daily rate for care coordination, it backs out from the bill the amount it has earned for Community Psychiatric Supportive Treatment (CPST) services for Medicaid eligible children. The lead agency bills Medicaid directly for the CPST services.

The CTSOC does not pay for placement services, so when a child served by one of the eight CCPs requires placement, the lead agency requests the CTSOC office to make a referral to either DCFS or the Juvenile Court. Placement services are provided at the expense of one of these two public agencies. To return the child to the family setting as quickly as is appropriate, the lead agency will continue to provide care coordination services while the child is placed and to receive reimbursement from CTSOC for the care coordination.

### **CO** Project BLOOM, Colorado *Utilizing Funding from Multiple Agencies and Sources*

- The Project BLOOM systems of care utilize funding from multiple agencies for early childhood mental health services, including:
- *Child Welfare* — Core services are provided by the child welfare system to keep children at home and avoid out-of-home placements and to facilitate reunification or another form of permanence. These include home-based interventions, intensive family therapy, life skills, day treatment, sexual abuse treatment, special economic assistance, mental health services, substance abuse treatment services, aftercare services to prevent future out-of-home placement, and optional county designated services that prevent out-of-home placement or facilitate reunification or another form of permanence. State general fund dollars are given to counties to provide or purchase these core services. At the end of the year, counties can transfer up to 10% of TANF and Child Welfare Block Grant dollars into Core Services Funding if they have funds left over. No Title IV-E funds are used for early childhood mental health.

- *Education/Special Education* — The Colorado Preschool Program can fund a preschool slot for a child involved in a Project BLOOM system of care on an individual case basis. A representative from the education system is involved in the Early Childhood Council in each local community.
- *Mental Health* — Financing includes funds from the SAMHSA system of care grant and the mental health block grant to finance an array of early childhood mental health services
- *Medicaid* — Finances an array of treatment services, behavioral aides, respite, and targeted case management
- *Primary Care* — Some financing is contributed through the Health Care Program for Children with Special Needs, which is the Maternal and Child Health Block Grant. The funds are specifically for care coordination.
- *Developmental Disabilities* — State general fund and local dollars are used to provide family support and case management services.
- *TANF* — El Paso County uses TANF dollars for direct services such as child care, and some areas are receiving funding for mental health consultation.
- *Part C* — State general fund, federal grants funds, and local mill levy funds are used to purchase direct services, based on a list of 14 types of services including social and emotional interventions and enhanced service coordination, which can be wraparound.
- *Child Care* — Child Care Development Block Grant funds used for training and professional development related to early childhood mental health consultation
- *Foundations* — The Rose Foundation finances some early childhood mental health consultation and the Colorado Health Foundation finances some professional development.

### **WI** **Wraparound Milwaukee** ***Utilizing Funds from Multiple Agencies and Sources***

Primarily using case rate and capitation financing, Wraparound Milwaukee draws on funds from Medicaid, child welfare (general revenue and Title IV-E), county juvenile justice (county detention diversion and diversion from state correctional facilities), mental health, and education systems.

## 2. Utilize Special Funding Streams

Several sites use special funding streams to finance children’s behavioral health services. For example, the Mental Health Services Act in *California* imposes a 1% tax on personal income over \$1 million, resulting in new funding for mental health. *Cuyahoga County* and *Project BLOOM* use local tax levies.

### **CA** California

#### ***Using Special Funds from Mental Health Services Act, Sales Tax and Licensure Fees***

California voters approved Proposition 63 in 2004, creating the Mental Health Services Act (MHSA), a new and substantial source of financing that primarily goes to the counties for mental health services. MHSA is derived from a 1% tax on taxable personal income over \$1 million and will generate \$2.1 billion for mental health funding over the next three years (\$690 million in FY 2006–07). Funding must go to new or expanded programs that are based on models proven to be effective and includes both treatment and prevention services as well as infrastructure, technology and training needs. It includes a focus (though not exclusively) on individuals who are uninsured or under-insured. The MHSA specifies the percentage of funds to be allocated to each of six major components as follows (FY 06-7 percentages): 55% to community services and supports, of which 5% is devoted to development and implementation of promising practices; 20% to prevention and early intervention, of which 5% is devoted to development and implementation of promising practices; 10% to training; 10% to local planning; 10% to capital facilities and technology; and 5% to state-level implementation and administration. State-level funding is allocated to 8 state agencies and to the Mental Health Services Oversight and Accountability Commission created by the Act. The state Department of Mental Health receives most of the state-level MHSA funding, but funds also are allocated to the state Medicaid agency, state substance abuse agency, Department of Education, state child welfare agency, vocational rehabilitation agency, the state agency administering the Healthy Families Program, and to the state human resources management system. The values underlying the MHSA resemble system of care values and include: community collaboration, cultural competence, consumer/family driven services, a wellness focus, and integrated services.

At the Contra Costa level, there was an extensive (state-required) planning process involving multiple stakeholders to obtain MHSA dollars. Contra Costa is using MHSA funds to target a population that includes at least 50% Spanish-speaking, largely indigent worker families in the far eastern part of the county, to provide 24-hour, 7-day a week wraparound family support teams, primarily targeting the uninsured (although part of the focus is to enroll families who are eligible in Medi-Cal). Up to 150 children are expected to be served. The county also is using MHSA to target services to transition-age youth with serious emotional disorders who are exiting foster care and those at risk of homelessness (or homeless), including mental health and substance abuse treatment, housing and job supports, and independent living skills. This initiative will serve up to 150 youth.

“Realignment funds,” which go to the counties and are comprised of sales tax and vehicle licensure fees collected by the state, are another unique and sizeable funding stream. The legislature enacted two tax increases in 1991, with the increased revenues deposited into a state Local Revenue Fund and dedicated to funding the county realigned programs. A portion funds mental health. The two sources of revenue are: 1) Sales Tax: In 1991, the statewide sales tax rate was increased by

a half-cent. The half-cent sales tax generated \$1.3 billion in 1991-92 and was expected to generate approximately \$2.4 billion in FY 2001-02. 2) Vehicle License Fee(VLF): The VLF, an annual fee on the ownership of registered vehicles in California, is based on the estimated current value of the vehicle.

The Senate Bill 90 reimbursement process, which requires the state to reimburse local governments for the costs of new programs or increased levels of service mandated by the state, also is unique. Until 2004, the state was allowed to reimburse counties over 15 years. However, in 2004, Proposition 1A was passed, which requires the legislature to include funding for a mandated activity, or the mandate is lifted for that year. The previous practice left counties with a shortfall; according to Contra Costa, this particularly has been a problem with special education funding.

### **OH** Cuyahoga County, Ohio *Using County Tax Levies*

Cuyahoga County uses funding from two county tax levies to support the Tapestry System of Care (CTSOC). These funds provide the county with the flexibility needed to cover costs that are not reimbursable with more traditional funding streams. The total received for the two levies is \$225 million/year. The levies underwrite the county Department of Health and Human Services, they provide local match, subsidize the mental health board and the alcohol and addiction services board, subsidize the public county hospital, and are used as match to leverage child welfare dollars. Funding from the levies provided the original local match (about \$9 million) for the SAMHSA system of care grant.

As are other sites visited, Cuyahoga County also is pursuing use of TANF funds. Because children and families enrolled in CTSOC may be eligible for TANF funds, the Administrative Services Organization (ASO) intends to identify applicable budget items for potential TANF reimbursement. Lead agencies in the Care Coordination Partnerships (CCPs) are therefore required to comply with applicable policies concerning eligibility criteria and applications and to identify children and families in CTSOC who meet TANF eligibility guidelines.

CTSOC has not yet approached the philanthropic community to contribute, although this has been discussed. They hope that the philanthropic community might be convinced to fund some pilots in the system of care or add-on services in the future.

### **CO** Project BLOOM, Colorado *Using Local Mill Levy Funding and Mental Health Special Districts*

Local mill levy funding is a possible strategy that could be used for early childhood services. The Policy Tool Kit prepared by Project BLOOM for the local communities describes this potential financing stream, which requires making application and putting the issue to local voters. Several communities have considered this strategy. It was reportedly defeated by voters in one county. Denver launched a campaign focused on early childhood and passed an early childhood preschool initiative that provides funds.

A state mill levy for early childhood is also possible to raise funds on a statewide basis, but was not being planned at the time of the site visit. Reportedly, current funding for early childhood services is only sufficient to address the needs of 50% of eligible children.

“Mental Health Special Districts” also became an option within the last few years. A local levy or a local sales tax can be used to raise funds for mental health services, which could be focused on early childhood. With permission from the County Commission, this would then have to go on the ballot for voters. It has not as yet been taken to the voters in any Colorado county.

## B. Coordinate Funding Across Systems

### Financing strategies include:

1. **Pool, blend, or braid funds across systems**
2. **Share costs for specific services and supports**
3. **Coordinate funding across child-serving systems at the system level**
4. **Coordinate the procurement of services and supports across agencies**
5. **Increase the flexibility of funding streams**

### 1. Pool, Blend, or Braid Funds Across Systems

A number of sites blend funds from multiple systems, often to create case rates. For example, **Central Nebraska; Choices, Erie County, Livingston County, and Wraparound Milwaukee** blend funds to finance services and use case rates. Other sites describe their approach as “braided” funding from different sources which remain in separate strands administratively but are joined or “braided” to pay for a coordinated package of services and supports for individual children, such as in **Cuyahoga County**.

#### **MI** Michigan

#### ***Blending Funds from Multiple Sources***

At the state level, the Child Care Fund (CCF), which is state child welfare general revenue dollars, is designed as a cost share between state and the counties and, as such, the CCF blends state and county funds. The counties incur the expenses and are reimbursed for 50% of those expenses by the state from this fund without limits. Local agencies develop contracts with the county commissioners or administrators for services and identify available dollars. Those dollars are added to the CCF and used to purchase services for eligible children. Eligible children are delinquent youth or abused/neglected youth (if a petition has been accepted by the court or if the abuse or neglects leaves them

at risk for out-of-home placement). Programs are eligible for reimbursement if they have intensive services, prevent the need for out-of-home placement or provide services for early reunification from placement and meet reporting and documentation requirements. The CCF is used to cover out-of-home costs and in-home community-based care.

Livingston County has a collaborative workgroup that is called the Funding Partners. The goal of this group is to provide responsive, flexible funding for evidence-based services and a wraparound approach to support children who require multi-system services and their families. This group oversees the wraparound process as well as pools funding to carry out this program. In 2007, the Funding Partners group pooled funding from 11 local, state and federal sources, including the Department of Public Health, the Juvenile Court and Friend of the Court, Education, the county Department of Human Services (child welfare), the mental health authority, and the substance abuse coordinating agency. In addition, the participating agencies also make in-kind contributions in the form of technical assistance and serving on various committees. This system pays a case rate as a consolidated public benefit for children who are enrolled, with the mental health agency serving as the lead to implement the wraparound approach. The amount of the pooled funds is the determinant of the number of children that may be enrolled. The pooled funding allows the child and family (wraparound) teams to be flexible because it pays for a comprehensive array of services from mental health, substance abuse, child welfare, and other systems. The total pooled funding for 2007 was \$510,680.

### **VT** Vermont ***Exploring a Medicaid Waiver to Pool Resources for Children with Multiple Needs***

The state negotiated a first of its kind 1115 (a) Medicaid waiver with the federal government in 2005. Called the Global Commitment Waiver, it is designed to reform the state's Medicaid program by helping both the state and federal governments manage Medicaid expenditures at a sustainable level over the 5-year pilot period. Under this waiver, the state accepts a cap on its Medicaid funding in exchange for greater flexibility in how it spends its Medicaid funds, and with the increased flexibility, the state hopes to provide more individualized services and to produce better outcomes. In addition, Vermont's child-serving partner agencies identified difficulties in funding services for children with multiple, severe needs as a high priority. Under the authority of the Global Commitment Medicaid waiver, the state is working to establish a mental health funding resource that would create a pool of resources funded by several agencies for services and supports for children with multiple and serious needs. Contributing agencies are likely to include: mental health, child welfare, education, health and substance abuse, developmental services, and juvenile justice.

## **NE** Central Nebraska *Blending Funds through Case Rates*

In **Central Nebraska**, a case rate methodology, created with blended funding sources, serves as a primary funding strategy to support and sustain an intensive care management model, the work of the family support organization, a number of services and its system of care. Funds were blended to achieve the Integrated Care Coordination Unit (ICCU) case rate of \$2,136.53 per child per month. The case rate was established in 2000 after an analysis of placement costs for 200 children in state custody. The primary funding sources for these children were state child welfare funds, juvenile services funds, and Title IV-E (federal). A small amount of “other” funds came from block grants, child care funds, reunification funds and state-only funding. Currently, the ICCU case rate consists of state funding (child welfare, state general funds and some juvenile justice funding) and federal funding (Title IV-E).

The case rate for the Professional Partner Program (PPP), a wraparound program for children with serious emotional disorders, is set by the state Division of Behavioral Health based on regional costs. Funding sources are 89.7% state general funds and 10.3% federal mental health block grant funds. The majority of placement costs are not included in the \$698.75/child/month case rate; however, some service costs are paid through flex funds included in the case rate.

Neither of these case rates includes funding for treatment services. Funding from Medicaid, Kid Connect (the Nebraska SCHIP program), and third-party reimbursement are used to pay for treatment services. While these funds are not within the control of Region 3 Behavioral Health Services (BHS), care coordinators and clinicians on the child and family teams work closely with Magellan (the administrative services organization for Medicaid) to fund the plan of care for each child.

Use of case rates has provided the flexibility to offer individualized care and develop new programs. This case rate methodology has been expanded to other areas of the state and is now used by five of the six regional behavioral health authorities in Nebraska.

## **Choices** Choices *Blending or Braiding Funds from Multiple Systems*

In the areas currently served by Choices, various child-serving agencies contribute to the financing of care. The method of contributing, however, varies. In Indiana, each referring agency — child welfare, juvenile justice, and education — pays the case rate for each child referred for care, which could be characterized as a braided funding approach. The state’s mental health managed care system adds to the case rate paid by the referring agency for each child served in Indiana as part of its contribution to building Indianapolis’ system of care; it amounts to a 4% contribution. Additionally, the state’s mental health system pays the match for the Medicaid Rehabilitation Option, which amounts to another \$1 million contribution in billable services.

In Ohio (Hamilton County), the participating agencies include child welfare, mental health and addictions, juvenile justice, and developmental disabilities. Each participating agency contributes a negotiated percentage amount of funding into a large pot of money, which is then blended by Choices. A “shareholder” referral system is used whereby a committee with cross-agency representation makes the decisions about youth who are referred to services based on eligibility criteria.

Choices also bills Medicaid for covered services for eligible youth. The case rates cover all services and supports that are not covered by Medicaid. In both Indiana and Ohio, the case rate dollars can be used to purchase any services that are included in the individualized service plan that is developed by the child and family team. The care plan drives the service delivery process, and any type of service or support included in the service plan is considered “authorized.”

### **OH** Cuyahoga County, Ohio ***Braiding or “Virtually Pooling” Funds from Multiple Systems***

For its Cuyahoga Tapestry System of Care (CTSOC), the county braids funds from different funding sources. The contracts between the Board of County Commissioners (BOCC) and the lead agencies in the Care Coordination Partnerships define “braided funding” as strands of money from the various public partners, which are separately tracked by the Administrative Services Organization (ASO), and joined to pay for a seamless service package for an individual child and family. These contracts identify the public partners as: the Office of Health and Human Services (HHS), the Alcohol and Drug Addiction Services Board (ADAS), the Community Mental Health Board (MHB), the Board of Mental Retardation and Developmental Disabilities (MRDD), the Department of Children and Family Services (DCFS), the Department of Justice Affairs, the Department of Employment and Family Services (TANF), the Family and Children First Council, the Juvenile Court.

The relationship of the public partners and the funding levels contributed for CTSOC are governed by a separate Public Partner Braided Funding Agreement. However, at the time of the site visit, the agreement was still in draft form and the county was braiding funds without a formal agreement. The public partners who are the primary contributors to the system of care include: Health and Human Services and the Dept. of Child and Family Services. The local public funds that are contributed to the system of care are braided with funding from the federal SAMHSA grants (i.e., the Tapestry system of care and Strengthening Communities-SCY grants). The plans of care developed by the Care Coordination Partnerships operating at neighborhood levels (using a wraparound approach) determine the services and supports that children and their families will receive, and the county’s System of Care Office, functioning as an Administrative Services Organization, determines which funds to draw on from the braided funding mix to finance the plan of care. One might also characterize this as a “virtual pooled” funding approach in that the funds are not literally blended, but from the family and provider perspective, the funds appear to be pooled.

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**CO** **Project BLOOM, Colorado**  
***Blending Funds through Local Early Childhood Councils and Special Legislative Funds***

Each of the Early Childhood Councils in local communities has a pool of funds that is used primarily to provide flexible funding for needed services and supports that are not financed through other sources. The funds come primarily from the developmental disabilities and mental health systems. The councils have tried to support all young children and to identify resources for children with special needs.

House Bill #1451 allows any county to form a collaborative team to serve a child with multiple needs. Communities apply to the state to become a “1451 community” and then are eligible to receive monies from a pool of funds to be used for specific purposes for children with multiple needs. If they achieve specific outcomes, they receive incentive dollars from state general revenue and cash funds that can be used flexibly. Two of the four communities in Project BLOOM are 1451 communities. The dollars from the funding pool are used for flexible funding and the wraparound process. Although this legislation was not originally intended for early childhood mental health services, there is nothing to preclude its use for this population. In the Policy Tool Kit that is available to communities, this is identified as a potential funding source for early childhood services. More information about his funding can be found at <http://www.cdhs.state.co.us/childwelfare/1451Legislation.htm>.

**WI** **Wraparound Milwaukee**  
***Blending Funds from Multiple Systems, Including Medicaid, Through Case Rates and Capitation***

Wraparound Milwaukee blends several funding streams: Medicaid dollars through a capitation from the state Medicaid agency of \$1,589 per member per month (pmpm); child welfare dollars through a case rate of \$3,900 pmpm; mental health block grant dollars; and both contract dollars and case rate dollars from the juvenile justice system.

Blending of funds for youth in the delinquency system is based on two target populations. These include youth whom the delinquency program would otherwise place and fund in residential treatment centers (about 350 youth), for whom Wraparound Milwaukee receives \$8.2 million in fixed funds from the budget that Delinquency and Court Services would otherwise use to pay for this level of care. The second target group is youth who would otherwise be committed to the state Department for Corrections for placement in a locked correctional facility (about 45 youth). Delinquency and Court Services pays Wraparound Milwaukee a case rate of \$3,500 per youth per month for these youth. If these youth were placed in a correctional facility, Milwaukee County would be charged about \$7,000 per youth per month for the cost of these placements under the state's charge-back mechanism to counties. These youth are diverted to Wraparound Milwaukee through a “Stayed, State Order” versus a direct County order. All of these youth must be Medicaid-eligible and have a serious emotional disorder.

As noted, because the county juvenile justice system gets charged the cost of correctional placements, which run about \$7,000 pmpm, it has an incentive to utilize Wraparound Milwaukee, whose costs run about \$3,500 pmpm for the juvenile justice population. Similarly, because both child welfare and juvenile justice, prior to Wraparound Milwaukee, paid for residential treatment, both systems have incentives to utilize Wraparound Milwaukee, which delivers lower per member per month costs and better outcomes. The child welfare and juvenile justice systems share 50/50 the cost of youth with dual delinquency and dependency court orders.

In addition to these funding streams, Wraparound Milwaukee operates the County's mobile crisis program for county youth (Mobile Urgent Treatment Team – MUTT), which also is supported by dollars blended from multiple funding streams. Every child enrolled in Wraparound Milwaukee automatically is eligible for services from MUTT, and other families in the county may use it for a crisis related to a child. The child welfare system and Milwaukee Public Schools wanted an enhanced, dedicated mobile crisis team to provide crisis intervention and on-going (30-day) follow-up. Each provides funding of \$450,000 to support this enhanced capacity. Wraparound Milwaukee also is able to bill Medicaid for this service under Wisconsin's crisis benefit. This includes the MUTT crisis team; a portion of care managers' time spent preventing or ameliorating crises; 60% of the cost of crisis placement in a group home, foster home or residential treatment facility; and the cost of 1:1 crisis stabilizers in the home. Since Wraparound Milwaukee can recover a percentage of its costs by billing Medicaid, it is able to add about \$180,000 to the Milwaukee Public Schools enhanced capacity and about \$200,000 to the child welfare capacity. Wraparound's total Medicaid crisis reimbursement was nearly \$6 million in 2006.

In addition to these funding streams, the developmental disabilities system gives Wraparound Milwaukee five of its Home and Community Based Waiver slots. There is no county tax levy for mental health services. The Wraparound Milwaukee MIS system interfaces with both the state child welfare (SACWIS) and state Medicaid data systems to keep track of Medicaid and Title IV-E expenditures for federal claiming and audit purposes.

## 2. Share Costs for Specific Services and Supports

The sites share costs among partner agencies for specific services. For example, the mental health and child welfare systems co-finance therapeutic foster care in **Arizona** and **Hawaii**; education and mental health co-finance school-based wraparound in **Central Nebraska**; and child welfare, education, mental health, and Medicaid co-finance crisis outreach services in **Wraparound Milwaukee**.

### **AZ** Arizona

#### ***Sharing Funding Responsibility for Specific Services***

The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) partners with other systems to share funding responsibility for certain programs. For example, the managed care system uses only therapeutic foster homes licensed by child welfare for the Regional Behavioral Health Authority (RBHA) networks (with the exception that tribes may license homes), which enables Title IV-E funds to be used for room and board costs for eligible children. Similarly, all child welfare in-home providers must be Medicaid providers, providing a foundation for a common network of service providers between these two systems. The managed care system also provides behavioral health services to about 78% of adult family members with substance abuse problems who are involved in child welfare.

### **CA** California

#### ***Sharing Costs to Finance Services***

**Contra Costa County** has a number of initiatives in which it either braids or cost-shares, as follows:

- County mental health division (CCMH) assigns a clerk and three consultant-liaisons to child welfare offices to consult with child welfare social workers regarding the mental health needs of their children and to obtain authorizations for mental health services. Funding is Title XIX (Medicaid administrative claims), with the local match shared between the two departments.
- CCMH finances a field-based unit of four licensed clinicians who provide assessment, short-term supportive treatment and case management for children and adolescents placed in emergency shelter (foster homes and group homes) by child welfare. Funding is through Medi-Cal billing.
- CCMH co-finances assessment units at county juvenile detention centers (which use the Massachusetts Youth Screening Instrument, Version 2 [MAYSI-2] screening instrument).
- Special education and CCMH dollars co-finance mental health-enhanced special education classrooms and day treatment.
- CCMH assigns mental health staff to a multi-disciplinary team serving caregivers of 0-6 year olds enrolled in the Children's Medical Services Program through public health.
- System of Care Multi-Agency Regional Teams ("SMART" Teams) are co-financed and co-staffed by CCMH, public health, child welfare, juvenile justice, and education to serve as intake points for wraparound services.

- CCMH co-finances a residential program with the developmental disabilities system for youth 12-18 with dual diagnoses of developmental disabilities and serious emotional disorders.
- CCMH co-funds programs with the 1st Five Commission serving children 0-6, including therapeutic nursery, Parent-Child Interaction Therapy (PCIT), and wraparound.
- CCMH co-finances housing assistance programs with the housing agency for transition-age youth, including master lease agreements for young adults placed with a family with a care manager; vouchers for temporary housing for families; and transition-age housing for 16-25 year olds.
- CCMH and juvenile justice jointly operate a 20-bed residential program for girls (primarily adjudicated; average length of stay of 9-12 months); the program is co-financed by county general revenue from mental health, child welfare, juvenile justice and the schools, as well as Medi-Cal.
- There are two juvenile drug courts in the county, jointly financed by the county substance abuse agency, county mental health, probation, public defenders office, district attorney's office, and Medi-Cal.

## **HI** Hawaii

### ***Sharing Costs with Child Welfare, Juvenile Justice, and Education***

Cost sharing is used in financing several of Hawaii's services. Cross-agency relationships are considered key to accomplishing these approaches and take significant time to develop. Examples of cost sharing include:

- Cost sharing between the mental health and child welfare systems for therapeutic foster home costs to allow permanent placements for troubled youth, maintaining them in a stable home with a reduced cost of services over time.
- Cost sharing with the juvenile justice system, using mental health block grant funds, to provide a psychologist and to place a mental health care coordinator at the detention facility to prevent unnecessary incarceration.
- The mental health system built a system of school-based services and then transferred the funding legislatively to the education system. The Department of Education (DOE) now manages these services on a statewide basis and has developed a system to bill Medicaid for mental health services. The Child and Adolescent Mental Health Division (CAMHD) provides more intensive services based on identified needs.

**VT Vermont*****Sharing Costs for Specific Services***

Under **Vermont's** Act 264 and in practice, agencies share costs for specific services and supports. A child's Coordinated Service Plan is considered, by law, an addendum to other state and federally mandated plans (e.g., educational 504 plan or Individualized Education Plan, mental health Individual Plan of Care, child welfare case plan). The Plan drives services and funds required. Typically, each of the partner agencies (mental health, education, children and families, developmental disabilities, etc.) funds those services for which it is responsible either through memoranda of understanding with the local lead agency or directly, depending on the service and delivery arrangement. Funds are also transferred across agencies for specific services (e.g., crisis services, respite), and state agency partners contribute funds from their general fund allotment to the mental health agency in order to draw down Medicaid funds to pay for services. Transfers include those especially aimed at building system capacity. For example, the Department for Children and Families has provided funds to the Department of Mental Health for preventive and early intervention services for children and families to avert placement into state care and to expand capacity in the mental health system. The focused effort to improve system response to families approaching or in crisis by blending planning and funding from the Department of Mental Health and the Department for Children and Families has significantly reduced the number of youth entering custody under emergency CHINS (Children in Need of Supervision) court orders.

Another example involves local education agencies (LEAs) and local mental health Designated Agencies, which are co-funding the Success Beyond Six initiative. This approach uses state general funds from LEAs as match to draw down mental health Medicaid through a contracting process. The LEA specifies the types and amount of services it wants for its Medicaid eligible students, such as a full- or part-time therapist to conduct groups on social skills or anger management, individual behavior intervention specialists, or home-school coordinators. The mental health agency hires and supervises appropriately trained and credentialed staff to provide the service.

**NE Central Nebraska*****Sharing Costs for Specific Services***

In addition to blending funds to achieve case rates, Central Nebraska shares costs across agencies, systems, and programs:

- *Integrated Care Coordination (ICCU)* — Care coordinators from child welfare and mental health are co-located at ICCU sites to facilitate the integration of services and to share resources. For example, the Region 3 Behavioral Health Services (BHS) and the Central Area Office of Protection and Safety (child welfare) share the cost for personnel, space, supplies, and furniture for the Integrated Care Coordination Unit (ICCU). Each agency employs half of the care coordinators in ICCU and divides the cost of supervision. Even though the care coordinators are employed by different agencies, ICCU directors indicated that the only way to tell the difference is to know who signs the pay check.
- *Multisystemic Therapy (MST)* — The development of MST was funded by the federal system of care grant. A variety of funding sources cover the actual service costs. MST providers are paid a case

rate based on outcomes achieved with each youth/family. Within the case rate, Medicaid pays for intensive outpatient services. Region 3 BHS also purchases MST for families who do not have another payer source.

- *School Wraparound*— Although there is no exchange of funds between the local school system and Region 3 BHS, they share the costs for space and personnel. The schools pay for the educational facilitator. Region 3 BHS pays for the professional partner (family facilitator). These two facilitators become a school wraparound team, work together with each child and family team, and are housed in the same office.
- *Family Support and Advocacy*— Families CARE shares office space and cars with the Grand Island Health and Human Services Office.

### **OH** Cuyahoga County, Ohio ***Sharing Costs through Co-Location***

Through co-location, **Cuyahoga County** shares costs across systems. When Cuyahoga County received the federal system of care grant, the ten existing (and later, four new) Neighborhood Collaboratives, financed largely by child welfare, provided the structure and the space to implement the system of care. This enabled the system of care to locate clinical services, financed largely by Medicaid and mental health, where families live and to help fund costs with the Collaboratives.

### **CO** Project BLOOM, Colorado ***Sharing Costs on Individual Case Basis and Funding Hierarchy for Part C***

Cost sharing for services can occur at the local level. Some costs are shared on an individual case basis, with each agency providing the services that it is responsible for within the overall wraparound plan. Disagreements on cost sharing are taken to agency supervisors or administrators, or if necessary to the system of care governing body in each community.

A funding hierarchy was created for using Part C early intervention funds based on a bill passed by the legislature (Senate Bill 07-4) that was to be implemented in January 2008 and is similar to a process used in Massachusetts. The bill requires insurance companies to cover early intervention services and sets liability to insurance companies at a fixed amount of \$5,700 per year for any eligible child up to 3 years of age (services specified in an eligible child's individualized family service plan – IFSP – are to be considered medically necessary). The Developmental Disabilities system and Medicaid then become the payers for additional services that are needed. The Community-Centered Boards for developmental disabilities are the lead agencies for implementation of this cost-sharing process. There was already a mandate in the state to pay for services to uninsured children, for which state general fund dollars were used. Now, state general fund monies can be used only for uninsured children, since insurance is now mandated to cover a fixed amount for covered children with the Developmental Disabilities system and Medicaid covering expenses for services over and above the fixed amount.

It is hoped that this hierarchy for payment will result in an expanded provider network because it will allow early childhood service providers to be reimbursed by insurance and by the Developmental Disabilities system. It is also hoped that Individualized Family Service Plans (IFSPs) will now be more comprehensive and will reflect all of the services and supports needed by a child and family, rather than limiting them to only those services that Part C would pay for previously.

Project BLOOM has developed a joint format for a service plan that integrates the wraparound elements into the IFSP, so that a single combined plan can be created for a child and family. The format allows the team to bring in more services and supports directed at the family, rather than just at the child. The new IFSP+ lists services needed, desired, and useful and can specify other funding sources to pay for them. Part C is responsible for financing 14 specific services; other services with other financing sources can now be a part of this more comprehensive service plan.

### **WI** Wraparound Milwaukee *Sharing Costs for Crisis Services*

Mental health, child welfare and Milwaukee Public Schools co-finance mobile crisis services, which also are billable to Medicaid for Medicaid-eligible children. Wraparound Milwaukee operates the County's mobile crisis program for county youth (Mobile Urgent Treatment Team – MUTT). Every child enrolled in Wraparound Milwaukee automatically is eligible for services from MUTT, and other families in the county may use it for a crisis related to a child. The child welfare system and Milwaukee Public Schools wanted an enhanced, dedicated mobile crisis team to provide crisis intervention and on-going (30-day) follow-up. Each provides funding of \$450,000 to support this enhanced capacity. Wraparound Milwaukee also is able to bill Medicaid for this service under Wisconsin's crisis benefit. This includes the MUTT crisis team; a portion of care managers' time spent preventing or ameliorating crises; 60% of the cost of crisis placement in a group home, foster home or residential treatment facility; and the cost of 1:1 crisis stabilizers in the home. Since Wraparound Milwaukee can recover a percentage of its costs by billing Medicaid, it is able to add about \$180,000 to the Milwaukee Public Schools enhanced capacity and about \$200,000 to the child welfare capacity through Medicaid billings. Wraparound Milwaukee's total Medicaid crisis reimbursement was nearly \$6 million in 2006. In addition to co-financing for MUTT, juvenile justice and child welfare co-finance crisis residential services, certain costs of which also can be billed to Medicaid.

### 3. Coordinate Funding Across Child-Serving Systems at the System Level

The sites use various mechanisms to coordinate funding across child-serving systems, including controlling and monitoring potential cost shifting. In **Hawaii**, memoranda of understanding have been negotiated between the mental health system and the Medicaid agency, as well as with the child welfare, education, and juvenile justice systems. **Vermont** enacted legislation mandating interagency coordination and establishing local and state interagency teams that address the coordination of resources and services, and other sites, such as **Michigan**, use local interagency structures for system-level coordination. **Table 5.3** shows the mechanisms used for coordinating funding across agencies in the sites studied.

**Table 5.3**  
**Mechanisms for Coordinating Financing Across Agencies**

Mechanism	States						Regional/Local Communities					
	AZ	CA	HI	NJ	VT	MI	Central NE	Choices	Cuyahoga County	Erie County	Project BLOOM	Wraparound Milwaukee
Interagency entity at state/tribal/local level		X			X	X	X	X	X	X	X	
Interagency expenditure plan					X	X Livingston Co.	X		X	X		
Memoranda of understanding/agreements	X	X	X		X	X Livingston Co.	X	X	X	X	X	X
Legislation		X			X						X	
Funding for cross-agency training	X		X	X	X				X	X	X	
Other (specify)					X				X	X		X

#### **HI** **Hawaii** **Implementing Memoranda of Understanding**

Memoranda of Understanding (MOUs) help with coordination of funding across systems. For example, the child welfare and mental health systems have agreements in place regarding Title IV-E funds, including an agreement that allows a child in therapeutic foster care to remain in the same placement to avoid a disruption and maintain treatment gains, even after their needed level of care may not be as intensive. An MOU with the state Medicaid Agency (Med-Quest) gives responsibility and resources to the Child and Adolescent Mental Health Division (CAMHD) for providing intensive mental health services to eligible children and adolescents through the Support for Emotional and Behavioral Development (SEBD) program. An MOU with the Dept. of Education

clarifies responsibilities for service delivery and financing between the children’s mental health and the education systems. An MOU with the Judicial Circuit Court (Family Court) provides resources for CAMHD to provide professional staff and mental health services at juvenile justice facilities, (including consultation to facility, court staff and officers) through CAMHD’s Family Court Liaison Branch.

The success of coordinating services and funding on an individual child level depends in large part on how well the child and family team functions. The most difficult decisions regarding services and financial responsibility can be “bumped up” to higher levels in the agencies; these decisions typically are related to responsibility for payment for residential placements where there may still be lack of clarity regarding responsibility for providing and paying for specific services.

Cross-agency training is provided to the education and child welfare systems regarding the SEBD program, system responsibilities, and coordinating services and resources. There are interagency MOUs and some funding for cross-agency training (Title IV-E resources).

CAMHD also has a Resources Development Section that is responsible for developing, managing, and coordinating federal revenues such as Title XIX and Title IV-E. This section collaborates with other state agencies to maximize federal revenues and to generate reimbursement and savings for CAMHD.

Local coordinating bodies (Community Children’s Councils – CCCs) were created as part of the Felix Consent Decree to give communities a voice in the children’s mental health system. They are comprised of families, providers, and others who serve on a volunteer basis to assess local needs, coordinate activities, and provide input on state-level policies. There are 17 CCCs across the state. A state-level coordinating body is housed in a separate office of the Department of Education. Quarterly statewide meetings of CCCs are held. The CCCs current role focuses on accountability, quality assurance, and advocacy.

## **MI** Michigan

### ***Using Local Collaboratives***

All Michigan counties, either by themselves or in collaboration with other counties, have established collaborative groups that address issues that impact the lives of children, families, and special populations in their area. The collaboratives: 1) Establish workgroups of agency staff, consumers, and community representatives to plan and/or implement services for a target population, 2) Share information regarding various programs, policies and procedures; 3) Manage state-funded collaborative initiatives, and 4) Collaborate with other community collaborative groups (e.g., Early On Local Interagency Coordinating Councils, Homeless Continuums of Care, Child Abuse/Neglect Councils, etc.). The Collaboratives are comprised of private and public sector leadership representatives from human services organizations that address various family support needs. These may include organizations such as Department of Human Services, transportation, community mental health, child abuse/neglect councils, domestic violence, etc.

Most Community Collaboratives conduct community needs assessments to better direct their efforts to guide funding decisions for programs/services and to communicate with elected officials (county commissioners, state legislators). Each Community Collaborative focuses resources on common “outcomes” and functions as the community interface with state agencies on state “collaborative” efforts in human services.

Livingston County has a collaborative workgroup that is called the Funding Partners. The goal of this group is to provide responsive, flexible funding for evidence-based services and a wraparound approach to support children who require multi-systems services and their families. This group oversees the wraparound process as well as pools funding to carry out this program. In 2007, the Funding Partners group pooled funding from 11 local, state and federal sources, including the Dept. of Public Health, the Juvenile Court and Friend of the Court, Education, the county Dept. of Human Services (child welfare), the mental health authority, and the substance abuse coordinating agency. In addition, the participating agencies also make in-kind contributions in the form of technical assistance and serving on various committees. This system pays a case rate under a single community plan of service to children who are enrolled. The amount of the pooled funds is the determinant of the number of children that may be enrolled. The pooled funding allows the child and family teams to be flexible because it pays for a comprehensive array of services from mental health, substance abuse and child welfare. The total pooled funding for 2007 was \$510,680.

## **VT** Vermont

### ***Enacting Legislation Mandating Interagency Coordination***

The system of care has as a fundamental goal, structure and functions to coordinate services and financing to meet the needs of the child and family. Many vehicles support that effort: Act 264, with mandated Local Interagency Teams (LIT) and a State Interagency Team (SIT) and a statutory, appointed state board that advises agency commissioners; interagency expenditure plans; interagency memoranda of understanding (these have expanded since the System of Care Plan began); a joint vision statement by the umbrella agency of human services and the Department of Education; cross-agency training and continuing education.

The LIT assists treatment teams to reach consensus on or find ways to implement a child's coordinated service plan when they need extra support. It may review a plan and make recommendations on the content of the treatment plan; suggest possible additional resources or support to implement the plan; recommend that an agency waive or modify a policy. Each LIT has a coordinator based at the local mental health center. Should the LIT not be able to resolve a problem or assist adequately, it can refer the matter to the SIT for review and further recommendation. The SIT is a state level forum for the next round of consideration. Its role and objectives are to:

- Assist LITs to implement coordinated service plans. They may review a plan and make recommendations on content; suggest possible additional resources to help implement the plan; and/or recommend that an agency waive or modify a policy

- Ensure the coordinated development of the system of care in the areas of service, policy, and fiscal management; and ensure that information on best practices is disseminated to agency staff and to the general community.

These teams have authority to review and make recommendations but *cannot order any agency to provide services*. The Vermont law provides appeal rights and a process for parties to follow. A second appeal process exists for children receiving services under IDEA.

**OH Cuyahoga County, Ohio*****Using Interagency Structures and Memoranda of Understanding***

**Cuyahoga County** coordinates funding across child serving systems through its Funders Workgroup and the Administrative Services Organization managed by the Cuyahoga Tapestry System of Care (CTSOC). The Family and Children First Council and the Early Childhood Invest in Children are also mechanisms for coordinating funding across agencies.

Formally, there are safeguards in place in contracts with the six Care Coordination Partnerships (CCPs) and in the memoranda of understanding (MOUs) with the providers to coordinate funding for specific services. For example, the MOU between CTSOC and each CCP indicates that CTSOC Provider Services Network funds will be the “payor of last resort”, after all other public and private funds for the services being purchased, including medical insurance and restricted contributions, have been exhausted. It also states that providers may not supplant Medicaid, HMO, or PPO funded services with funding under this MOU. The contract with the CCPs requires them to back out the amount earned for children who are Medicaid eligible when billing the ASO for these enrolled children. An annual reconciliation process allows Medicaid billing to be considered.

Informally, county agency directors have built strong relationships, trust each other, and even “lend” money from one system to another. For example, when the mental health and alcohol and addictions services boards did not have the Medicaid match needed to offer family preservation services, the Department of Family Services (DCFS) entered into a MOU with the two boards. The DCFS director believed that having clinical services available to help preserve families would reduce the number of children needing placement, ultimately reducing DCFS’ board and care costs. DCFS agreed to use these savings to pay the match for the two boards.

**CO Project BLOOM, Colorado*****Using Interagency Structures - Blue Ribbon Policy Council, Smart Start, Colorado System of Care Collaborative, and Local Early Childhood Councils***

At the state level, system-level coordination and leadership is provided by the Blue Ribbon Policy Council and the Smart Start initiative. The Blue Ribbon Policy Council was formed in 2003 to provide a high-level policy council to support the early childhood efforts in the state. It is comprised of representatives of state agencies, the legislature, families, advocates, universities, provider organizations. The Blue Ribbon Policy Council’s role involves broad strategic planning and policy setting, including financing.

Smart Start, housed in the Lt. Governor’s office, is an integral part of the strategy to integrate early childhood services into existing early care, education, and mental health systems. It is described as a statewide alliance of early childhood partnerships working together to create a comprehensive system for young children birth to age 8 and their families. With the help of a federal grant from the Maternal and Child Health Bureau (the Early Childhood Comprehensive Systems Initiative), a formal

council was created. The federal funds provided seed money to hire staff for this effort. A “collective” of private foundations involved in funding early childhood services also was enlisted to support Smart Start. Through monthly meetings and eight task forces working under its auspices, a strategic plan was created. The strategic plan blends early care and education, health care and medical home, family support and parent education, mental health, and school and community with the child and family in the center.

House Bill 1451 has a state-level coordinating and advisory body that reviews the plans submitted by communities regarding serving multi-need children.

At the state level, there is the Colorado System of Care Collaborative with representation from multiple state agencies, the Colorado Federation of Families for Children’s Mental Health, the Denver Indian Family Resource Center, and others. This Collaborative funded a statewide conference on systems of care in 2004 and will fund a second statewide system of care conference. The Collaborative also developed a report on priority system of care needs for the state, one of which is an increased focus on family-professional partnerships. The Collaborative started from Project BLOOM, but has grown beyond a focus on children’s mental health to a broader focus on children and families with complex needs. The group is co-facilitated by a family member. There is considerable cross-over in membership among the state-level groups, and the Collaborative serves as a core leadership team that coordinates efforts for children and families across all of these activities.

At the local level, system-level coordination is provided by the Early Childhood Council in each community. Early Childhood Councils are comprised of community leaders representing education, mental health, health, family support, and education. Parents, families, and stakeholders from higher education, business, local government, libraries, and other community resources also sit on local councils. Councils are public/private partnerships and have oversight structures that guide their work through a formalized governance process.

Project BLOOM communities each have a local governance team. They vary across the four communities, but generally have representatives from the CMHC, the Early Childhood Council, Part C system, child welfare system (Human Services), community center board, Colorado preschool program, families, and others. Memoranda of understanding were developed among the agencies on the system of care governing body regarding the coordination of services, the use of child and family teams for wraparound service planning, etc.

Cross-agency training is provided regarding the early childhood mental health funding matrix and wraparound training (locally and statewide).

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## 4. Coordinate the Procurement of Services and Supports Across Agencies

Strategies for coordinating the procurement of services across agencies were found in several sites. For example, **Hawaii** developed uniform contracting protocols that include both performance standards and practice guidelines that are shared between the education and mental health systems. **Wraparound Milwaukee** has centralized the procurement of residential treatment services and has uniform rates for over 80 different home and community-based services and supports for utilization by wraparound teams. **Erie County, New York** has uniform rates for wraparound vendor services.

### **HI** Hawaii

#### ***Developing Uniform Contracting Protocols***

There are some uniform contracting protocols comprised of performance standards and practice guidelines that are shared between the education system and the children's mental health system. In addition, the Department of Health (DOH) and Department of Education (DOE) jointly developed a manual detailing interagency performance standards and practice guidelines for use by DOH and DOE personnel and contracted providers when developing and implementing individualized service plans for youth and their families. These standards and guidelines are designed to define services and improve the effectiveness of both school-based mental health services and the intensive mental health services provided through CAMHD's system of care.

### **VT** Vermont

#### ***Using Uniform Contracting and Procurement Protocols***

Vermont's system of care utilizes purchasing collaboratives, joint procurement practices, uniform contracting protocols, and a uniform rate structure to coordinate procurement of services and supports. Vermont's local Designated Agencies (DAs) for the provision of community mental health services operate as a preferred provider network in the state and work together in a consortium through the Vermont Council for Developmental and Mental Health Services and with the Department of Mental Health to address service and business issues. They share the same basic contract and operate as a full group or in sub-groups. They use the same protocols to make purchases for operations (relevant services, information technology, and material items). Various DA leadership groups (CEOs, CFOs/business directors) meet regularly to discuss issues under their purview. They have, for example, discussed bond issues for capital improvements and service expansions, as well as negotiated a master contract with all Agency of Human Services' departments.

**OH** ***Cuyahoga County, Ohio***

Modeled after Wraparound Milwaukee's approach, the county's System of Care Office, functioning as an Administrative Service Organization, has created an established range of services and supports and pre-approves rates with members of the Provider Services Network that are part of the Care Coordination Partnerships. Thus, there are uniform rates across the neighborhood partnerships, as well as uniform contracting protocols.

**NY** ***Erie County, New York***  
***Uniform Rates for Purchase of Wraparound***

Mental Health has been designated as the lead agency for system of care contracts for new community services development. Wraparound purchase of vendor services utilizes uniform rates. A performance contracting pilot is being monitored by the partnering systems and may result in uniform contracting protocols.

**WI** ***Wraparound Milwaukee***  
***Using Centralized Procurement for Residential Treatment***

**Wraparound Milwaukee**, in effect, has eliminated the practice of individual child-serving systems purchasing residential treatment on their own. Procurement of services for the populations needing this level of care is done through Wraparound Milwaukee. Wraparound Milwaukee also developed standard rates for over 80 different types of services and supports utilized throughout its provider network of over 200 providers, and it utilizes uniform contracting protocols and performance standards.

## 5. Increase the Flexibility of Funding Streams

Flexible use of resources is an important element in financing systems of care and services. For example, in **Hawaii**, local lead agencies (Family Guidance Centers) have significant flexibility in the use of resources, and child and family (wraparound) teams determine how resources will be used for each individual child and family. Several sites use managed care approaches and managed care financing mechanisms (capitation and case rates) which allow for the flexible use of resources to meet individual needs.

### **CA** California *Incorporating Local Flexibility*

The consolidation of Medi-Cal and Short-Doyle (community mental health) funds in 1995 and legislation in 1991 requiring that mental health and social services dollars go down to the counties, combined with the implementation of Medi-Cal managed care with the 1915 b waiver, there is a great deal of flexibility at the county level. In addition, the Medi-Cal benefit is broad, and MHSA (Prop 63) funds create additional flexibility. Contra Costa county also described flexibility with SB 163 (wraparound AFDC-FC) funds, and its many agreements with various other child-serving systems as supporting greater flexibility.

### **HI** Hawaii *Incorporating Local Flexibility*

At the state level, **Hawaii** is able to move funds across budget categories in mental health (e.g., from out-of-home into community-based services), move funds across fiscal years in Medicaid and Title IV-E, move some funds across systems with memoranda of understanding, and utilize savings in one budget category to fund increases in another within mental health (e.g., residential to intensive community-based services), as long as the bottom line is not affected.

At the local level, communities (primarily Family Guidance Centers as the primary provider agencies) have significant flexibility in the use of resources. Child and family teams decide how resources are spent on an individual case basis, with significant flexibility in how resources within the mental health budget are used. The only restriction is the requirement to answer a series of questions prior to sending a child to the mainland for treatment.

### **MI** Michigan *Using a State Child Care Fund*

The Child Care Fund (CCF) was established for the purpose of the state and counties sharing the cost of court-ordered services for children who are court wards. The state reimburses 50% of eligible county funds spent for services when the county bills the state under the CCF. The CCF serves as

a cost sharing between the state and the counties. The fund is used to flexibly fund in-home and community based care, as well as out-of-home placement costs. More than half of the children served under the CCF (54%) are neglected or abused. It is the largest funding source for children in child welfare, though a large part of the fund is also for youth involved in juvenile justice. Counties can narrow or widen the criteria for services covered under the CCF. It can be used for wraparound services, and it is used to provide match to draw down Medicaid dollars. The state uses the CCF for blended funds due to the potential for matching federal, state and donated funds as well as the ability to use the CCF for community programs and to meet the needs of the local communities.

### **VT** Vermont *Incorporating Local Flexibility*

Vermont's system incorporates flexibility at state and local levels in the use of funding streams to finance services and supports. The individual treatment team from the local lead agency assesses needs, determines the service plan, and identifies the resources that fit based on fund requirements. While specific funding sources maintain their budget identity (have appropriate identifying codes used for reporting and monitoring purposes at local and state levels), local agencies have the authority to decide and utilize budget resources to deliver the individual plan. Medicaid is the principal funding source with wide application, and most services are covered under that stream. For those that cannot be covered using Medicaid, local agency staff considers an array of options that include other federal and state funding sources. Depending on governing statutes and agreements, funds may be moved and used across child-serving systems (e.g., the Department for Children and Families funds mental health for early intervention and crisis prevention services); savings realized in one category may support other services, as is the case with the Home and Community-Based Services Medicaid waiver; and state dollars may be used to provide flexible funding.

### **OH** Cuyahoga County, Ohio *Developing a Continuum of Flexible Funding Sources*

The Cuyahoga Tapestry System of Care (CTSOC) developed a continuum of funding sources noting the least flexible to the most flexible and uses this in making decisions on how to spend the dollars. For example, when funds were needed to pay for Parent to Parent Support Services, the county used the Health and Human Services tax levy dollars from the CTSOC budget (\$310,000) for parent support activities (food, transportation, recreation). By virtually blending a number of county, state and federal grant funding streams, the system supports Care Coordination Partnerships operating at neighborhood levels to create very flexible plans of care.

**CO** **Project BLOOM, Colorado**  
**Funding Hierarchy, Legislation, Risk-Based Financing, and Other Strategies**

A number of strategies have been used to incorporate flexibility in state and local funding streams:

- Utilizing Part C — Creating a funding hierarchy that facilitates the use of Part C dollars for early childhood services including mental health
- 1451 Legislation — Allows communities to apply to the state to become a “1451 community” and then receive monies from a pool of funds to be used for specific purposes for children with multiple needs.
- Medicaid managed care system — Capitated system that allows BHOs to cover a range of optional services
- Senate Bill 101 — Allows schools to bill Medicaid for services that they already provided, essentially refinancing school-based services. This can be used for early childhood mental health services. Fremont County, one of the Project BLOOM communities, is tracking the services they provide in schools to see if they can be reimbursed under Medicaid. This strategy is now being folded into the Smart Start Financial Mapping process.

**AZ** **Arizona, NE** **Central Nebraska, Choices** **Choices, and****WI** **Wraparound Milwaukee****Incorporating Flexibility through Managed Care Approaches and Financing**

Flexibility due to managed care approaches with capitation and case rate financing:

- **Arizona** stakeholders maintain that they have flexibility because of the managed care structure, which eliminates rigid budget categories across Medicaid, mental health and substance abuse block grant and state general revenue funds and gives Regional Behavioral Health Authorities flexibility.
- In **Central Nebraska**, the case rate structure provides flexibility at the system level in how funds are expended as well as at the practice level to allow the flexible use of funds to meet individualized needs of children and families and to fund services/supports that are not reimbursable with more traditional funding streams.
- In **Choices**, the case rate financing approach allows considerable flexibility in the use of funds from multiple funding streams.
- **Wraparound Milwaukee’s** blended funding, supported by capitation and case rate approaches, allows for considerable flexibility in use of multiple funding streams.

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## II. Maximize Federal Entitlement Funding

### Financing strategies include:

- A. Maximize Medicaid
- B. Maximize Title IV-E Child Welfare Funds
- C. Maximize Special Education Funds

### A. Maximize Medicaid

#### Financing strategies include:

- 1. Maximize eligibility and/or enrollment for Medicaid and SCHIP
- 2. Cover a broad array of services and supports under Medicaid
- 3. Use multiple Medicaid options and strategies
- 4. Use Medicaid in lieu of other state funds
- 5. Generate Medicaid match

#### 1. Maximize Eligibility and/or Enrollment for Medicaid and SCHIP

Strategies for maximizing eligibility and enrollment in Medicaid and SCHIP programs were found in all of the sites. For example, Hawaii set eligibility at 300% of the federal poverty level for Medicaid and covers additional children through SCHIP; individuals are allowed to buy in to the Medicaid program. In Colorado, outreach and training are used in addition to a single streamlined application for both programs. **Table 5.4** shows the eligibility levels for Medicaid and SCHIP in the sites studied.

**Table 5.4**  
**Eligibility Levels for Medicaid and SCHIP<sup>1</sup>**

	AZ	CA	CO	HI	IN	MI	NE	NJ	NY	OH	VT	WI
Medicaid Eligibility Percent: Federal Poverty Level <sup>2</sup>	0-1: 140% 1-5: 133% 6-19: 100%	0-1: 100% 1-5: 133% 6-19: 100%	0-5: 133% 0-5: 133%	300%	0-1: 200% 1-19: 150%	0-1: 185% 1-19: 150%	185%	0-1: 200% 1-19: 133%	0-1: 200% 1-5: 133% 6-19: 100%	200%	225%	250% (300%)
SCHIP Eligibility: Percent Federal Poverty Level <sup>2</sup>	200%	250%	205%	New program <sup>3</sup>	250%	200%	Based on family income <sup>4</sup>	350%	250% (400%)	Healthy Start <sup>5</sup>	300%	All children under 19 at all income levels

- 1:** Income eligibility levels noted are in effect as of April 1, 2009 and expressed as a percentage of the Federal Poverty Level (FPL), without regard to income disregards or deductions.
- 2:** Income eligibility levels for children's Medicaid includes SCHIP-funded Medicaid expansions; separate SCHIP programs are shown under children's SCHIP. Note that New York and Wisconsin use state funds to cover children in families with incomes above CHIP levels; eligibility for state-funded coverage is shown in parentheses.
- 3:** Hawaii ended their SCHIP program in December 2008; new legislation passed in May and begins July 2009 and covers uninsured children.
- 4:** In Nebraska, eligibility is determined by adjusted family income level
- 5:** Ohio offers two programs for children and pregnant women with limited income to receive health insurance coverage: Healthy Start, and Healthy Families. Healthy Start program is available to children with family incomes within 200% of federal poverty level; for Healthy Families program, household income can be up to 90% of federal poverty level.
- Source:** D. Cohen Ross & C. Marks, "Challenges of Providing Health Coverage for Children and Parents in a Recession," Kaiser Commission on Medicaid and the Uninsured (January 2009); updated by the Center for Children and Families

**AZ** **Arizona**

**Improving Medicaid Eligibility Determination for Youth in Juvenile Justice**

The Arizona Department of Health Services (ADHS) and juvenile justice have collaborated to improve Medicaid eligibility determination for youth in juvenile justice as a result of state legislation mandating that the juvenile justice system implement a system to track the number of youth who are Medicaid eligible. The juvenile justice system is looking at the Medicaid eligibility of every youth coming into detention or otherwise involved with the court, and probation workers have to check eligibility. This work is supported by both a telephone hook-up to the state Medicaid agency and a website. The legislature also allocated funds to the juvenile justice system for mental health services for non-Medicaid eligible youth, and juvenile justice has been able to spend more on non-Medicaid youth because of doing a better job identifying those who are eligible for Medicaid. In Maricopa County, the juvenile justice system has a goal of linking every Medicaid-eligible youth in need of mental health services to a Comprehensive Service Provider (CSP), which is the behavioral health system's core service provider. ADHS, Division of Behavioral Health Services (BHS), developed a technical assistance document focused on Medicaid eligibility for youth involved in juvenile justice, which is available on their website. (See: <http://www.azdhs.gov/bhs/guidance/cid.pdf>) Value Options co-located staff in juvenile detention to ensure that youth are enrolled with the Regional Behavioral Health Authority (RBHA) if eligible, are enrolled with a CSP, and to work with detention to offer a community placement to the courts. This is a strategy to prevent youngsters involved in juvenile justice from losing their Medicaid eligibility and to divert youth from deep-end services.

## **HI** Hawaii

### ***Maximizing Eligibility Levels for Medicaid and SCHIP***

In **Hawaii**, Medicaid eligibility level is 300% of the federal poverty level. SCHIP is a Medicaid expansion and covers additional children. Higher levels of eligibility are accomplished by allowing individuals to buy into the Medicaid program.

## **MI** Michigan

### ***Maximizing SCHIP Eligibility***

**Michigan's** SCHIP program is called MICHild and functions as a health insurance program for uninsured children of Michigan's working families. Many HMOs and other health plans provide MICHild services. The services covered under this program are almost identical to Medicaid and include mental health and substance abuse services. Not unlike many other states, Michigan receives a greater percentage of its funding for MICHild from the federal government than it does for Medicaid. MICHild covers children: 1) aged one or less living in a household with income of 185–200 percent of the federal poverty level and 2) aged 1–18 in a household with income of 150–200 percent of the federal poverty level.

## **VT** Vermont

### ***Maximizing Eligibility Levels for Medicaid and SCHIP***

Medicaid and SCHIP are highly integrated in Vermont. Medicaid covers uninsured children up to 223% of the federal poverty level, and underinsured children up to 300%. SCHIP covers uninsured children between 225% and 300% of the federal poverty level. The application is the same for both programs, and the benefit package and delivery systems also are the same. Vermont began providing health care coverage to children through age 20 under the Medicaid program in 1967. "Dr. Dynasaur" was created in 1989 as a state-funded program for pregnant women and children through age 6, who did not have health insurance and did not qualify for traditional Medicaid. In 1992, "Dr. Dynasaur" was integrated into Medicaid and expanded to children through up to age 18. It later incorporated the SCHIP program. All children (and pregnant women) are covered under the "Dr. Dynasaur" program, regardless of whether they are Medicaid or SCHIP enrolled. Vermont's Medicaid program now includes "Dr. Dynasaur," traditional Medicaid, the Vermont Health Access Plan (VHAP), VHAP Managed Care, Medicaid Managed Care, VHAP Pharmacy and VScript. Together with private insurance coverage, these programs provide almost universal health coverage for Vermont children.

**AK Bethel, Alaska**  
***Implementing Outreach to Maximize Enrollment***

Medicaid services for every American Indian and Alaska Native are reimbursed to the state with 100% federal match dollars if the services are provided through a Tribal provider. Additionally, services rendered to Medicaid-enrolled children by the Yukon Kuskokwim Health Corporation (YKHC) that are included in their children's agreement are reimbursed at full cost through an annual cost settlement process.

About 80-85% of youth are Medicaid eligible, but there are significant barriers to enrollment as documented in the December 2003 study *American Indian and Alaska Native Eligibility and Enrollment in Medicaid, SCHIP and Medicare* funded by the federal Centers for Medicare and Medicaid Services (CMS). The barriers include general distrust of government, the perception of federal responsibility for health care for the American Indian and Alaska Native population as an entitlement to care through the Indian Health Service, transportation, distance, lack of knowledge about the programs, language, literacy and other cultural barriers. For these reasons, YKHC implemented outreach efforts that specifically target enrollment in Medicaid. Children are eligible for Medicaid for 6-month periods at a time (except disabled children and newborns, who are eligible for one year), so an additional challenge for the Delta is the seasonal activities for subsistence during which families travel to remote camps and have no phone or mail services for months at a time, making it impossible to reach families for eligibility re-determination. Alaska's eligibility level for SCHIP is 185% of the 2004 Federal Poverty Level.

**CO Project BLOOM, Colorado**  
***Outreach, Training, Presumptive Eligibility, and Seamless Applications for Medicaid and SCHIP***

There has been considerable outreach in the state to maximize enrollment in SCHIP (Child Health Plan +). The application for Medicaid and SCHIP in the state is seamless; a family can apply for both with one streamlined application. With some funding support from a Robert Wood Johnson Foundation grant, a statewide project was initiated in 2002 (Colorado Covering Kids and Families [CKF]) to ensure that all children and families eligible for Medicaid and the Child Health Plan *Plus* (CHP+) are enrolled in these programs. The project is continuing with the support of local foundations. Through this initiative, people in the state have been trained to do outreach and enrollment, including schools, health departments, family resource centers, Headstart centers, and other community-based agencies.

In addition, "Presumptive Eligibility" for children under age 19 in CHP+ and Medicaid was implemented in January, 2008. Presumptive Eligibility allows a child to be presumed eligible for a limited period of time prior to their final eligibility determination by a county or Medical Assistance site. For the purposes of Presumptive Eligibility, income and citizenship and identity status are self-declared, although those elements must be documented with the submission of the Joint Application for Colorado Health Care. Presumptive Eligibility is determined by sites that have been certified by the Department of Health Care Policy and Financing. Legislation also was passed expanding the diagnoses covered by CHP.

## 2. Cover a Broad Array of Services and Supports Under Medicaid

All of the states represented in the sample cover a broad array of services and supports under their Medicaid programs. They include an extensive list of services in their state Medicaid plans in addition to traditional services, including services such as respite, family and peer support, supported employment, therapeutic foster care, one-to-one personal care, skills training, intensive in-home services, treatment planning, therapeutic camps, wraparound services, and many others. Alaska has developed a mechanism to cover traditional Native healing services under its state Medicaid program.

### **AZ** Arizona

#### ***Including a Broad Array of Services in the State Medicaid Plan***

In connection with the JK settlement agreement, Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) and the state Medicaid agency expanded covered services and revised licensure rules and rates. Prior to JK, the Medicaid benefit was fairly traditional, covering counseling, medication management, day treatment, partial hospitalization, inpatient, residential treatment and therapeutic group homes. With JK, the state deliberately pursued coverage for a very broad array of services and supports from wraparound to community-based to medical, either by adding new covered services or by changing definitions for already covered services. The following new services were added: sub-acute step down, respite, case management, peer and family support, supported employment, and therapeutic foster care. Also, a new provider type – community service agencies – was created to provide rehabilitation services so that these services would not have to be provided strictly by clinics or hospitals. The definition of day treatment was expanded to include a less intensive version, such as after school, which can be provided as a rehab service by behavioral health technicians and can be provided in schools. At the same time, a more intensive day program with a medical component was added for children who are medically fragile, and the state added a 1:1 personal care provider. The state removed limitations on place of service so that services can be provided in any location. The state also added general revenue funds to cover nontraditional services, such as traditional Native healing and acupuncture for substance abuse.

In addition to expanding the array of covered services, in an effort to change practice, the state also increased rates so that out-of-office rates are higher than office-based rates. Reportedly, the state Medicaid staff that worked with BHS had a good understanding of service delivery for children's behavioral health (many came from the service side), and both agencies worked cooperatively. Also, the two agencies did a lot of training on the new array of covered services.

Arizona's list of services covered under Medicaid includes:

- Behavioral counseling and therapy
- Assessment, evaluation and screening
- Skills training and development and psychosocial rehabilitation skills training
- Cognitive rehabilitation
- Behavioral health prevention/promotion education and medication training and support services
- Psychoeducational services and ongoing support to maintain employment
- Medication services
- Laboratory, radiology and medical imaging
- Medical management

- Case management
- Personal care services
- Home care training family (Family support)
- Self-help/peer services (Peer support)
- Therapeutic foster care
- Unskilled respite care
- Supported housing
- Sign language or oral interpretive services
- Non medically necessary services (flex fund services)
- Transportation
- Mobile crisis intervention
- Crisis stabilization
- Telephone crisis intervention
- Hospital
- Subacute facility
- Residential treatment center
- Behavioral health short-term residential, without room and board
- Behavioral health long term residential (non medical, non acute), without room and board
- Supervised behavioral health day treatment and day programs
- Therapeutic behavioral health services and day programs
- Community psychiatric supportive treatment and medical day programs
- Prevention services

For a complete description of AZ's covered services, see the state's Covered Behavioral Health Services Guide, available at: [http://www.azdhs.gov/bhs/bhs\\_gde.pdf](http://www.azdhs.gov/bhs/bhs_gde.pdf). Appendix B2 to the guide describes provider types and fee for service rate guidance, available at: [http://www.azdhs.gov/bhs/app\\_b2.pdf](http://www.azdhs.gov/bhs/app_b2.pdf).

## **CA** California

### ***Covering a Broad Array of Services in State Medicaid Plan***

Through EPSDT (and following the Emily Q. EPSDT lawsuit), children have access to a broad array of services, including: assessment, individual and group therapy, collateral contacts, medication management, crisis intervention, crisis stabilization, short-term crisis residential, day care intensive, day care rehabilitative, therapeutic behavioral services (one-to-one interventions, including at home, school, etc.), inpatient and outpatient services, and targeted case management. The more recent Katie A. EPSDT lawsuit is seeking coverage of therapeutic foster care and wraparound services. This is not currently covered, although the state tried to get a separate Medicaid billing code and bundled rate for wraparound, which was denied by federal CMS. Contra Costa County reported that it can bill aspects of wraparound as "plan development" through EPSDT. There are 6 wraparound elements that are covered in the current state Medi-Cal plan, including: engagement of child/family; crisis

assessment; team formation; plan development; crisis and safety planning ongoing; and transition. Certain elements of therapeutic foster care, including any EPSDT services, can be billed, such as individual therapy. EPSDT spending has grown 133% since the 1995 Emily Q. lawsuit.

Counties get charged half of 10% of the growth of county EPSDT spending beyond their baseline; the state covers the remaining growth in spending. Contra Costa County indicated that state funds make up about 48% of the Medi-Cal match, and county funds comprise about 5%. (There reportedly has been some discussion of increasing the EPSDT county share to 35% of growth in an effort to discourage expansion, as well as discussion of capping utilization, but advocates would consider these steps as running counter to the lawsuits.) Contra Costa indicated that, since the lawsuits, their system has become more dependent on Medi-Cal. Of the \$35m. spent on children's mental health services in the county, \$25 million is Medi-Cal. The increase in use of Medi-Cal has led to a decrease in county funding, which previously constituted 16% of funding and is now 8% (a reduction of \$12 million).

## HI Hawaii

### ***Including a Broad Array of Services in the State Medicaid Plan***

The state Medicaid plan covers a broad array of mental health services and supports. Modification of the state Medicaid plan to add the broad array of services provided through the Child and Adolescent Mental Health Division (CAMHD) system (the Medicaid carve-out) was accomplished by developing a strong relationship with the leadership of the Medicaid agency through frequent face-to-face meetings. CAMHD's efforts have included: identifying services to be added to the Medicaid plan; proposing definitions, rates, and credentialing status; and identifying fiscal incentives for the state (such as how much is currently being spent using state resources and any savings that can be realized). Under the category of Community Mental Health Rehabilitative Services, a range of services is covered to promote the "maximum reduction and/or restoration of a recipient to his/her best possible functional level relevant to their diagnosis of mental illness and/or abuse of drugs/alcohol." Covered services include the following:

- ***Crisis management*** — telephone hotline, face to face, and mobile crisis assessment and intervention in a variety of community settings
- ***Crisis residential services*** — short-term interventions to address a crisis and avert or delay the need for acute psychiatric inpatient services or similar levels of care
- ***Biopsychosocial rehabilitative programs*** — therapeutic day rehabilitative social skill building service
- ***Intensive family intervention*** — time-limited interventions to stabilize the child and family and promote reunification or prevent the utilization of out-of-home therapeutic resources; includes Multisystemic Therapy (MST) and intensive in-home services
- ***Therapeutic living supports*** — therapeutic services (not room and board) in group homes
- ***Therapeutic foster care supports*** — therapeutic services (not room and board) in therapeutic foster home settings

- **Intensive outpatient hospital services** — to provide stabilization of psychiatric impairments and enable individuals to reside in the community or return to the community from a more restrictive setting (partial hospitalization)
- **Assertive community treatment** — intensive community rehabilitation service including a range of therapeutic and supportive interventions

At the time of the site visit, a number of additional services were being added to the state Medicaid plan for fiscal year 2007, with draft definitions developed. These had not as yet been approved, but include:

- **Peer supports** — services provided by peer counselors to youth, young adults, and their families to promote socialization, recovery, self-advocacy, development of natural supports, and maintenance of community living skills
- **Parent (skills) training** — teaching evidence-based behavior management interventions to parents or caregivers in order to develop effective parenting skills to promote more competencies in the parent/caregiver's ability to manage the child's behavior
- **Intensive outpatient substance abuse independent living** — a package of services designed to assist youth and young adults with co-occurring mental health and substance abuse issues to enable them to remain in their home environments while receiving treatment
- **Community hospital crisis stabilization** — short-term crisis intervention to youth or young adults experiencing mental health crises as a closely supervised, structured alternative to or diversion from acute psychiatric hospitalization
- **Multisystemic Therapy (MST)** — an intensive, family and community-based model of treatment for youth and their families who are at risk of out-of-home placement, based on evidence-based interventions that target specific behaviors with individualized behavioral interventions (currently covered under intensive family interventions)
- **Multidimensional Treatment Foster Care** (elements currently could be funded under therapeutic foster care supports)
- **Functional Family Therapy** — an evidence-based family treatment system provided in a home or clinic setting with the goal of engaging all family members and targeting and changing specific risk behaviors
- **Community Based Clinical Detox** — a short-term, 24 hour clinically managed detoxification service delivered with medical and nursing support in a secure residential facility

Consideration is being given to transferring responsibility for acute psychiatric hospitalization and assessment and outpatient services from the Quest Health Plans to the CAMHD system. Effective 2/07, CAMHD will be responsible for all services to include acute and outpatient services for youth enrolled in the CAMHD carve-out.

**MI Michigan*****Covering a Broad Array of Services***

Through Michigan's use of the 1915(b) waiver and 1915(c) Habilitation Supports Waivers (HSW), community-based mental health, substance abuse and developmental disability specialty services and supports are covered by Medicaid when the services are provided by an approved Prepaid Inpatient Health Plan (PIHP). The state has permission from the federal Centers for Medicare and Medicaid Services (CMS) to use the 1915 (b) (3) waiver under this Specialty Services and Supports Program which allows the state, in addition to its Medicaid plan services, to use Medicaid funds for additional services. The services may be a mix of state plan, HSW, and additional (b)(3) services, depending on the services that best meet the need of the person receiving the services and what will help that person to reach his/her goals.

The 1915(c) home and community-based services waiver for children with serious emotional disturbance (SED) provides Medicaid coverage to children who would otherwise require hospitalization or institutionalization and who would not be eligible for Medicaid while residing with their birth or adoptive families. The waiver also provides federal match funds that support collaboration in service delivery and provides services that enhance or that are in addition to what is covered by the state Medicaid plan. Services covered by the waiver include wraparound services, therapeutic foster care, therapeutic overnight camp, respite, natural supports, in-kind services provided by community agencies, Medicaid billable fee-for-service activities covered under the state's Medicaid Plan, community living supports, family training/supports and transitional services. Children are eligible for this plan if they meet the medical criteria or if they meet the CMHC's contract criteria and are at risk for placement in a more restrictive setting, particularly the state psychiatric hospital. In order to draw down federal dollars for the home and community-based waiver, the counties have to come up with match. The local match is then contributed to the Child Care Fund (CCF), which is then contributed to the Department of Community Health (DCH) to be used as part of the state share for the SED waiver. The state uses the CCF as a flexible blended fund that can be matched to federal, state and donated funds to support community programs and to meet the needs of the local communities to better serve children and youth with dependency or delinquency court orders. The 1915 c SED waiver is limited to certain counties and has a limited number of slots. Waiver services are provided by Community Mental Health Services Programs (CMHSP) that are enrolled as providers under this waiver. The Department of Community Health (DCH) reimburses for these services through a fee-for-service (FFS) system.

**Covered Services**

Services covered under Medicaid (and their definitions according to the State's Medicaid manual) include:

- **Psychiatric Evaluation** — This is a comprehensive evaluation, performed face-to-face by a psychiatrist, who investigates a beneficiary's clinical status, including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination.
- **Psychological Testing** — Standardized psychological tests and measures rendered by full, limited-licensed, or temporary-limited-licensed psychologists.

- **Behavioral Management Review** — A behavior management or treatment plan, where needed, is developed through the person-centered planning process that involves the child and family. The person-centered planning process determines whether a comprehensive assessment should be done in order to rule out any physical or environmental cause for the behavior.
- **Child Therapy** — Treatment activity designed to prevent deterioration, reduce maladaptive behaviors, maximize skills in behavioral self-control, or restore or maintain normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships. A child mental health professional may provide child therapy on an individual or group basis.
- **Crisis Interventions** — Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy.
- **Crisis Residential Services** — Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert a psychiatric admission, or to shorten the length of an inpatient stay.
- **Family Therapy** — Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a mental health professional.
- **Home-Based Services** — Mental health home-based service programs are designed to provide intensive services to children (birth through age 17) and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to promote normal development, promote healthy family functioning, support and preserve families, reunite families who have been separated, and reduce the usage of, or shorten the length of stay in, psychiatric hospitals and other substitute care settings. Treatment is based on the child's need with the focus on the family unit. The service style must support a strength-based approach, emphasizing assertive intervention, parent and professional teamwork, and community involvement with other service providers.
- **Individual/Group Therapy** — Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by mental health professionals within their scope of practice.
- **Intensive Crisis Stabilization Services** — Intensive/crisis stabilization services are structured treatment and support activities provided by a mental health crisis team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated.
- **Medication Administration** — Medication Administration is the process of giving a physician-prescribed oral medication, injection, intravenous (IV) or topical medication treatment to a beneficiary.

- **Medication Review** — Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, physician assistant, nurse practitioner, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews.
- **Physical Therapy**
- **Speech, Hearing, and Language** — Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO).
- **Substance Abuse** — These services are for individuals who reside in the specified region and request services. Outpatient treatment is a non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug treatment.
- **Targeted Case Management** — Targeted case management is a covered service that assists the child and family to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.
- **Telemedicine** — Telemedicine (also known as telehealth) is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real time interactive audio and video telecommunications system.
- **Treatment Planning** — This includes activities associated with the development and periodic review of the plan of service, including all aspects of the person-centered planning process, such as pre-meeting activities, and external facilitation of person-centered planning. This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending person-centered planning meetings per invitation; and documentation.
- **Psychiatric Inpatient Hospitalizations** — The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services.

Additional services covered by Michigan's 1915(c) home and community based waiver for children with serious emotional disturbance include wraparound services, therapeutic foster care, therapeutic overnight camp, respite, natural supports, in-kind services provided by community agencies, community living supports, family training/supports and transitional services. The definitions for some of these additional covered services are as follows:

## Wraparound Services for Children and Adolescents

Wraparound services for children and adolescents involve an individualized planning process performed by supports coordinators who coordinate the planning and delivery of these services. Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies, and informal supports. The Team also helps to create an individualized plan of service for the child that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, or waiver services. A child qualifies for wraparound if they meet two or more of the following:

### Involved in multiple systems

- At risk of out-of-home placements or are currently in out-of-home placement
- Been served through other mental health services with little improvement
- Have risk factors that exceed capacity for traditional community-based options
- A family that has many providers serving multiple children and outcomes are not being met.

### Respite Care Services

These are services provided to assist in maintaining a goal of living in a natural community home by temporarily relieving the unpaid primary care giver and are provided during those portions of the day when the caregivers are not being paid to provide care. Decisions about the methods and amounts of respite should be decided during person-centered planning. PIHPs may not require active clinical treatment as a prerequisite for receiving respite care. Respite care may be provided in the following settings:

- Beneficiary's home or place of residence or home of a friend or relative chosen by the beneficiary and members of the planning team
- Licensed family foster care home or licensed respite care facility
- Facility approved by the state that is not a private residence, such as group home or licensed camp
- In community settings with a respite worker trained, if needed, by the family
- **Family Support and Training** — These are family-focused services provided to families of persons with serious mental illness, serious emotional disturbance or developmental disability to assist the family in relating to and caring for a relative. The services target the family members who are caring for and/or living with an individual receiving mental health services. Coverage includes these models:
  - Education and training.
  - Counseling and peer support provided by trained peers.
  - Family Psycho-Education (SAMHSA model) for individuals with serious mental illness and their families.
  - Parent-to-parent Support which is designed to support parent/families to be empowered, confident and have the skills to enable them to assist their children to improve in functioning.

- **Prevention-Direct Service Models** — These programs use individual, family and group interventions which are designed to reduce the incidence of behavioral, emotional or cognitive dysfunction, thus reducing the need for individuals to seek treatment through the public mental health system. One or more of the following direct prevention models must be made available by the PIHPs or their provider network: Children of Adults with Mental Illness/Integrated Services, Infant Mental Health when not enrolled as a Home-Based program, Parent Education, Child Care Expulsion Prevention, and School Success.

### **NJ** New Jersey

#### ***Including a Broad Array of Services in the State Medicaid Plan***

In order to achieve a more expansive benefit design, the state expanded services covered under Medicaid through the Rehabilitation Services Option. The services now covered under Medicaid include nontraditional and traditional services. These services include: assessment, mobile crisis/emergency services, group home care, treatment homes/therapeutic foster care, intensive face-to-face care management, wraparound, out-of-home crisis stabilization, intensive in-home services, behavioral assistance, wraparound services, and family-to-family support.

### **VT** Vermont

#### ***Including a Broad Array of Services in the State Medicaid Plan***

Medicaid is the principal payer for behavioral health and system of care services. The state has sought through its Medicaid plan, EPSDT, SCHIP/"Dr. Dynasaur" and waivers to fund an array of prevention, treatment and support services that are provided to children in a variety of settings. Medicaid covers the following categories and services:

- Inpatient hospital services prescribed by a physician, including diagnostic interviews with immediate family members and psychotherapy if a component of the treatment plan; most children are screened by community mental health centers prior to emergency hospitalization
- Outpatient hospital clinic (including rural health center and Federally Qualified Health Center) services – mental health services, directed by a physician or psychologist that would be covered if provided in another setting
- Evaluation, diagnosis and treatment services from licensed independently practicing psychologist
- Inpatient psychiatric facility services, crisis diversion beds, inpatient hospitalization, residential treatment, therapeutic foster care – must be physician prescribed, have interagency team certification that beneficiary cannot be treated effectively in the community, and prior authorization by external review
- Mental health clinic evaluation, diagnostic and treatment services — psychotherapy, group therapy, day treatment, prescribed drugs for treatment and prevention, emergency care services — that are specified in a treatment plan directed by or formulated with physician input
- Rehabilitation services provided by qualified professional staff in designated community mental health centers that cover services listed in the preceding plus specialized rehab services including

basic living skills, social skills, and counseling, as specified in the treatment plan

- School health services — mental health assessment and evaluation, medical consultation, mental health counseling, development and assistive therapy, case management — ordered by an individual education plan (IEP) or individualized family service plan for special education students
- Child sexual abuse and juvenile sex offender treatment services — individual group and client-centered family counseling; care coordination, clinical review and consultation
- Intensive family-based services — family-focused, in-home treatment services that include crisis intervention, individual and family counseling, basic living skills and care coordination
- Targeted case management services — assessment, case plan development, monitoring and follow-up services, and discharge planning
- Home and community-based waiver services — case management, respite care, residential and day services
- Transportation

### **AK** Bethel, Alaska

#### ***Including a Broad Array of Services in the State Medicaid Plan***

Alaska's state Medicaid plan covers a broad array of mental health services. The Yukon Kuskokwim Health Corporation (YKHC) provides these services and then bills Medicaid for reimbursement. The Medicaid reimbursable services include: assessment and evaluation; individual, group, and family therapy; home-based services; day treatment; crisis services; psychiatric inpatient care; group homes; residential treatment; case management; school-based services; respite; and behavior management skills development. For Alaskan Native populations, specialized traditional Native healing services are reimbursed by Medicaid. YKHC has developed a crosswalk that places traditional Native healing services into the appropriate "western" slot. YKHC bills for the Medicaid service, and Medicaid pays for the "western" service.

### **CO** Project BLOOM, Colorado

#### ***Expanding State Medicaid Plan Requirements for BHOs, Cross-Walk of Early Childhood Diagnoses, and Sub-Capitation***

The state Medicaid plan requires the managed behavioral health organizations (BHOs) to cover certain specific services, and each BHO may also cover a range of optional services. Medicaid requires its contractors to demonstrate a commitment to the "recovery model," as expressed in the Surgeon General's Report on Mental Health, and requires the provision of all medically and/or clinically necessary mental health services to be provided in the most appropriate and least restrictive setting.

The Project BLOOM sites at first thought that they could not finance most of the early childhood mental health services with Medicaid. However, with research, they learned that many services could be reimbursed by Medicaid. For example, the wraparound process can be covered as targeted case

management, and consultation to multiple children can be covered as group therapy and education. The Family of One provision allows Medicaid to pay for residential care so that the family does not have to relinquish custody to the child welfare system in order to finance residential treatment. Medicaid covers the following services.

- **Required Services:**

- Individual therapy
- Family therapy
- Group therapy
- Case management
- Medication management
- Psychiatric services
- Inpatient services
- Day Treatment
- Psychosocial Rehabilitation
- Emergency Services
- Residential Services
- School-Based Services

- **Optional Services:**

- Behavioral aides
- Respite services (based on mental health needs)

Wraparound is an example of an optional service that some BHOs cover, as defined by the BHO. Early childhood mental health consultation can be covered under optional services, under rehabilitation, or as an approach to individual, family, or group therapy. The evidence-based practices offered for early childhood mental health services are covered under optional services or as an approach to individual, family, or group therapy.

Project BLOOM did an analysis of services covered by the BHOs to help the local communities determine how Medicaid could be used to fund early childhood mental health services. It was found that under current Medicaid contracts, everything could be covered with the exception of services for children without a diagnosis and the program part of mental health consultation.

In order to facilitate the use of Medicaid (and other payers) for early childhood services, a “Crosswalk of DC: 0–3R to ICD–9–CM” was completed to clarify how diagnoses for early childhood mental health problems could be used. DC: 0–3R was first published in 1994 to address the need for a systematic, developmentally based approach to the classification of mental health and developmental difficulties in the first four years of life. Because DC: 0–3R codes are not billable, they must be cross-walked to ICD-9-CM for billing purposes. Other states (including Florida, California, Maine, Minnesota, Nevada, Washington, and Arizona) are using similar crosswalks; many have gotten Medicaid approval to use the crosswalk, and other states have crosswalks under development. For example, Axis I 150 diagnosis of deprivation/maltreatment disorder under DC: 0–3R can be coded as 313.89 under ICD–9–CM, Other or mixed emotional disturbances of childhood or adolescence, Other (reactive attachment disorder of infancy or early childhood). This crosswalk will ultimately be on the Project BLOOM website.

The BHOs that manage the behavioral health benefit under Medicaid subcapitate the community mental health centers (CMHCs), which are the primary providers of services. The use of sub-capitation was expected to result in increased flexibility in service delivery. However, the Department of Health Care Policy and Financing’s requirement for “shadow billing” of the units of services provided reportedly curtails flexibility and the ability to implement the wraparound approach.

The Medical Home Advisory Board has a task force that is examining Medicaid reimbursement for early childhood mental health services. An issue paper is under development addressing: the need for a diagnosis (it was determined that a “deferred diagnosis” is possible), whether a family can receive services without the identified child being present, and the extent to which clinical services can be provided in home and community-based settings.

Schools can also obtain Medicaid reimbursement for services that had been paid for with school funds, such as targeted case management, that are provided in accordance with an Individualized Education Plan (IEP), Individualized Family Services Plan (IFSP), 504 plan, or an individualized health care plan.

### 3. Use Multiple Medicaid Options and Strategies

The sites studied have maximized Medicaid financing of behavioral health services for children by taking advantage of the multiple options available to states under the Medicaid program, including the clinic and rehabilitation options, targeted case management and several different types of waivers. For example, Michigan has four different types of waivers to maximize the ability to use Medicaid to finance children’s behavioral health services and supports. Some states also have expanded use of the Early and Periodic Screening, Diagnosis and Treatment Program (EPSDT) in Medicaid to expand access to behavioral health services. **Table 5.5** demonstrates the extensive use of multiple options.

<b>Option</b>	<b>AZ</b>	<b>CA</b>	<b>CO</b>	<b>HI</b>	<b>MI</b>	<b>VT</b>	<b>NE</b>	<b>NJ</b>	<b>NY</b>	<b>OH</b>	<b>WI</b>
Clinic Option	X	X	X	X	X	X	X	X	X	X	X
Rehab Option	X	X	X	X	X	X	X	X	X	X	X
Targeted Case Management		X	X	X	X	X	X	X	X		X
Psych Under 21	X		X	X	X	X	X	X	X		X
EPSDT	X	X	X	X	X	X	X	X	X	X	X
Katie Becket (TEFRA)			X		X	X	X				X
1915c Waiver - Home and Community Based	DD*		DD	DD*	X	X**	DD*	DD*	X	DD*	X
1915b Waiver -Managed Care/ Freedom of Choice		X	X		X	X	X		X		
1115 Waiver – Research and Demonstration	X		X	X		X***					X
Family of One	X	X	X		X						X
1915 (a)										X	X
*DD = Developmental Disabilities      **DD and SED waivers      ***1115 (a) Global Commitment Waiver											

## **AZ** *Arizona* *Using Tribal Behavioral Health Authorities*

Two of Arizona's 21 tribes opted to provide their own behavioral health services as Tribal Regional Behavioral Health Authorities (TRBHAs) through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) managed care system. They saw the TRBHA as a means to maximize their ability to use Medicaid and integrate Tribal-run and county-based services under the TRBHA network. Health and behavioral health services provided by Indian-run facilities are eligible for 100% federal Medicaid contribution, known as the federal pass-through program. In effect, Arizona tribes deal with a bifurcated Medicaid system – the 1115 waiver in the state and the federal pass-through for tribes. The federal pass-through benefit is more traditional than the array of services covered under the 1115 waiver, but the federal rate for services is higher than state rates, and there is 100% federal funding. For example, case management is not a covered service by the pass-through, but it can be paid for through the 1115 waiver. The TRBHA can “pick and choose” whether to bill the federal pass-through or the 1115 waiver. The federal pass-through can only be used for services directly provided by the tribe.

## **MI** *Michigan* *Using Multiple Medicaid Waivers*

If adults or children present with serious mental health problems, they are enrolled in the state's Comprehensive Healthcare Program (CHP), which is a combination 1915(b) and (c) waivers that provides Medicaid pre-paid specialty mental health and substance abuse services and support for persons with Developmental Disabilities. This program is administered through Department of Community Health (DCH). The waivers operate concurrently to manage and provide specialty mental health, substance abuse, and developmental disabilities supports and services under a capitation payment. The capitated payment is calculated based on the historical costs for these specialty services. Michigan has four waivers that affect children with mental health problems:

- A. The Habilitation Supports Waiver 1915(c) (HSW)** can serve 7902 children. These children must present with a developmental disability as defined in the Mental Health Code; be Medicaid eligible; reside in the community (not a hospital, nursing home, jail, or institution) and be at risk for Intermediate Care Facility for the Mentally Retarded (ICF/MR) services without the waiver services. There is no age requirement for this waiver. The services covered are community supports; chore services; enhanced pharmacy; enhanced medical equipment and supplies; environmental modifications; family training; non-vocational habilitation; personal emergency response system; and prevocational services. The Habilitation Supports Waiver also provides private duty nursing; respite care; supports coordination and supported employment services. Children can access the HSW through an evaluation for eligibility by the Prepaid Inpatient Health Plan (PIHP) (or its affiliate CMHC). Evaluation is done through the person-centered planning process. Participants must receive at least one waiver service per month to continue to be eligible. This waiver funding is included in the capitation payment to the PIHPs in the combo 1915 b/c waiver.

- B. The Managed Specialty Supports & Services Waiver 1915(b)** has no age requirement and covers persons that have a serious and persistent mental illness or developmental disability and who are Medicaid eligible and living in the community. This waiver is also a prepaid shared risk arrangement funded through the capitation payment to the PIHPs in the combo 1915 b/c waiver and is accessed through the PIHP or an affiliated CHMC. The persons enrolled in this waiver must meet the medical necessity criteria or the developmental disability Service Selection Guideline outlined in the PIHP contract. Covered services include Assertive Community Treatment, Assessments, Behavioral Management Review, Child Therapy, Clubhouse Psychosocial Rehabilitation, Crisis Intervention and Residential, Family Therapy, Health Services, Home-Based Services, Individual & Group Therapy, Intensive Crisis Stabilization, ICF/MR, Medication Administration/Review, Nursing Facility MH Monitoring, OT, PT, Speech, Personal Care in Specialized Homes, Substance Abuse, Targeted Case Management, Telemedicine, Transportation, and Treatment Planning. Additional services include Assistive Technology, Community Living Supports, Enhanced Pharmacy, Environmental Modifications, Crisis Care, Family Support and Training, Housing Assistance, Peer Delivered and Operated Supports/Peer Specialists, Drop-In Centers, Prevention Direct Service Models, Respite, Skill-Building, Support Coordination, Supported Employment, and Wraparound services.
- C. The Children's Waiver 1915(c) can serve 415** children and also has an ongoing waiting list. Children under 18 are eligible for this program if they have a developmental disability as defined in the Mental Health Code; are Medicaid eligible when viewed as a family of one (parental income is waived); are living in the community and not in a hospital, or institution; and would require active treatment similar to services provided in an ICF/MR. Children enter into this waiver through the Community Mental Health Services Program (CMHSP). The family has to request a Prescreen Evaluation that would be completed by the CMHSP and submitted to Children's Waiver Program (CWP) for scoring. Slots are issued on a priority basis to the beneficiary with the greatest need/highest score when there is an opening. The waiver's covered services include Community Living Supports; Enhanced Transportation; Family training; Non-family Training; Respite; Specialized Medical Equipment & Supplies; Environmental Accessibility Adaptations (EAA) and Specialty Services. Children with developmental disabilities can stay on this waiver indefinitely. The waiver is funded as a fee for service program through Medicaid.
- D. The SED Waiver (Children with Serious Emotional Disturbance — SED) 1915(c)** is the newest waiver and currently can serve 43 children. The program is available in 5 CHMCs. The projection is to serve 78 children in 8 CMHCs through the waiver next year. To be eligible for this waiver, children must: demonstrate serious functional limitations based on a Child and Adolescent Functional Assessment Scale (CAFAS) score of 90 or greater (if under age 13) or 120 or greater (if age 13 or older), as determined by the local CMHSP; meet financial criteria outlined in the Provider Manual; meet current criteria for state psychiatric hospitalization; be connected to multiple systems (i.e., courts, DHS, etc.); and be a child under 18 years of age. A family living in one of the five covered counties would request services through the CHMC and have to be enrolled in at least one waiver service per month to continue eligibility. The services covered under this waiver include: community living supports; family training/support; respite care; child therapeutic foster care; therapeutic overnight camp; transitional services; and wraparound services. The SED waiver is also funded as a fee for service program through Medicaid. Family income limits

and the requirement for SSI eligibility are both waived as the child is considered a fiscal and asset group of one. Local dollars are the match for this waiver, and match depends on the estimated total SED waiver budget for that locality. The local match then has to be contributed to the state Child Care Fund (CCF). The CCF is a general fund of Michigan's Department of Human Services which was established for the purpose of the state and counties sharing the cost of court-ordered services for children who are court wards. The State reimburses 50% of eligible county funds spent for services when the county bills the state under the CCF. The CCF serves as a cost sharing mechanism between the state and the counties and is then contributed to Community Mental Health (CMH) to be used as part of the state share to pull down federal dollars for the SED waiver. Match sources are general revenue funds, Child Care Fund, CMHC and other local funds (such as the United Way).

**In Ingham County**, the county's financing plan for the system of care aims to maximize federal, state, and local funding by:

- Incorporating integral activities, such as youth involvement, family support and advocacy in the SED Children's Waiver rates as a part of Medicaid administration
- Exploring the Medicaid Federally Qualified Health Center (FQHC) billing and cost-based reimbursement system and the Medicaid administration and outreach benefit to see how they can be used to finance behavioral health services and supports for children and families.
- Developing possible ways to maximize Medicaid coverage for system of care activities and linkages with local partners to extend access to an organized system of health care.
- Approaching private employers to purchase home and community-based services for children
- Enrolling eligible children into the SED children's waiver.

## **VT** Vermont

### ***Implementing a Home and Community-Based Services Waiver***

One of the early steps taken by Vermont to cover children with serious emotional disturbances, including those not eligible for Medicaid, was to secure a home and community-based services (HCBS) waiver. In the early 1980s, Vermont sought the waiver to provide home and community alternatives for children in residential programs whose number had been growing substantially, in part due to the closing of the state psychiatric hospital. The waiver program, implemented in 1982, was the first HCBS waiver in the country and allowed the state to: 1) cover additional children, some of whom were otherwise ineligible for Medicaid and 2) offer additional home and community services (e.g., respite care, crisis intervention, therapeutic foster-care, family supports, community/social supports, and environmental modifications) than the state could support prior to the waiver. In 1988, Vermont Act 264 was passed, giving the state a codified structure to expand and coordinate services with increased state funding that could be used to fund services directly and to provide Medicaid match. Further expansion and investment to support home and community-based services occurred in 1991 when the state began covering children with serious emotional disturbance and other disabilities under the Katie Beckett option, and later under an expanded rehabilitation option that includes targeted case management. These strategies form the foundation of financing home and community services in Vermont's system of care.

**Choices** Choices***Employing Care Coordinators in Medicaid Provider Agencies***

Choices uses several strategies to maximize the use of Medicaid to finance service delivery. In both Indiana and Ohio, the case rates do not necessarily finance all of the services included in the service coordination plan, and other funding sources are also employed to cover the full costs of services and supports. For example, for children who are Medicaid eligible (about 90% qualify for Medicaid), Medicaid is billed for allowable behavioral health services, such as individual and group therapy, day treatment, and inpatient hospitalization, as well as for case management and other services through the rehabilitation option, leaving the case rate funds to finance many of the supportive services that might not be covered by Medicaid.

In Indiana, care coordinators are hired by the mental health centers and are employees of those centers although they work with Dawn. In this way, Medicaid can be billed for care coordination services under the Rehabilitation Option, bringing \$1.7 million of Medicaid resources into the mix of resources supporting service delivery. Also in Indiana, Medicaid can be billed for individual, family, and group therapy; day treatment; and acute hospitalization for eligible youngsters, bringing in financing to support services above and beyond the case rate provided by the referring agencies.

In Ohio, Choices became a Medicaid provider, thereby allowing care coordination staff employed by Choices to receive Medicaid reimbursement under Ohio's Medicaid regulations. This brings approximately \$800-900,000 in resources into the system. Choices bills Medicaid for services delivered that are covered under Medicaid. If Medicaid denies payment, or if services are not covered, Choices finances these services and supports from the case rate funds.

**OH** Cuyahoga County, Ohio  
***Using 1915 (a)***

The county uses 1915 (a) of the Social Security Act (Medicaid statute) to operate what is, in effect, a specialty intensive case management program, called the PEP Connections program. The program is operated by a non profit agency, Positive Education Program (PEP), which uses a unique mix of traditional mental health services covered by the State Medicaid plan and high-fidelity wrap-around in providing intensive care management for 300 children, youth, and their families. The PEP Connections program was established in Cleveland in the late 1980s as an intensive care management service resource for youth at risk of placement. A case rate of \$1,602/child/month provides the flexibility needed to provide a wraparound approach and intensive care coordination for youth who are at risk of out-of-home placement. A strategy under discussion for accessing additional Medicaid funds for the system of care is to expand use of 1915 (a) county wide so that more children served by the Care Coordination Partnerships operating at neighborhood levels can be linked to intensive care management services.

**NY** Erie County, New York

***Using Multiple Medicaid Options and Child and Family Clinic PLUS***

New York State uses a number of Medicaid options, including the clinic option, rehab option, targeted case management, and a Home and Community-Based Waiver (HCBS) for children with serious emotional disturbances. Erie County has 68 HCBS waiver slots, and these slots are blended with the other wraparound slots in the system of care. Children’s Targeted Case Managers are also blended with the wraparound slots.

One recent reform in New York State has been the Child and Family Clinic PLUS initiative which offers fiscal incentives to community mental health clinics to provide in home clinic visits and school-based services including screening and assessment. At the time of the site visit, only the state share of Medicaid was available to fund these services. New York State was required to submit a Medicaid plan amendment in order to use federal Medicaid funds for this initiative. Erie County has 5 providers with approved plans that were to start offering services in the last quarter of 2007.

**AZ** Arizona and **WI** Wraparound Milwaukee

***Using “Family of One”***

“Family of One” allows states to waive parental income limits for a child who is expected to utilize an institutional level of care for 30 days or more.

- Arizona uses the “Family of One” strategy for inpatient and residential treatment services, in addition to other Medicaid options.
- Wisconsin uses this strategy for inpatient services only.

**Using 1915 (a)**

The State Medicaid agency uses 1915 (a) of the Medicaid statute to establish Wraparound Milwaukee as, in effect, a specialty intensive case management program for children who would otherwise be in institutional out of home care. The Medicaid capitation rate paid to Wraparound Milwaukee, along with its other blended funds from other systems, enables Wraparound Milwaukee to provide a highly flexible home and community based wraparound approach.

## 4. Use Medicaid in Lieu of Other State Funds

Some sites have implemented specific strategies for using Medicaid to finance services and support instead of state-only funds. For example, **New Jersey** added services to its state Medicaid Plan that had previously been paid for with child welfare revenue, and **Central Nebraska** redefined therapeutic group homes more accurately in order for them to be eligible for reimbursement rather than using all general revenue funds.

### **AZ** Arizona

#### ***Identifying Medicaid-Reimbursable Services and Expanding Authorization Criteria***

State Medicaid officials indicated that in planning for implementation of the JK settlement agreement, they went through a process of matching services provided by the juvenile justice system to Medicaid-codeable services. Also, the mental health and child welfare systems worked to identify utilization and costs associated with behavioral health services financed by the child welfare system that were being provided to Medicaid-eligible children and which could be covered by Medicaid instead of using all state general revenue dollars. Specifically, the two systems, working with Medicaid actuaries, determined what was being spent by child welfare on services to Medicaid-eligible children in licensed secure and non-secure residential treatment centers and acute inpatient hospital care. The analysis also showed that most of these children were in Maricopa County. Specific dollars were re-allocated to the contracted Medicaid behavioral health managed care organization in Maricopa County to begin funding these services through the behavioral health managed care system. Through their analysis of service utilization, the agencies also identified a number of child welfare-involved children whom they felt should be in Medicaid-financed therapeutic foster care or in Medicaid-financed counseling services. Additional funds were earmarked for the behavioral health managed care system for child welfare-involved children to support their involvement in these less restrictive services, including therapeutic foster care and outpatient programs.

### **NJ** New Jersey

#### ***Adding Services to State Medicaid Plan***

New Jersey identified services previously supported solely with state dollars that could be considered part of the state Medicaid plan. The state then covered these services under Medicaid through the Rehabilitation Services Option. This allowed the state to secure federal funding for services that it had provided to children before 2001 for which it had not claimed federal match. New Jersey used these “freed” state dollars as seed money to build the infrastructure for new community services across the state. In the first year of its system of care reform, New Jersey financed its share of Medicaid costs by combining \$167 million in existing state dollars for children with serious emotional disorders from the child welfare and mental health divisions (including \$117 million which was previously expended by the Department of Youth and Family Services—DYFS on residential care) with \$39 million in new funds authorized for children with serious emotional disorders in the Governor’s 2001 budget.

### **NE** Central Nebraska ***Redefining Services to be Medicaid Reimbursable***

The state child welfare system had paid the cost of care for youth placed in a “Group Home 2.” These homes actually were serving youth with significant treatment needs and offered 24-hour awake supervision, maintained a high staff-to-child ratio, and offered specific treatment techniques. The state believed that this was a mental health service rather than a placement service, renamed it as “enhanced group home” care, built it as a medical model, and began using Medicaid, rather than child welfare, funds to reimburse for the treatment services.

### **OH** Cuyahoga County, OH ***Maximizing Medicaid in Lieu of Other Financing Streams***

The county has maximized the use of Medicaid in its contracts with the Care Coordination Partnerships (CCPs) and through its Memoranda of Understanding (MOUs) with providers in the Provider Services Network:

- The county has devoted considerable energy in attempting to capture Ohio’s Medicaid dollars for wraparound services. For example, the county undertook a Medicaid/Wraparound crosswalk matching the 93 wraparound skill sets to Medicaid billing categories.
- To maximize Medicaid funding, the CCP contract requires the lead agencies to ensure that all care coordination activities that are eligible for Community Psychiatric Supportive Treatment (CPST) billing are performed in accordance with the Ohio Department of Mental Health standards governing CPST.
- The MOUs between the Cuyahoga Tapestry Systems of Care (CTSOC) and providers indicates that the CTSOC funds will be the “payor of last resort” after all other public and private funds restricted to the services being purchased, including medical insurance and restricted contributions, have been exhausted. They also note that the provider may not supplant Medicaid, HMO or PPO funded services with funding under the MOU.

At the time of the site visit, the county was considering applying for an expansion of its use of 1915 (a) of the Medicaid statute (i.e., designated intensive care management) beyond its current geographic and diagnostic (SED) limits in order to link more children served through the Care Coordination Partnerships to intensive care management paid for by Medicaid.

## 5. Generate Medicaid Match

Some of the sites reported that they have been successful in generating Medicaid match, typically using not only mental health dollars but funds from other child-serving systems programs and systems as well. For example, in **Vermont** the ability to secure Medicaid match from other systems has been a significant factor in the ability to maintain and expand services.

### **CA** California

#### ***Providing Training on Maximizing Medicaid Billing***

The state primarily has utilized training about EPSDT and availability of Therapeutic Behavioral Services, as well as training provided by the California Institute for Mental Health on how to bill and document for Medi-Cal mental health services, to maximize use of Medi-Cal. Some county mental health plans increased the number of their EPSDT providers and are drawing down significant EPSDT revenue. However, other counties are reluctant to do so because of the financial risk. Although the state reimburses counties up to 95% of their EPSDT costs, the counties have to pay up front (and then get reimbursed).

There are a variety of funding streams than can be used for match – Prop 63 (Mental Health Services Act - MHSA), realignment funds (sales tax and vehicle licensure fees), Assembly Bill 3632 special education state funds, and Senate Bill 90 (state reimbursement funds to counties for mandated AB 3632 services exceeding available resources). Also, counties can use county general funds; in addition to all of these, Contra Costa also uses a small amount of match funds from the juvenile justice system for its Mentally Ill Offenders Criminal Reduction Act (MIOCR) grant project, providing community-based mental health services to divert youth in juvenile justice with serious emotional disturbance from group home placement.

### **VT** Vermont

#### ***Using Funds from Other Programs and Systems for Match***

The state uses funding contributed by other child-serving systems and mental health general revenue to provide the Medicaid match. Vermont's success in identifying and securing funds for Medicaid match from other systems is a significant factor in the ability to maintain and expand services. For example, the autism spectrum program operated by the Howard Center (the Designated Agency in Chittenden County) has expanded since its beginnings in 2000 to now provide a continuum of specialized, comprehensive educational and behavioral support and treatment services to children, youth, and young adults ages 2–21. The program is directly funded by school districts, whose payments to the Howard Center serve as match for the billing of Medicaid for treatment-related services. This funding mechanism supports Vermont's vision of partnership between local schools and community mental health centers to meet the needs of children with mental health and developmental disabilities. Medicaid has become a greater proportion of all revenues as children's mental health services have expanded. State agency partners also expanded their support for systems of care from their general fund allotments, providing a source of Medicaid match.

**OH** **Cuyahoga County, Ohio**  
***Using Local Mental Health Board***

In Cuyahoga County, the Mental Health Board (MHB) pays the match for all Medicaid service dollars spent in the system of care. The Mental Health Board is committed to the system of care approach. It wrote the SAMHSA grant in collaboration with the Family and Children First Council. When the grant was awarded, it was acknowledged that the MHB would implement it. While the MHB wanted to retain its identity as the county mental health agency, it understood that the grant needed to be managed by a cross-system body with the political authority and financial leverage to successfully implement the system of care. Therefore, within a couple of months of the award, the MHB turned the grant over to the County Administrator's Office and the Board of County Commissioners. The MHB remains a committed partner in the system of care. The MHB contributes between \$3 million and \$4 million in match dollars.

**WI** **Wraparound Milwaukee**  
***Using Funds from Other Systems for Match***

Use of Milwaukee Public Schools and child welfare general revenue for mobile crisis services helps to generate Medicaid match for this service. Wraparound Milwaukee operates the County's mobile crisis program for county youth (Mobile Urgent Treatment Team – MUTT), which is supported by multiple funding streams. Every child enrolled in Wraparound Milwaukee automatically is eligible for services from MUTT, and other families in the county may use it for a crisis related to a child. The child welfare system and Milwaukee Public Schools wanted an enhanced, dedicated mobile crisis team to provide crisis intervention and on-going (30-day) follow-up. Each provides funding of \$450,000 to support this enhanced capacity. Wraparound Milwaukee also is able to bill Medicaid for this service under Wisconsin's crisis benefit. This includes the MUTT crisis team; a portion of care managers' time spent preventing or ameliorating crises; 60% of the cost of crisis placement in a group home, foster home or residential treatment facility; and the cost of 1:1 crisis stabilizers in the home. Since Wraparound can recover a percentage of its costs by billing Medicaid, it is able to add about \$180,000 to the Milwaukee Public Schools enhanced capacity and about \$200,000 to the child welfare capacity. Wraparound's total Medicaid crisis reimbursement was nearly \$6 million in 2006.

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## B. Maximize Title IV-E Child Welfare Funds

Few sites reported success in maximizing the use of Title IV-E. One example is provided by Cuyahoga County, which frees up child welfare dollars for the system of care by maximizing the use IV-E within the child welfare system.

### **OH** Cuyahoga County, Ohio

#### ***Maximizing IV-E Funds to Free Child Welfare Dollars for System of Care***

Title IV-E funds are not supporting the system of care per se. However, maximizing the use of IV-E funds within the Department of Child and Family Services (DCFS) creates more local DCFS dollars, which can be used more flexibly than IV-E, to contribute to the system of care. Any child in the system of care who needs a placement is referred either to DCFS or to the court. The system of care does not pay for placements, DCFS does. DCFS endorses care in the child's community and believes that the system of care (as structured in Cuyahoga County) enables families to receive intensive services in their homes and neighborhoods, thus avoiding many residential placements. This reduces DCFS' placement costs, so it is very willing to contribute local DCFS funds to the system of care.

## C. Maximize Education/Special Education Funds

Few sites reported success in maximizing special education funding. However, an example of maximizing special education funds is provided by Choices, where the education system pays a case rate to obtain services to avert the need for an out-of-school or residential placement. Also, California has had legislation in place for many years that provides funding to county mental health agencies to provide mental health services that are included in Individualized Education Plans (IEPs) to special education students.

### **CA** California

#### ***Using Special Education Funding***

Assembly Bill 3632 funds, which must be used to support mental health services that are included in individualized education plans (IEPs), have provided a dedicated funding stream since 1986 for children enrolled in special education. AB 3632 funding came about as a result of a 1985 lawsuit to prevent low income families from having to relinquish custody to access mental health services. It has become an entitlement, in effect, for all families (with resultant growing costs). At the time of the site visit, changes were being made in AB 3632 to allow education agencies to contract with any entity to provide related mental health services in IEPs (and not just the "designated" county mental health agency, as has been the case).

**Choices** **Choices**

***Receiving Case Rates from the Education System***

Of children served in **Indiana** by **Choices** (Dawn), 70% are in special education. When children are referred by the education system, their case rate is paid by the education system. Some of these children are in the “at risk” tier of services (with a case rate at \$1,809 per month), with the goal of averting the need for an out-of-school or residential placement.

### **III. Redirect Spending from “Deep-end” Placements to Home and Community-Based Services and Supports**

**Financing strategies include:**

- A. Redirect Dollars from Deep-End Placements to Home and Community-Based Services and Supports**
- B. Invest Funds to Build Capacity for Home and Community-Based Services and Supports**
- C. Promote the Diversification of Residential Treatment Providers to Provide Home and Community-Based Services and Supports**

#### **A. Redirect Dollars from Deep-End Placements to Home and Community-Based Services and Supports**

All of the sites have implemented strategies to redirect resources from deep-end placements to home and community-based services and supports. This is a critical financing strategy as there are seldom new dollars for children’s services; expansion of home and community-based capacity must depend on redirected resources to a great extent. In most sites, significant reductions in the use of residential treatment have been achieved, and the practice approach has shifted to home and community-based services within systems of care. **Cuyahoga County** and **Wraparound Milwaukee** provide good examples of this strategy. In Project BLOOM, with the focus on the early childhood population, the rationale for the system of care is the concept of “cost of failure,” that is, with the failure to provide services through systems of care, significant future costs for deep-end services will be inevitable. An example of the effects of redirecting resources on service utilization in Erie County is shown on **Table 5.6**.

**Table 5.6**  
**Effects of Redirecting Resources on Service Utilization in Erie County, New York**

Impact on Utilization	Increased	Decreased
Admissions to residential treatment services		18% from 2005 Base
Length of stay in residential treatment		20% from 2005 Base
Residential Treatment Bed Day Utilization		34.6% from 2005 Base
Psych Inpatient Bed Utilization		38% of Certified Beds
Utilization of secure juvenile detention (average daily census)		37% from 2005 Base
Utilization of non-secure juvenile detention (average daily census)		70% from 2005 Base
Utilization of home and community-based services	223% from 2005 Base Capacity	

**AZ** **Arizona**

***Using 1115 Waiver to Develop Home and Community-Based Services***

The entire thrust of the 1115 Medicaid waiver is to develop home and community-based alternatives to out-of-home services. The Arizona behavioral health system, working in partnership with the state Medicaid agency, significantly expanded the array of covered services and supports by adding new service types to the Medicaid benefit and expanding service definitions of already covered services. In addition, payment rates were restructured to better correspond to system goals of encouraging the provision of home and community-based services and reduced reliance on residential treatment. Rates for residential treatment, for example, decline as lengths of stay increase. The state reported that in 2003, 39% of the child behavioral health budget went to 3.6% of enrolled children served in residential treatment centers (RTC) and inpatient hospitals. In 2005, this had been reduced to 29% – 16.25% on inpatient hospitalization and 13.4% on other out-of-home (residential Level I, II, III, including therapeutic foster care). Currently, 2.6% of the 33,000 youth served statewide (about 850 youth) are served in out-of-home treatment settings, but 40% of those placements are in family-based therapeutic foster care (TFC), rather than congregate settings. In 2003, the system had nine TFC placements statewide, compared to about 400 today. Value Options (VO) in Maricopa County reported that it spent \$25-30 million of its budget (about 25%) on out-of-home services and \$70-90 million (about 75%) on home and community-based services. At the same time, child welfare in Maricopa reported that it is spending less on RTC because of successful appeals to get VO to pay for the service.

VO indicated that “while we never used to talk to judges, court appointed special advocates, or guardians ad litem,” they have begun trying to educate these stakeholders about alternatives to RTCs. In addition, Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/ BHS) developed Practice Improvement Protocols related to use of RTCs, including one on Use of Out-of-Home Care Services and one on Therapeutic Foster Care. (See: <http://www.azdhs.gov/bhs/guidance/guidance.htm>.)

**CA California*****Using Legislation and Funding to Reduce Residential Placements and Develop Community-Based Service Capacity***

The state has provided incentives (and disincentives) to counties with respect to reducing out-of-home, high-end placements. In 1998, the state implemented a Senate Bill (SB) 933 Group Home Reform Initiative to decrease high-end group home placements and to promote family-based care and therapeutic foster care. This state legislation made major changes to group home policies, including a reexamination of the rate structure.

In 1997, the state enacted SB 163 to provide “wraparound” funds to counties to prevent out-of-home placements. The authorizing legislation was based on a pilot operated by Santa Clara County and Eastfield Ming Quong Children and Family Services. SB 163 targets the development of alternatives for children in child welfare and juvenile probation who are in or at risk for residential treatment, using the wraparound approach. Counties must submit a Wraparound Implementation Plan to the state DSS to access the state SB 163 funding. **Contra Costa** is using SB 163 funds to provide a wraparound approach for 40 children in or at risk of high end out-of-home placements (e.g., residential treatment, high-end group homes) and their families to reduce placements and lengths of stay. SB 163 funds are the state and county portion of Aid to Families with Dependent Children-Foster Care (AFDC-FC) funds. Contra Costa is financing this wraparound initiative using these funds, AB 3632 (special ed), Medi-Cal, and county match dollars. Most services provided to children in the initiative are financed using Medi-Cal; AFDC-Foster Care is paying for non Medi-Cal covered individualized services identified in a child and family team plan of care and for non-Medi-Cal children. The amount paid per child per month is \$2,997 for non federally-eligible youth and \$5,994 for federally-eligible youth. (There is richer financing for the federally eligible youth because of federal match funds). Counties can keep savings generated by reducing lengths of stay or admissions to residential treatment centers. Contra Costa saved \$800,000 in 06-07, with three-quarters of the youth served staying in the community. To expand the initiative further, the county noted that it needs to recruit more therapeutic foster parents. The county has an Interagency Placement Resource Expansion Team to develop both high-end and low-end services. SB 163 has provided a mechanism to pay for wraparound approaches that were in danger of being cut with the ending of the federal system of care grant and the state’s Children’s System of Care grant program.

The state also provides Strategic and Treatment Options Program (STOP) funds to counties, with Contra Costa reporting that 50% of the dollars are used for child welfare, 25% for juvenile probation, and 25% for county mental health, to divert non Medi-Cal eligible children from residential treatment centers (RTCs). The financing is comprised of 70% state general revenue and 30% county match. Contra Costa receives about \$220,000 in STOP funding, which it uses to defray service costs for uninsured children. The state also is in the process of moving youth in state youth corrections facilities to community-based care and is supposed to give counties \$100,000 per youth moved to county responsibility.

In addition to SB 163 funds, Contra Costa was using state Children’s System of Care funding (now ended because of larger state deficits) and federal SAMHSA and Children’s Bureau (child welfare) system of care grants to provide home and community based alternatives and a wraparound approach. Savings from redirection allowed the county to maintain some of this wraparound capacity, but 17 staff were let go because of larger county deficits. Contra Costa noted that the county has had five years of deficit problems, driven mainly by retiree benefits and health care costs (the

county deficit was \$26 million at the time of the site visit). The county also noted that more work still needs to be done to get education and child welfare staff to buy into the wraparound approach. Except for one school district (Mount Diablo), with which county mental health has successfully partnered to locate wraparound teams in the schools, the school system has not been particularly receptive to wraparound approaches. Also, with county mental health paying for RTC costs for children with IEPs (using AB 3632 monies that go to county mental health), the schools do not have a financial incentive to avoid use of RTCs since they do not pay for it.

County mental health has been able to significantly reduce placement and length of stay for youth served through its wraparound approaches. It also has been supporting a shift in the philosophy toward RTCs, to get people to see them as an intervention and not as a “lifetime placement.” The county indicated that this is a difficult shift especially for child welfare staff and supervisors, who manage their own RTC placements. County mental health indicated that juvenile justice was more on board and wanting more community-based care especially as the state moves youth out of state youth corrections facilities. County mental health recently developed a collaboration with the county probation department to provide community-based best practice alternatives, including wraparound, Multidimensional Family Therapy, and Multidimensional Treatment Foster Care, to divert youth with serious behavioral challenges who are involved with juvenile justice from institutional or group home placements. The initiative is financed by a Mentally Ill Offenders Crime Reduction (MIOCR) grant from the state Department of Corrections and Rehabilitation Corrections Standards Authority, Medi-Cal (75-80% of the youth are Medi-Cal eligible) and AFDC-FC dollars. The initiative creates a Children’s Alternative Treatment (CAT) team, consisting of a licensed mental health professional, a parent partner, 3 probation officers, one part-time educational liaison and one part-time health professional. The team is based at juvenile hall and is committed to system of care values. The CAT Project, which has the capacity to serve 90 youth at any given time, coincides with several other county strategies, including the Disproportionate Minority Contact Initiative, the California Institute of Mental Health’s best practice implementation strategy, and the county’s SB 163 wraparound strategy for children in child welfare. The Project is targeting three geographical areas of the county that reflect a disproportionate number of minority youth involved in the juvenile justice system. These are the same areas that are being targeted by child welfare to reduce disproportionate involvement of minority families with Child Protective Services.

## **HI** Hawaii

### ***Using Training and Individualized Service Approach to Shift Practice and Resources***

The state has sought to redirect dollars from deep-end placements to home and community-based services and supports as the service array has been expanded. Access to deep-end services has not been restricted, and there are no specific line items in the budget for residential vs. nonresidential services. Rather, education/training and technical assistance have been used in an attempt to shift practice to a home and community-based approach. As community-based service capacity has expanded, utilization of residential services has been reduced. The approach taken by the state

has relied upon training and encouragement to shift to a home and community-based service philosophy. Child and family teams, however, are empowered to authorize whatever services they deem necessary, and the Child and Adolescent Mental Health Division (CAMHD) is obligated to pay for the services they authorize for a child and family.

The state has had a focused initiative on bringing children back from out-of-state placements. The initiative represents a collaboration among the mental health system (Department of Health), education system, and the court system. In 1999, there were 89 children out of state. Individualized service plans were developed child by child to bring these children back. Currently, there are only 6 children in out-of-state placements. In order to send a child to the mainland for treatment, all three departments (Departments of Health, Education, and Human Services) must sign off; this requirement alone creates a disincentive to out-of-state placements.

CAMHD in the Department of Health bears the cost of out-of-state placements. The state has found that it is not necessarily less costly to develop and implement a wraparound plan and to keep a child in the community as compared with an out-of-state placement. This approach, however, is considered to be better practice. Attempts are made to bring children from out-of-state placements back to therapeutic foster care rather than residential treatment centers. Dollars in the budget are not held to line items, so that dollars can follow the child. Thus, dollars can be moved from mental health residential care to community-based services as the locus of treatment shifts.

A Resource Management Section of CAMHD's Clinical Services Office tracks matches between children's needs and system resources to facilitate development activities that focus on ensuring sufficient capacity and efficient use of available resources. Patterns and trends in service delivery are examined that identify and discourage the prolonged use of ineffectual services, overly restrictive services, or non-evidence-based interventions. Regular reviews are conducted to examine documented needs and the intensity of services provided. When problems are identified, this section provides the data necessary for CAMHD to take action to align services with CAMHD's practice guidelines and policy.

## **MI** Michigan

### ***Requiring Minimum Rate of In-Home Placement***

One of the ways the state has been redirecting funds is using a Child Care Fund (CCF) which has an in-home care option. Over time, the amount of monies being spent from the CCF on home and community-based services has increased and the total cost for out-of-home services has decreased. In 2007, the state's contribution to the fund was \$209 million. It is a line item in the budget and is comprised primarily of state general revenue dollars, though some TANF funds are included. The purpose of the Child Care Fund in legislation is to reduce the rate of children in out-of-home placement; therefore, the restriction is that there has to be a state established rate of 80% in in-home placement. In addition, the CCF will reimburse for out-of state placements, but the county commission, the local Department of Human Services, and the judge must approve the plan for an individual child to go out of state. Livingston County, which is committed to a strengths-based wraparound approach, has the lowest out-of-home rate per capita in the state.

**NJ** New Jersey***Implementing a Statewide System of Care Reform with Care Management Organizations for Youth with Complex, Multi-System Issues***

The state has committed to move dollars from deep-end placements to community-based services by creating entities such as a Contracted Systems Administrator (CSA), Care Management Organizations (CMOs), and Family Support Organizations (FSO's). Though the state has struggled in this area and a lot of monies are still used for residential services, the amount has been steadily declining over time. There is one CMO and FSO per region; they work together to provide care coordination and create individualized plans for children with complicated and intensive needs. The FSOs employ Family Support Coordinators and Community Resource Development Specialists, who are responsible for identifying and formulating natural helpers and informal community supports to enhance treatment services.

Spending on residential care has increased in recent years because New Jersey has provided services to more children, expanded the capacity of the residential system to meet the need, and raised the reimbursement it pays to facilities. However, growth in spending for community services has dramatically outpaced growth in spending for residential care, meaning that residential care now constitutes a smaller fraction of the overall budget for children's mental health than it did before New Jersey implemented its system of care reform – 60% instead of 90%. State officials, however, believe that the amount spent on residential care, while a significant improvement, remains significantly too high.

Data are also available on the cost per child served on a county basis. In fiscal year 2000, New Jersey spent the bulk of its children's mental health service expenditures, 72%, on inpatient and residential care. The percent of total expenditures utilized for residential and inpatient services ranged from 48% (a significant outlier) to 85%. This picture has changed considerably in all counties. In 2005, the statewide average was 39% spent on inpatient and residential care. Ocean County had the lowest rate, 20%, and Warren County the highest at 56%.

A further examination of 2005 data stratified by county reveals how system of care implementation, still underway in New Jersey, affects the use of out-of-home care. There appears to be little difference in the way that system of care has affected the number of children using inpatient services, however the use of residential care appears to have shifted considerably with the implementation of systems of care.

**VT** Vermont***Implementing Gate-Keeping Process and Developing Home and Community-Based Capacity***

The state's vision and goal seeks to build home and community-based services capacity resulting in a low use of residential services. Savings from reduced utilization of residential treatment services are captured and redirected to community-based services. While there are specialized residential services and a hospital for statewide access, the system of care vision, state law and practice have worked to establish home and community-based capacity and expand services, utilizing dollars that would

have otherwise been allocated to more costly options (i.e., redirection), as well as using new funds for community services.

In the early 1980s, few types of mental health services were available in Vermont; typically, there was a 50-minute therapy session or psychiatric in-patient care for a few weeks. The system of care concept encouraged the state to develop an array of services to meet needs in the home, school, and community, most notably case management, respite, and short-term hospital diversion beds. The number of children ages 0-12 and 13-19 who received children's services through community mental health centers tripled from 1989 through 2005, from about 3,200 to 10,000. This is a high penetration rate, about 8%, compared to most states, and very few of the children served are in hospital-level care.

Vermont used its Medicaid Home and Community-Based Services waiver as one financing component in building the system of care and supporting effective services to more children with serious disturbances in their communities rather than in inpatient settings. Evaluation of the Vermont waiver program found that the cost per child under the waiver was about \$150 per day compared to \$1,200 per day for inpatient services.

Training has also been provided over several years to staff on how to wrap intensive services around children with high needs and their families, thus helping to avoid unnecessary disruption to a child's family life and school/social environment.

In addition to expanding home and community based service capacity, the state also created a gate-keeping mechanism for intensive, restrictive services. Vermont's Case Review Committee (CRC) was established by the State Interagency Team to provide assistance to local teams as they identify, access and/or develop less restrictive resources, or when less restrictive alternatives are not appropriate, to ensure the best possible match between child and residential treatment facility. The CRC reviews all requests for intensive residential placement and intensive wraparound services that provide overnight staff 24 hours a day, 7 days a week for children or adolescents with severe emotional disturbance. While the representatives from the departments review the proposed services together, funding decisions are made on a child-specific basis. CRC and/or agency staff may also provide technical assistance to ensure the child's return to home and community as quickly as possible.

### **NE** Central Nebraska

#### ***Developing a System of Care for Children in State Custody***

The Cooperative Agreement between the Nebraska Department of Health and Human Services (DHHS) and Region 3 Behavioral Health Services (BHS) to create an individualized system of care for children in state custody who have extensive behavioral health needs identifies reinvestment of costs savings to allow for more preventative, front-end, community-based services as one of its core principles. The agreement stipulates that if Region 3 BHS experiences costs less than the agreement amount, an expected outcome of the program, the cost savings may be used to: develop a risk pool (no more than 10%), serve additional youth in the target population or to expand services to youth at risk of becoming part of the target population, and provide technical assistance to other Regions/Service Areas to implement similar programming statewide.

In its 2005 Annual Report, Region 3 BHS demonstrates that the Integrated Care Coordination Unit has reduced out-of-home placements and increased the percentage of children who live in the community:

- At enrollment, 35.8% of the children (n= 341) were living in group or residential care; at disenrollment 5.4% of the children (n = 131) were in group or residential care
- At enrollment 2.3% were living in psychiatric hospitals; at disenrollment no children were hospitalized
- At enrollment 7% were living in juvenile detention or correctional facilities; at disenrollment no children were in these facilities
- At enrollment 41.4% were living in the community (at home – 4.4%, with a relative – 1.5%, or in foster care – 35.5%); at disenrollment, 87.1% lived in the community (at home – 53.5%, with a relative – 7.6%, in foster care – 14.5%, independent living – 11.5%).

Other outcome measures show that scores on the Child and Adolescent Functional Assessment Scales (CAFAS) dropped significantly (i.e., improved) for children enrolled in the Professional Partners Program, Integrated Care Coordination Unit, or Early Intensive Care Coordination, and their living situations improved.

### **Choices** Choices

#### ***Using Redirection to Home and Community-Based Care as Basis for Service Delivery***

The philosophy of Choices, and how its services are marketed, is the concept of redirecting care from deep-end placements to home and community-based services. This forms the basis for the entire concept of service delivery. Choices is applying this approach, using braided funding, risk-based financing (e.g., case rates), and a strengths-based wraparound approach with various populations of high utilizing, high cost youth, such as those diverted from residential placements and from detention.

### **OH** Cuyahoga County, Ohio

#### ***Reducing Child Welfare Placement and Residential Treatment Costs and Redirecting Funds to the System of Care***

The Department of Family and Children's Services (DCFS) reduction in placement and residential treatment costs has enabled it to redirect its spending and contribute significantly to the Cuyahoga Tapestry System of Care (CTSOC). Between 1995 and 2001, due to the crack cocaine epidemic and a fear for child safety, the foster care population increased from 2400 to 6456. More than 350 children per month were being placed and approximately 500 were in residential care (250 of them out of state). DCFS began to look closely at why many of these children were remaining in care, to question whether it was still an issue of safety, and to identify what it would take to return children home and support their families. Through team decision-making and the development of safety plans at the point that children entered the child welfare system, DCFS has reduced the number of children

entering custody to 80 per month. Many children who were placed in therapeutic foster care (TFC) returned home, and this allowed the agency to step down the children in residential treatment to TFC. At the time of the site visit, DCFS had approximately 2400 children in placement, with 250 of them in RTCs. Board and care expenditures dropped from \$105 million in 2001 to \$55 million in 2007. DCFS believes that the “only way out of the box” is to provide services for children and families in their neighborhoods, and that best practices and cost effectiveness are in sync. DCFS has redirected its placement funds to support 14 neighborhood collaboratives (\$4.2 million) and eight Care Coordination Partnerships (\$3 million). CTSOC outcomes reflect the goals of reducing deep-end placements and redirecting care to community settings:

- Children are with their families in the community
- Reduced length of stay in residential settings
- Reduced length of stay in psychiatric settings
- Reduced recidivism in referrals to juvenile court

Another potential for the redirection of funds to community-based services is the closure of the Youth Development Center (YDC), a juvenile justice facility. It has a capacity to serve approximately 300 youth annually and an operating budget of \$9–\$10 million per year. The county was planning to close YDC by 12/31/2008, and the court and other partners were planning a pilot alternative treatment approach.

- These efforts to redirect resources have had substantial effects on service utilization:
- Admissions to residential treatment services decreased from 2,340 in 2001 to 746 in 2007
- Length of stay in residential treatment decreased from 2 years in 2001 to 90 – 120 days in 2007
- Utilization of juvenile detention/correctional facilities decreased 15.5% from 2006 to 2007
- Utilization of home and community-based services increased dramatically

Cuyahoga County also has engaged in a number of strategies to incentivize providers to develop home and community-based services. For example, they created a “soft landing” for providers when the number of referrals for residential treatment centers (RTCs) dropped off. The county child welfare agency (DCFS) traditionally has had a strong relationship with a group of residential care providers through contracts for services and dollars. As DCFS reformed its system and reduced the number of children entering child welfare custody (e.g., due to front end services and supports through Family Team Decision Making), the number of children needing residential care dropped. However, rather than immediately reducing its contracts with the RTCs, DCFS held the RTC providers harmless for two years and allowed them to develop community based services with the extra funds that resulted from serving fewer children in residential care. In the third year, contract amounts with the residential providers dropped, and DCFS invested these dollars into the greater system of care. This process helped many of the RTCs to survive the change and to develop the kind of community-based services that children and families served by DCFS needed. At one point, DCFS was spending \$105 million for board and care. It now spends \$54 million.

**NY Erie County, New York*****Implementing Strategies for Reducing Use of Residential Treatment and Investing Cost Savings in Community-Based Services***

In 2005, the base year of its system of care initiative, Erie County had 233 admissions to residential treatment center beds representing 80,556 bed days that were paid for with a formulaic blend of state and county foster care dollars at a total cost of \$21,995,721. Staff used existing data to identify the breakdown of admissions by persons in need of supervision (PINS), juvenile delinquency (JD), and mental health/child welfare subpopulations. Unique projections of diversions from residential care were made for each sub-population, based upon subsystem of care readiness to implement clinical administrative and diversion service strategies and specific risk profile challenges presented by the youth in the JD subgroup.

The implementation of diversion strategies was projected to reduce admissions in 2006 to 190, and achieve further reduction in admissions for 2007 to 163. The county implemented a related initiative on a pilot basis to reduce the average length of stay in residential treatment from 13 months to 4 months for selected youth. The combined impact of reduced admissions and the shortened length of stay pilot was projected to achieve an average daily census of 159 youth in 2006 and 126 for 2007. In order to meet these targets, it was estimated that 350 wraparound slots would be needed for 2006, and 400 slots by 2007.

The diversion and reduction in length of stay (LOS) goals were not fully achieved due to start up issues related to system of care readiness; however, the actual results demonstrated significant reductions in both milestone areas. In fact, utilization estimates for 2007 projected a 35% reduction in average daily census and bed day utilization through September, compared to 2005 base utilization levels. This reduction represents an 80% performance milestone achievement of the initial projected cumulative reduction in RTC utilization over the two years. In the pilot to demonstrate the efficacy of the shortened length of stay initiative with the two participating Residential Treatment Centers (RTCs), the average LOS for youth successfully discharged was 4.2 months.

Cost savings associated with the achieved reductions in utilization were further diminished by 2006/2007 rate increases granted by New York State that were approximately 70% higher than the average increases for the previous several years. However, even with these difficulties in start-up and larger than projected rate increases, the savings achieved through September 2007 is on target to achieve an actual \$5.1 million reduction in cost from the 2005 base expenditures for residential treatment. The demonstrated savings level in 2006 produced a reinvestment of \$2.1 million in 2007. At the time of the site visit, 2007 performance had produced an additional reinvestment pool of \$850,000 for an annualized total of \$2.95 million in the 2008 county budget.

Cost savings from these efforts are being invested in community-based service delivery. The system of care is monitoring the utilization of institutional care across all youth service systems (i.e., residential treatment, psychiatric inpatient, and state and local juvenile justice detention). Reports on utilization are distributed and monitored monthly. By the time of the site visit, significant reductions in all deep-end care across each of the systems had been achieved. There was also significant investment (i.e., \$10.43 million) in community services across systems.

### **CO** **Project BLOOM, Colorado** ***Using Cost of Failure Study as Basis for Redirection***

A “Cost of Failure” study was conducted under Project BLOOM’s auspices in 2000. The study followed the stories of several children who were helped by the early childhood mental health pilots and estimated what the costs of care would have been if they had not received help. This was compared with the costs of the services provided through the early childhood mental health program, demonstrating what the benefit was. These data were highly persuasive with the state legislature. It is easier to show cost savings with adolescents, for example, who may avoid involvement with the juvenile justice system, and then advocate for redirection of those dollars. However, for early childhood services, services cost more initially and the savings may not be realized until later in the child’s developmental progression. Early childhood services must be seen as an investment, and a longer-term view of the benefits is essential, similar to the longer view of the benefits of preventive health care. Since so few children under age 6 are in high-cost residential placements (only one at the time of the site visit), there are no dollars to redirect to early childhood mental health services as there might be for an older population. The argument for funds redirected from other sources to early childhood mental health services must be based on the concept of an investment with a long-term view of potential cost savings.

The study made the argument that early childhood emotional or behavioral problems lead to disruptions in learning and relationship and are linked to later problems in adolescence and adulthood, including school failure and need for special education, child abuse, delinquency, and mental illness. The effectiveness of early intervention programs was documented with data, along with the potential to achieve significant savings from reduced social, educational, and mental health problems in the future. For example, it was determined that significant future costs could be offset (e.g., \$5,693 per year in special education, \$7,200 for six months of foster care, or \$32,130 for 63 days of psychiatric hospitalization) if children could receive early intervention services (at an average cost of \$987 per year) and be diverted from these deeper-end services. This study contributed to decisions to invest in early childhood mental health services and to bring these services to scale statewide

### **WI** **Wraparound Milwaukee** ***Using Redirection to Home and Community-Based Care as Basis for Service Delivery***

Wraparound Milwaukee has achieved significant reductions in use of deep-end placements, specifically in the use of inpatient hospitalization, residential treatment, and juvenile corrections facilities.

Prior to Wraparound Milwaukee, Milwaukee County’s Child and Adolescent Services Branch operated a 120-bed inpatient unit with an average length of stay (ALOS) of 70 days. Over about a 15 year period, as Wraparound Milwaukee developed, the Branch closed beds. The state Medicaid agency provided “bridge” money to close inpatient beds by giving the Branch 40% of the DRG (Diagnosis Related Group) rate for every child diverted from inpatient care. These dollars helped to build home and community-based service capacity. At the time of the site visit, the average length of stay was 1.7 days, and inpatient utilization had declined from 5,000 days a year to 200.

In Milwaukee County, the child welfare and juvenile justice systems pay for residential treatment centers (RTC); RTC level of care is not paid for by Medicaid, mental health or education systems. By re-directing dollars spent by child welfare and juvenile justice to home and community based services and a wraparound approach, Wraparound Milwaukee has reduced the use of residential treatment centers (RTCs) from an average daily population of 375 to 50 youth. The average length of stay is 90-100 days. Wraparound Milwaukee estimates that if the child welfare system had not invested in Wraparound Milwaukee, the \$18 million that child welfare was spending ten years ago on residential treatment would be \$46 million today. Instead, Wraparound Milwaukee essentially is using the same monies that were in the system ten years ago, without new state or county revenues, to serve more children in home and community services with better outcomes. Even with the results it has achieved, Wraparound Milwaukee stakeholders note that out-of-home placements are expensive, and the costs of out-of-home care have been rising. Sixty percent of Wraparound Milwaukee's budget goes to residential treatment, group home, therapeutic and regular foster care. The average per-child-per-month cost of care is \$3,500, whereas the average cost for a child using only home and community services and supports is \$1,700. (Note. These costs must be considered within the context of Wraparound Milwaukee's very "high-end" target population, which is those youth with the most serious behavioral health challenges, who also are involved in multiple systems. These are not costs spread across all children in the county. They also need to be considered in the context of the costs of residential treatment, which run about \$7,000 per member per month (pmpm), inpatient hospitalization, which run about \$18,000 pmpm, and correctional placements, which run about \$6,000 pmpm.)

The county juvenile justice system pays for the cost of placements for youth in state corrections facilities. By diverting youth to Wraparound Milwaukee, the county juvenile justice system can save dollars and get better outcomes. Wraparound Milwaukee's average monthly costs for youth referred by juvenile justice are about \$3,500 pmpm, compared to \$6,000 pmpm for juvenile detention. Wraparound Milwaukee also has reduced recidivism rates for youth in juvenile justice by 60% from one year prior to enrollment to one year post enrollment. Looking at subsets of the juvenile justice population, Wraparound Milwaukee achieved a 34% decrease in the average per child per month cost of residential care for youth with sex offenses. (This was in spite of a 15% increase in residential fees during the same period.) Use of group homes dropped 75%. In place of congregate care, Wraparound Milwaukee provides crisis one-to-one stabilization, parent assistance, therapeutic foster care, offense-specific doctoral-level individual therapy, in-home therapy, parent education and support, safety plans, and a range of other individualized services to this population.

In addition to use of the wraparound approach to reduce use of deep-end services, Wraparound Milwaukee also operates a mobile crisis team – Mobile Urgent Treatment Team (MUTT) - paid for by a Medicaid crisis benefit (separate from the Medicaid capitation Wraparound Milwaukee receives). The county provides 40% of the match and receives 60% of federal reimbursement from the state. Milwaukee's mobile crisis capacity can be utilized very flexibly, including providing access to psychiatrist, psychologist, and paraprofessional services (using different billing codes). The team itself is comprised of three licensed psychologists and five clinical social workers and is available 24 hours a day. The crisis benefit is utilized for mobile crisis stabilization by the crisis team, as well as by Wraparound Milwaukee care coordinators, who can use the benefit for time spent on crisis planning and crisis stabilization activities. Time spent by crisis team members or by care coordinators on activities related to preventing crises, ameliorating crises, or linking youth and families to crisis services is covered under the crisis benefit. The benefit also can be used to cover crisis group homes

and crisis foster homes, up to \$88/day in non-room and board costs. Milwaukee has found that the crisis benefit is a key factor in reducing use of deep-end services. Wraparound Milwaukee has a separate \$450,000 contract with the child welfare system for use of MUTT, which it has found is helping to prevent placement disruption of children in child welfare; this funding from child welfare enabled MUTT to add staff, who also can bill Medicaid. The placement disruption rate in child welfare has been reduced from 65% to 38%. Recently, Milwaukee Public Schools contracted with Wraparound Milwaukee (a \$450,000 contract) to utilize MUTT in the schools.

## B. Invest Funds to Build Capacity for Home and Community-Based Services and Supports

Most sites reported significant investments to develop home and community-based service capacity. For example, *California* invested state general revenue, special education funds, Mental Health Services Act (new tax dollars), and child welfare funds in expanding home and community-based services.

### **AZ** Arizona

#### ***Increasing Funds Spent on Home and Community-Based Services***

Through the behavioral health managed care system and as a result of the JK lawsuit, there has been an increase in dollars spent on home and community-based services. The behavioral health system, working in partnership with the state Medicaid agency, significantly expanded the array of Medicaid-covered services, both by adding new service types and expanding service definitions of already covered services. Rates were restructured to encourage provision of home and community-based services. A new type of Medicaid provider was created – community service agencies – specifically to broaden the availability of home and community based services. In addition, Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) includes non-Medicaid dollars, including state general revenue and block grant funds, in the capitation that Regional Behavioral Health Authorities (RBHAs) receive, which can be used for expanding the availability of home and community-based services. Any “savings” generated through managed care are re-invested, and there is a legislative prohibition against using savings generated by children’s programs for adult services. Value Options (VO) in **Maricopa County** has used savings to expand the availability of therapeutic foster care.

### **CA** California

#### Using Multiple Funding Sources for Investment in Service Capacity Development

The state had used Children’s System of Care funding (state general revenue) to expand home and community-based services until this funding was eliminated because of larger state deficit issues. At the time of the site visit, the major sources of funding, besides redirection, for expanding home and community based services included:

1. Senate Bill 163 (Aid to Families with Dependent Children – Foster Care) wraparound funds from the state Department of Social Services to the counties
2. Prop 63 (Mental Health Services Act—MHSA) funds (tax on income of millionaires)
3. EPSDT funding, particularly for Therapeutic Behavioral Support (TBS) (Contra Costa uses TBS in three ways: to prevent placement disruption; to step down support to lower levels of care; and for transitions in general; the county hired an expert to train its TBS staff, who are supervised and receive consultation support from the trainer.)
4. Assembly Bill 3632 (special education) funding.

In addition to TBS, **Contra Costa** reported the following investments in expanding home and community based services:

- \$700,000 expansion in school-based mental health services and wrap teams, financed principally through Medi-Cal and Title I after school funds
- \$5.2m expansion over three years for transition-age youth (housing and employment supports, mental health and substance abuse counseling, independent living skills) supported by MHSA funds
- \$4.7 million expansion over three years for family teams to work with indigent worker population and others in far eastern part (i.e., underserved) of the county supported by MHSA funds
- School-based health clinic in Mt. Diablo school district, including mental health clinic managed by county mental health, largely Medi-Cal financed with school district putting up the match; county mental health also provides access to a benefits specialist
- Partnership with West Contra Costa Unified School District to have school-based counseling at 24 elementary and middle schools and two high schools; school based counselors can provide individual, family and group therapies and screen and link children to wraparound in the county; financed by Medi-Cal, with the schools providing the match and a small amount of funding to cover non Medi-Cal children

## **HI** Hawaii and **NJ** New Jersey

### ***Investing in Service Capacity Development with State Funds***

- **In Hawaii**, capacity building and start-up funds come from the existing Child and Adolescent Mental Health Division (CAMHD) budget. CAMHD resources have been used to build capacity to provide services such as Multisystemic Therapy (MST), and Multi-Dimensional Treatment Foster Care.
- **In New Jersey**, the state changed its Medicaid plan to include reimbursement for more comprehensive services and to create new service capacity. State dollars were also used to fuel this initiative by investing in service capacity development. Some of the community-based services that were added include: care management, mobile crisis services, wraparound, family care homes and family support services.

## **VT** Vermont

### ***Using Multiple Funding Sources for Service Capacity Development***

Vermont's system of care history illustrates capacity building financed by federal Medicaid and grant dollars, state general revenues and private resources. The state's Home and Community-Based Services Medicaid waiver and federal Child and Adolescent Service System Program (CASSP) funding in the 1980s, along with state dollars and a grant from the Robert Wood Johnson Foundation, spurred the creation of interagency networks and services leading to the establishment of the system of care. Federal Medicaid and grant funding, along with state statutes and policies, foster and fund continuing growth in behavioral health services for children. Medicaid is the principal payer for most services and the state's high levels of Medicaid and SCHIP eligibility and broad package of coverage have contributed significantly to service expansion. Funding for new services comes from a variety of sources. For example, the Children's Upstream Services project (CUPS), funded by a federal system of care grant, seeded Vermont's community-based mental health services for young children experiencing emotional disturbance. The initiative focused attention on very young children, the kinds of services they and their families needed, and the resources and networks required. The initial CUPS financing model supported only "pull-out" services (i.e., services that call for removing a child from a setting for treatment/intervention with subsequent reintegration back into the initial setting). However, interagency teams of parents and providers engaged in the process identified a primary need for early education and consultation services to public and private child care and service providers to increase their skill level in working with young children with mental health issues and their families and in developing more supportive environments for them. This reduced the need for removal of the child and increased the knowledge and skills of community providers about the development of all children. The latter involved conversations with the state's higher education community and, ultimately, led to expanded curricula, certification, and degree options. Based on positive outcomes of the CUPS initiative, mental health, other agencies, and family representatives at state and local levels partnered successfully to secure funds (federal grant, state general revenue) to develop service capacities in these areas so that children would not have to be removed from pre-school classrooms, child care programs and the like.

## **NE** Central Nebraska

### ***Using Savings to Invest in Service Capacity Development***

In addition to improved outcomes, the Integrated Care Coordination program (ICCU) has also achieved a cost savings. With this savings, Central Nebraska has been able to implement the principle of reinvestment and expand services for youth at risk of becoming part of the target population. In 2001, ICCU produced a cost savings of \$500,000 (this later grew to \$900,000). There was discussion of returning these funds to the state to help with a significant budget deficit facing child welfare. Instead, the director of the Department of Health and Human Services supported the alternatives that were laid out in the cooperative agreement. Central Nebraska kept the cost savings and used it both to provide technical assistance to other regions/service areas to implement similar programming and to expand the population of children and families served.

A portion of the ICCU cost savings was used to create the Early Intensive Care Coordination Program (EICC), which seeks to prevent children who have entered the child welfare system from being removed from their homes and from remaining in the system. If they are removed, EICC works to expedite their return home by using the wraparound approach and family-centered services. EICC served 67 youth and their families in Fiscal Year (FY) 05. They prevented placement in state custody for 88.1% of these youth. (Note: Currently, Central Nebraska is unable to continue its EICC Program due to state policy changes limiting the use of these funds to children who are currently in state custody. As a result, the local system of care identified other service gaps for children already in custody who are served by ICCU. The funds are now being used to provide a School-Based Intervention Program for these youth.)

### **CO** Project BLOOM, Colorado *State Funding for Early Childhood Mental Health Specialists*

The work of Project BLOOM was not intended to result in a short-term “project” per se, but to strategically build the foundation for early childhood mental health services to be incorporated into mental health and early childhood service systems on a statewide basis. Weaving and integrating early childhood mental health services into the services, funding, and operations of other existing systems is one of the major vehicles being used to accomplish this statewide expansion.

The funding of early childhood mental health specialists in each of the 17 CMHCs in the state is an example of investment in building service capacity for early childhood mental health services. This approach has brought the CMHCs “to the table,” bringing an early childhood focus to their agendas and requiring linkages with the Early Childhood Councils in their respective communities. This was in its first full year of implementation at the time of the site visit and is considered one important vehicle for bringing early childhood mental health services to scale. The early childhood mental health specialist position is conceptualized as a combination of direct services, consultative services to families and early care and education providers, and cross-system program development. They conduct screening, provide consultation, and train other practitioners in the skills needed to serve young children and their families. State funds are used to support these positions. They provide direct services to non-Medicaid eligible children. The early childhood specialists are intended to significantly increase the capacity of the public mental health system to provide early intervention services, many of which will be provided in conjunction with existing programs, such as Part C of IDEA.

This strategy of taking early childhood services to scale statewide originated with the funding to two mental health early intervention pilots for young children in childcare settings from 1997 to 2002 (Kid Connects). Evaluations demonstrated significant improvements in the behavior of children receiving early intervention services integrated into early childhood systems, greater than the improvements among children receiving services through the regular mental health system and at a lower cost. Two other studies demonstrated the need and cost effectiveness of early childhood services. One found that one in six children (15.4%) in Colorado have emotional/behavioral problems and that child care providers handle multiple incidents per child (four on average) and felt that

regular consultations with mental health professionals would be beneficial. Project BLOOM also produced a Cost of Failure study, which found that significant future costs could be offset if children could receive early intervention services and be diverted from deeper-end services. Based on these studies, the Colorado Department of Human Services advanced a “decision item” in 2002 for \$1.1 million to place an early childhood specialist in each of the 17 CMHCs.

**WI** ***Wraparound Milwaukee***  
***Using Savings to Invest in Service Capacity Development***

All of the savings generated by Wraparound Milwaukee are reinvested in the system to serve more youth or build more service capacity. Wraparound Milwaukee has over 200 providers (agencies and individuals) in its network, representing 85 different services and supports and including over 40 racially and culturally diverse providers. The approach it takes to building capacity is to build “target population by target population”. At the time of the site visit, additional service capacity issues were identified for girls and for youngsters with co-occurring emotional disturbance and developmental disabilities and youngsters with autism, who are at risk for residential placement and whose families are involved with child welfare. These children often end up in Wraparound Milwaukee, constituting about 10% of the Wraparound population. Wraparound Milwaukee’s approach is to develop customized service network responses to population issues as they arise.

## **C. Promote Diversification of Residential Treatment Providers to Home and Community-Based Services and Supports**

Most of the states and communities studied have worked with residential treatment providers to encourage them to adopt the system of care philosophy and approach, to work in partnership with local systems of care, and to diversify by providing new types of services and supports. For example, Cuyahoga County held residential providers harmless for two years, allowing them to use excess dollars in their contracts resulting from reduced referrals to build home and community-based service capacity.

**AZ** **Arizona**  
***Collaborating with Residential Treatment Providers to Diversify***

At the time of the site visit, the state was undertaking a number of strategies, including putting a workgroup together to look at service gaps and what the research says for particular subsets of youth, such as those with sexual offenses, who often are sent to out-of-state residential treatment centers (RTCs). The state was then planning to bring the in-state RTC providers to the table to look at service development issues. Therapeutic foster care also will continue to play a bigger role, with the state looking at possibly increasing rates for therapeutic foster care and developing or implementing a

training curriculum for therapeutic foster homes. The curriculum would be built on the curriculum for child welfare foster homes, which emphasizes the role of active support for family reunification.

Value Options (VO) in **Maricopa County** reported that it was rewriting scopes of work for residential providers and Comprehensive Services Providers (CSPs) in their network to put responsibility on the RTCs and CSPs for continuing child and family teams while youngsters are in residential facilities, and VO was putting language in RTC contracts that these providers must work with the family of origin. VO also reported that they were talking to the state's child welfare system about training RTCs and others in the use of "Family Finding" (e.g., using Internet search engines to locate extended family of youth in foster care in RTCs). VO also was trying to change its own case management from one of prior authorization/utilization management to one of coaching and facilitating skill sets to get RTCs and others more involved in the child and family team approach. VO also launched an "under 12" initiative to keep youngsters under the age of 12 out of RTCs and has talked to the RTCs about diversifying to provide more home and community-based care. Reportedly, VO has reduced the number of children under age 12 in RTCs, some RTCs have diversified, and two RTCs serving younger children closed. VO also was consciously trying to move youngsters to lower levels of care and was considering re-directing any "savings" to further developing community-based supports, rather than simply renewing RTC contracts. Most of the RTCs in the state are located in Maricopa County.

Providers indicated that most of the RTCs are diversifying their services (reportedly, all but one in Maricopa), and apparently beds are closing (one 80-bed facility in Maricopa, for example). One example given was that of Touchstone, an RTC provider in Maricopa that is now providing Multisystemic Therapy (MST), Functional Family Therapy (FFT), and therapeutic foster care.

## **CA** California

### ***Incentivizing Residential Treatment Providers to Provide a Continuum of Services***

The state tried to launch an alliance among the major children's systems, residential treatment providers, legislators and families in 1998 (at the time of the legislation to cap high-end group home rates) to look at the issue of re-engineering residential treatment centers, but it failed to gain traction. However, the statewide residential providers' association has been working with its membership to create buy-in to a wraparound approach and system of care values.

**Contra Costa** has worked with its residential treatment centers (RTCs), of which there are few, to provide a continuum of services. County mental health will be giving selected RTCs some Senate Bill 163 (Aid to Families with Dependent Children-Foster Care) wraparound dollars to step youth down beginning in 2008, and the county is developing intensive treatment foster care, Multisystemic Therapy, Cognitive Behavioral Therapy, and Family Finding, in addition to wraparound. The county is moving to shorter lengths of stay in RTCs and reports that, with the shift to wraparound and the cap on high-end group home rates, there has been a decrease of 65 RTC beds in the Bay Area.

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**HI** Hawaii and **VT** Vermont  
***Working with Residential Providers to Adopt System of Care Approach and Diversify***

RTCs developed a broader service array as part of the system of care:

- **In Hawaii**, residential treatment centers are contract provider agencies to the children's mental health system. Some have diversified and now provide a broader service array, including such services as intensive in-home services and therapeutic foster care.
- **In Vermont**, residential treatment centers/programs have diversified and incorporated the system of care vision. For example, the child mental health program at Howard Center, the lead community mental health provider in Chittenden County (Vermont's most populous county), formerly served as a major residential treatment facility in the state. It now offers an array of programs and services from an integrated pre-school program (for pre-schoolers with and without mental health issues) to a day school to a residential program.

**Choices** Choices  
***Working with Residential Providers to Adopt System of Care Approach and Develop New Types of Services***

Choices has worked with residential providers, particularly in Indiana, to develop new types of services within the overall system of care. These include residential services which are based on system of care values and principles such that children are significantly more involved in their homes and communities and families are full partners in the service delivery process. A unique addition to the continuum of care provided through the Dawn Project is the Family Community Program at the Lutherwood Residential Treatment Center. Operated in partnership with Dawn, the program offers a nontraditional, strength-based residential program in which youngsters are integrated in the community as much as possible, family reunification is the goal, and parents are highly involved in treatment and decision making as members of the treatment team. Innovations include: families are engaged in new ways in the intake process; youth and families co-design the goals and interventions; youth are able to go home at night; no level systems are required before getting the "right" to go home; the strengths and culture of child and family are tied to the solutions; families are consulted for solutions to problem behaviors; a mobile support team for intensive family preservation is provided; families can be on the unit at any time; medications are left in charge of the family and community physician with consultation by the facility psychiatrist; an educational liaison is provided; and many youth remain in their home schools.

**OH Cuyahoga County, Ohio*****Holding Residential Providers “Harmless” and Providing Resources to Develop Community-Based Service Capacity***

Historically, the Department of Family Services (DCFS) was essentially the placement system for the county, including placements for mental health services. The agency began moving in the direction of serving children in their communities by recruiting foster homes in neighborhoods where youth lived and later moving other pre-placement child welfare services into neighborhood settlement houses. In 1992, DCFS began to contract with Neighborhood Collaboratives, which are associations of organizations, including residents, parents, providers, schools, faith-based organizations and others, that come together to respond to the needs of children and families in their neighborhoods; these contracts gradually increased. The Neighborhood Collaboratives follow the Family to Family model from the child welfare system.

When the Board of County Commissioners released a Request for Applications (RFA) to establish four Care Coordination Partnerships (CCPs) to serve as care management entities for several targeted populations of children and families, it required that all proposals be submitted by a partnership between a large mental health provider agency (contracted to provide Medicaid services with residential services capacity) and at least one contracted Neighborhood Collaborative. This brought the residential providers, who historically had served children from their offices in the outer suburbs, into the city and expanded their focus into home and community-based services.

In changing the focus from residential placement to community-based care, DCFS worked closely with its contracted providers. Rather than immediately decreasing the contracts of residential providers, DCFS held the providers harmless for two years, allowing them to keep the excess dollars in their contracts resulting from reduced referrals for residential treatment. With these resources, the residential providers were asked to develop community-based services. DCFS referred to this a “soft landing”. In the third year, DCFS reduced the contract amounts for residential providers and reinvested its excess funds in the system of care, the Cuyahoga Tapestry System of Care (CTSOC). However, due to the “soft landing,” many of these providers were poised to participate in the system of care.

CTSOC also developed and manages a Provider Services Network (PSN), a network of available local services and supports that a family can “shop” when in wraparound care. By joining the PSN, providers can receive referrals from the CCPs and have access to flexible wraparound dollars. The PSN offers a fee-for-service model (no contracts), and the fee includes indirect costs as part of the fee. Funds to manage the PSN (\$1,000,000/year) come from the Board of County Commissioners and Department of Health and Human Services levy funds.

**NY** **Erie County, New York**

***Incentivizing Residential Providers to Provide Community Services***

One deliberate strategy of Family Voices Network, Erie County's system of care, is to encourage traditional residential providers to shift towards offering home and community-based services and to reduce lengths of stay in residential care. For those providers who are willing to do so, the Erie County Department of Mental Health (ECDMH) offered them fiscal incentives, including new contracts for wraparound services. The two providers who participated in the pilot and were successful in reducing lengths of stay were asked to manage large pots of flexible dollars and to develop vendor services that are accessed by the child and family teams.

One innovative CEO of a large children's agency is partnering in a number of ways with the mission of Family Voices Network by moving 30 staff, including his executive team, from a suburban location to an urban, high-risk neighborhood. The agency has recently opened a Family Resource Center on the East Side of Buffalo, another high-risk area. The Family Resource Center is inviting other agencies to locate staff and services in the building and is hiring community members for specific roles and tasks.

Four of the Residential Treatment Providers in Erie County (i.e., Gateway Longview, New Directions, Hopevale, and Child & Family) are also providers of Wraparound and other community services within the system of care continuum of services.

**WI** **Wraparound Milwaukee**

***Using Market Forces to Create Changes in Residential Treatment Centers***

In effect, Wraparound Milwaukee let the market dictate the future of residential treatment centers (RTCs). Milwaukee made it clear it was going to utilize RTCs differently and was in the market for a broad range of services and supports. Virtually all of the RTCs in Milwaukee diversified in response to what Milwaukee Wraparound indicated it was willing to purchase, including contracting to provide care coordination. While few RTCs actually closed, beds were reduced, in some cases, campus facilities were sold or leased, and new home and community-based products were developed.

## IV. Implement Financing Strategies for Children with Intensive Service Needs and their Families

### Financing strategies include:

- A. Finance Care Management Entities as a Locus of Accountability for Services, Cost, and Care Management
- B. Use Risk-Based Financing Strategies for Populations with High Needs

### A. Finance Care Management Entities as Locus of Accountability for Services, Cost, and Care Management

Most of the sites finance some type of entity as a locus of accountability and management for children with serious and complex challenges, who are involved in or at risk for involvement in multiple systems. These may be either a government entity or a private, nonprofit entity. For example, government entities are found in Hawaii, where the state children's mental health agency administers a carve-out under the state Medicaid program and utilizes seven public mental health agencies located throughout the state to coordinate service delivery. An example of private nonprofit entities is found in New Jersey, which contracts with nonprofit Care Management Organizations in each region of the state.

#### **HI** Hawaii

##### ***Using a State Government Agency***

Hawaii's children's mental health system is administered by the state government, specifically the Child and Adolescent Mental Health Division (CAMHD) of the Hawaii Department of Health (DOH). Over the past five years, CAMHD's system of care shifted from a comprehensive mental health service system for all children and youth to a system focused on providing more intensive mental health services to the population of youth with more serious and complex behavioral health disorders and their families. Through a memorandum of understanding (MOU) with the state Medicaid agency, CAMHD operates a carve-out under the state Medicaid program that serves youth with serious emotional and behavioral disorders (the Support for the Emotional and Behavioral Development of Youth or SEBD Program). CAMHD receives a case rate (\$542 per child per month at the time of the site visit) from Medicaid for each child in service and provides a comprehensive array of services and supports. Operation as the prepaid health plan for Medicaid eligible youth began in 2002. The functions under the purview of the state office include governance of the system, performance management, business and operational management, research and evaluation, and training and practice development/improvement. Under the CAMHD structure are seven public Family Guidance Centers (community mental health centers), located throughout the state, which are responsible for mental health service delivery to children and adolescents and their families. CAMHD also contracts with a range of private organizations to provide a full array of mental health services. Public employees within the Family Guidance Centers provide care coordination services, assessment and outpatient services, and arrange for additional services with contracted provider agencies.

## **NJ** **New Jersey** ***Using Nonprofit Care Management Organizations***

New Jersey's system of care initiative created Care Management Organizations (CMOs), which are nonprofit entities at the local level (one per region) that provide individualized service planning and care coordination for children with intensive service needs under contract with the state. Currently, contracts are non risk-based. CMOs use child and family teams to develop individualized plans, which are required to be strengths-based and culturally relevant. They also must address safety and permanency issues for those children referred to CMOs who are involved with the child welfare and juvenile justice systems. The CMOs employ care managers, who carry small caseloads (1:10) and who receive close supervision and support from clinical supervisors. Care managers and child and family teams are supported by family support coordinators and community resource development specialists, whose job it is to identify and develop informal community supports and natural helpers to augment treatment services. The Care Management Organizations work closely with Family Support Organizations (i.e., family-run organizations) to link families to natural supports and a peer network.

## **VT** **Vermont** ***Using Local Lead Agencies and Interagency Teams***

Vermont's system of care for children with behavioral health problems has state and local structures that serve as focal points at each level and across systems for policy and management. The Department of Mental Health is the lead state office for children's mental health. The Department's Child, Adolescent and Family Unit contracts with 10 local Designated Agencies (nonprofit, designated by the Commissioner) that serve the state's 14 counties to provide community mental health services for a specific geographic region. The Designated Agency is the locus of accountability for services, cost, and care management for children with intensive mental health needs. The local agency that has lead responsibility for ensuring that the coordinated service plan (developed by an individual interagency treatment team) is in place can vary depending on the needs of the child and family. If the child is in the custody of the Department for Children and Families (child welfare agency), then that agency takes the lead. If the issues are primarily exhibited in the child's educational environment and the child is not in state custody, then the local school district is responsible. In all other cases, the designated community mental health agency is responsible for developing and making sure that the coordinated services plan that outlines goals and needed services and supports is carried out. Decisions about services, care and cost are made at the local level, driven by the needs of the child and family and provided within the limits of legislative mandates and existing resources. If problems or issues arise that the individual treatment team cannot resolve, the team or any member may initiate a referral to the Local Interagency Team in the region for help. The State Interagency Team is a mandated state-level unit for further consideration of issues that are not resolved locally and for additional assistance with implementation of the coordinated service plan.

**NE** **Central Nebraska*****Using Integrated Care Coordination Units Supported by Regional Behavioral Health and Child Welfare Authorities***

Region 3 based its system of care on an existing infrastructure (Region 3 Behavioral Health Services - BHS). When it received a federal system of care grant in 1997, there was no need to create and support a new structure to implement the system of care. Region 3 BHS already had a statutory responsibility to administer behavioral health services. Using the existing infrastructure rather than creating a new, separate entity with grant funds greatly enhanced the chances for sustainability. The cooperative agreement between the Nebraska Department of Health and Human Services (DHHS) and Region 3 BHS to establish an individualized system of care for youth with intensive needs who are in state custody included a joint responsibility for utilization management to monitor utilization of higher levels of care and assist care coordinators in accessing alternative placement and treatment services. The Care Management Team (CMT) serves this function. It was developed to ensure that children/youth are cared for in the least restrictive, highest quality, and most appropriate level of care. It serves children at risk of out-of-home placement, as well as children in out-of-home placement. To determine the most appropriate level of care, the CMT administers an initial assessment using the Child and Adolescent Functional Assessment Scale (CAFAS), interviews caregivers, reviews youth records (including mental health assessments and risk assessment) and participates in the child and family team meetings when necessary. The CMT tracks referrals from DHHS and other service providers, determines needed services and supports, and identifies service gaps. The CMT determines which children/families in Central Nebraska meet the criteria for the Intensive Care Coordination Unit (ICCU), which ICCU has the capacity to accept them, and which children should be prioritized to receive care first. If there is no opening in an ICCU, the CMT will facilitate a child and family team meeting. The CMT conducts ongoing utilization review of children in ICCU. The CMT is staffed by licensed mental health clinicians. This is very helpful in the negotiations with Magellan, the statewide Administrative Services Organization, for access to Medicaid services for individual children. Region 3 BHS and the Central Area Office of Protection and Safety fund the CMT. In FY 2005, 210 youth were referred to the CMT.

**Choices** **Choices*****Using a Private, Nonprofit Corporation***

Choices is a care management entity that serves as the locus of accountability for youth with intensive service needs. The county (Marion County, Indiana and Hamilton County, Ohio) or state (for Montgomery County and Baltimore City, Maryland) contracts with Choices to assume this role. Choices is a private nonprofit corporation that was created by four Marion County community mental health centers as a separate and independent entity to manage the Dawn system of care. Fulfilling the role of a "care management organization," Choices provides the necessary administrative, financial, clinical, and technical support structure to support service delivery and manages the contracts with the provider network that serves youth and their families. The responsibilities of Choices include providing financial and clinical structure; providing training; organizing and maintaining a comprehensive provider network (including private providers); providing system accountability to the interagency consortium; managing community resources; creating community collaboration and partnerships; and collecting data on service utilization, outcomes, and costs.

## **OH** Cuyahoga County, Ohio *Using an Administrative Services Organization and Care Coordination Partnerships*

Cuyahoga County has established a locus of accountability at two levels:

1. Administrative Services Organization (ASO) — the Cuyahoga Tapestry System of Care (CTSOC)
2. Care Coordination Partnerships (CCPs).

The CTSOC office serves as a public Administrative Services Organization (ASO) and reports to the Deputy County Administrator for Health and Human Services and the county's System of Care Funders Group (the system of care governing body). The ASO manages multiple braided funding streams and provides planning, communications, operational and fiscal management for the system of care. The ASO manages Continuous Quality Improvement (CQI) and tracks outcomes (through a web-based management information system leased from Wraparound Milwaukee, called Synthesis). The ASO handles care authorization and enrollment for the 900 children and families enrolled by the eight Care Coordination Partnerships. The ASO is funded with SAMHSA grant funds and county levy funds.

There are eight care management entities, called Care Coordination Partnerships (CCPs), each of which is a partnership of at least one Department of Child and Family Services (DCFS) contracted Neighborhood Collaborative and one Mental Health Board agency that provides Medicaid treatment services and has residential services capacity. Each Neighborhood Collaborative includes one or more specific community centers or settlement houses. The eight CCPs, based in 14 different county neighborhoods, provide care management and wraparound plans for up to 900 children and families in the target populations. Target populations include various high utilizing and very high risk populations, including children with serious emotional and behavioral health challenges, youth with status offenses, youth diverted from out-of-home placements, and a subset of children, ages birth–3, whose families have been difficult to engage for the county's early intervention system. The director of DCFS describes the eight CCPs as a new business model with the lead mental health agency as the clinical/Medicaid provider and the Neighborhood Collaborative as the resource for natural and neighborhood-based supports. Contractually, the Neighborhood Collaboratives and the lead provider agencies must form a partnership to provide culturally competent, strengths based services and supports for children and families. In effect, the county wed the Family-to-Family reform initiative represented by the Neighborhood Collaboratives (which, historically, have focused on families at risk for child welfare involvement) and the system of care approach. The county required the Neighborhood Collaboratives and lead provider agencies to develop a joint response to the county's request for applications for a locus of care management responsibility for designated populations of children, youth and families. A number of different state and county funding streams support the CCPs, including mental health and child welfare.

Each CCP must agree that the direct services it provides to children and families referred for care coordination will total no more than 25% of the total monthly expenditures, exclusive of placement costs, for provider network services used through its contract. For direct services, the CCPs are paid a per child/per day rate by the ASO. When billing the ASO for the enrolled children, the CCP backs out the amount earned for children who are Medicaid eligible. The CCP bills Medicaid directly for Community Psychiatric Supportive Treatment (CPST) services in accordance with a separate Medicaid agreement.

County administrators noted that establishing the CCPs forced the mental health providers and the Neighborhood Collaboratives to come together. Both entities had to engage in fast paced relationship building, learn to integrate new software, operate under a new financial structure and serve new children, youth, and families.

### **NY** Erie County, New York

#### ***Using the Erie County, New York System of Care***

The locus of accountability for care management of high-need youth and their families is Erie County's Family Voices Network (the system of care for children with complex and serious mental health challenges) and its six wraparound agencies, a PINS Diversion Family Service Team, and an emerging Juvenile Delinquency Services Team. The county is working toward developing a virtual single point of accountability that will manage access to all high-end community and institutional services.

There are six Wraparound Agencies in Erie County operating through the Family Voices Network. Each currently manages the child and family team process and the service dollars for their enrolled families. The county is moving toward a separate Administrative Support Organization (ASO) that establishes a management capacity outside of county government to oversee the efficacy and quality of practice of Wraparound and vendor agency services. The entity will administer the pool of flexible funds and the related vendor services that are purchased by the child and family teams.

Family Voices Network is a partnership among the Departments of Mental Health and Social Services and the family organization, Families CAN. It is financed with a combination of county and state mental health and child welfare dollars, New York's 1915 (c) home and community-based waiver, reinvestment funds from reduced utilization of institutional care, and a federal system of care (SAMHSA) grant. Its 2007 budget was \$10 million.

### **CO** Project BLOOM, Colorado *Using Community Mental Health Centers*

Community Mental Health Centers (CMHCs) are the locus of accountability for children being served under the Project BLOOM systems of care. Through the CMHC, most of the children served have a wraparound facilitator. Some of the wraparound facilitators are full-time, dedicated positions, and others are portions of FTEs devoted to wraparound facilitation. Some children and families served are not receiving wraparound, but have someone from the CMHC assigned to coordinate their services.

The CMHCs are funded by contract for early childhood mental health services through Project BLOOM. Funding is based on a formula that uses census data to consider the number of children in the general population and the poverty level. CMHCs receive a base amount, and additional amounts based on this formula.

### **WI** Wraparound Milwaukee *Using a Local Government Agency*

Wraparound Milwaukee's primary function is to serve as a designated locus of accountability for children and youth with intensive needs and their families, specifically those with serious behavioral health challenges who are at risk for inpatient, residential treatment, or correctional placement. At the administrative level, the locus of accountability is through the Child and Adolescent Services Branch of the Milwaukee County Behavioral Health Agency, which serves as a "Management Services Organization," similar to an Administrative Services Organization in managed care. The Branch utilizes the tools of managed care to manage utilization and quality and is at financial risk through the Medicaid capitation it receives, as well as through case rates from child welfare and juvenile justice. At the service delivery level, care coordinators with case ratios of no more than 1:8 serve as the locus of accountability for individual children and their families. Also, individualized child and family teams are accountable for ensuring appropriate plans of care for individual children and their families. The plans of care they develop constitute "medical necessity" for Medicaid purposes.

## **B. Use Risk-Based Financing Strategies for Populations with High Needs**

Most of the sites use some type of risk-based financing and various risk adjustment strategies for children and youth with complex needs. In Arizona, for example, the state contracts with four Regional Behavioral Health Authorities and finances them with capitation rates; higher, risk adjusted rates are provided for children in state custody. Case rate financing is found in several sites. For example, Central Nebraska uses case rate financing, with differential case rates based on the target population and a risk pool to protect against higher than anticipated expenses, Choices has a case rate structure with four tiers, based on youth with different levels of need, and Wraparound Milwaukee also utilizes case rates for different high utilizing populations. **Table 5.7** shows the types of risk-based financing used by the sites.

**Table 5.7**  
**Types of Risk-Based Financing**

Types of Risk-Based Financing	States						Regional/Local Communities					
	AZ	CA	HI	NJ	VT	MI	Central NE	Choices	Cuyahoga County	Erie County	Project BLOOM	Wraparound Milwaukee
Case rates			X			X	X	X				X
Risk adjusted rates	X						X				X	X
Differential capitation rates	X										X	X
Other risk adjustment mechanisms							X					

**AZ** **Arizona**

***Using Capitation Financing and Risk Adjusted Rates***

The Arizona State Medicaid agency contracts with the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (BHS), to manage a behavioral health carve-out. ADHS/BHS, in turn, contracts with four Regional Behavioral Health Authorities (RBHAs), covering six geographic areas throughout the state, and two Tribal Behavioral Health Authorities (TRBHAs). Arizona has a population of about 6 million, with nearly 2 million children under 18 (about 32%). **Maricopa County** (Phoenix) has most of the state’s population, with over 3.5 million total and 1.2 million children under 18 (34%). At the time of the site visit, the RBHA in Maricopa County was Value Options (VO), a commercial behavioral health managed care company. RBHAs receive a capitation for Medicaid and state Children’s Health Insurance (SCHIP) covered services; they also receive state general revenue dollars and federal mental health and substance abuse block grant monies to provide services to non-Medicaid/SCHIP populations and to pay for non-covered services.

There are risk-adjusted capitation rates for children in state custody that are nearly 20 times higher than for other children. In Maricopa County, the capitation rate for children in custody is \$600 per member per month (pmpm); for other children, the rate is \$35 pmpm. The rate was determined by projecting the number of children in child welfare expected to use therapeutic foster care, the number expected to use counseling services, and the number expected to use residential treatment and group home care. Case rates (i.e., population-based financing strategies) are not used in the behavioral health system.

## **HI** Hawaii *Using Case Rates*

Medicaid pays a case rate of \$542 per child per month if the child meets the definition and is enrolled in mental health services. There are interagency provisions for reconciliation to the federal share of cost at the end of each fiscal year (because this rate is acknowledged up-front as too low). Determination of eligibility is made by the Child and Adolescent Mental Health Division (CAMHD) Medical Director, based on guidelines in the memorandum of understanding (MOU) between CAMHD and the state Medicaid agency. Eligibility is based on criteria, including an Axis 1 Diagnosis and a CAFAS score of 80, though there is some flexibility allowing youth to become eligible provisionally with a CAFAS score as low as 50. Each child is reviewed by a psychiatrist at the Family Guidance Center and the CAMHD Medical Director reviews and approves each case. This process was developed in response to a concern of the Medicaid agency regarding the potential for over-identifying children as having serious emotional disorders and qualifying for this case rate. Concern about the case rate possibly being too low has been expressed, although it is a Medicaid-only financed case rate and does not include the multiple funding sources that finance children's behavioral health services in the state. The state has attempted analyses on service utilization and costs; however, the population size is small and it was, therefore, difficult to obtain defensible utilization and cost data only on the Medicaid-eligible population of children with serious disorders. The state plans to attempt new analyses.

## **MI** Michigan *Case Rates From Blended Funds*

**Livingston County** has a collaborative workgroup that is called the Funding Partners. The goal of this group is to provide responsive, flexible funding for evidence-based services that support children who require multi-system services and their families. This group oversees the wraparound process as well as pools funding to carry out this program. In 2007, the Funding Partners group pooled funding from 11 local, state and federal sources, including the Department of Public Health, the Juvenile Court and Friend of the Court, Education, the county Department of Human Services (child welfare), the mental health authority, and the substance abuse coordinating agency. In addition, the participating agencies also make in-kind contributions in the form of technical assistance and serving on various committees. The amount of the pooled funds is the determinant of the number of children that may be enrolled. The pooled funding allows the child and family teams to be flexible because it pays for a comprehensive array of services from mental health, substance abuse and child welfare. The total pooled funding for 2007 was \$510,680.

**NE** **Central Nebraska**  
***Using Case Rates and a Risk Pool***

Central Nebraska utilizes a case rate of \$2,136.53 per child per month for the children in state custody who are served by the Integrated Care Coordination Unit (ICCU). This rate does not include treatment costs paid for by Medicaid; it includes placement costs and support services that are not covered by Medicaid. Central Nebraska also uses a case rate of \$698.75 per child per month for children in the Professional Partner Program (PPP). The majority of placement costs are not included in the PPP case rate, however, as this is an early intervention strategy targeted to children who have not yet had considerable “deep-end” service involvement. State administrators have the responsibility to determine whether the case rates are sufficient and to make adjustments if they are not; the case rate has remained at the same level for the past five years.

Region 3 Behavioral Health Services (BHS) has applied other managed care principles to operating its system of care. They have an operating reserve and a risk pool for ICCU. The risk pool is 10% of the annual case rate revenue. The pool was established for children whose expenses are higher than the revenue from the case rate. However, Region 3 BHS must use its current revenue to replace any funds it spends from the risk pool, so the Region does not tend to tap into the risk pool. The operating reserve is one month’s case rate (e.g., 220 kids x amount of case rate). It is intended to cover the cost of wrapping up the program in the event the state would decide not to continue its partnership with Region 3 BHS, or if funds were not available to continue the ICCU. Region 3 BHS also reinvests costs savings, as stipulated in the cooperative agreement. Thus, when the risk pool is fully funded, and they achieve a cost savings, these savings are reinvested in either programs and services for earlier intervention (to prevent youth from becoming state wards) or is used to expand the program to serve more children who are already in custody.

**Choices** **Choices**  
***Using Tiered Case Rates***

Choices uses a case rate approach in Marion County, Indiana and Hamilton County, Ohio. A tiered case rate structure accounts for differences in anticipated level of service need. In 2007, Indiana adopted a 4-tiered case rate system, with matching eligibility that embeds the Child and Adolescent Needs and Strengths (CANS) instrument into the eligibility and referral process. At the highest level, the case rate is approximately \$6,500 per child per month. Youth in this group are likely to require residential treatment placement. A certain number of youth must be in this highest level of care (140) in order to offer the rate, based on the assumption that some youth will require expensive out-of-home care, while others will be served with less costly alternatives. Without the variance in cost created by the volume of youth served, the cost of this highest tier would increase. The second-level tier case rate is approximately \$4,290 per child per month, considered to be for youth in out-of-home placement or at risk of placement. The third tier case rate of \$2,780 is intended to support community-based care, without residential treatment, therapeutic foster care and hospitalization. The lowest tier case rate is approximately \$1,565 per child per month, intended for youth with less intense service needs and lower levels of risk and which is intended to cover care coordination and home-based supports through flexible funds.

The addition of tiers adds complexity to the case rate approach in terms of determining which tier is the most appropriate for a child referred for services. The temptation among referring agencies is to believe that a child fits within the lower rate categories. However, to achieve the volume needed within each tier to provide sufficient resources for services across all three tiers (similar to insurance premiums), Choices must “manage” the tiered rate structure carefully. A matrix with criteria for determining the appropriate case rate tier for children was developed. The financial viability of the tiered case rate structure is dependent upon “volume purchasing.” With enough youth served, the case rate dollars will be sufficient to account for the percentage of youth who will need costly residential care.

The case rates establish a fixed and predictable cost for payers and allow greater flexibility in using funds for individualized services. The case rate is given to a fiscal intermediary (Choices) to cover the costs of treating all children in care, regardless of actual utilization. Thus, the fiscal intermediary holds the risk and is incentivized to manage care in a way that keeps the average cost of treating the population in services at or below the aggregate of the case rates. The child and family team approach is seen as the key ingredient to achieving cost containment balanced with effective results. Monthly feedback on the service package allows an opportunity for immediate adjustment to services, discarding ineffective directions and implementing new, more effective approaches.

### **OH** Cuyahoga County, Ohio *Using Case Rates*

Using 1915 (a) of the Social Security Act (Medicaid statute) in Cleveland and East Cleveland since 1992, the county has employed a case rate methodology with a lead non profit agency – Positive Education Program (PEP) – to operate PEP Connections, a specialty intensive case management program. Children served through the Care Coordination Partnerships operating at neighborhood levels may be linked to PEP Connections for intensive care coordination services. PEP Connections receives \$1,602 per month per child to serve 300 children with serious emotional disturbance who are involved with two or more county agencies, and who are at risk of removal from their families and community, or are returning to their families and community from placement. The case rate covers intensive care coordination and a wraparound service planning and monitoring approach.

Cuyahoga County’s Funders Group is discussing whether to expand use of 1915 (a) countywide through a subcontract between the county Mental Health Board and the system of care Administrative Services Organization. Doing so would provide a more flexible funding source for the system of care and would assist in sustaining the system of care.

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**CO** **Project BLOOM, Colorado**  
***Capitation of Medicaid BHOs and Sub-Capitation of CMHCs***

The Medicaid managed care system capitates the behavioral health managed care organizations (BHOs) for mental health services. The BHOs that manage the behavioral health benefit under Medicaid subcapitate all of the community mental health centers (CMHCs), which are the primary providers of services. The use of sub-capitation was expected to result in increased flexibility in service delivery. However, the Department of Health Care Policy and Financing's requirement for "shadow billing" of the units of services provided reportedly curtails some of that flexibility and impedes the ability to implement the wraparound approach. Rates are risk adjusted for high risk populations. Other (non CMHC) providers are paid on a fee-for-service basis.

**WI** **Wraparound Milwaukee**  
***Using Risk Adjusted Capitation Rates and Case Rates***

Wraparound Milwaukee is a specialty service delivery system for youth with serious emotional disorders. As such, it receives a risk-adjusted capitation rate for youth with serious emotional disorders from the state Medicaid agency for the population it serves (\$1,589 per child per month), higher than the rate paid to other entities serving the Medicaid population in general. It also receives case rates from child welfare and juvenile justice (average of \$3,900 per child per month). The capitation rate was developed by an actuary who looked at utilization and expenditures for 200 "high utilizing" children in each of two years for mental health care paid for by Medicaid and then gave Wraparound Milwaukee 95% of that for the capitation. The child welfare case rate was determined by looking at what child welfare was spending on residential treatment; that amount was reduced by 40% to comprise the case rate, on the basis of more children remaining at home and/or staying in residential treatment centers (RTCs) for shorter periods of time and the costs of the home and community-based care that Milwaukee would provide.

Wraparound Milwaukee maintains auditable trails for its different funding streams. It reports that the state Medicaid audit has shifted over time from a traditional audit focused on episodes of care and case record reviews to one that is process and outcomes-oriented, looking at whether youth have child and family teams and integrated plans of care, what outcomes youth are experiencing, the adequacy of the provider network, and the like.

There is not a risk sharing pool connected to Wraparound Milwaukee, but the program can roll dollars over into the next fiscal year, and it can defer billing because billing can be done up to a year after the service is provided.

## Chapter 6. Financing Services and Supports and an Individualized, Wraparound Approach

By definition, systems of care include a comprehensive array of services and supports to meet the multiple and changing needs of children and adolescents with emotional disorders and their families. Financing to cover this broad array of both clinical and supportive services is a fundamental requirement. The system of care philosophy and approach also emphasizes an individualized approach to service delivery, such that the needs, strengths, and preferences of the youth and family dictate the types, mix, and duration of services and supports. Thus, in addition to financing that covers a broad service array, financing mechanisms must support and promote individualized, flexible service delivery. Financing strategies also are needed to support the incorporation of evidence-based, evidence-informed, and promising practices to improve the effectiveness of services, mental health services to young children and their families, early identification and intervention, and mechanisms to coordinate care across child-serving agencies at the service delivery level.

### Financing strategies include:

- I. Finance a Broad Array of Services and Supports
- II. Finance an Individualized, Flexible, Wraparound Approach to Service Delivery
- III. Finance Evidence-Based, Evidence-Informed, and Promising Practices
- IV. Finance Early Childhood Mental Health Services
- V. Finance Early Identification and Intervention
- VI. Finance Services for Uninsured/Underinsured Children

### I. Finance a Broad Array of Services and Supports

#### Financing strategies include:

- A. Finance a Broad Array of Services and Supports through Medicaid and Other Funding Streams

#### A. Finance a Broad Array of Services and Supports through Medicaid and Other Funding Streams

The study examined coverage of the array of services and supports shown below in **Table 6.1**. All of the sites studied cover virtually all of these services and supports and, often, additional services and supports, such as supported employment, peer support, traditional healing, flexible funds, respite homes, respite therapeutic foster care, supported independent living services, intensive outpatient

services, treatment/service planning, parent skills training, ancillary support services, family and individual education, consultation, peer support, emergency/hospital diversion beds, after school and summer programs, substance abuse prevention, youth development, and mentor services. These services and supports typically are covered using Medicaid and a variety of additional financing streams from mental health and other child-serving systems. **Table 6.2** provides examples from **California** and **Project BLOOM, Colorado** as to how each of the services is financed, typically both with Medicaid and with additional funding sources.

<b>Nonresidential Services</b>	<b>Residential Services</b>	<b>Supportive Services</b>
<ul style="list-style-type: none"> <li>• Assessment and diagnostic evaluation</li> <li>• Outpatient therapy — individual, family, group</li> <li>• Medication management</li> <li>• Home-based services</li> <li>• School-based services</li> <li>• Day treatment/partial hospitalization</li> <li>• Crisis services</li> <li>• Mobile crisis response</li> <li>• Behavioral aide services</li> <li>• Behavior management skills training</li> <li>• Therapeutic nursery/preschool</li> </ul>	<ul style="list-style-type: none"> <li>• Therapeutic foster care</li> <li>• Therapeutic group homes</li> <li>• Residential treatment center services</li> <li>• Inpatient hospital services</li> </ul>	<ul style="list-style-type: none"> <li>• Care management</li> <li>• Respite services</li> <li>• Wraparound process</li> <li>• Family support/education</li> <li>• Transportation</li> <li>• Mental health consultation</li> </ul>

<b>Service</b>	<b>California</b>		<b>Project BLOOM, Colorado</b>	
	<b>Medicaid</b>	<b>Other Funding Source</b>	<b>Medicaid</b>	<b>Other Funding Source</b>
Assessment and diagnostic evaluation	X	General Revenue for non Medi-Cal children (AB 3632, MHSA); County General Revenue	X	Part C, MCH, Block Grant, General Fund, CHP+
Outpatient psychotherapy (individual, family, and group)	X	General Revenue for non Medi-Cal children (AB 3632, MHSA); County General Revenue	X	Block Grant, General Fund, Core Services (Child Welfare)
Medical management	X		X	Block Grant
Home-based services/Home Visitation	X	General Revenue for non Medi-Cal (AB 3632, MHSA); also AFDC-FC; County General Revenue	X	Part C, Child Welfare Tobacco monies and private foundation funding support home visiting in each community
Day treatment/partial hospitalization	X	General Revenue for non Medi-Cal children	X	

**Table 6.2** (continued)  
**Funding Sources for Service Array in California and Project BLOOM, Colorado**

Service	California		Project BLOOM, Colorado	
	Medicaid	Other Funding Source	Medicaid	Other Funding Source
Crisis services (Family)	X	General revenue for non Medi-Cal children	X	SAMHSA Grant Funds
Mobile crisis response and stabilization services	X			
Behavioral aide services (some)	X			Family Support (General Fund), Part C
Behavioral management skills training	X		X	Block Grant, Child Care Development Block Grant
Therapeutic foster care		Co-financed by DSS, AB 3632, JJ		
Therapeutic group homes		Co-financed by DSS, AB 3632, JJ		
Residential treatment centers		Co-financed by DSS, AB3632 (special ed), JJ		
Crisis residential services		Co-financed by DSS, AB3632, JJ		
Inpatient hospital services	X	Private insurance		
Case management services	X	Other system dollars	X	Part C, Health Care Special Needs
School-based services (Child Care, Preschool)	X	Other system dollars	X	Head Start, Child Care Development Block Grant, General Fund, Early Childhood Specialists
Respite services			X	Part C
Wraparound services/process	X	General Revenue (AB 3632, MHSA); also AFDC-FC	X	General Fund, Part C, SAMHSA Grant
Family support/education		County General Revenue	X	Community Center Board System, General Fund
Transportation (limited)		Flex funds (grants and MHSA)	X	SAMHSA Grant
Mental health consultation	X		X	SAMHSA Grant, Child Care Block Grant, General Fund

Service	California		Project BLOOM, Colorado	
	Medicaid	Other Funding Source	Medicaid	Other Funding Source
Therapeutic nursery/preschool	X		X	Child Welfare (one closed)
Other, Specify	X	General Revenue (AB 3632, MHSA); also AFDC-FC (Independent living skills training, Parent partners)		

**AZ** **Arizona**

***Covering a Broad Array of Services and Supports***

In **Arizona**, services are financed primarily by Medicaid dollars through the behavioral health managed care system. The managed care system covers a very broad array of services and supports. Arizona has used the JK lawsuit to expand the array of covered services under Medicaid and redirection of spending from out-of-home to home and community based services to expand availability of these covered services. The managed care system also includes state general revenue and block grant dollars, in addition to Medicaid and SCHIP, which can be used to pay for services that are not covered within the Medicaid benefit. For example, non-Medicaid dollars can be used to pay for traditional Native healers. The array of covered services includes:

- Behavioral counseling and therapy
- Assessment, evaluation and screening
- Skills training and development and psychosocial rehabilitation skills training
- Cognitive rehabilitation
- Behavioral health prevention/promotion education and medication training and support services
- Psycho-educational services and ongoing support to maintain employment (supported employment)
- Medication services
- Laboratory, radiology and medical imaging
- Medical management
- Case management
- Personal care services
- Home care training family (Family support)
- Self-Help/Peer services (Peer support)
- Therapeutic foster care
- Unskilled respite care
- Supported housing
- Sign language or oral interpretive services
- Non medically necessary services (flex fund services)

- Transportation
- Mobile crisis intervention
- Crisis stabilization
- Telephone crisis intervention
- Hospital
- Sub-acute facility
- Residential treatment center
- Behavioral health short-term residential, without room and board
- Behavioral health long term residential (non medical, non acute), without room and board
- Supervised behavioral health day treatment and day programs
- Therapeutic behavioral health services and day programs
- Community psychiatric supportive treatment and medical day programs
- Prevention services
- MST, FFT, ACT teams,
- Traditional healing (non Medicaid funds)
- Flex funds for discretionary (these are small – about \$850,000 statewide)

Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) is trying to get telephone consultation covered under Medicaid and just completed a white paper on the issue for Medicaid (e-mail consultation is covered).

For a complete description of Arizona's covered services, see the state's Covered Behavioral Health Services Guide, available at: [http://www.azdhs.gov/bhs/bhs\\_gde.pdf](http://www.azdhs.gov/bhs/bhs_gde.pdf). Appendix B2 to the guide describes provider types and fee for service rate guidance, available at: [http://www.azdhs.gov/bhs/app\\_b2.pdf](http://www.azdhs.gov/bhs/app_b2.pdf).

## **CA** California

### ***Covering a Broad Array of Services and Supports***

California covers a broad array of services and supports both through its broad Medicaid service coverage and a number of more flexible funding streams, particularly the Mental Health Services Act (Proposition 63). County funds also help to finance a broad service array. Either through Medicaid or other state or county funding, California covers all of the services in 5.1. In addition, the Mental Health Services Act specifically includes funding for prevention and early intervention services as well as evidence based and promising practices.

**HI Hawaii*****Covering a Broad Array of Services and Supports***

All services in the chart are covered under Medicaid, with match from mental health general funds. Mental health services at lower levels of intensity are provided through the education system through school-based mental health service delivery approaches (School-Based Behavioral Health Services and Supports– SBBH). If the need for more intensive services is identified, the youth is referred to the Family Guidance Center in his/her area. These youth are enrolled in the Educationally Supportive (ES) Intensive Mental Health Program (they generally are IDEA-eligible and have an individual education plan (IEP) with a recommendation for mental health services from the Child and Adolescent Mental Health Division – CAMHD). Medicaid-eligible youth may also receive basic mental health services from their Quest health plan. If they require mental health services that exceed the scope and intensity that can be provided by their health plan, they are enrolled in the Support for Emotional and Behavioral Development (SEBD) program (criteria include Medicaid eligibility, a DSM IV diagnosis of at least 6 months, and a CAFAS or PECAFS score of 80 or greater, with eligibility determined by the CAMHD Medical Director).

CAMHD’s website describes its service array as including: Emergency Crisis Intervention Services – 24-hour crisis telephone stabilization, mobile crisis outreach, residential crisis stabilization; Intensive Care Coordination, which is provided by CAMHD mental health care coordinators (MHCCs) located in Family Guidance Centers (intensive clinical case management); Intensive Treatment Services, which are intensive home and community-based interventions, Multisystemic Therapy (MST); and Community-Based Treatment Services including therapeutic foster homes, therapeutic group homes, community-based residential programs, and hospital-based residential programs. CAMHD’s service array is described is defined further in its Interagency Performance Standards and Practice Guidelines:

**Emergency Public Mental Health Services**

- Crisis telephone stabilization
- Crisis mobile outreach
- Crisis therapeutic foster home
- Community-based crisis group home

**Educationally Supportive Intensive Mental Health Services**

- Psychosocial assessments
- Intensive in-home intervention
- MST
- Respite therapeutic foster home
- Respite homes
- Community mental health shelter (24 hour temporary care for youth awaiting placement in an appropriate treatment facility)
- Therapeutic foster homes
- Multidimensional treatment foster care
- Therapeutic group homes
- Independent living programs (16-18 and 18-21)
- Community-based residential (Levels I, II, and III)
- Hospital-based residential (inpatient treatment)

**Support for Emotional and Behavioral Development (SEBD) Program Services**

- Comprehensive mental health assessment
- Focused mental health assessments
- Summary annual assessments
- Psychiatric evaluation
- Medication management
- Individual therapy
- Group therapy
- Family therapy
- Partial hospitalization
- Functional family therapy
- Peer support
- Parent skills training
- Intensive outpatient treatment for co-occurring substance abuse
- Intensive outpatient services for independent living skills
- Community-based clinical detoxification
- Community hospital crisis stabilization
- Acute psychiatric hospitalization

**Care Coordination (not sought through RFP, provided by CAMHD personnel)**

- Mental health care coordination
- Treatment/service planning participation/IEP participation
- School consultation
- Case consultation
- Family court testimony

**Support Services (not sought through RFP, provided by CAMHD personnel)**

- Ancillary support services
- Respite supports

**MI Michigan*****Covering a Broad Array of Services and Supports***

There is a minimum set of services that the Prepaid Inpatient Health Plans (PIHPs) managed care contracts must include and have available, including newly developed services. In addition, the contracts enable PIHPs to be flexible in their ability to offer additional services. The state rationale was that there would be cost savings from implementing the managed care model, which would allow PIHPs to afford the development of new services. The minimum set of services includes:

- **Psychiatric Evaluation** — This is a comprehensive evaluation, performed face-to-face by a psychiatrist who investigates a beneficiary's clinical status, including the presenting problem; the history of the present illness; previous psychiatric, physical, and medication history; relevant personal and family history; personal strengths and assets; and a mental status examination.
- **Psychological Testing** — Standardized psychological tests and measures rendered by full, limited-licensed, or temporary-limited-licensed psychologists.

- **Behavioral Management Review** — A behavior management or treatment plan, where needed, is developed through the person-centered planning process that involves the child and family. The person-centered planning process determines whether a comprehensive assessment should be done in order to rule out any physical or environmental cause for the behavior.
- **Child Therapy** — Treatment activity designed to prevent deterioration, reduce maladaptive behaviors, maximize skills in behavioral self-control, or restore or maintain normalized psychological functioning, reality orientation and emotional adjustment, thus enabling the child to function more appropriately in interpersonal and social relationships. A child mental health professional may provide child therapy on an individual or group basis.
- **Crisis Interventions** — Unscheduled activities conducted for the purpose of resolving a crisis situation requiring immediate attention. Activities include crisis response, crisis line, assessment, referral, and direct therapy.
- **Crisis Residential Services** — Crisis residential services are intended to provide a short-term alternative to inpatient psychiatric services for beneficiaries experiencing an acute psychiatric crisis when clinically indicated. Services may only be used to avert a psychiatric admission, or to shorten the length of an inpatient stay.
- **Family Therapy** - Family Therapy is therapy for a beneficiary and family member(s), or other person(s) significant to the beneficiary, for the purpose of improving the beneficiary/family function. Family therapy does not include individual psychotherapy or family planning (e.g., birth control) counseling. Family therapy is provided by a mental health professional.
- **Home-based Services** — Mental health home-based service programs are designed to provide intensive services to children (birth through age 17) and their families with multiple service needs who require access to an array of mental health services. The primary goals of these programs are to promote normal development, promote healthy family functioning, support and preserve families, reunite families who have been separated, and reduce the usage of, or shorten the length of stay in, psychiatric hospitals and other substitute care settings. Treatment is based on the child's need with the focus on the family unit. The service style must support a strength-based approach, emphasizing assertive intervention, parent and professional teamwork, and community involvement with other service providers.
- **Individual/Group Therapy** — Treatment activity designed to reduce maladaptive behaviors, maximize behavioral self-control, or restore normalized psychological functioning, reality orientation, remotivation, and emotional adjustment, thus enabling improved functioning and more appropriate interpersonal and social relationships. Evidence-based practices such as integrated dual disorder treatment for co-occurring disorders (IDDT/COD) and dialectical behavior therapy (DBT) are included in this coverage. Individual/group therapy is performed by a mental health professional within their scope of practice.
- **Intensive Crisis Stabilization Services** — Intensive/crisis stabilization services are structured treatment and support activities provided by a mental health crisis team and designed to provide a short-term alternative to inpatient psychiatric services. Services may be used to avert a psychiatric admission or to shorten the length of an inpatient stay when clinically indicated.
- **Medication Administration** — Medication Administration is the process of giving a physician-prescribed oral medication, injection, intravenous (IV) or topical medication treatment to a beneficiary.

- **Medication Review** — Medication Review is evaluating and monitoring medications, their effects, and the need for continuing or changing the medication regimen. A physician, physician assistant, nurse practitioner, registered nurse, licensed pharmacist, or a licensed practical nurse assisting the physician may perform medication reviews.
- **Physical Therapy**
- **Speech, Hearing, and Language** — Diagnostic, screening, preventive, or corrective services provided on an individual or group basis, as appropriate, when referred by a physician (MD, DO).
- **Substance Abuse** — These services are for individuals who reside in the specified region and request services. Outpatient treatment is a non-residential treatment service or an office practice with clinicians educated/trained in providing professionally directed alcohol and other drug treatment.
- **Targeted Case Management** — Targeted case management is a covered service that assists the child and family to design and implement strategies for obtaining services and supports that are goal-oriented and individualized. Services include assessment, planning, linkage, advocacy, coordination and monitoring to assist beneficiaries in gaining access to needed health and dental services, financial assistance, housing, employment, education, social services, and other services and natural supports developed through the person-centered planning process. Targeted case management services must be available for all children with serious emotional disturbance, adults with serious mental illness, persons with a developmental disability, and those with co-occurring substance use disorders who have multiple service needs, have a high level of vulnerability, require access to a continuum of mental health services from the PIHP, and/or are unable to independently access and sustain involvement with needed services.
- **Telemedicine** — Telemedicine (also known as telehealth) is the use of an electronic media to link beneficiaries with health professionals in different locations. The examination of the beneficiary is performed via a real time interactive audio and video telecommunications system.
- **Treatment Planning** — This includes activities associated with the development and periodic review of the plan of service, including all aspects of the person-centered planning process, such as pre-meeting activities, and external facilitation of person-centered planning. This includes writing goals, objectives, and outcomes; designing strategies to achieve outcomes (identifying amount, scope, and duration) and ways to measure achievement relative to the outcome methodologies; attending person-centered planning meetings per invitation; and documentation.
- **Psychiatric Inpatient Hospitalizations** — The PIHP is responsible to manage and pay for Medicaid mental health services in community-based psychiatric inpatient units for all Medicaid beneficiaries who reside within the service area covered by the PIHP. This means that the PIHP is responsible for timely screening and authorization/certification of requests for admission, notice and provision of several opinions, and continuing stay for inpatient services.

## **NJ** New Jersey **Covering a Broad Array of Services and Supports**

The state has expanded the services covered by Medicaid dollars as well as those covered by non-Medicaid dollars. The system design features a flexible, broad benefit plan that covers a wide array of traditional and non-traditional services. Services covered include: assessment, mobile crisis/emergency services, group home care, treatment homes/therapeutic foster care, acute psychiatric inpatient care, intensive face-to-face care management, wraparound, out-of-home crisis stabilization, intensive in-home services, psychotropic medications, medication management, behavioral assistance, wraparound services, and family-to-family support. The state also allows the Care Management Organizations (CMOs) to use flexible funds in order to meet additional individual needs that are not met through covered services.

## **VT** Vermont **Covering a Broad Array of Services and Supports**

The Vermont system of care includes the following services and supports, which are available regionally:

**Immediate Response:** Each Designated Agency (DA) provides access to an immediate response service and/or short-term assistance for children and adolescents who are experiencing a crisis and their families. Crisis services are time-limited (usually up to 2-3 days) and intensive and include the following:

- I. Assessment, support, and referral over the telephone
- II. Crisis assessment, outreach, and stabilization face-to-face
- III. Family and individual education, consultation, and training
- IV. Service planning and coordination
- V. Screening for crisis bed (hospital diversion) and for in-patient psychiatric hospitalization

**Clinic-based Treatment:** Each DA offers clinic-based treatment services for children and families. These services are available during daytime and evening hours for school-age children and/or when families can easily access them. The intensity of the service is based on the needs of the child and family, and the family's request for one or more the following elements:

- Clinical assessment
- Group, individual, and family therapies
- Service planning and coordination
- Medication services

**Outreach Treatment:** Each DA offers outreach treatment services for children and families. These services are available in the home, school, and general community settings. The intensity of the service is based on the needs of the child and family and the family's request for one or more the following elements:

- Clinical assessment
- Group, individual and family therapies
- Service planning and coordination

- Intensive in-home and out-of-home community services to child and family
- Medication services
- Family and individual education, consultation, and training

**Family Support:** Support services can be very important in reducing family stress and providing parents and caregivers with the guidance, support, and skill to deal with a difficult-to-care-for child. Each DA provides and/or has direct community connections to support services for families and youth. These services are offered in partnership with parents and consumer advocates. Participation in one or more of the following support services is voluntary and based on the family's needs and desires:

- Skills training and social support
- Peer support and advocacy
- Respite
- Family and individual education, consultation, and training

**Prevention, Screening, Referral and Community Consultation:** The goal is to provide prevention for all by: promoting healthy development, increasing protective factors, and reducing risk factors; early screening and intervention activities for those at risk; and, community consultation activities for non-mental health professionals, community groups, and the public.

In addition, the following services are available statewide:

- Emergency/Hospital Diversion Beds
- Intensive Residential Services
- Hospital Inpatient Services

## **AK** Bethel, Alaska

### ***Covering a Broad Array of Services and Supports***

In addition to the mental health assessment and treatment services that are available at the village level through teams of licensed mental health professionals and behavioral health aides, the following unique services are available in Bethel and offered to youth and families throughout the YKHC region—

#### **Fetal Alcohol Spectrum Disorders Diagnostic Team**

A multidisciplinary team composed of pediatricians, pediatric nurse practitioner, behavioral health clinician, Family Advocate, Clinical Psychologist, Occupational Therapist, Speech Pathologist and case manager provide diagnostic assessments for children and youth suspected of prenatal alcohol exposure.

#### **Kuskokwim Emergency Youth Services**

This is a 12-bed facility that houses two emergency shelter programs. One program, a Residential Diagnostic Treatment Center, provides evaluation and short-term residential treatment for children experiencing a life crisis so disruptive that it cannot be managed in an outpatient setting. The RDT offers an alternative to hospitalization in Anchorage for many youth and has the ability to address client needs in a culturally appropriate way by providing services closer to the home community, thus allowing family participation in treatment, and by primarily employing staff who are Alaska Native.

### **Inhalant Abuse Treatment Center**

This is the only residential treatment program in the nation specifically addressing the problem of inhalant abuse, offering a 14–16 week treatment program for up to six young people ages 10 - 17. Highlights of the program include a four-phase program starting with detoxification, then treatment. The family is integrated into all parts of the program, and the center works closely with the child's home community to develop a network of support for the child following treatment.

### **NE Central Nebraska Covering a Broad Array of Services**

During fiscal year 2005, Region 3 Behavioral Health Services (BHS) expended a total of \$6,313,638 for the purchase of services for children and families, intensive case management, youth leadership, family empowerment, evaluation and system coordination activities. Region 3 BHS contracts with a network of providers that offer the following services and supports for children and their families:

- 24 hour crisis services
- Mobile crisis services
- School-based outpatient family education, information, support and advocacy
- Family care partners
- Youth Encouraging Support (YES)
- Children's day treatment
- Medication management
- Mental health outpatient therapy
- Multisystemic Therapy
- Crisis inpatient services
- Substance abuse outpatient therapy
- Youth assessment (SA)
- Adolescent intensive outpatient
- Respite

Region 3 BHS provides directly:

- Professional partner program
- Integrated care coordination unit
- Early intensive care coordination (wraparound model)
- Alcohol, tobacco and other drug abuse prevention
- Mentor services

In addition to the services listed above that are provided or purchased by Region 3 BHS, specific treatment services for Medicaid-eligible children and families are authorized by Magellan, the statewide Medicaid behavioral health managed care organization. These include therapeutic foster care, therapeutic group homes, residential treatment centers, inpatient hospital services, case management services, transportation, and mental health consultation.

**Choices** **Choices**

**Covering a Broad Array of Services and Supports**

Choices provides a broad array of services and supports, all covered under the case rate structure in all the communities served. In addition to the services and supports, there are 11 different categories of flexible funds, which allows for creative service delivery and the provision of whatever services and supports may be needed by the youth and family.

Service Array			
Behavioral Health	Psychiatric	Mentor	Placement
<ul style="list-style-type: none"> <li>• Behavior management</li> <li>• Crisis intervention</li> <li>• Day treatment</li> <li>• Evaluation</li> <li>• Family assessment</li> <li>• Family preservation</li> <li>• Family therapy</li> <li>• Group therapy</li> <li>• Individual therapy</li> <li>• Parenting/family skills training</li> <li>• Substance abuse therapy, individual and group</li> <li>• Special therapy</li> </ul>	<ul style="list-style-type: none"> <li>• Assessment</li> <li>• Medication follow-up, psychiatric review</li> <li>• Nursing services</li> </ul>	<ul style="list-style-type: none"> <li>• Community case management/case aide</li> <li>• Clinical mentor</li> <li>• Educational mentor</li> <li>• Life coach/independent</li> <li>• Living skills mentor</li> <li>• Parent and family mentor</li> <li>• Recreational/social mentor</li> <li>• Supported work environment</li> <li>• Tutor</li> <li>• Community supervision</li> <li>• Intensive supervision</li> </ul>	<ul style="list-style-type: none"> <li>• Acute psychiatric hospitalization</li> <li>• Foster care—nontherapeutic</li> <li>• Therapeutic foster care</li> <li>• Group home care</li> <li>• Relative placement</li> <li>• Residential treatment</li> <li>• Shelter care</li> <li>• Crisis residential</li> <li>• Supported independent living</li> </ul>
Respite	Service Coordination	Discretionary	Other
<ul style="list-style-type: none"> <li>• Crisis respite (daily or hourly)</li> <li>• Planned respite (daily or hourly)</li> <li>• Residential respite</li> </ul>	<ul style="list-style-type: none"> <li>• Case management</li> <li>• Service coordination</li> <li>• Intensive case management</li> </ul>	<ul style="list-style-type: none"> <li>• Activities</li> <li>• Automobile repair</li> <li>• Childcare/supervision</li> <li>• Clothing</li> <li>• Educational expenses</li> <li>• Furnishings/appliances</li> <li>• Housing (rent, security deposits)</li> <li>• Medical</li> <li>• Monitoring equipment</li> <li>• Paid roommate</li> <li>• Supplies/groceries</li> <li>• Utilities</li> <li>• Incentive money</li> </ul>	<ul style="list-style-type: none"> <li>• Camp</li> <li>• Team meeting</li> <li>• Consultation with other professionals</li> <li>• Guardian ad litem</li> <li>• Transportation</li> <li>• Interpretive services</li> </ul>

## **OH** Cuyahoga County, Ohio *Financing a Broad Array of Services and Supports*

The system of care reform focuses specifically on financing a broad array of services and supports for the identified populations. Cuyahoga Tapestry System of Care CTSOC has created a Service Description List which includes both Medicaid and non-Medicaid funded services. Providers who apply to join the Provider Services Network must choose from this list which services they propose to offer. The list includes the following categories of service:

- Alcohol and Other Drugs
- Camp
- Family Support
- Independent Living Services
- Mental Health
- Mentoring
- Personal and Recreational Skill Development
- Residential
- Respite
- School-Related Services
- Therapeutic Services
- Transportation
- Vocation

The types of mental health services reimbursed by Medicaid include:

- Counseling/Therapy
- Assessment
- Community Psychiatric Supports
- Crisis Intervention
- Partial Hospitalization
- Pharmacy Management
- Residential Care
- Respite Care.

The list of covered services, their descriptions, and the service units for each can be found on the CTSOC website at: <http://cuyahogatapestry.org/pdf/Partners/ProviderServices.pdf>.

**NY** Erie County, New York***Financing a Broad Array of Services and Supports***

The following services are included in the service array financed by the Erie County system of care:

- Full Flex Wraparound
- Multisystemic Therapy
- Functional Family Therapy
- Urgent Access Intensive In-Home
- Integrated Youth Chemical Dependency Recovery Services
- Intensive Tracking, Monitoring, In-Home Services
- 24/ 7 Mobile Crisis Response Team
- PINS Diversion Early Intervention
- Preventive Services for Educational Neglect
- Family Advocacy/ Family Support
- Case Management
- PINS Diversion Family Mediation

**CO** Project BLOOM, Colorado***Financing Mental Health Promotion, Prevention, and Intervention/ Treatment Services and Supports Based on the Pyramid of Needs and Supports***

The services provided through the Project BLOOM system of care are guided by the “pyramid of needs and supports” and include mental health promotion for all children at the bottom of the pyramid, prevention for at-risk groups of children (middle of the pyramid), and intervention/treatment services for children with identified mental health problems (top of the pyramid). Although the federal funding is intended to focus on the top of the pyramid, i.e., those children already diagnosed with a serious emotional disorder and requiring intensive services and supports, early childhood systems of care must focus on the entire spectrum of interventions including universal interventions focusing on a total population of young children aimed at mental health promotion, indicated interventions focusing on intervening with at-risk populations, and targeted interventions for those already identified with emotional disorders. Providing universal mental health promotion activities to a total population of young children and their families, or providing services to high-risk children and families, impacts the need for higher levels of intervention in a more obvious and immediately recognizable way. Project BLOOM, together with other funded early childhood systems of care, advocated with the federal Children’s Mental Health Initiative (CMHI) to recognize the need for this conceptual shift from funded systems of care focusing on older children, resulting in a focus that is broader and represents an expansion from the focus solely on treatment for children with serious mental health problems.

The specific services financing by the BLOOM systems of care include:

- Assessment and diagnostic evaluation
- Outpatient psychotherapy (individual, family, and group)
- Medical management
- Home-based services/Home Visitation
- Crisis services (Family)
- Behavioral aide services (some)
- Behavioral management skills training
- Crisis residential services
- Inpatient hospital services
- Case management services
- School-based services (Child Care, Preschool)
- Respite services
- Wraparound services/process
- Family support/education
- Mental health consultation

The major funding sources for these services and supports include Medicaid, Part C, Maternal and Child Health Block Grant, General Fund, SCHIP, Child Welfare Core Services, SAMHSA system of care grant, and Child Care development block grant.

**WI** **Wraparound Milwaukee**  
***Covering a Broad Array of Services and Supports.***

Services are funded primarily by Medicaid, child welfare, juvenile justice, and mental health through capitation and case rate financing. Wraparound Milwaukee has over 200 providers (agencies and individuals) in its network, representing 85 different services and supports and including over 40 racially and culturally diverse providers. The services and supports it covers range from highly specialized clinical treatment services to nontraditional services and natural supports, including:

<ul style="list-style-type: none"> <li>• Care Coordination</li> <li>• Individual and Family Therapy</li> <li>• Substance Abuse Counseling</li> <li>• Group therapy</li> <li>• Crisis 1:1 Stabilization</li> <li>• Mentors</li> <li>• Tutors</li> <li>• Intensive In-Home Therapy</li> <li>• Psychiatric In-Patient Treatment</li> <li>• Residential Treatment</li> <li>• Group Home</li> <li>• Foster Care</li> <li>• Therapeutic Foster Care</li> <li>• Professional Foster Care</li> <li>• Medical Day Treatment</li> <li>• Crisis/Respite Group Home</li> <li>• Specialized Sexual Offender Services</li> <li>• FOCUS – Alternatives to Correctional Care</li> <li>• Medication Management</li> </ul>	<ul style="list-style-type: none"> <li>• Transportation</li> <li>• After school</li> <li>• Job coaches</li> <li>• Independent Living</li> <li>• Housing</li> <li>• Child care</li> <li>• Household management</li> <li>• Specialized educational services</li> <li>• Behavioral Aides</li> <li>• Supervised Apartments</li> <li>• Intensive In-Home Monitoring for Court</li> <li>• Discretionary funds</li> <li>• Parent Aides</li> <li>• Interpretation</li> <li>• Kinship Care</li> <li>• Rent/Food Assistance</li> <li>• Employment Training/Placement</li> <li>• Transitional care</li> </ul>
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## II. Financing an Individualized, Flexible, Wraparound Approach to Service Delivery

### Financing strategies include:

- A. Incorporate Flexible Funds for Individualized Services and Supports
- B. Finance the Functions of Child and Family Teams
- C. Incorporate Care Authorization Mechanisms that Support Individualized Care

### A. Incorporate Flexible Funds for Individualized Services and Supports

Most of the sites incorporate flexible funds that can be used to pay for services and supports that are not covered by Medicaid or other sources. The services purchased with flexible funds can be treatment services that may not be covered for individual children and their families and/or ancillary services and supports, varying by site. Typically, funds are designated as flexible resources, and child and family teams can access the funds to provide services and supports as needed. In some sites, such as **Central Nebraska** and **Wraparound Milwaukee**, the managed care financing approaches make the resources within the system inherently flexible to meet individualized needs. **Choices** created categories of flexible funds, and **Project BLOOM** developed detailed guidance for using flexible funds.

#### *Using Funds Designated as “Flexible Funds”*

- **In Arizona**, Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/ BHS) distributes about \$850,000 in discrete flexible funding to the Regional Behavioral Health Authorities (RBHAs), using general revenue and block grant dollars. RBHAs have flexibility in how they spend these dollars for individual children. However, they are small, amounting to an average of \$23 per child per year. Value Options indicated that individualized and coordinated plans of care are facilitated primarily by the child and family team approach and not by financing or single purchasing strategies.
- **In California**, flexible monies are available through Senate Bill 163 (Aid to Families with Dependent Children-Foster Care) wraparound funds, realignment funds (sales tax and vehicle licensure fees), Proposition 63 – Mental Health Services Act (MHSA), Assembly Bill 3632 (special education), and federal and state discretionary grant funds.
- **In Hawaii**, flexible funds are provided by the Child and Adolescent Mental Health Division (CAMHD) and are available to child and family teams to finance services and supports not covered by other sources. Flexible funds for “ancillary” services and supports can be used for a variety of purposes for children and their families as needed.

- **In New Jersey**, Care Management Organizations (CMOs) have allocations of flexible funds to assist in the development of individual service plans (ISPs) for the families they serve. This is done in conjunction with the child and family teams.
- **In Vermont**, flexible funds derived from mental health state general revenue dollars and federal grant funds are used to cover services and supports that are not allowable under Medicaid, the principal payer for services and supports. Decisions made by the individual child and family team and local lead agency drive the use of funds based on individual child and family needs. Many children with mental health needs also have needs across departmental lines of responsibility and are entitled to a Coordinated Service Plan. This broadens the scope of the child and family's plan to include both public and private services and funding resources.
- **In Cuyahoga County, Ohio**, funding from two county tax levies help to finance the system of care. These funds provide the county with the flexibility needed to cover costs that are not reimbursable with more traditional funding streams. Providers who enroll in the Provider Services Network have access to wraparound dollars. Each family's care coordinator can authorize up to a preset monthly maximum of \$200/family for individualized services.
- **In Erie County, New York**, there are approximately \$4.8 million of flexible service dollars allocated to the 458 slots of Wraparound. In addition, there is an approximate total of \$600,000 in additional flexible service dollars managed by the Mobile Crisis Response Team, the Persons In Need of Supervision (PINS) Diversion Family Service Team, and Step-Down Case Management. Funding is blended. The use of flexible dollars is determined by the child and family team planning process. A soft restriction is that, except on an exception basis, Medicaid reimbursed services and institutional costs are not paid for by flexible service dollars. The average annual flex dollar allocation for each child/family enrolled in Wraparound is \$11,375; this amount does not include Medicaid funded services or the cost of residential treatment center placements.

### **NE** **Central Nebraska and Wraparound Milwaukee** ***Using Managed Care Approaches to Provide Flexible Funds***

- **Central Nebraska's** case rate system allows care coordinators in the Integrated Care Coordination program (ICCU) and Professional Partners Program to have access to flexible funds that can be used to meet individualized needs of children and families and to fund services/supports that are not reimbursable with more traditional funding streams. Providers noted that care coordinators in ICCUs are willing to experiment with new strategies and that services are less restricted and categorical.
- **Milwaukee's** use of blended funding and of managed care approaches, such as capitation and case rates, and its broad, diverse provider network enable it to use funds in a flexible manner to implement an individualized approach to service delivery.

## Choices Choices

### ***Creating Categories of Flexible Funds for Discretionary Services and Supports***

The matrix listing service codes that can be provided by Dawn includes 11 categories of flexible funds, including activities, automobile repair, childcare/supervision, clothing, educational expenses, furnishing/appliances, housing, medical, monitoring equipment, paid roommate, supplies/groceries, utilities and incentive money. This demonstrates the degree of flexibility that child and family teams are given in planning services and supports that are tailored to the specific needs of each child and family. The flexible funds are used to finance supports including transportation (bus, car repairs, etc.), housing, utilities, clothing, food, summer camps (including for siblings), home repairs, and others. The expenditures must be within the care plan structure, and the plan must document how such expenditures will support the service plan goals for the child and family.

## CO Project BLOOM, Colorado

### ***Developing Guidance for Use of Flexible Funds***

Flexible funds are provided by the SAMHSA system of care grant. In addition, local Community Center Boards and other nonprofit or religious organizations are sources of flexible funding for services and supports that are not funded through other sources.

The **Project BLOOM** communities identify in their budgets how much they want to allocate to flexible funds each year. The budgeted amount ranges from about \$4,000 to \$7,000 in total or per child/family for the year?. A document was developed in 2005 to provide guidance to the communities regarding the use of flexible funds (A Guidance Document for Flexible Funding for Families of Children Receiving Services and Supports through Project BLOOM). It identifies parameters and provides examples. In general, flexible funds can be used for services and supports that are identified in the wraparound plan and that relate to the needs of the child. The document outlines the following guiding principles for flexible funding: 1) empowering families as decision makers, 2) respecting values and culture through individualization, 3) creating options with families, and 4) using local resources effectively. The categories for flexible funding include: respite care; professional services (such as counseling, therapies, or home health); medical; transportation; other individual expenses; equipment/assistive technology; home modification, and parent, sibling and social support. A sample decision making guide for the use of flexible funds also is included in the guidance. The document can be accessed at <http://www.ProjectBLOOM.org/ASP/DocumentationView.asp?NUMBER=77>.

Efforts at the state level are being directed to exploring the potential of other state agencies to contribute to flexible funding.

Respondents from the Colorado Federation of Families for Children's Mental Health reported that flexible funds from the SAMHSA system of care grant resources often are used to provide services and supports to families that are not covered in other ways, such as gift cards for groceries, home supplies, or other items identified in the wraparound plan that would make a difference in the lives of the child and family. A concern is that flexible funding may be difficult to sustain after the termination of the federal system of care grant.

Providers reported that flexible funds have been used for a short-term home health aide for a medically fragile mother, respite, swimming lessons at the YMCA, a deposit for an apartment, food, clothing, school supplies, medical bills, behavioral aides, etc. These limited resources are used as a last resort. In Aurora, a committee of two agency representatives and two family members review requests for flexible funds that are made by wraparound facilitators. Only families involved in wraparound are eligible for flexible funds.

## B. Finance the Functions of Child and Family Teams

In addition to flexible funds, individualized care requires the convening of a child and family team that, in partnership with the youth and family, develops and implements an individualized service plan. Strategies to finance the participation of staff and providers in the individualized service planning process and on child and family teams have been implemented by the sites. In several sites, staff and providers can bill Medicaid for time spent in child and family team processes as case management, and in some sites contract providers can bill the local lead agency for their time. Hawaii, for example, has a specific billing code for “treatment planning.”

### **AZ** Arizona

#### ***Covering Provider Participation as Billable Case Management***

Child and family teams are mandated in and covered by the managed care system. The state has given direction to providers as to how to bill for child and family teams (CFTs). Essentially, the CFT process is billed as case management. Elements of the process also can be billed as assessment, transportation, family or peer support, and interpretation services. The costs of transportation for families to participate are built into the rates paid to providers, unless the distance exceeds 25 miles in which case providers can bill separately. The state Medicaid agency has been cautious about using a case rate or bundled rate for CFTs. Child and family teams are required to be held at detention centers for youth who are in detention.

Child welfare uses Team Decision Making (TDM), which is used when the system is considering removal or temporary removal, and requires that TDM be implemented within 48 hours. It focuses primarily on safety issues, and then a child and family may move to a CFT process in the behavioral health managed care system. Behavioral health providers expressed concern that, while they can bill for participation in CFTs, they cannot bill for participation in TDM.

### **CA** California

#### ***Using Multiple Funding Sources for Wraparound Process***

Child and family teams can be financed through Senate Bill 163 (Aid to Families with Dependent Children-Foster Care) wraparound funds, Proposition 63 (Mental Health Services Acts — MHSA), Assembly Bill 3632 (special education) funds, and federal and state discretionary grants. Medi-Cal can be used for certain aspects of wraparound teams — for example, Contra Costa bills Medi-Cal for plan development.

**HI** Hawaii***Using Billable Code for Treatment Planning***

Child and family teams are organized as part of the Coordinated Service Plan (CSP) process. The CSP is an overarching, strengths-based plan that coordinates all services and supports for an individual child and family. Mental health care coordinators (MHCCs) play a pivotal role in service delivery by convening an initial CSP meeting and coordinating the development of the service plan. All services included in the CSP are then authorized. MHCCs are state employees who are attached to the Family Guidance Centers that are part of the Child and Adolescent Mental Health Division (CAMHD). Their lead role in individualized service planning is an integral part of their responsibilities. Many other agency staff who participate in teams are also state employees and participation is considered to be part of their role. For contract providers (such as outpatient therapists), participation in individualized service planning process is billable time under a service code for “treatment planning.” For some providers (such as intensive in-home service providers), participation in the wraparound planning process is considered part of their unit cost. Some in home provider agencies suggested that this can create cost pressure, particularly if the provider must travel to another island for the child and family team meeting. Parent partners participate in individualized service planning process if requested by a family and are paid through a contract with the family organization that is funded through block grant dollars.

Teleconferencing is being used to a greater extent to facilitate this process; videoconference would be helpful but the capability is not fully developed.

**MI** Michigan***Using Waivers to Finance Child and Family Teams***

Wraparound services for children and adolescents involve an individualized planning process performed by support coordinators who coordinate the planning and delivery of these services. Wraparound utilizes a Child and Family Team with team members determined by the family, often representing multiple agencies and informal supports. The Team creates an individualized plan of service for the child that consists of mental health specialty treatment, services and supports covered by the Medicaid mental health state plan, or waiver services. Children qualify for wraparound if they meet two or more of the following:

- Involved in multiple systems
- At risk of out-of-home placements or are currently in out-of-home placement
- Been served through other mental health services with little improvement
- Have risk factors that exceed capacity for traditional community-based options
- A family that has many providers serving multiple children and outcomes are not being met.

Child and Family Teams are financed through wraparound, which is a reimbursable service under all four of the waivers – a 1915(c) Habilitation Supports Waiver, 1915(b) Managed Specialty Supports and Services Waiver, 1915(c) Children’s Waiver, and 1915(c) Children with Serious Emotional Disturbance Waiver.

**VT Vermont*****Covering Provider Participation as Case Management and Individualized Service Planning***

Vermont's system of care provides financing via Medicaid, block grant, and general fund dollars to support staff participation in the service planning and the work of individual child and family teams. These teams have the responsibility of developing the individual service plan for the child. System of care financing supports the development of a Coordinated Service Plan, which is required by state statute for children with severe emotional disturbance and their families. Payment for participation in team planning can be billed as case management under Medicaid. In addition, provider participants not located in the Designated Agency (DA) can bill the DA for their time participating on child and family teams for individualized service planning. Family members on child and family teams may receive some support to aid participation (e.g., transportation).

**Choices Choices*****Covering Participation as Case Management and Additional Service Hours***

Participation in child and family team meetings is billable time under Medicaid for care managers. Providers participating in child and family team meetings in support of individualized services may request payment for their participation by adding extra hours onto their care authorizations. A primary role of the care coordinator is to create and convene a child and family team, which is done as soon as possible, always within 30 days of the referral, and continues to meet at least monthly thereafter. Child and family teams are comprised of all the individuals who can contribute to the child and family's services and support (parents or other caregivers, child if appropriate, care coordinator, referring worker, currently involved service providers, therapist, school representative, other natural or community supports identified by the family, e.g., minister, relative, respite provider). Team members participate in a care planning process referred to as the "strengths discovery process," used as a framework to jointly develop and reach consensus on goals and a course of action. This process involves analyzing the child and family's strengths and needs across significant life domains, including health/medical, safety/crisis, family/relationships, educational/vocational, psychological/emotional, substance abuse, social/recreational, daily living, cultural/spiritual, financial, and legal. The resources and strengths of the child and family are used as tools to create solutions and to build a "care coordination plan," which is the individualized service and support plan. The care coordination plan focuses on three to five of the identified needs determined to be the top priorities to be addressed during the next 30 days. For each need, the plan specifies desired outcomes (measurable), specific interventions (services, supports, or resources) planned to achieve the outcomes, and who is responsible for providing each of the specified interventions. A safety and crisis plan also is developed by the team and includes clear-cut instructions for what to do whenever a crisis may occur. The child and family team is responsible for reviewing and monitoring progress toward goals at least every 30 days and altering service plans and/or providers as needed.

**OH Cuyahoga County, Ohio*****Using Employees as Wrap Specialists and Care Coordinators***

The care coordinators and wrap specialists are all employees in the system of care and thus their participation in the team meetings is covered. For providers, the Provider Services Network (PSN) brochure indicates that indirect costs are included as a part of the cost of care. Providers are expected to provide services according to the wraparound plan of care and are included in Child and Family Team meetings at the families' request.

**NY Erie County, New York*****Using Redirected Dollars to Finance Wraparound***

With an investment of resources from its two primary partnering departments (mental health and social services) and the SAMHSA System of Care Grant in a system of care/wraparound approach, the county launched a jointly sponsored cost savings initiative projected to generate a cumulative sixty per cent (60%) reduction in Residential Treatment Center bed day utilization over four years. Cost savings generated by reducing use of RTC placements and lengths of stay were targeted to the development of expanded capacity for Wraparound Services and other evidence based/emerging service models to interrupt system penetration and/ or provide effective service alternatives to institutional placement.

Entering 2008, Wraparound capacity was to be funded at a capacity of 469 slots with approximately \$4.8 Million of flexible service dollars. There are six Wraparound Agencies in Erie County. Each currently manages the child and family team process and the service dollars for its enrolled families. The county is moving toward a separate Administrative Support Organization (ASO) that establishes a management capacity outside of county government to oversee the efficacy and quality of the practice of Wraparound and Vendor Agency services. The entity will administer the pool of flexible funds and the related vendor services that are purchased by the child and family teams.

There are approximately \$4.8 million of flexible service dollars allocated to the 458 slots of Wraparound. The average annual flex dollar allocation for each child/family enrolled in Wraparound is \$11,375; this amount includes all services except those funded by Medicaid and the cost of RTC placements. Care coordinators carry a caseload of 11 families; supervisors have a caseload of one family. In total, there are up to 458 families served at any point in time in Wraparound, which incorporates a uniform standard of practice consistent with system of care values, culture and practice for child and family teams. Many of the other services in the system of care continuum have incorporated the individualized service planning practices of Wraparound. In addition, there is an approximate total of \$600,000 in additional flexible service dollars managed by the Mobile Crisis Response Team, the PINS Diversion Family Service Team and Step-down Case Management. The use of flexible dollars is determined by the child and family team planning process.

**CO** **Project BLOOM, Colorado*****Using Grant, Medicaid and Part C Funding for Wraparound Facilitators***

Full-time wraparound facilitators are funded by the SAMHSA system of care grant in the four **Project BLOOM** communities and by the community mental health centers (CMHCs). Some Medicaid reimbursement is received for the functions of the wraparound facilitators under case management. In addition, Part C service coordinators and some staff from other systems (e.g., child welfare workers) are trained as wraparound facilitators.

Providers agree to be a part of child and family teams as integral to participating in the system of care; it is considered to be part of their jobs. In some cases, their time can be billed as case management. However, the time spent by some providers participating in child and family team meetings may not be billable if they are not providing a “clinical intervention.”

**WI** **Wraparound Milwaukee*****Covering Participation with Blended Funds***

Participation by clinical staff in team meetings is not a billable service for Medicaid purposes. However, Wraparound Milwaukee pays therapists and other staff as needed to participate in team meetings, using its other funding sources.

## C. Incorporate Care Authorization Mechanisms that Support Individualized Care

A number of the sites use child and family teams as the mechanism for authorizing services. The plan of care developed by the child and family team determines medical necessity and all or most services specified by the plan are considered to be authorized.

### *Using Child and Family Teams to Authorize Services*

- **In Arizona**, except for residential treatment, which requires prior authorization, the child and family team plan of care determines medical necessity and drives service authorization.
- **In Hawaii**, the child and family teams develop the service plan (Coordinated Service Plan), and all services in the plan are authorized; the mental health care coordinator completes needed written service authorizations. The team is the decision maker regarding care authorization.
- **In New Jersey**, the Care Management Organizations (CMOs) are responsible for the coordination of care for children with serious emotional problems and their families. To enable care managers to provide intensive care management, caseloads are capped at a ratio of 1 care manager to 10 children. Care coordinators use child and family teams to plan and coordinate services and supports, and services included in the plan are authorized by the Contracted Systems Administrator (CSA).
- **In Vermont**, care authorization takes place at the local agency level, based on the treatment team plan. Should questions or disputes arise for children with serious emotional disorders receiving services under the system of care, the Local Interagency Team is available to assist and help achieve resolution. Further assistance may be requested of the State Interagency Team should issues remain unresolved through the local forums.
- **In Choices**, the child and family team creates a care coordination plan for each child and family. This care plan is the authorizing document, in that any service prescribed in the plan is considered to be authorized. Providers submit bills based on this authorization and are paid on a fee-for-service basis.
- **In Cuyahoga County, Ohio**, the care coordinator's supervisor has the authority to authorize a pre-defined limit of service units each month for a single recipient, e.g., \$200 in discretionary funds, based on the child and family team plan of care. If the quantity requested by the care coordinator (i.e. by the team) exceeds the preset monthly maximum, the Cuyahoga Tapestry System of Care (CTSOC) Office, which functions as an Administrative Service Organization reviews the request and can approve or disapprove. However, the child and family teams have a great deal of discretion within the defined utilization parameters.
- **In Wraparound Milwaukee**, the child and family team, using a strengths-based, individualized approach, determines "medical necessity"; including for Medicaid purposes, and services specified by the team are considered authorized, except for inpatient hospitalization, residential treatment, and day treatment which require prior authorization by Wraparound Milwaukee functioning in its role as a managed care organization.

### III. Finance Evidence-Based, Evidence-Informed, and Promising Practices

#### Financing strategies include:

- A. Incorporate Financing and Incentives for Using Evidence-Based, Evidence-Informed, and Promising Practices and for Development, Training, and Fidelity Monitoring

#### A. Incorporate Financing/Incentives for Using Evidence-Based, Evidence-Informed, and Promising Practices and for Development, Training, and Fidelity Monitoring

The sites are involved in promoting and financing the implementation of evidence-based, evidence-informed, and promising practices. Their strategies range from establishing billing codes for specific evidence-based practices to providing financial support for the initial training and start-up or developmental costs involved in adopting evidence-based practices, and, in some cases, providing resources for ongoing training and fidelity monitoring. A range of evidence-based approaches is supported in the sites, such as Multisystemic Therapy (MST), Functional Family Therapy (FFT), Multidimensional Treatment Foster Care (MDTFC), Dialectical Behavior Therapy, Cognitive Behavioral Therapy, Brief Strategic Family Therapy, Aggression Replacement Therapy, Integrated Co-Occurring Treatment, Parent-Child Interaction Therapy, the Incredible Years, and Touch Points among others. Nearly all the sites use the wraparound process.

#### **AZ** Arizona

##### ***Financing Specific Evidence-Based Practices***

In addition to its commitment to fund a wraparound approach throughout the system, the system at the time of the site visit was also funding Multisystemic Therapy (MST), Functional Family Therapy (FFT), Multidimensional Treatment Foster Care in Maricopa County only, and Dialectical Behavior Therapy. At both the state and Regional Behavioral Health Authority (RBHA) levels, there also is interest in developing several evidence-based practices (EBPs) in the substance abuse area, including: Stages of Change, Motivational Interviewing, Seven Challenges, and the Matrix Model. The Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) has a best practices committee structure, which includes representation from the RBHAs and families, but does not yet include the other system partners like child welfare. (This committee was in the process of being restructured at the time of the site visit.)

MST at the time of the site visit was funded on a single day rate of \$65/day, as a partial day program. At the time MST was instituted (2004), this was the only option for coding the service; more recently, ADHS/BHS was looking at using the federal MST code. In general, rates are negotiated for

each EBP, and quality supervision is built into the rate. Providers indicated that the managed care structure provides more flexibility to tailor rates to individual EBPs.

Development of EBPs is financed through ADHS/BHS, using mainly grant funding and some block grant monies, as well as by other state agencies. For example, MST and FFT were developed initially by juvenile justice, using state general revenue funds, and then these providers became part of RBHA networks. Also, the RBHAs are allowed to spend up to 7% of their budgets on administration, which could include development of EBPs. ADHS/BHS, using grant dollars, has funded consultants and trainers and has subsidized providers so they can participate in training (i.e. paying them for lost billable time). Value Options (VO) indicated that because most revenue is based on actual encounters, it is difficult to find dollars for EBP development and fidelity monitoring, although VO has supported agencies in the network to develop certain EBPs, using specific contracts for that purpose.

### **CA** California

#### ***Financing a Technical Assistance Center to Support Implementation of Evidence-Based Practices (EBPs) and Using Multiple Funding Streams to Finance EBP Delivery***

The **California** Institute of Mental Health (CIMH), which was created by the county mental health administrators as a training arm, houses the Cathie Wright Technical Assistance Center, which had received funding through the state Children's System of Care program (now eliminated) to provide technical assistance to the counties on building systems of care. The state still provides some general revenue funding for the center, and CIMH has a larger contract funded by Prop 63 (Mental Health Services Act) funds, with a portion supporting promising practices in the children's arena.

Development of evidence-based practices are not specifically mandated or incentivized by the state. However, CIMH works with interested counties and private, nonprofit community-based organizations to facilitate state-level support for development and implementation of EBPs, including training and addressing systemic barriers to EBP implementation. For example, State Department of Mental Health released an information notice at the request of CIMH clarifying a billing issue related to implementation of the Incredible Years. In this case, county mental health departments were uncertain as to whether or not they could bill for the BASIC Parent Groups when the child – the Medi-Cal beneficiary – was not present. DMH Letter 07-03, Medi-Cal Reimbursement of Collateral Services Provided to Significant Support Persons in Group Settings, outlined the circumstances under which services such as Incredible Years can be billed as a collateral service. As another example, Multidimensional Treatment Foster Care requires multiple financing streams – Medi-Cal, Title V-E, and dollars for respite and for an augmented foster parent rate. Cobbling the financing together is a deterrent to counties to implement MDTFC. CIMH is working on trying to get the state to use a bundled rate.

CIMH, which plays a key facilitative role in supporting counties and the state to implement EBPs, is financed with state general funds, federal grants, MHTA (tax levy on millionaires), private foundations, and fees charged to counties or community based organizations. Generally, county mental health agencies take the lead in working with CIMH, but other child-serving systems may access CIMH technical assistance as well.

Through research and experience, CIMH has developed an approach designed to support the implementation of practices that adhere to model practice, particularly evidence-based practices. In this model, the Community Development Team establishes a cohort of sites that work with the EPB developers, who, in turn, provide training and coaching in the practice. CIMH guides the planning process, provides organizational support and offers implementation and evaluation support. Whenever possible, CIMH secures contracts and grants to subsidize the cost of the implementation project on behalf of the county agencies or community-based organizations that participate and pay fees to address remaining project costs.

While the state believes that the MHSA will help to build stronger accountability for use of EBPs, it also noted that there is “community-defined evidence” for effective practices that also should be supported. It cited the promotores model as one example (outreach and system navigation support using culturally relevant natural helpers), and noted that these practices may also have a bearing on reduction of disparities in access based on race/ethnicity.

**Contra Costa** is an example of a county mental health plan that has partnered with CIMH. The county identified the following EBPs as ones that it has already received CIMH support to develop or for which it is planning to enlist CIMH support:

- Multidimensional Family Therapy (implemented)
- Brief Strategic Family Therapy (next for implementation)
- CBT-School depression (in training-of-trainers phase)
- Multisystemic Therapy (MST)
- Aggression Replacement Therapy (will train clusters, including at drug court – is a county mental health and alcohol and other drug – AOD – collaboration)
- Multidimensional Treatment Foster Care Wraparound

Contra Costa reported receiving the following types of technical support financed through a combination of state (MHSA dollars) and federal grant financing of the CIMH and county funds: sending county employees and providers to Oregon for training; financing Oregon coaches to come to Contra Costa to train and mentor foster families; evaluation; and paying for training of trainers.

At the time of the site visit, the county was in early implementation of its Children’s Alternative Treatment (CAT) Project, focused on diverting youth with serious emotional disturbances in juvenile justice from institutional and group home placement by providing best practice alternatives, including Multisystemic Therapy (MST), Multidimensional Treatment Foster Care (MTFC), and Wraparound. The project is financed by a Mentally Ill Offenders Criminal Reduction Act (MIOCR) grant from the state corrections agency, Medi-Cal and Aid to Families with Dependent Children-Foster Care (AFDC-FC) funding. Development costs (training, coaching, etc.) and ongoing services once developed related to the best practices are financed as follows:

- MST – MIOCR grant pays for training; Medi-Cal and state juvenile justice general revenue pay for services
- MDTFC and California Institute of Mental Health using an NIMH grant pay for training; AFDC-FC pays for room and board; Medi-Cal pays for clinical; also state juvenile justice general revenue funds are used for non Medi-Cal covered youth or costs
- Wraparound – Mental Health Services Act (Prop 63), CIMH, and First 5 Commission funds pay for training (because wraparound training is open to everyone); Medi-Cal and state juvenile justice general revenue funds pay for wraparound.

Contra Costa indicated that EBPs, in the absence of bundled or case rates, are “a lot of work” for providers, who have to cobble together different billing streams to cover the costs.

**HI** Hawaii***Promoting the Use of Evidence-Based Practice Components and Financing Specific Evidence-Based Practices***

There are financial incentives for using evidence-based practices, including evidence-based decision-making and using practices that produce results. One of the goals in the strategic plan for 2003–2006 was to consistently apply current knowledge of evidence-based services in the development of individualized plans and to ensure that the design of the mental health system facilitates the application of these services.

The Child and Adolescent Mental Health Division (CAMHD) has an Evidence-Based Services Committee comprised of academicians, CAMHD leadership, providers, and families to review and evaluate relevant research to inform service delivery and practice development. The committee completed extensive work to identify the specific “practice components” or elements that comprise those clinical approaches that are supported by research evidence. The state is now collecting information from providers about the use of these practice components as part of the clinical intervention process in service delivery. A coding system was developed along with an accompanying codebook to define and identify the various practice components or intervention strategies. Some of these components/strategies include: assertiveness training, biofeedback, cognitive/coping, commands/limit setting, communication skills, crisis management, educational support, emotional processing, family engagement, family therapy, functional analysis, hypnosis, insight building, interpretation, mentoring, modeling, natural and logical consequences, parent coping, peer modeling, play therapy, problem solving, relationship/rapport building, relaxation, response cost, self-reward, social skills training, supportive listening, tangible rewards, time out, and twelve-step programming.

However, practice has not shifted significantly toward increased use of the practice components as has been intended. CAMHD contracts with approximately 48 agencies with over 500 clinicians. Although supervisors may attend training, not all clinicians are reached through training efforts. Despite evidence that clinicians are not adopting and using the practice components to the extent intended, measurement has produced better outcome data than in the past, leading to questions as to what factors are tied to improved outcomes. It has been suggested that child/family engagement with clinicians may be a better predictor of good outcomes than use of the evidence-based practice components. Regardless, Hawaii’s approach is not to be “wedded” to any particular evidence-based treatment, but rather to offer the practice components that comprise evidence-based treatments as options that providers can use to improve their practice approaches.

RFPs for providers emphasize the commitment to evidence-based practices. In addition, the state invests resources in practice development, including training, supervision, workshops, and the development of materials and tools to support the adoption of evidence-based practices (such as menus or “blue cards”, fact sheets, and curricula).

Various evidence-based practices are being added as services that will be covered under the state’s Medicaid plan, including Multisystemic Therapy (MST), Functional Family Therapy, Parent Skills Training, Multidimensional Treatment Foster Care, and others. There is funding for the development, training, and fidelity monitoring of evidence-based practices. The state has “practice development specialists”, who have provided training and technical assistance to supervisors and clinicians. The state has provided resources for start-up, training, supervision, and fidelity monitoring of MST and will be doing this for Multidimensional Treatment Foster Care and Functional Family Therapy.

The state has contracted for these evidence-based services. For example, CAMHD has contracted for 8 MST teams statewide, and will be contracting for Functional Family Therapy statewide at all agencies. Multidimensional Treatment Foster Care will be started in two sites and outcomes will be examined. General fund dollars are used to support the training, start-up, supervision, fidelity monitoring and other expenses attendant to developing the capacity and delivering these interventions.

## **MI** Michigan

### ***Financing an Evidence-Based Practice (EBP) Initiative to Support EPB Implementation and Using State Funds to Support Implementation of Specific EBPs***

The state expects that as part of the Medicaid covered specialty services, the Prepaid Inpatient Health Plans (PIHPs) will utilize evidence-based and promising practices whenever possible. The PIHPs are also expected to employ staff that has been properly trained in the appropriate model(s) to provide the services.

In 2004, the Department of Community Health (DCH), Mental Health and Substance Abuse Administration, launched an EBP initiative and established a Steering Committee (now called the Practices Improvement (PI) Steering Committee) to undertake the dissemination of EBPs in the state. The original aim of the initiative was to improve the practices used by the adult public mental health system, but the committee also oversees the implementation of EBPs at pilot sites for children with serious emotional disturbance. The committee is comprised of consumers, advocacy organizations, representatives from the PIHPs, major state universities and DCH staff.

In that same year, the state announced the intention to use the Community Mental Health Block Grant funds to support the implementation of three evidence-based practices. Request for Proposals were issued to the 18 PIHP's. In addition, one condition for receiving up to \$140,000 (for two years) in block grant funds was that each PIHP had to establish an Improving Practices Leadership Team. This team administers local initiatives to implement the EBPs. As a result, the teams are expected to create organizational cultures that want to implement other EBPs and improve existing practices. Ten of the 18 PIHPs proposed to employ Family Psycho-Education, and nine proposed to implement Co-Occurring Disorders: Integrated Dual Diagnosis Treatment. The remaining seven PIHPs were selected to implement Parent Management Training, the Oregon model (PMTO).

At the time of the site visit, the state was using PMTO, which helps parents develop the skills needed to help manage the challenging behaviors that their children may exhibit. The training helps parents to successfully support and maintain their children at home and in the community. When parents are given the skills needed to help their children, they are also able to have an improved quality of life. There is evidence that using this in concert with other home-based training doubles the effect. PMTO is a preferred evidenced-based intervention as well as Multisystemic Therapy (MST). Communities can use block grant funds (which can pay for training and infrastructure), the Child Care Fund (CCF) and Medicaid to cover these services. The state has a certified PMTO trainer that is currently training three others. There are currently no fiscal incentives offered by payers to use EBPs.

**AK** Bethel, Alaska***Financing Specific Evidence-Based Practices***

Some state grant funding is available for evidence-based practices (e.g. Fetal Alcohol Syndrome, Youth Substance Abuse treatment). Training on evidence-based practices (EBPs), for example, is only offered if it is covered by a state grant. In addition, Medicaid incentivizes the use of EBPs by identifying services that are covered that can be used to pay for various EBPs.

**Alaska's** Department of Juvenile Justice (DJJ) strongly supports implementation of EBPs including Multisystemic Therapy (MST) and Aggression Replacement Therapy. DJJ also uses Youth Level of Services (YLS), a required intake form which collects criminal history, mental health needs, and family history. There is a strong focus on family strengths and efforts to get the family involved. DJJ is also participating in an Office of Juvenile Justice and Delinquency Prevention-funded project on performance based standards for juvenile facilities.

**NE** Central Nebraska***Financing Specific Evidence-Based Practices***

Through cross-system collaboration and strategic financing at the state and regional level, Central Nebraska families now have access to Multisystemic Therapy (MST). Nebraska built MST into its application for a federal system of care grant because it viewed MST as a therapeutic intervention with good outcomes for youth in the juvenile justice system. Federal grant funds were used for the development phase of MST, for clinical consultation, and to train two mental health centers to become MST providers. Nebraska "grew its own" MST, rather than inviting a MST provider to come into the state and set up shop. Although no one system is able to pay for all the costs of MST, by sharing the financing responsibilities, the provider is guaranteed to receive the full case rate amount. One mental health center continues to offer MST; the second center, located in a rural area, was not able to sustain the service. Approximately 226 youth and families participate in MST each year.

Nebraska's federal State Infrastructure Grant (SIG) has enabled the state to review evidence-based practices (EBPs) from a statewide perspective; to study the "real" costs for implementing EBPs, including development, training, monitoring, licensing; and to make decisions about how to proceed. There has been discussion of shifting funds from services that are not evidence-based to those that are, but this raises concern about limiting the types of services that are available and prescribing specific services, which is counter to Nebraska's philosophy of individualized and family-centered care. Through its SIG work, Nebraska is engaged in a comprehensive process to assess and select evidence-based practices that fit the unique character and needs of the state.

The wraparound approach is the basis for the work in Central Nebraska's system of care. To ensure fidelity to the wraparound model, Region 3 Behavioral Health Services (BHS) contracts with Families CARE to collect Wraparound Fidelity Index information from parents, youth and care coordinators. This feedback allows for continual improvements of the program and builds a capacity for parent-to-parent support by using a family evaluator. Other team members who participate on the child and family teams also are asked to assess wraparound fidelity on a semi-annual basis.

**Choices** Choices***Providing Technical Assistance on Implementation of Evidence-Based Practices***

The state mental health agency contracts with Choices to operate a Technical Assistance Center (TA Center) to provide training, coaching and technical assistance for more than 60% of Indiana's counties that are developing local systems of care. The state and the TA Center are now exploring mechanisms for identifying and disseminating effective models of care (i.e., evidence-based practices –EBPs) and strategies for “building a culture” supportive of implementation. One barrier is that, aside from some resources for technical assistance, there are no extra resources for the capital expenditures that are required to become a provider of particular evidence-based practices, nor are there resources for ongoing training, support, and fidelity monitoring. Reimbursement mechanisms for EBPs also are needed, e.g., Medicaid billing codes. MST and Functional Family Therapy can be billed under the current Medicaid plan. The TA Center currently is assembling a group of stakeholders to identify the EBPs that are being implemented in Indiana with fidelity and to assess gaps.

In addition, to assess fidelity to the wraparound approach that forms the basis for service delivery in systems of care, the TA Center is responsible through a subcontractor for completion of the Wraparound Fidelity Index (version 4) for a sample of more than 100 caregivers, care coordinators and youth in 2007.

**OH** Cuyahoga County, Ohio***Financing Implementation, Training, Coaching, and Fidelity Monitoring of EBPs***

Even though **Ohio** is home to the Center for Innovative Practices, Cuyahoga finds it a challenge to implement evidence-based practices. Ohio Medicaid pays for services for the identified child and not for other family members, while most EBPs are family- based. However, the Cuyahoga Tapestry System of Care (CTSOC) has taken on the challenge of implementing EBPs.

One function of the Funders Group is “to determine which services should be recommended for continued funding and what new services and EBPs should be made available for the families and children of Cuyahoga County.” A secondary goal of system of care initiatives is “to introduce several EBPs into the array of services provided to children and their families”, including:

- **High Fidelity Wraparound** — CTSOC initiated the National Wraparound Fidelity Initiative in 2005 and has been highly successful in its implementation. CTSOC funds contracts with consultants to provide high fidelity wraparound coaching for care managers, wrap specialists, parent advocates, and supervisors across the system of care initiatives (including the Family to Family Initiative, Care Coordination Partnerships, and PEP/Tapestry). A key challenge of the system is to ensure fidelity across all the sites and to measure this fidelity. CTSOC also has a subcommittee on Wraparound Fidelity. The committee is charged with ensuring fidelity across the various efforts that use wraparound, developing a system for certification/skill verification, implementing Coaching Learning Communities across the various efforts, and developing and supporting a pool of trainers. This committee links with subcommittees for Continuous Quality Improvement. Ohio has developed its own in-state training model and CQI model for wraparound, and a small pool of trainers is being trained. The clinical outcomes from high-fidelity wraparound are strong.

- **Brief Strategic Family Therapy** — Cuyahoga County was asked to implement Brief Strategic Family Therapy by the evaluation arm of the federal CMHS system of care grants. After many starts and stops, it has not yet been implemented.
- **Integrated Co-Occurring Treatment** — CTSOC is using SAMHSA funds to test this EBP for youth with co-occurring substance abuse and mental health disorders because it is not covered by Medicaid. Data from the county's system of care grant for adolescents with substance abuse problems showed that 85% of adolescent girls with substance abuse issues also are depressed. This EBP has shown positive results in other places. Other CMHS SOC sites are also participating in implementation of this treatment model.
- **Multisystemic Therapy (MST)** — MST is already well-established in Cuyahoga County (4 providers). Medicaid covers part of the costs of MST.

### **NY** Erie County, New York *Financing Implementation, Training, Coaching, Fidelity Monitoring of Specific EBPs*

The county system of care has implemented several initiatives with full financial support to reinforce evidence-based and effective practice:

1. A multi-step training, coaching and mentoring initiative for Wraparound services;
2. Development of coaching supports (consultation, data dashboard, learning communities) for Wraparound supervisors;
3. Local evaluation integrating the Wraparound Fidelity Index (WFI) into the evaluation of Wraparound; and,
4. Utilization of CareManager management information system as clinical administrative database to reinforce fidelity to practice standards.

Other evidence-based and emerging practices funded include Multisystemic Therapy, Functional Family Therapy, Urgent Access In Home, and Integrated Youth Chemical Dependency Recovery Services. Supervision levels and other fidelity to practice supports are built into the funding model for these services.

In addition, the county is piloting a performance contract that aligns reimbursement with the achievement of milestones that support fidelity to practice and achievement of outcomes that are valued by families.

These activities related to EBPs are supported by federal system of care grant funds. The sustainability of these activities will be integrated into the operational costs of the service models and the emerging capacity of the Administrative Support Organization, an entity under development that will be separate from county government and will provide administrative support services to the local system of care, including management of the blended funding pool.

Medicaid financing for evidence-based practices in clinic settings has been a challenge because clinic services are paid for on a fee-for-service basis, and the current financing structure does not support EBP implementation activities, such as training, consultation, and fidelity assurance mechanisms.

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**CO** **Project BLOOM, Colorado**  
***Using Block Grant Funds, Medicaid, and Early Childhood Council Funding for EBPs, Training, and Fidelity Monitoring***

Block Grant funds were made available to CMHCs to submit proposals for the implementation of EBPs, though not specific to early childhood. For example, Fremont County submitted a proposal to implement wraparound. The child welfare system also set aside Core Services dollars to fund EBPs, such as Multisystemic Therapy and Functional Family Therapy.

A blend of funds is used to support EBPs including Parent-Child Interaction Therapy (PCIT), the Incredible Years, and Touch Points. Some Medicaid funding is available for these interventions under existing billing codes for therapy (individual, family, and group) as well as SAMHSA system of care grant funds. The mental health centers and Early Childhood Councils are likely to pick up the costs of these interventions when grant funds are no longer available.

**Project BLOOM** and the Colorado Association for Infant Mental Health organized a conference on EBPs for early childhood mental health in 2007 to provide training on infant and early childhood mental health interventions statewide (“Infant and Early Childhood Mental Health in Colorado: Connecting Policy with Research and Practice”). There is a great deal of national expertise in infant and early childhood mental health in Colorado, and the state has attempted to connect communities with this expertise.

Training in wraparound and in the use of the Wraparound Fidelity Index (WFI) is supported with SAMHSA system of care grant funds. SAMHSA system of care grant funds also support training and ongoing coaching in the use of the DC: 0–3R diagnostic system, a diagnostic system specific to young children. This training is provided by the Harris Infant Mental Health Program at the University of Colorado Health Sciences Center. All training provided is based on a “train the trainers” model so that additional individuals can continue to provide training. The individual Project BLOOM communities are responsible for their own training and fidelity monitoring on the EBPs they have chosen to implement. The state does not provide financing for these functions.

To learn more about the status of the use of EBPs, the state conducted a survey among mental health clinicians serving young children to assess the interventions they are using with young children, how effective these are deemed, their perceived level of expertise, gaps, and which interventions should be considered for targeted resources and support to establish them within the systems of care. The survey concluded that four interventions were rated as highly effective and/or important and were identified as areas in which clinicians would like to develop additional expertise: Circle of Security, Parent-Child Interaction Therapy, Trauma-Focused Cognitive Behavioral Therapy, and Child-Parent Psychotherapy for Family Violence. In response, training has been provided on Circle of Security and Trauma-Focused Behavioral Therapy.

## IV. Finance Early Childhood Mental Health Services

### Financing strategies include:

- A. Finance a Broad Array of Services and Supports for Young Children and Their Families
- B. Use Multiple Funding Sources for Early Childhood Mental Health Services and Supports
- C. Maximize Part C and Child Find Financing
- D. Finance Early Childhood Mental Health Consultation to Natural Settings
- E. Finance Services to Families of Young Children

### A. Finance a Broad Array of Services and Supports for Young Children and their Families

Five of the sites had paid particular attention to providing early childhood mental health services to young children and their families. Several finance a broad array of services and supports for the early childhood population. For example, **Project BLOOM**, which is comprised of early childhood systems of care in four communities in Colorado, provides a broad array of services and supports based on a “pyramid of needs and supports” that includes mental health promotion, prevention for at-risk groups of children, and intervention/treatment services for children with identified mental health problems.

#### **AZ** Arizona

#### ***Financing a Broad Array of Early Childhood Mental Health Services and Supports***

The Arizona Department of Human Services/Behavioral Health Services Division (ADHS/BHS) conducted a cross-walk of DC 0–3 and ICD 9–CM services with Medicaid-covered services to provide guidance to providers on how to bill Medicaid for 0–3 services. (See: <http://www.azdhs.gov/bhs/provider/icd.pdf>) Many covered services can be provided in natural settings. The system can cover mental health consultation services to child care, Head Start, etc. even if the child is not present as long as the consultation pertains to an identified child. The system also can provide consultation to families even when the child is not present, again, as long as the consultation pertains to the identified child. The system also covers family education and support services.

**CA California**

**Contra Costa** County mental health has contracts with providers for therapeutic nursery, collateral contacts, mental health consultation, school linkages and wraparound for the 0-6 population. These services have been part of the county system for over 20 years.

**MI Michigan*****Financing a Comprehensive Array of Services for Young Children***

Michigan's policy is to ensure that all infants and toddlers with disabilities receive the appropriate early intervention services that are needed, including Indian infants and toddlers with disabilities and their families residing on a reservation geographically located in the state, infants and toddlers with disabilities who are homeless, and infants and toddlers with disabilities who are wards of the state. The state intends that the services offered will be available statewide, and that they will also be comprehensive, coordinated, multidisciplinary, interagency systems to provide early intervention services, for infants and toddlers with disabilities and their families.

The state's infant mental health services provide parent and infant support in the home. These services reduce the incidence and prevalence of abuse, neglect, developmental delay, behavioral and emotional disorder. Community mental health services programs may provide infant mental health services as a specific Medicaid service or as part of a Department of Community Health home-based waiver program for children enrolled in a waiver program.

The state's early intervention services program for infants and toddlers birth to age 36 months with disabilities and their families is called Early On. It is an interagency statewide program, coordinated by the Michigan Department of Education, that offers a comprehensive array of services. Early On services are funded under Part C of the Individuals with Disabilities Education Act (IDEA). Each local community has an Intermediate School District (ISD), which receives funding to implement Early On. Each locality's ISD has an interagency coordinating council (made up of parents, educators, individuals from human service agencies, and other agency personnel who serve families) that provides guidance for local implementation. Implementation is also guided through local memoranda of understanding between education, mental health, public health, and social services. Each local lead agency gets funding that represents 80% of the federal Part C award.

Project Find is Michigan's child find program, which is a system established to identify, locate, and evaluate children who may be eligible for special education services. Project Find is funded by the Michigan Department of Education, Office of Special Education and Early Intervention Services under Part B of IDEA. Project Find conducts various public awareness campaigns and other referral activities designed to identify children, youth, and young adults with disabilities and refer them for special educational services.

Some mental health services for young children are funded by Medicaid, block grant and prevention dollars under the Child Care Expulsion Program (CCEP). CCEP programs provide early childhood mental health consultation for parents and child care providers caring for children ages 0-5, who are experiencing behavioral or emotional challenges that put them at risk for expulsion from child care. CCEP aims to reduce expulsions, improve the quality of child care, and increase the number of parents and providers who successfully nurture the social-emotional development of infants, toddlers and preschoolers. CCEP programs offer child and family-centered short-term mental

health consultation for children with challenging behaviors, which includes in home (or in child care settings) functional assessment and observation, individualized plan of service developed by a team, and various interventions such as coaching and support for parents and providers to learn new ways to interact with children, providing educational resources for parents and providers, modifying the physical environment, connecting families to community resources and providing counseling for families in crisis.

There are 12 CCEP projects (serving 26 Michigan counties) funded through the Michigan Department of Human Services and administered by the Michigan Department of Community Health in collaboration with the Michigan Community Coordinated Child Care (4C) Association. Community mental health agencies partner with local/regional 4C offices to implement these projects. Several other CCEP-type projects in Michigan are funded by different sources.

**CO** **Project BLOOM, Colorado**  
***Financing Mental Health Promotion, Prevention, and Intervention/Treatment Services and Supports Based on the Pyramid of Needs and Supports***

The services provided through the **Project BLOOM** system of care are guided by a “pyramid of needs and supports” (**Figure 6.1** below). The pyramid encompasses mental health promotion for all children at the bottom of the pyramid, prevention for at-risk groups of children (middle of the pyramid), and intervention/treatment services for children with identified mental health problems (top of the pyramid). Although Project Bloom’s federal grant funding is intended to focus on children at the top of the pyramid, i.e., those children already diagnosed with a serious emotional disorder and requiring intensive services and supports, early childhood systems of care must focus on the entire spectrum of interventions, including universal interventions focusing on a total population of young children aimed at mental health promotion, indicated interventions focusing on intervening with at-risk populations, as well as targeted interventions for those already identified with emotional disorders. Project BLOOM, together with other federally funded early childhood systems of care, advocated with the federal Children’s Mental Health Initiative (CMHI) to recognize the need for a conceptual shift from funded systems of care focusing on older children, resulting in a focus that is broader and represents an expansion from the focus solely on treatment for children with serious mental health problems.

The specific services financed by the BLOOM systems of care include:

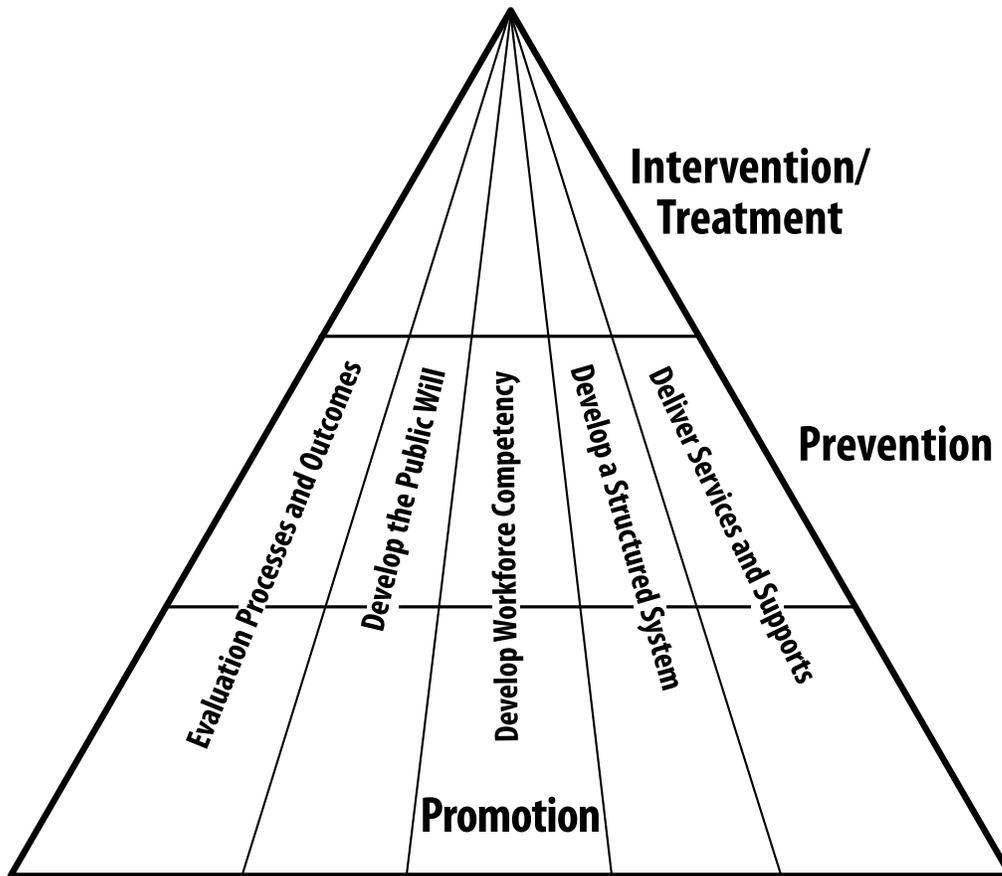
- Assessment and diagnostic evaluation
- Outpatient psychotherapy (individual, family, and group)
- Medical management
- Home-based services/Home Visitation
- Crisis services (Family)
- Behavioral aide services (some)
- Behavioral management skills training
- Crisis residential services
- Inpatient hospital services
- Case management services
- School-based services (Child Care, Preschool)
- Respite services

- Wraparound services/process
- Family support/education
- Mental health consultation

The major funding sources for these services and supports include Medicaid, Part C, Maternal and Child Health Block Grant, General Fund, SCHIP, Child Welfare Core Services, SAMHSA system of care grant, and the Child Care development block grant.

A number of evidence-based interventions are included in the service array, including Parent-Child Interaction Therapy (PCIT), the Incredible Years, and Touch Points. Some Medicaid funding is available for these interventions under existing billing codes for therapy (individual, family, and group) as well as SAMHSA system of care grant funds. The mental health centers and Early Childhood Councils are likely to pick up the costs of these interventions when grant funds are no longer available.

**Figure 6.1**  
**Pyramid of Needs and Supports**



## B. Use Multiple Funding Sources for Early Childhood Mental Health Services and Supports

Multiple sources of funding are utilized to finance early childhood mental health services in the sites, including Medicaid, general revenue, Part C of the Individuals with Disabilities Education Act (IDEA), Head Start, and a variety of other federal, state, and local funding streams. **Project BLOOM**, an early childhood system of care, demonstrates how multiple funding streams can be combined to fund early childhood mental health services, and developed a funding matrix to identify potential sources of financing.

### Arizona and Vermont *Using Multiple Funding Streams for Early Childhood Mental Health Services*

- **In Arizona**, sources of financing for early childhood behavioral health services and supports include: Medicaid, state general revenue, Part C, child welfare, education (State School for the Deaf and Blind), mental retardation/developmental disabilities, general revenue, Medicaid developmental disabilities waiver, Head Start, and some local school district funding.
- **In Vermont**, federal, state, and private funding contribute to financing for early childhood mental health services. These resources include: IDEA, Part B and Part C, Medicaid (including EPSDT and waiver options), SCHIP, SAMHSA block grant and special initiative funding, MCH (Title V) and other HRSA funding, Head Start, Child Care Development Fund, TANF funding, private sector grants, private insurance, and family contributions.

### CA California

The state Department of Mental Health (DMH) has distributed a Medi-Cal DC 0-3 to DSM-IV crosswalk to allow linking a more accurate diagnosis for children, 0-5, with DSM criteria for medical necessity, but many counties reportedly are reluctant to use Medi-Cal specialty mental health for the 0-3 population, fearing state audits. Also, children still need to have a mental health diagnosis, and they cannot be receiving the mental health services from a primary care provider (PCP) (as PCP services are reimbursed through the state Medicaid agency, not through the state mental health agency). The state also listed Part C, early childhood education, DSS and the First Five Commission as funding sources. The First Five Commission was created in 1999 through Proposition 10, which levied an additional \$1 per pack on cigarettes to be used for health, mental health and school readiness for the 0-5 population. (There is apparently little coordination, however, between the Commission and Part C). Prop 10 funding is allocated 20% to the state for statewide programs and 80% to the counties; every county has a First Five Commission. Initially, state DMH received about \$5m. in Prop 10 funding, which it used for an "Infant Preschool Mental Health Initiative", which provided funding to 8 counties for capacity development and training in early childhood mental health. The Infant Preschool Mental Health Initiative funded development of a manual of competencies to guide training, identification of screening and assessment protocols, and disseminated the DC 0-3 to DSM IV crosswalk to facilitate billing for early childhood mental health services under Medi-Cal. Some of the 8 funded counties have used First Five Commission funding creatively – for example, to implement the Incredible Years and Triple P – and have sustained their programs using county First 5 funding, expanded EPSDT billings, grants and county general revenue.

**Contra Costa** (which was not one of the 8 counties to receive state First 5 funds) uses county First 5 Commission funds to finance early childhood mental health services for non Medi-Cal eligible children. (First 5 Commission can begin to work with a woman during pregnancy.) The county also uses EPSDT, a small amount of county general revenue, discretionary grants, and is planning to use Prop 63-Mental Health Services Act (MHSA) monies when state guidelines are issued for prevention/early intervention services under the MHSA.

### **CO** **Project BLOOM, Colorado** ***Utilizing Funding from Multiple Agencies and Sources***

- **The Project BLOOM** systems of care utilize funding from multiple agencies for early childhood mental health services, including:
- **Child Welfare** — Core services are provided by the child welfare system to keep children at home and avoid out-of-home placements and to facilitate reunification or another form of permanence. These include home-based interventions, intensive family therapy, life skills, day treatment, sexual abuse treatment, special economic assistance, mental health services, substance abuse treatment services, aftercare services to prevent future out-of-home placement, and optional county designated services that prevent out-of-home placement or facilitate reunification or another form of permanence. State general fund dollars are given to counties to provide or purchase these core services. At the end of the year, counties can transfer up to 10% of TANF and Child Welfare Block Grant dollars into Core Services Funding if they have funds left over. No Title IV-E funds are used for early childhood mental health
- **Education/Special Education** — Colorado Preschool Program can fund a preschool slot for a child involved in a Project BLOOM system of care on an individual case basis. A representative from the education system is involved in the Early Childhood Council in each local community
- **Mental Health** — Financing includes funds from the SAMHSA system of care grant and the mental health block grant to finance an array of early childhood mental health services
- **Medicaid** — Finances clinical services for Medicaid-eligible children
- **Primary Care** — Some financing is contributed through the Health Care Program for Children with Special Needs, which is the Maternal and Child Health Block Grant. The funds are specifically for care coordination.
- **Developmental Disabilities** — State general fund and local dollars are used to provide family support and case management services.
- **TANF** — El Paso County uses TANF dollars for direct services such as child care, and some areas are receiving funding for mental health consultation.
- **Part C** — State general fund, federal grants funds, and local mill levy funds are used to purchase direct services, based on a list of 14 types of services including social and emotional interventions and enhanced service coordination, which can be wraparound.

- **Child Care** — Child Care Development Block Grant funds are used for training and professional development related to early childhood mental health consultation
- **Foundation** — The Rose Foundation finances some early childhood mental health consultation; Colorado Health Foundation finances some professional development.

In addition, Project BLOOM took the funding matrix for early childhood mental health services created by the National Technical Assistance Center for Children’s Mental Health at Georgetown University and explored the various funding streams that come into the state. More than 50 funding sources were researched, and information on 45 was included in the materials developed for Project BLOOM communities and other Colorado communities on financing streams for early childhood services. This information was provided to the four Project BLOOM communities so that they could assess potential funding streams to finance services and supports and the potential applicability and use of the financing streams locally.

This funding matrix is included in a packet that is used to conduct workshops with each of the four Project BLOOM local communities to assist them in considering all potential sources of financing for early childhood mental health services. Information on the funding streams and worksheets for planning are included in the packet. The training is conducted with an interagency group of participants and family members. Family participants pushed the agency representatives to look at possibilities and not to discount possible financing options. Project BLOOM reported that many individuals, even at the state level, are not aware of the possible financing options that exist to fund early childhood mental health services. The funding matrix information includes the following funding sources:

Project Bloom Funding Matrix		
State Funds:	Federal Funds Entitlements:	Federal Discretionary Grants:
<ul style="list-style-type: none"> <li>• Developmental Disabilities Early Intervention</li> <li>• Exceptional Children’s Education Act</li> <li>• Colorado Preschool Program</li> <li>• Core Services (Child Welfare)</li> </ul>	<ul style="list-style-type: none"> <li>• Medicaid</li> <li>• Title IV-E</li> <li>• Social Security Income</li> <li>• IDEA Part C and Part B sec. 611 and 619</li> <li>• ECEA</li> </ul>	<ul style="list-style-type: none"> <li>• Community Based Grants for the Prevention of Child Abuse and Neglect</li> <li>• Family Violence Prevention and Services</li> <li>• Head Start</li> <li>• Juvenile Justice Formula Grants</li> <li>• Indian Health Care Improvement Act</li> <li>• Promoting Safe and Stable Families</li> <li>• TANF</li> <li>• Title 1</li> <li>• Title-IV-B</li> <li>• Title V Incentive Grants for Local Delinquency Prevention</li> <li>• WIC</li> <li>• Workforce Investment Act</li> </ul>
Other Sources:	Block Grants:	
<ul style="list-style-type: none"> <li>• Lottery Funds</li> <li>• Tax Check Off</li> <li>• Tobacco Funds</li> <li>• Gaming-Casino Tax</li> <li>• Divorce Fees</li> <li>• Fees on Speeding Tickets</li> <li>• Local Taxes</li> <li>• Tax Credit</li> <li>• Mental Health Districts</li> <li>• Children’s Health Plan</li> </ul>	<ul style="list-style-type: none"> <li>• Child Care Development</li> <li>• Community Mental Health</li> <li>• Substance Abuse Prevention and Treatment</li> <li>• Social Services</li> <li>• Maternal and Child Health</li> <li>• Community Services</li> </ul>	

At the time of the site visit, this information was being put into a searchable database and also on a CD for use by communities statewide. The information was also being folded into the Smart Start Financial Mapping process.

## C. Maximize Part C and Child Find Financing

In several sites, the children's behavioral health system has worked with the Part C system to better identify and address the social and emotional needs of young children. For example, in **Arizona**, the behavioral health system has collaborated with Part C to develop workshops in early childhood mental health, to create an assessment tool for the 0 to 5 population and accompanying training for providers, and to build provider capacity for working with young children. In **Colorado**, considerable work was completed to determine how to better address social-emotional issues under Part C, resulting in delineation of responsibilities, development of a joint format for a service plan integrating wraparound into the individual family service plans (IFSPs), and a funding hierarchy.

### **AZ** Arizona *Using Part C Funds*

In **Arizona**, there has been increasing recognition of early childhood mental health issues by the mental health system. For example, the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) gave the Part C program funds to develop a 7-part series of workshops on early childhood mental health; most of those who attended, however, were providers in the Part C network, not the Regional Behavioral Health Authorities (RBHAs).

ADHS/BHS now requires RBHAs to use a 0-5 assessment tool. In late 2005, ADHS/BHS contracted with a provider that specializes in the 0-5 population to help develop the 0-5 assessment tool and train providers on its use. ADHS/BHS is using federal Child and Adolescent System Infrastructure (CA-SIG) grant dollars to support this effort. One impetus behind the use of the tool was the changes in the Child Abuse Prevention and Treatment Act, requiring referral of young children involved with child protective services (CPS) to Part C. The 0-5 assessment tool was developed by families, providers, Part C and other stakeholders. RBHAs are required to screen CPS-involved children, 0-5, within 24 hours and then refer to Part C if appropriate. Part C stakeholders indicated that, initially, only 18% of referrals met Part C eligibility criteria so a developmental screen was added; now children are referred if there is a developmental issue involved. ADHS/BHS also added a new contractual requirement in RBHA contracts, requiring RBHAs to hire 0-5 specialists, (which Value Options indicated it had some trouble in finding). The state is using federal SIG grant dollars to support a competency roll-out for the 0-5 population, using the Harris Training Center in-service model of 3-tiers of competency, covering paraprofessionals through credentialed specialists.

At the time of the site visit, Part C and ADHS/BHS were involved in further discussions about how to improve coordination and capacity for the 0-5 population. A few providers are in both Part C and RBHA networks and, reportedly, are overtaxed because of high need and insufficient capacity. Value Options (VO) in Maricopa County was taking the lead in putting together a group of Part C, provider, child welfare, family and other stakeholders to develop a training program for building more capacity, but this was in the early development stage. VO also was concerned about getting the adult system involved, particularly to coordinate services for adults with substance abuse problems who have young children. Also, the Governor's Office on Children, Youth and Families is trying to develop an infant mental health plan that could be endorsed by all agencies. Part C has an interagency early intervention team, on which ADHS/BHS sits. In the past, Part C and ADHS/BHS worked together to develop an early childhood SAMHSA grant application, but it was not funded.

**MI Michigan*****Using Part C, Medicaid, and Other Funding to Finance a Comprehensive Array of Services for Young Children***

Michigan's policy is to ensure that all infants and toddlers with disabilities in the state receive the appropriate early intervention services that are needed (this includes Indian infants and toddlers with disabilities and their families residing on a reservation geographically located in the state, infants and toddlers with disabilities who are homeless children and their families, and infants and toddlers with disabilities who are wards of the state). The state intends that the services offered will be available statewide, and that there will also be comprehensive, coordinated, multidisciplinary, interagency systems to provide early intervention services for infants and toddlers with disabilities and their families.

The state's infant mental health services provide parent and infant support in the home and support and intervention services to at-risk families. Services reduce the incidence and prevalence of abuse, neglect, developmental delay, and behavioral and emotional disorders. Community mental health services programs may provide infant mental health services as a specific Medicaid service or through enrollment in a Department of Community Health (DCH) Medicaid home-based waiver program.

The state's early intervention services program for infants and toddlers birth to age 36 months with disabilities and their families is called Early On. It is a statewide program, coordinated by the Michigan Department of Education, that is interagency coordinated and offers a comprehensive array of services. Early On services are funded under Part C of the Individuals with Disabilities Education Act (IDEA). Each local community has an Intermediate School District (ISD), which receives funding to implement Early On. Each locality's ISD has an interagency coordinating council (made up of parents, educators, individuals from human service agencies, and other agency personnel who serve families) that provides guidance for local implementation. Implementation is also guided through local memoranda of understanding between education, mental health, public health, and social services.

Each local lead agency gets funding that represents 80% of the federal Part C award.

Project Find is Michigan's child find program, which is a system established to identify, locate, and evaluate children who may be eligible for special education services. Project Find is funded by the Michigan Department of Education, Office of Special Education and Early Intervention Services under Part B. Project Find conducts various public awareness campaigns and other referral activities designed to identify children, youth, and young adults with disabilities with disabilities and refer them for special educational services.

Some infant mental health services are funded by Medicaid and prevention dollars under the child care expulsion program (CCEP). CCEP programs provide early childhood mental health consultation for parents and child care providers caring for children ages 0-5, who are experiencing behavioral or emotional challenges that put them at risk for expulsion from child care. CCEP aims to reduce expulsions, improve the quality of child care, and increase the number of parents and providers who successfully nurture the social-emotional development of infants, toddlers and preschoolers. CCEP programs offer child and family-centered short-term mental health consultation for children with challenging behaviors which includes: in home (or in child care settings) functional

assessment and observation; individualized plans of service developed by a team; and various interventions, such as coaching and support for parents and providers to learn new ways to interact with children, providing educational resources for parents and providers, modifying the physical environment, connecting families to community resources and providing counseling for families in crisis. There are 12 CCEP projects (serving 26 Michigan counties) funded through the Michigan Department of Human Services and administered by the Michigan Department of Community Health in collaboration with the Michigan Community Coordinated Child Care (4C) Association. Community mental health agencies partner with local/regional 4C offices to implement these projects. Several other CCEP-type projects in Michigan are funded by different sources (<http://earlychildhoodmichigan.org/articles/10-03/CCEP10-03.htm>).

## **VT** Vermont

### ***Using Part C Funds to Finance Early Childhood Services***

In Vermont, the Early Intervention Program under Part C is known as the Family Infant and Toddler Program. Vermont has a comprehensive Child Find system, including policies and procedures that ensure all infants and toddlers who may be eligible for services under Part C are identified and evaluated. (An eligible child is a child from birth to three years of age who is at risk for and/or who experiences measurable developmental delays and/or has a diagnosed physical or mental condition that is likely to result in developmental delay.) State education policy gives the local education agencies Child Find responsibility for children birth to age three. The Department of Education has ultimate responsibility for ensuring that a comprehensive Child Find system exists in Vermont. The Agency for Human Services (AHS), the umbrella agency that houses the Department of Mental Health, has specific supporting roles and responsibilities, including administration of funds. Child Find is funded under Part B so that “each non-educational public agency, including state Medicaid, precedes the financial responsibility of the local education agency”. Part C funds are utilized as payer of last resort for the services covered.

AHS and the Department of Education, the co-lead agencies for efforts under Part C, have a formal agreement (July 2006) that specifies roles and responsibilities. AHS specifically funds coordination and early intervention services, consistent with federal rules governing expenditure of Part C dollars (requiring non-supplantation, state maintenance of effort, and payer of last resort).

**OH** **Cuyahoga County, Ohio**  
***Using Part C to Finance Early Childhood Services Coordinated with the System of Care***

Invest in Children, the county's early childhood system of services and supports, is administered by the Board of County Commissioners. It is a public-private partnership of individuals, organizations, community-based service providers, medical institutions, and philanthropic and private organizations working together to increase the development, funding, visibility and impact of early childhood services in Cuyahoga County. Each of the early childhood programs in Invest in Children is administered by lead agencies and implemented through partnerships with community-based organizations. Invest in Children secures public and private funding and maximizes the individual efforts of partner organizations and agencies, working with them to develop and expand essential programs and services for children and their families.

To provide one continuous system of care for families whose children have mental health needs (regardless of the child's age), the county integrates the Cuyahoga Tapestry System of Care (CTSOC) which serves children six and older with Invest in Children. Children younger than age six are not referred directly to CTSOC. Instead, they are referred to Invest in Children. However, any family referred to CTSOC who has children under age six in need of services will be referred by the CTSOC to Invest in Children. The care manager assigned to the family by Invest in Children is included on the CTSOC child and family team. The same provider agencies serve Invest in Children and the CTSOC. By integrating these two systems, the county intends to eliminate service gaps for families with young children and improve service coordination and interagency communication. Also, CTSOC through its neighborhood-based resources strengthens the county's capacity to reach out to and engage families, including families that Invest in Children may have difficulty engaging. While the CTSOC does not fund early childhood services, its care managers communicate directly with the early childhood care managers and the family benefits from the funding and services available through the early childhood system, including Part C of IDEA.

**NY** **Project BLOOM, Colorado**  
***Implementing Committee Recommendations on Part C for Behavioral Health and Funding Hierarchy***

A committee was formed in 2004 to provide information on how social-emotional development was addressed in Part C. This work resulted in recommendations including: 1) utilize screening tools and procedures that address social-emotional development as part of the state's Child Find Efforts, 2) use the DC: 0-3R diagnostic process and codes, 3) partner with the state's infant/children's mental health efforts, and 4) make available mental health consultation in early intervention teams.

To implement these recommendations, the early childhood specialists at the mental health centers have been directed to coordinate with local Child Find Efforts. In 2007, a joint meeting was held between Part C Coordinators and early childhood mental health specialists to facilitate these connections. In addition, some DC: 0-3R diagnoses are included as established conditions within Part C, and Part C is actively soliciting feedback for other diagnoses that should be included in established conditions.

The committee's work also resulted in a document that delineates the responsibilities of the local Part C partners in eligibility determination, assessment, and IFSP development for young children eligible for Part C due to social-emotional concerns. The document covers:

- Signs that a significant social-emotional delay may exist (e.g., lacking emotional display, sad affect, resisting being held or touched, difficult to soothe or console, fearful, rarely making eye contact, clinging to caregiver, inability to comfort/console self, reluctant to explore environment)
- Risk factors (e.g., maternal depression, caregivers with substance abuse or mental illness, domestic violence, foster care, poverty, adoption, exposure to maltreatment)
- Social-emotional screening tools that are appropriate for young children (A screening paper developed in 2004 outlines the types of screening tools for identifying issues with social-emotional development that might be appropriate for the Child Find process)
- The process for determining eligibility (Referral to the local early intervention system which assigns a service coordinator to assist the family in accessing evaluation, assessment, and other early intervention entitlements)
- What social-emotional assessment instruments are appropriate (Child Find team includes evaluation and assessment of the child in all areas of development, including social-emotional)
- Development of the Individualized Family Service Plan (IFSP) by the team and family (with service coordinator)
- How to talk to parents about social-emotional delays
- What are appropriate services and supports that can be written into IFSPs for social-emotional delays (Assessment and intervention services that address social-emotional development in the context of the family and parent-child interaction; home visits; social or emotional developmental assessment; collaboration with family, service coordinator, and other early intervention service providers; referral for community services; individual or family counseling to the family; social skill building activities; addressing issues related to living or care giving; identifying, mobilizing, and coordinating community resources and services; family training, education, and support; mental health consultation; psychological services and developmental intervention)
- What funding is available to use.

The document can be found at: [http://www.earlychildhoodconnections.org/Files/Social\\_Emoional\\_TA%20Brief-FINAL.pdf?CFID=782078&CFTOKEN=67181626](http://www.earlychildhoodconnections.org/Files/Social_Emoional_TA%20Brief-FINAL.pdf?CFID=782078&CFTOKEN=67181626)

A Funding Hierarchy was developed to help the family and service coordinator determine how services will be covered. The funding hierarchy includes the following in order of which sources should be considered first to fund services:

- Private insurance
- Public insurance (Medicaid and CHP+)
- Health Care Program for Children with Special Needs (Title V)
- Child Welfare, Temporary Assistance to Needy Families (TANF) and Child Care
- Department of Education
- Division of Developmental Disabilities (Community Centered Boards)
- Federal Part C

Mental health centers also have state funding to serve non-Medicaid children through the Early Childhood Mental Health Specialists, grants, or other funds.

In addition, a joint format for a service plan was developed by Project BLOOM that integrates the wraparound elements into the IFSP, so that a single combined plan can be created for a child and family. The format allows the team to bring in more services and supports directed at the family, rather than just at the child. The new IFSP lists services needed, desired, and useful and can specify other funding sources to pay for them.

There are 14 allowable services under Part C, one of which is social work. The Part C program agreed to pay for enhanced service coordination, which can be wraparound. In addition, a change has allowed Part C to pay for “social and emotional interventions” which can be any of the direct interventions provided by Project BLOOM.

Six communities that are “low identifiers” for Part C in general will receive technical assistance in screening through the ABCD project (Assuring Better Child Development). A state coordinator has been hired through grant funds and will train Part C, pediatricians, and others. Groups will be pulled together in these communities and training provided via videoconferencing. The groups will include primary care practitioners, pediatric practices, etc. in an effort to reach out to those who are involved in early identification.

Project BLOOM is trying to work with Child Find to include more behavioral health focus in the early screening process. One strategy involves bringing the Part C staff together with the Early Childhood Specialist in each community. In addition, Project BLOOM is working on a “behind the scenes” chart to identify systemic barriers to early screening and identification.

## D. Finance Early Childhood Mental Health Consultation to Natural Settings

Mental health consultation to early childhood settings (such as day care centers, Head Start, preschools, pediatricians’ offices, etc.) is an important component of the array of early childhood mental health services and supports. The sites finance early childhood mental health consultation using Medicaid dollars, mental health general revenue funds, and others. **Project BLOOM** created a tool kit on early childhood mental health consultation with a financing section.

### ***Financing Early Childhood Mental Health Consultation***

- **In Arizona**, the system can cover mental health consultation services, using Medicaid dollars, to child care, Head Start, etc. as long as the services pertain to an identified child (the child does not have to be present). Part C stakeholders indicated that Early Head Start and Head Start programs have their own mental health staff with whom they contract or hire directly (i.e., not through Regional Behavioral Health Authorities – RBHAs). They also indicated that there is some discussion occurring at the Governor’s Office on Children, Youth and Families about expanding mental health capacity for consultation to child care settings. In Maricopa County, Value Options used prevention dollars to contract with a provider to implement the “Incredible Years” in child care centers.
- **In California**, Medi-Cal administrative billing is used to finance a small portion of mental health consultation. In addition, county general revenue in Contra Costa pays for mental health consultation, as well as First 5 Commission dollars.

- **In Vermont**, consultation is covered both to families and other professionals in a variety of natural settings. Besides in-home mental health services, consultations take place in child care centers, parent-child centers, preschools, Head Start, pediatricians' offices, and others. Early childhood mental health consultation is financed by mental health general revenue dollars.

### **CO** **Project BLOOM, Colorado** ***Using Multiple Funding Sources and Developing a Tool Kit with Financing Section***

Pilot projects were initially funded in Colorado which financed early childhood mental health consultation in several communities. These pilots built competencies and provided the basis for current work. A tool kit for early childhood mental health consultation was developed to provide information on: 1) what it is and how to do this, 2) what core knowledge and competencies (skill set) are required, and 3) how to pay for this. A survey also was done to determine who was providing this service in the state, with the finding that most providers were at the Master's level or above. It was determined that at least 15 different funding sources were being used to fund early childhood mental health consultation (for example, federal mental health block grant funds, Medicaid, state funds supporting early childhood specialists who provide consultation, Head Start, school-based health care funds, education, TANF, child care, foundation grants, and private insurance). A self-evaluation checklist of the skills needed was developed, and an overview of potential funding sources to consider was created.

The resource and sustainability tool kit for providers is entitled "Mental Health Consultation in Early Care and Education," and includes:

- Section I. Program Implementation and Workforce Development, including a mental health consultation brief, mental health consultation competencies, and a monograph
- Section II. Funding, including a funding source overview, and a funding fact sheets series that provide information on the range of financing streams that might be tapped to support early childhood mental health consultation
- Section III. Issues and Advocacy, including landscape and opportunities, talking points, funding perspectives, and a mental health consultation Colorado survey report.

A missing area was on how to evaluate early childhood mental health consultation. Work with the National Technical Assistance Center for Children's Mental Health at Georgetown University resulted in a tool kit on evaluating this service that is a complement to Colorado's tool kit.

Training has been provided in the state on early childhood mental health consultation, including how to use Medicaid, school-based Medicaid, and other financing streams.

## E. Finance Services to Families of Young Children

Some sites finance services to families of young children, without the requirement of the child being present. These services are reimbursable as long as the services relate to the child's behavioral health needs and are outlined in the individualized service plan. For examples in **California, Project BLOOM, Arizona, and Vermont**, Medicaid can be billed if the service is in relation to the identified child.

- **In Arizona**, the managed care system can provide services to the family when the child is not present as long as the services relate to the child's behavioral health issues and needs.
- **In California**, services can be provided to the family (even if child is not present) and billed to Medi-Cal if the service is about the identified child. **Contra Costa** emphasizes the importance of documentation, and it uses collateral contacts and plan development Medi-Cal billing codes.
- **In Vermont**, many different services to families of young children are financed, including home visiting and other parenting services, family support, respite care and financing to support and engage parents as part of decision-making teams. The child does not need to be present, but the services must relate to the issues/problems outlined on the service plan.
- **In Project BLOOM, Colorado**, some providers identify this as a barrier, while others find a way to provide services to the families, not just to the identified child. There may be some variance in policy across behavioral health organizations (BHOs), but billing under Medicaid for services to families should be allowable. The Project BLOOM communities are working with families, and wraparound plans address family issues. Some families may have their own therapists and/or their own coverage. If the family's need for services is directly related to the child, services to the parents should be covered.

## V. Finance Early Identification and Intervention

### Financing strategies include:

- A. Finance Behavioral Health Screening of High-Risk Populations and Linkages to Services**
- B. Incorporate Behavioral Health Components in EPSDT-Funded Screens**
- C. Finance Early Intervention Services for At-Risk Populations**
- D. Finance Linkages With and Training of Primary Care Practitioners**

## A. Finance Behavioral Health Screening of High-Risk Populations and Linkages to Services

Strategies for screening children and youth at high risk for behavioral health problems and linking youth to needed services were found in the sites. Typically, sites screen youth entering the child welfare or juvenile justice systems and make appropriate referrals for further evaluation or for services as indicated. Arizona screens youth within 48 hours of entering detention, using the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2), and California's Contra Costa County screens all children entering non-relative child welfare placements. New Jersey has developed common screening tools to use across agencies, and Project BLOOM has recommended specific tools for screening young children in early care, education, and primary care settings.

### **AZ** Arizona

#### ***Financing Screening of Child Welfare and Juvenile Justice Populations***

In response to the Child Abuse Prevention and Treatment Act (CAPTA), Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), the Part C program and child welfare worked out a system for rapid referral of children under 3, who come to the attention of Child Protective Services (CPS), to receive a developmental assessment through the managed care system within 24 hours and referral to the Part C program if a developmental issue is found. In addition, child welfare and ADHS/BHS have developed an urgent response system with referral to the managed care system within 24 hours when a child of any age comes into contact with CPS and is removed from home. ADHS/BHS took the lead in developing a Practice Improvement Protocol focused on serving children and families involved in child welfare, which also describes the urgent response system requirements. (See [http://azdhs.gov/guidance/unique\\_cps.pdf](http://azdhs.gov/guidance/unique_cps.pdf).)

The juvenile justice system in Maricopa County has recently implemented use of the MAYSI-2 (Massachusetts Youth Screening Instrument, Version 2) to identify high risk youth coming into detention; all detained youth are administered the MAYSI-2 within 48 hours of coming into detention. The juvenile justice system uses its own staff (and dollars) to administer the screening. An issue in serving youth in detention is that Comprehensive Service Providers in the Regional Behavioral Health Authority (RBHA) network cannot always bill Medicaid for services provided on site at detention, depending on the youth's legal status, even if the youth is eligible for Medicaid. ADHS/BHS has issued a technical assistance document specific to youth in detention settings to clarify and maximize ability to utilize Medicaid for this population to the extent possible. (See: [http://www.azdhs.gov/bhs/provider/sec.5\\_1pdf](http://www.azdhs.gov/bhs/provider/sec.5_1pdf).)

**CA** California***Financing Screening of the Child Welfare and Juvenile Justice Populations***

In **Contra Costa**, county mental health has staff on site at juvenile hall to screen all first time admissions within 48 hours, using the Massachusetts Youth Screening Instrument, Version 2 (MAYSI-2). This screening capacity is financed through a combination of county general revenue and Medi-Cal, which can be used for any youth that is a pre-adjudicated, first time offender and for youth that have a placement order for foster care or residential treatment. The screen also helps to flag youth who need help while in juvenile hall, including youth with suicidal ideation and those on medications.

Contra Costa mental health also has a mental health liaison in each of the three child welfare regional offices in the county, who participate on Team Decision Making (TDM) meetings and with the county's Family-to-Family Neighborhood Collaboratives and help link children to a full range of mental health services, including wraparound teams. County mental health screens every child entering non relative placement; screenings are financed with Medi-Cal and county child welfare general revenue for non Medi-Cal children.

**HI** Hawaii***Screening the Child Welfare Population***

A multidisciplinary team (MDT) is contracted by the child welfare system to assess children to determine if a mental health assessment (psychological or psychiatric evaluation) is needed. The Child and Adolescent Mental Health Division (CAMHD) has recently entered into a memorandum of understanding (MOA) with child welfare to give them additional funds to support expanding their contract as a means of increasing access to care.

**MI** Michigan***Developing a Tool for Screening***

The EPSDT screen is done through Medicaid managed care organizations (i.e. HMOs) contracting with the state Medicaid agency. The mental health system has an agreement with the HMOs regarding reciprocal referrals with the Community Mental Health Services Programs. A Comprehensive Behavioral Health Assessment (CBHA) is required in child welfare cases, but it is not always completed because there is no established financing mechanism that pays for the CBHA for children in foster care (this is a gap in the system).

In general, screening activities, including a comprehensive health and developmental history and an assessment of mental development, are usually performed first by health care providers or practitioners (including the Medicaid Health Plans, primary care physicians, health departments, etc). Then, based on the result of the preliminary assessments, Medicaid policy requires that the initial health care provider determines if the child needs to be referred to the specialty Prepaid Inpatient Health Plan for more specialized assessment of mental development or for treatment related to a need that has been identified through the initial screening activity.

**NJ** New Jersey***Using Common Screening and Assessment Tools Across Agencies***

The state utilizes common screening and assessment tools that are used across various systems and agencies that serve children. The tools are used at the point of access into the various systems, to screen and evaluate children for risk and mental health treatment needs. The standardized tools that New Jersey uses are a version of the CANS (Child and Adolescent Needs and Strengths) tool, which is a standardized assessment instrument that incorporates a quantitative rating system within an individualized assessment process. Versions of the CANS are used for initial screening and assessment, for crisis assessment, and for use by Care Management Organizations to guide service planning for youth with the most intensive service needs. The state mandates that the Crisis Assessment Tool (CAT) be used by the state's mobile response and stabilization providers. The Needs Assessment tool is mandated for use by the Contracted Systems Administrator and system partners (such as child welfare workers and providers) at entry to screen for level of intensity of service need. The Comprehensive Strengths and Needs Assessment tool is mandated for use by Care Management Organizations, youth case management providers, and by residential treatment providers for individualized service planning. The tools are part of the state's Information Management and Decision Support (IMDS) system. **New Jersey** has developed a web-based training capacity on use of the CANS tools.

**VT** Vermont***Screening the Child Welfare and Juvenile Justice Populations***

**Vermont** supports screening for every child coming into child welfare or juvenile justice custody. The Department for Children and Families (DCF) has taken the responsibility for creating a screening process for children entering custody. As part of the screening process, DCF contracts with various agencies throughout the state for the following activities: gather existing medical, educational, and psychological information on new entrants into custody; meet with youth, families and treatment teams to gather the family's history; and utilize several screening tools to identify concerns and to assist with care planning. It is the goal that this process will be completed within 30 days of assignment to a screener. The DCF screening may be done in conjunction with additional expert assessments of specific issues. Screening tools used are based on the age and known background of the child and may include: Child Behavior Checklist (CBCL), Massachusetts Youth Screening Instrument (MAYSI), geno-grams, eco-maps, and the Ansell-Casey Life Skills Assessment. Medicaid finances the screening and assessment.

## **NE** Central Nebraska *Screening the Juvenile Justice Population*

Medicaid currently is leading efforts in **Nebraska** (statewide) to provide a Comprehensive Child and Adolescent Assessment (CCCA) for youth who enter the juvenile justice system. Medicaid has contracted with a number of providers to conduct clinical evaluations of mental health/substance abuse treatment needs before youth are committed. Although a number of assessment tools have been identified for these evaluations, the clinicians are not required to use a specific one. Instead, they are asked to select the most appropriate tool(s) for each youth. Their assessments and recommendations focus on clinical issues and the level of care that may be needed for each youth. Medicaid pays \$1,500 for each of these comprehensive evaluations. Authorization of the services that are recommended rests with Magellan (the statewide behavioral health managed care entity).

## **CO** Project BLOOM, Colorado *Financing Social-Emotional Screening in Early Care, Education, and Primary Care Settings*

In 2003, Project BLOOM, Harambee and Kid Connects convened a group of stakeholders to discuss and make recommendations about screening tools, practices, and resources to support social-emotional screening in Colorado. The 2004 report outlined recommendations to support screening in three settings: early care and education, Child Find, and primary care. A workgroup was developed to consider screening in each of these settings. The groups recommended screening tools for each of these settings, as well as the training and support needed to implement screening. The recommended tools include:

- Ages and Stages Questionnaires: Social-Emotional (ASQ-SE) and Devereaux Childhood Assessment (DECA) for early care and education
- ASQ-SE, Brief Infant Toddler Social-Emotional Assessment (BITSEA), and Temperament and Atypical Behavior Rating Scale (TABRS) Screener for Child Find Teams
- Parents' Evaluation of Developmental Status (PEDS), ASQ, ASQ-SE, and Family Psychosocial Screening for primary care practices.

The report with recommended tools and a discussion of how behavioral health fits into screening processes in child care settings, primary care settings, and through Child Find can be found at: <http://www.projectProjectBLOOM.org/ASP/DocumentationView.asp?NUMBER=49>.

A grant from the Colorado Health Foundation allowed for pilot testing of some of these tools, specifically ASQ and PEDS. Testing of the tools in both Mesa and Aurora Counties found that 2% of children were identified with a positive screen. Contrary to anticipated complaints of excessive

burden in administering the screenings, primary care practitioners did not feel that it was too much work. A flow chart was developed for primary care offices to show them where to refer young children with mental health problems. A flow chart was created for the 0-3 age group, and work is underway to create a flow chart for children ages 3-5. All agencies have worked on this together.

Screening is also part of Project BLOOM's work with early care and educational settings. The Devereaux Early Care Assessment Tool (DECA) has been used and extensive training in using this tool has been provided. Training was provided around the state to interested child care and mental health providers. Colorado conducted a training of trainers session so that training could be conducted locally. The DECA can be found at: [http://www.devereux.org/site/PageServer?pagename=deci\\_index](http://www.devereux.org/site/PageServer?pagename=deci_index).

Project BLOOM is trying to work with Child Find to include more behavioral health focus in the early screening process. One strategy involves bringing the Part C staff together with the Early Childhood Specialist in each community. In addition, Project BLOOM is working on a "behind the scenes" chart to identify systemic barriers to early screening and identification.

El Paso County purchases "Ages and Stages" and provides these to a significant number of pediatric practices in the county to support screening and early identification of behavioral health problems. A supplemental funding proposal to SAMHSA was successfully submitted to seek support for additional work on screening and additional work with pediatric practices. The state conducted focus groups to determine what type of literature would be helpful for parents to receive from their primary care offices and what information primary care providers would like on social-emotional issues. After these resources are developed, local training will be conducted for primary care providers to assist them in including social-emotional screening as a part of their developmental screening.

Children's Hospital in Boston developed a widely respected package for screening in pediatric settings; the ABCD group may take examples from this and build it into Colorado's package. (See <http://www.developmentalscreening.org/>)

Qualstar is a group that does quality ratings for child care. Efforts are underway to encourage them to explore mental health issues in their quality assessment processes. These groups have a trainer registry and trainers are required to meet certain criteria. The goal is to build a cadre of qualified trainers who have some behavioral health knowledge and expertise.

## B. Incorporate Behavioral Health Components in EPSDT-Funded Screens

In some sites, EPSDT screens, paid for by Medicaid, incorporate behavioral health screening components. In **Vermont**, mental health professionals are co-located in pediatric settings to improve access to behavioral health assessment and intervention. **Project BLOOM** has developed an EPSDT tool kit and has financed implementation strategies for early identification of behavioral health issues in pediatric settings.

### **CA** California

#### ***Financing for Piloting Developmental and Behavioral Health Screening in Medicaid***

State EPSDT guidelines require screening for behavioral health, but there is no standardized tool in use or particular monitoring of this, and EPSDT screens are conducted by primary care providers through the Medi-Cal physical health managed care organizations contracted by the state Medicaid agency.

The Commonwealth Fund funded five states, including California, to improve developmental and behavioral health screening in Medicaid. The California project operated in two counties. It trained primary care practitioners in use of the Ages and Stages Questionnaire.

### **VT** Vermont

#### ***Incorporating Behavioral Health Screening in EPSDT Screens***

EPSDT, administered through the Department of Health, provides comprehensive assessments for young children and has played a key role in growing early childhood mental health services in the state. Trained health and mental health care personnel conduct EPSDT screens, including appropriate behavioral health screens in an increasing variety of locations, including in schools under contract with some districts. Vermont's efforts recognize the need for appropriate screening tools and interventions. The state does not prescribe a single tool but rather provides a menu of state-approved tools. Several screening tools and guidelines are available, including the Pediatric Symptom Checklist and the Child Behavior Checklist, along with references for additional resources.

Opportunities for identification of behavioral health problems and referral for treatment also are provided in the pediatric collaborative efforts that the state has undertaken. The model co-locates a community mental health professional jointly trained in mental health and substance abuse in a pediatric or family practice office to screen, refer as appropriate, and coordinate mental health and substance abuse treatment, provide short-term intervention, and provide staff consultation. This model augments the primary care practice, provides assessment and intervention resources, creates a smooth connection for families, helps train professionals in the field, and increases community awareness about the importance of addressing mental health. About 15 mental health professionals are working to improve screening and services in primary care and private agency settings across the state. Medicaid finances the EPSDT screens.

### **CO** Project BLOOM, Colorado *Financing for EPSDT Tool Kit, Training, and Resources for Behavioral Health Screening*

A consultant was brought in to provide training for the leadership team on screening in EPSDT. Colorado's "Children's Medicaid Benefits EPSDT Toolkit" states that, in addition to other components, a comprehensive periodic screening exam includes "Assessment of physical, emotional, and developmental history" and "Assessment of mental/behavioral health." However, reportedly, there is spotty use of behavioral health screens as components of EPSDT screens in the state. Specific instruments or processes for this have not as yet been provided.

## **C. Finance Early Intervention Services for At-Risk Populations**

Financing strategies to provide early intervention services for children at-risk were found in most sites, using various financing sources. For example, among other funding, state funds support school-based early intervention services in **California**, education funds in **Hawaii**, and child welfare funds in **Cuyahoga County**.

### **CA** California *Using Multiple Funding Sources for Prevention and Early Intervention Services*

The state legislature enacted the School-Based Early Mental Health Intervention and Prevention Services Act in 1991 (Proposition 98), which is for the purpose of enhancing the social and emotional development of young students and minimizing the need for more costly services as they grow older. It is administered by the Department of Mental Health (DMH) and targets children in preschool through third grade, providing competitive grants to local school districts. The funds are used primarily for paraprofessionals working with children in the classroom. At the time of the site visit, 83 school districts in 27 counties were receiving these three-year grants, which have to be matched by the school district. This is a \$10 million initiative, and the state was expecting an additional \$5 million. Two school districts in **Contra Costa** have these grants.

In addition to the School-Based Mental Health Initiative, the Mental Health Services Act (Prop 63) includes Prevention and Early Intervention (PEI) as one of five core components. At the time of the site visit, DMH was completing a draft of the Prevention and Early Intervention requirements for counties. 51% of PEI resources must be dedicated to children and youth ages 0-25. Priority populations include: children and youth in stressed families, children and youth at risk for school failure, and those at risk for juvenile justice involvement. The first core component funded through MHSA was Community Services and Supports. Priority populations were identified through county-based community input processes. Contra Costa is using these funds to target services to youth in transition and to indigent worker families in an underserved part of the county. The Transition Age Youth (TAY) initiative is a \$1.2 million, 18 month effort (includes \$400,000 in Medi-Cal funding), targeting 150 youth who are exiting foster care and youth at risk of homelessness (or who are homeless). It is particularly targeted to youth in the Richmond area, where there are high homeless rates. It is a partnership among

county mental health, public health (which runs programs for the homeless), the housing agency, child welfare, a private lead agency with expertise in serving this population, a small Latino provider organization and the Interfaith Ecumenical homeless partnership. County mental health, using MHPA dollars, financed one-time costs for converting existing cottages to modular units separate from adults, and homeless dollars are paying for operating costs. Public housing will use county general revenue and McKinney Act funds to create a range of supportive housing, and the Department of Community Development is developing permanent housing (8 units) for the TAY population.

## **HI** Hawaii

### ***Providing Behavioral Health Services to At-Risk Children in Schools***

The Department of Education (DOE) provides a “Comprehensive Student Support System” that provides a range of short-term behavioral health services with the goal of early identification and intervention with students before they may become eligible for special education services through an individual education plan (IEP). Following the identification of a need (through consultation with teachers) and initiation of services, the team reconvenes to decide if a more formal evaluation is needed to determine if there is a disability which requires more intensive or longer-term services.

Beginning with fiscal year 2000-2001, DOE also took responsibility for serving students with less severe emotional and/or behavioral challenges through newly established school-based behavioral health services. Youth needing less intensive mental health services, such as outpatient counseling, now receive these services through school-based mental health (SBBH) services. The coordinated relationship between the education and mental health systems provides a system of care with the school as the central access point for mental health services for youth with educational disabilities. Medicaid health plans also provide assessment and basic levels of outpatient treatment, which can be considered early intervention. More intensive services, if needed for the Medicaid eligible youth, are then obtained through the Child and Adolescent Mental Health Division (CAMHD) children’s mental health system.

## **VT** Vermont

### ***Providing Services to High-Risk Families***

Financing for screening, assessment and a range of services is available for children and their families with identified problems, as well as those at risk. There are efforts through Vermont’s system of care to identify high-risk families. For example, the CUPS early childhood initiative has focused on identifying high-risk families with young children including teen parents, families affected by substance abuse, families in crisis, families with children exposed to domestic violence, and others. Linkages with the child welfare agency (Department for Children and Families) and the state’s domestic violence network have both been used to focus attention on high-risk families and identify those in need of intervention. Each local education agency (LEA) is responsible for operating a Student Support System that identifies and intervenes with students before they require special education services, including youth with behavioral health issues. Referral may be made to a local mental health Designated Agency (DA) or services may be provided at the school under a contract with the DA. Almost half of all public mental health services to Medicaid eligible children and adolescents in **Vermont** are provided in conjunction with a school—a major benefit in a rural state with little public transportation.

**NE Central Nebraska*****Providing Wraparound Approach to At-Risk Children***

The mission of the Early Intensive Care Coordination Program (EICC) is to use the wraparound approach and family-centered practice to coordinate services and supports for families involved with the child welfare system whose children are at risk of becoming wards of the state. The EICC is a voluntary program intended to prevent children from being removed from their homes or going into higher levels of care (if not needed). The EICC also addresses parental mental health, substance abuse, and developmental issues. At the time of the site visit, there was concern about sustained funding for EICC at its current case rate. EICC is financed primarily by cost savings generated by the Integrated Care Coordination (ICCU) program that focuses on increasing permanency and reducing use of restrictive placements and lengths of stay for children in placement. In fiscal year 2005, \$355,780 was invested in EICC; however, the Integrated Care Coordination (ICCU) program cost savings for fiscal year 2005 was only \$66,608. Therefore, Region 3 Behavioral Health Services (BHS) had to draw upon its previously accumulated savings to fully fund EICC in fiscal year 2005. (Note: Since the site visit, Central Nebraska has been unable to continue its EICC Program due to state policy changes limiting the use of funds to children who are current wards of the state. In place of EICC, a new School-Based Intervention Program is being implemented for children and youth in custody.)

**OH Cuyahoga County, Ohio*****Financing Service to At-Risk Populations***

The very design of **Cuyahoga County's** system of care promotes early intervention to at risk populations. In its Cuyahoga Tapestry System of Care (CTSOC), Cuyahoga County has brought together the Family-to-Family Neighborhood Collaborative model developed through the Annie E. Casey Foundation with a system of care approach. Fourteen Neighborhood Collaboratives, which provide early intervention services and supports for families at risk for child welfare involvement, partner with lead provider agencies that have the capacity to serve children with serious emotional challenges and their families. The Collaboratives and lead provider agencies work together in Care Coordination Partnerships, which use the wraparound model of service delivery for all families who receive services, no matter what target population they are part of, nor the extent of their service needs. The director of the county child welfare agency is an advocate for the system of care/ wraparound service model and has invested funds to ensure that additional families (more than those who have children with serious emotional disturbance) are served using this practice model. Thus, the county will be able to serve an additional 2500 + families annually who are at risk of involvement in child welfare and mental health, using funds from DCFS (approximately \$4 million) and from SAMHSA (\$1.1 million). These families are served by "wrap specialists" in the 14 Neighborhood Collaboratives, which provide access to a wide variety of early intervention and support services offered including services such as: budgeting, respite care, meal planning, prenatal infant care, religious and spiritual services, senior citizen's programming, kinship care and foster care, day care, recreation, summer camp, food, shelter, afterschool programs, employment assistance, etc. Children needing more intensive services and supports are linked through the Cuyahoga Tapestry System of Care (CTSOC) to a mental health assessment and appropriate treatment services provided by lead provider agencies and their networks. Families of children who do not have serious emotional disturbances

are connected with other services and supports through the Neighborhood Collaboratives and may receive assistance from the Family to Family Wrap Specialists who are funded by DCFS and the SAMHSA grant funds as described above.

In addition to its Neighborhood Collaborative-Care Coordination Partnership Model reaching a broad population of children and families, the county also has been able to ensure service access to a broader population of children with intensive service needs or at very high risk than the original 240 children with serious mental health needs who were to be served with federal SAMHSA grant funding by leveraging other system dollars. Through contributions to the system of care from the Board of County Commissioners (\$6 million) and from the Department of Child and Family Services (DCFS) (\$3 million from savings achieved by reducing residential care), the system of care has the capacity to serve an additional 600 children. Two populations of children were targeted for services with this additional funding:

- 300 children referred by DCFS (to divert 100 children from residential care and serve them in the community through the Care Coordination Partnerships; 200 children/youth in kinship care who have behavioral health problems)
- 300 youth referred by the court system (to divert 100 children from residential care and serve them in the community through the Care Coordination Partnerships; 200 who have domestic violence convictions, i.e., status offenses)

### **CO** Project BLOOM, Colorado *Using Multiple Financing Sources*

If the child is age 0-3, early intervention services are financed by Part C. For children ages 3-5, community mental health centers provide early intervention services within the range of financing sources available, or special education preschool dollars are used to finance early intervention services.

A Funding Hierarchy was developed by Project BLOOM to help the family and service coordinator determine how services will be covered. The funding hierarchy includes the following in order of which sources should be considered first to fund services:

- Private insurance
- Public insurance (Medicaid and CHP+)
- Health Care Program for Children with Special Needs (Title V)
- Child Welfare, Temporary Assistance to Needy Families (TANF) and Child Care
- Dept. of Education
- Division of Developmental Disabilities (Community Centered Boards)
- Federal Part C

## **WI** **Wraparound Milwaukee** ***Providing Wraparound Approach at an Earlier Stage***

Wisconsin has a new Comprehensive Community Services Medicaid benefit that covers more community-based interventions than outpatient and that allows for cost reimbursement up to a certain level of cost per day; the provider has to show the actual cost of care, so it is rather labor-intensive. The counties co-finance the benefit by putting up 40% of the match. Wraparound Milwaukee is looking at using this new benefit to implement a “Wrap Light” that would provide less intensive services than Wraparound Milwaukee but at an earlier stage. It is considering the possibility of using child welfare and juvenile justice dollars to cover the match; for example, the juvenile justice system has access to county levy money (which mental health does not) and could use these types of dollars as match.

## **D. Finance Linkages with and Training of Primary Care Practitioners**

Several sites incorporate financing for linkages with primary care practitioners (PCPs) and training. For example, **Project BLOOM** has placed clinicians in primary care settings, used Part C and grant funds to train PCPs, and purchased behavioral health screening tools for use in pediatric practices. Flow charts and other materials for PCPs were developed to guide identification and referral for behavioral health problems.

## **CA** **California** ***Incorporating Requirements for Collaboration with Primary Health Care***

Medi-Cal review protocols require collaboration between primary care providers (PCPs) and behavioral health. The county mental health plans are reviewed every three years, and all counties have memoranda of understanding (MOUs) in place with primary care. Actual collaboration varies by county. Also, current Medi-Cal requirements that prohibit Federally Qualified Health Centers (FQHCs) from billing more than one Medi-Cal service in a day present a barrier to collaboration as FQHCs cannot claim both a physical and a mental health service on the same day for a given individual.

The Mental Health Services Act (MHSA) Community Services and Supports component requirements include collaboration with PCPs and MHSA's Prevention and Early Intervention Component focuses on health and mental health in the schools.

## **VT** **Vermont** ***Implementing a Pediatric Collaborative Approach***

**Vermont** has been piloting a pediatric collaborative approach for since 2002, and it has been an effective model for provision of preventive care, early screening, early intervention, and service coordination for children and their families at risk for mental illness and/or substance abuse disorders. The primary care office seems to be a less stigmatizing environment where parents and children

are more likely to address many health concerns, including issues of social and emotional health. The model co-locates a community mental health professional jointly trained in mental health and substance abuse in a pediatric or family practice office to screen, coordinate mental health and substance abuse treatment, provide short-term intervention, and provide staff consultation. The state does not mandate any special instrumentation for behavioral health screens but has an approved list of tools. In addition, the primary care office will have regular consultation with a child psychiatrist for two hours a week. Finally, the model provides immediate access to more intensive mental health and substance abuse treatment when necessary and allows early interventions which result in the reduction of mental health and substance abuse related issues. More than a dozen mental health professionals are working to improve screening and services in primary care and private agency settings across the state, and there is great interest in expanding the effort and increasing the number of practices and practitioners involved. Medicaid is a source of financing for this approach.

### **Choices** Choices

#### ***Addressing Health/Medical Domain***

One of the life domains addressed in service plans is “health/medical.” As such, it is seen as the responsibility of Choices to ensure that every child has a medical home and that medical, dental, and eye care needs are addressed. If the child and family do not have private insurance or Medicaid, then flexible funds are used to pay for health services. Care coordinators assist the family in determining if they have any form of private or public health insurance; flexible funds also can be used to cover co-payments, prescriptions, or emergency room visits.

### **Choices** Project BLOOM, Colorado

#### ***Using Multiple Funding Sources for Medical Homes, Clinicians in Primary Care Settings, and Training for Primary Care Providers***

**Colorado** has been one of four states that federal funders — Substance Abuse and Mental Health Services Administration (SAMHSA) and the Maternal and Child Health Bureau — have brought together to work on the “medical home” concept. There has been an effort to link the medical home concept with Project BLOOM’s early childhood system of care development and to make mental health a part of the medical home concept. The Colorado Behavioral Health Council was brought together with the Medical Home Directors to further this collaboration. Through outreach to primary care practitioners, there is a continual effort to raise their awareness of mental health needs and resources.

A pilot in Aurora County started in 2007 which places a mental health clinician in a primary care setting. A staff member of the community mental health center (CMCH) is now physically located in a private pediatric practice that serves 60% Medicaid clients. The CMHC agreed that the staff person would be able to serve all children, not just those who are Medicaid eligible. The CMHC clinician does assessments when mental health issues are identified through screening, consultation, and facilitation of referrals rather than providing direct treatment services to children and families.

Part C provides financial support for training primary care practitioners and has a goal of significant outreach to physicians. Project BLOOM funds from the SAMHSA system of care grant

have also been used to train pediatricians on screening for behavioral health and referral processes. El Paso County purchases the “Ages and Stages” Questionnaire and provides these to a significant number of pediatric practices in the county to support screening and early identification of behavioral health problems.

A supplemental funding proposal to SAMHSA was successfully submitted to seek support for additional work on screening and additional work with pediatric practices. The state conducted focus groups to determine what type of literature would be helpful for parents to receive from their primary care offices and what information primary care providers would like on social-emotional issues. Resources are being developed for primary care providers, and local training will be conducted to assist them in including social-emotional screening as a part of their developmental screening.

Children’s Hospital in Boston developed a widely respected package for screening in pediatric settings; the ABCD group may take examples from this and build it into Colorado’s package. (See <http://www.developmentalscreening.org>)

A grant from the Colorado Health Foundation allowed for pilot testing of tools for use in primary care settings for behavioral health screening — Ages and Stages-SE and PEDS. Testing of the tools in both Mesa and Aurora Counties found that 2% of children were identified with a positive screen. Contrary to anticipated complaints of excessive burden in administering the screenings, primary care practitioners did not feel that it was too much work. A flow chart was developed for primary care offices to show them where to refer young children with mental health problems. A flow chart was created for the 0–3 age group, and work is underway to create a flow chart for children ages 3-5. All agencies have worked on this together. The flow chart for the 0–3 age group can be found at: <http://www.earlychildhoodconnections.org/index.cfm?fuseaction=Referral.content&linkid=163>

The ABCD initiative (Assuring Better Child Health and Development) was initially started in North Carolina with support from the Commonwealth Fund. Colorado was one of five states selected for replication, with the goal of improving developmental and behavioral screening in primary care practices. In 2007, a set of materials was developed by the Colorado chapter of the American Academy of Pediatrics (COAAP) and many collaborating agencies, including Project BLOOM, by adapting North Carolina’s materials, “Integrating Developmental Screening and Surveillance.” These materials include information about developmental screening in primary care practices, references and resources, and developmental screening tools that can be used. In addition, the packet includes a worksheet for “Getting Started” that assesses the extent to which primary care practitioners currently are doing developmental screening, identifying staff, selecting a screening tool, integrating screening and referral, identifying system supports (materials and partners), and conducting staff orientations. It also includes information about referrals for early intervention services and a referral flow chart.

### **WI** **Wraparound Milwaukee** ***Conducting Reviews with Primary Care Practitioners***

**Wraparound Milwaukee** conducts weekly reviews with primary care practitioners (PCP) at the city’s Federally Qualified Health Center (FQHC), where most of the population that they serve go for primary care. It also is considering developing a walk-in psychiatric clinic at the FQHC. In addition, Wraparound Milwaukee requires its care coordinators to document the child’s PCP in the plan of care and whether the child is receiving psychotropic medication so that Wraparound Milwaukee and PCPs can keep each other informed.

## VI. Finance Services for Uninsured and Underinsured Children and their Families

### Financing strategies include:

- A. Finance Services for Uninsured and Underinsured Children and their Families
- B. Incorporate Strategies to Access Services without Custody Relinquishment
- C. Encourage Private Insurers to Cover a Broader Array of Services and Supports

### A. Finance Services for Uninsured/Underinsured Children and their Families

All sites have implemented strategies to try to better finance services for uninsured and underinsured children and their families, often using state or local general revenue funds. For example, **New Jersey** established a classification of a “system of care child,” which allows non-Medicaid eligible children to receive services. **Table 6.3** shows the types of mechanisms used by sites to finance care for children who are uninsured or underinsured.

Mechanism	States						Regional/Local Communities					
	AZ	CA	HI	NJ	VT	MI	Central NE	Choices	Cuyahoga County	Erie County	Project BLOOM	Wraparound Milwaukee
Offering sliding fee scales	X					X	X		X		X	
Allowing families to buy into Medicaid			X									
Using Medicaid family of one and/or TEFRA options	X	X		X		X					X	X
Using home and community-based waivers that cover uninsured and underinsured children					X	X		X		X		X DD*
Pooling or blending funding to serve uninsured and underinsured children		X				X	X			X		X
Use of general fund dollars	X	X	X	X	X	X	X	X	X	X	X	X

\* Developmental Disabilities

**AZ** Arizona***Using Sliding Fee Scales and State Funds***

Regional Behavioral Health Authorities (RBHAs) are required to screen families for implementing sliding fee scales, and they receive state general revenue and mental health/substance abuse block grant funds which they can use to serve children not eligible for Medicaid or SCHIP. These dollars make up about 8-10% of the total funding for the system. Arizona also uses the “family of one” option, which, according to Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), can give a child 5-6 months of Medicaid eligibility even if he/she is not in an out-of-home setting that entire time.

**CA** California***Using Multiple Financing Streams***

There are several funding sources available from the state to the counties to finance services for uninsured/underinsured children, including Prop 63 (Mental Health Services Act — MHSA) funds, which prioritize populations that are historically underserved, realignment funds (sales tax and vehicle licensure fees), though these funds have been eroded over the years due to inflation, and Assembly Bill 3632 (special ed) funding. The state distributes \$9.9 million in state general revenue to counties through the Strategic and Treatment Options Program (STOP), which provides funding for community alternatives for non Medi-Cal youth at risk of residential placement. Counties are required to provide a 30% match to access this funding. Counties also may use county general revenue and school financing through partnerships with the schools as Contra Costa County does, as well as state and county juvenile justice general revenue, state and county child welfare general revenue, and First 5 Commission funding as **Contra Costa** also has done.

The MHSA (Prop 63) is a major new source of funding for uninsured or underserved populations. In Contra Costa, families up to 300% of the federal poverty level will be targeted; while Medi-Cal children are not excluded, the county primarily is focusing on non-Medi-Cal, non-SCHIP, and non-privately insured families. MHSA funds also allow them to serve undocumented families, and the area of the county being first targeted by Contra Costa has many immigrant farm worker families. The lead agency will be Familias Unitas, now a small agency, in partnership with county mental health and another provider, Asian Pacific Psychological Services. The county is providing technical assistance to Familias Unitas in recognition that the MHSA grant will double this small provider’s size. The service model is intensive wraparound, not clinic based, with close attention to basic supports such as housing, transportation, legal services, as well as mental health and substance abuse services, and natural supports through teen peer mentors, and parent partners. Staff is multilingual, including Tagalog, Vietnamese and Spanish. County public health is partnering to ensure inclusion of primary care.

**HI** Hawaii***Using General Revenue to Finance Services for Uninsured/Underinsured and Allowing Families to Buy Into Medicaid***

Recently, the state added a mechanism to fund behavioral health services through general revenue funds in the category of “mental health only.” This category was created to serve youth not eligible for services through other mechanisms, but who are determined to be in need of mental health services by the Child and Adolescent Mental Health Division (CAMHD) Medical Director. To be eligible for this category, a child cannot be eligible for any other program – not educationally disabled and in need of services through an individual education plan (IEP), not Medicaid eligible or eligible for the Support for Emotional and Behavioral Development (SEBD) plan through Medicaid, and not incarcerated. The population includes youth found eligible by their schools for Section 504 of the Rehabilitation Act, uninsured youth, youth who may have lost Medicaid eligibility due to incarceration or furlough, and youth with private insurance but with uncovered service needs. CAMHD serves these youth with general funds that are legislatively appropriated. If found eligible, a child can then access services that are paid by general revenue funds. The CAMHD Medical Director makes service decisions and can authorize necessary services for children with serious emotional disorders. The entire range of services can be authorized with no predetermined limits, though the overall availability of funds is limited. If the child has private insurance, attempts are made to bill insurers for covered services; however, the state’s insurance parity law does not apply to childhood diagnoses so that many children’s mental health services are not covered by private insurance plans.

In addition, the state Medicaid program allows families above the eligibility level to buy into the Medicaid program.

**MI** Michigan***Using General Fund Dollars and Grants to Prepaid Inpatient Health Plans (PIHPs)***

In **Michigan**, uninsured children can go to Community Mental Health Centers to receive services on a sliding fee scale. The ability to cover services for children who are uninsured is becoming more difficult because the general fund dollars that are used to support this have decreased.

To finance specialty services for persons who are not eligible for Medicaid, the state uses a population-based formula to award grants to PIHPs for this purpose. The grants are funded using federal block grants and state general revenue dollars. The grants are not related to the Medicaid payments and are not based on capitation.

Michigan also has a home and community-based waiver for children with serious emotional disorders that can include non Medicaid eligible children, but the waiver serves a small number of children.

**NJ** **New Jersey*****Establishing Eligibility as a “Children’s System of Care Child”***

The children’s system of care initiative allows for presumptive eligibility for children needing behavioral health care if they are Medicaid eligible or eligible for **New Jersey’s** SCHIP program (New Jersey Family Care). In addition, children are eligible as a “children’s system of care child,” a child who has a serious emotional disorder and is involved or at risk for involvement in multiple systems. Regardless of whether the child is eligible for the system of care through a Medicaid or non-Medicaid eligible route, and regardless of the other systems in which the child may be involved (e.g., child welfare or juvenile justice), he/she is assigned a “system of care” identifier number that is tracked through the state Medicaid agency’s management information system.

In addition, the state allows for designation of a child with a serious disorder as a “family of one” to qualify for Medicaid-reimbursed residential treatment services.

**NE** **Central Nebraska*****Using Flexible Funds and Sliding Fee Scale***

The Professional Partner Program includes flex funds that can be used to pay for treatment when a family does not have access to a third party payer (Medicaid, private insurance or Kid Connection — **Nebraska’s** SCHIP). When care coordinators request flexible funds, they must show how using the funds will lead to specific outcomes. Families are not charged to participate in the Professional Partners Program or Integrated Care Coordination program. Region 3 Behavioral Health Services (BHS) offers a sliding fee scale to assist families in paying for specific treatment services.

**OH** **Cuyahoga County, Ohio*****Using Local Funds***

For children who do not have insurance of any kind or who have exhausted their insurance, the county uses local funds to cover the cost of services. Community mental health centers have sliding fee scales for families that are uninsured; however, the fee can be waived completely. The county tracks expenses for children who are Medicaid eligible and those who are not.

**NY** **Erie County, New York*****Using Blended Funding***

Through the use of blended funding, wraparound care coordination and the array of system of care services (e.g., Multisystemic Therapy, Functional Family Therapy, Mobile Crisis Response Teams, Intensive In Home, Chemical Dependency, Family Supports, etc.) are available to children and families without regard to private insurance or Medicaid coverage. New York State also has a home and community-based waiver for children with serious emotional disorders that can include non Medicaid eligible children, but the waiver serves a small number of children.

### **CO** Project BLOOM, Colorado *Using Early Childhood Mental Health Specialists and Funding for Indigent Care*

Early childhood mental health specialists at each community mental health center (CMHC) pick up services for uninsured and underinsured children and families. In addition, state general fund dollars go to the CMHCs to fund indigent care.

A high-level commission in the state (Blue Ribbon Commission for Health Care Reform created by Senate Bill 06-208) is exploring health care reform models for expanding affordable health care coverage and will examine the issue of the uninsured and underinsured, including in relation to mental health. The Commission has 27 bipartisan members, representing consumers, purchaser, health care providers, business leaders, insurance experts, elected officials, and policy experts. The Commission solicited ideas and received 31 proposals; four of these will be studied further with the assistance of the Lewin Group. A final report with recommendations to the General Assembly completed in 2008 can be seen at <http://www.colorado.gov/208commission>

## **B. Incorporate Strategies to Access Services without Custody Relinquishment**

Several sites implemented specific financing strategies to ensure access to care without relinquishing custody. For example, **Vermont** enacted legislation that prohibits custody relinquishment for the purpose of obtaining needed mental health care, and in **Central Nebraska**, a wraparound approach to services is used to work with youth and families to avoid placing youth in state custody; voluntary placement agreements are used when necessary.

### **VT** Vermont *Enacting State Statutes to Prohibit Custody Relinquishment for Services*

**Vermont** statute [Title 33 Human Services §4305(g)] prohibits requiring custody relinquishment in order for parents to obtain mental health care for their children. In addition, years ago, state level data analysis revealed that a significant percentage of children in parental custody would experience a “crisis,” and then be admitted to state custody on an Emergency Detention Order (EMO) as a child in need of supervision (CHINS). These children then would emerge from state custody within 30 days once the “crisis” was understood and a plan of supports and services was developed and begun. To prevent families from having to relinquish custody in these situations, the state initiated a major effort, supported by a federal grant, to re-think “crisis” response services. Significant reductions in EMOs for CHINS have occurred and been sustained over the last decade.

**NE** **Central Nebraska*****Implementing Wraparound Approach to Prevent Custody Relinquishment***

The mission of the Early Intensive Care Coordination Program (EICC) is to use the wraparound approach and family-centered practice to coordinate services and supports for families whose children are at risk of being placed in state custody and to ensure that families have a voice, ownership and access to a comprehensive, individualized family support plan. Of the 67 children served in EICC during fiscal year 2005, 88.1% were prevented from being placed in the state's custody. Families in Region 3 rarely transfer custody of their children to access services. When children do need to be placed to access treatment services, a voluntary placement agreement will be pursued, rather than involving the court. The Office of Protection and Safety and Region 3 Behavioral Health Services (BHS) work together to determine how to avoid inappropriate custody relinquishment. Some respondents indicate that additional care coordination services are needed statewide. Nebraska's Child and Adolescent State Infrastructure Grant has formed a subcommittee to gather more data on the custody relinquishment issue and reintroduce legislation that did not pass previously. (Note: Since the site visit, Central Nebraska has been unable to continue its EICC Program due to state policy changes limiting the use of funds to children who are currently in state custody. In place of EICC, a new School-Based Intervention Program for children and youth in custody is being implemented)

**OH** **Cuyahoga County, Ohio*****Using Multiple Financing Sources***

The system of care model created by **Cuyahoga County** focuses on providing community-based services in the child/family's neighborhood, rather than on placement services. Due to the strength of the child and family team (i.e. wraparound) process, the efforts to offer families what they need in their own homes, and the desire of most parents to avoid residential placements, the "floodgate" to residential treatment and placement services is small.

The Department of Family Services assumes responsibility for placement services, so when a child does need placement for treatment purposes, he/she is referred to DCFS. DCFS may use 100% local funds to pay a residential treatment provider, or through a shared payment agreement, juvenile court, mental retardation/developmental disabilities, and the parents may pay part of the cost. Parents participate in developing the service plan which includes the payment agreement, visitation, etc. A social worker is assigned and meets weekly with the parents to support their role and reunification as soon as appropriate. DCFS does not take legal custody of these children.

**CO** **Project BLOOM, Colorado*****Using Legislative Funding***

The Child Mental Health Treatment Act provides state general fund resources for residential treatment services for children who are not categorically eligible for Medicaid (based on the Family of One provision) without the need for families to relinquish custody to the child welfare system. However, Family of One only applies when a child is in out of home care (e.g., residential treatment), not in community services and at home.

## C. Encourage Private Insurers to Cover a Broader Array of Services and Supports

Several sites have attempted to work with private insurers to cover a broader array of services. For example, **Hawaii** attempts to bill private insurers for covered services and, in addition, has had preliminary talks with Blue Cross about allowing their insured access to the service array in the system of care. **Vermont** and **Colorado** enacted parity laws requiring health plans to cover mental health and substance abuse services to the same extent as other health services.

### **HI** Hawaii

#### ***Billing Private Insurers***

Under the “mental health only” category, if the child has private insurance, attempts are made to bill insurers for covered services; however, the state’s insurance parity law does not apply to childhood diagnoses so that many children’s mental health services are not covered by private insurance plans.

Blue Cross has approached the state to allow some of their covered lives to access the Child and Adolescent Mental Health Division (CAMHD) service array. The state is attempting to determine how to bill the insurance company for services and to build the capacity to do so. Concern has been expressed that the state’s children’s mental health system could become a provider for families with insurance, and would, therefore, have diminished capacity to serve uninsured children and families. This has led to a discussion on the mission and role of the public mental health system. This is still being worked on at present.

### **VT** Vermont

#### ***Enacting Parity Legislation***

**Vermont’s** mental health parity law, which went into effect in January 1998, requires health insurance plans to cover mental health and substance abuse services at no greater cost to the consumer than insurance for other health services. The law eliminates separate and unequal deductibles and out-of-pocket costs for mental health and substance abuse services. The law applies to all health plans offered by Vermont insurance companies, including health maintenance organizations (HMOs), but it does not apply to self-insured plans. It requires a single deductible and the same out-of-pocket co-payments or co-insurance for mental health and substance abuse services and all other covered health services. It also removes separate yearly and lifetime visit limits and dollar maximums. State leaders acknowledge that the law has been significant in helping to change some practice and to continue calling attention to disparities. They point out that there are still a lot of loopholes for private insurers that are not based in Vermont.

In 2006 Vermont passed a law that establishes a new state-funded insurance program for the uninsured, called Catamount Health, which requires employers to pay assessments if they do not offer health care coverage to their workers. (This program will provide individual adult and family coverage for those not eligible for Medicaid and its extended programs; children and adolescents are already covered under the Vermont Medicaid “Dr. Dinosaur” program up to 300% of the federal poverty level.)

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**CO** **Project BLOOM, Colorado**  
***Enacting Parity Legislation***

A mental health parity bill was passed by the state legislature in 2007. Private insurance is now mandated to cover treatment for a broader array of diagnoses. Private insurance is also mandated to cover up to a certain dollar amount annually for early intervention.

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# Chapter 7. Financing Key System of Care Features

## I. Finance Cross-Agency Service Coordination

### Financing strategies include:

#### A. Finance Cross-Agency Service Coordination and Dedicated Care Managers at the Service Delivery Level

#### A. Finance Cross-Agency Service Coordination and Dedicated Care Managers at the Service Delivery Level

Cross-agency service coordination at the service delivery level is financed by the sites, typically by financing dedicated care managers through various mechanisms. For example, in **Hawaii**, care coordinators are state employees, and in **Central Nebraska** several care coordination programs with wrap facilitators are financed through shared funding across agencies.

#### **CA** California

##### *Using Multiple Funding Sources for Wraparound Approach*

The state has promoted a wraparound approach and system of care values stressing coordination at the service level through multiple financing sources, including in the Mental Health Services Act (Prop 63), which requires most counties to implement wraparound, SB 163 wraparound funds in child welfare, and the Children's System of Care program (now ended).

**Contra Costa County** utilizes a wraparound approach that is financed with multiple sources, including Medi-Cal, Aid to Families with Dependent Children-Foster Care (AFDC-FC), state juvenile justice general revenue, county general revenue, school funding, and federal and state grants. There are wraparound facilitators in each regional mental health center, in the schools in one school district, and attached to the juvenile detention program.

#### **HI** Hawaii

##### *Financing State- Employed Mental Health Care Coordinators*

Mental health care coordinators (MHCCs) are state employees of the Child and Adolescent Mental Health Division (CAMHD), placed in each of the Family Guidance Centers. These care coordinators are responsible for the individualized service planning process, involving the convening of child and family teams to develop and implement a Coordinated Service Plan (CSP). The care coordinators are responsible for authorizing and coordinating the services specified in the plan across providers and agencies. A key function of the care coordinators is to develop collaborative working relationships with other child serving agencies. The specific responsibilities of the MHCCs include the following:

- Ensuring a sound clinical assessment is conducted
- Convening team meetings to conduct strength-based planning via the CSP process
- Developing the written CSP and obtaining agreement and signatures of all participants
- Implementing the CSP, including linkages to other services and programs, referrals to natural community supports, advocacy, and coordination with agencies and individuals
- Performing ongoing monitoring and evaluation of the effectiveness of the CSP and services
- Revising/adapting the plan as needs change through team participation
- Ensuring that system of care principles always guide planning for all services

In order to fulfill their duties, MHCCs are trained in: engagement skills, intensive case management, the CSP process, mental health assessments, CAMHD outcome measures (CAFAS, CALOCUS, Achenbach), and evidence-based services/best practices.

### **NJ** New Jersey

#### ***Financing Care Management Organizations with Care Managers***

Cross-agency care management is provided through **New Jersey's** Care Management Organizations (CMOs), which are non profit organizations specifically created to perform this function. The CMOs are funded through performance-based contracts with the New Jersey Department of Children and Families. CMOs are designed to serve the needs of children with the most serious behavioral health challenges and their families and function as a community-based alternative to more restrictive out-of-home services. To enable care managers to provide intensive care management, caseloads are capped at a ratio of 1 care manager to 10 children.

### **VT** Vermont

#### ***Financing Designated Agencies with Care Managers***

State law and policy fix the responsibility for system of care management. The Designated Agency is the locus of accountability for planning and implementing services and for care management for children with intensive mental health needs. The local agency that has lead responsibility for ensuring that the Coordinated Service Plan, developed by an individual treatment team, is in place can vary depending on the needs of the child and family. If the child is in the custody of the Department for Children and Families, then that department takes the lead. If the issues occur primarily in the educational setting and the child is not in state custody, then the local school district is responsible. In all other cases, the designated community mental health agency is responsible for developing the Coordinated Services Plan that outlines goals and for ensuring that the plan is implemented and modified as appropriate. Whichever agency takes the lead, an agency case manager has the principal role in activating the coordinated service plan process. The system of care supports dedicated care/case managers for the approximately 200 children in the system who require high-end services. If problems or issues arise that the individual treatment team cannot resolve in case planning or service implementation, the team or any member may initiate a referral to the Local Interagency Team (LIT) in the region for help. Case management financing comes largely from Medicaid, but may vary depending on the lead agency and scope of activities.

## **NE** Central Nebraska *Financing Care Coordination Programs*

The service system in **Central Nebraska** is built on a belief in cross-agency coordination, one care coordinator per family, and partnering with families. This philosophy is reinforced by funding several care coordination programs. The Professional Partners Program (PPP), the Integrated Care Coordination Units (ICCU), the Early Intensive Care Coordination Program (EICC), the School Wraparound Program, and the Care Management Team all offer care coordination to certain targeted populations of children and families. A case rate methodology funds the care coordinators in the PPP and the ICCU. The Central Service Area of the Department of Health and Human Services (child welfare) and Region 3 Behavioral Health Services (BHS) share the cost of the care coordinators in ICCU and EICC and co-fund the Care Management Team. Region 3 BHS and the school system share the costs of employing the facilitators in the School Wraparound Program. Reaching agreement on the care plan often requires negotiation, e.g., if the care plan calls for specific Medicaid-funded services, first the child and family team must agree upon recommended services and then the clinician from the team negotiates with a liaison at Magellan (the statewide Medicaid managed care Administrative Service Organization).

## **Choices** Choices *Financing Care Coordinators*

Each child and family served by **Choices** is assigned to a care coordinator who works with the family to form a child and family team. For support and supervision purposes, each care coordinator belongs to a Choices team, typically comprised of a supervisor, five care coordinators, and one to three case managers. In Indiana, the teams are physically located at Dawn, and most of their training and supervision occurs at Dawn, but they are actually employed by the four community mental health centers to enable them to bill Medicaid through the Rehabilitation Option for the care management services provided to eligible children. Care coordinators are employed by Choices in Ohio and Maryland. Each care coordinator carries a case load of about eight to ten children; case managers are considered “care coordinators-in-training” and play a supportive role. The responsibilities of the care coordinator are extensive and involve: organizing and convening a child and family team, facilitating a strength-based discovery/assessment process, developing an individualized care coordination plan with the team, assisting teams in finding the services and supports necessary to address care plan goals, authorizing services monthly for the upcoming month, monitoring and evaluating service provision and outcome attainment, coordinating service delivery among all involved providers and the family, writing all required reports, providing information to referring workers and other team members, and serving as an educator and facilitator for the family and the various systems. The approach used by the care coordinators is referred to as “participatory care management.” Developed by Choices, the approach uniquely blends the concepts of both managed care and systems of care by integrating the system of care philosophy and its core values (e.g., family involvement, individualized/ wraparound approach, coordinated care) with managed care technologies for clinical and fiscal management (e.g., case rates, outcome, focus).

### **OH** Cuyahoga County, Ohio *Financing the Wraparound Process*

Every child and family is served through the wraparound process which promotes cross-agency service coordination. Each child has a child and family team and a “wrap specialist” or care manager. The system of care in **Cuyahoga County** is built on a high fidelity wraparound model.

### **NY** Erie County, New York *Financing the Wraparound Process with Child and Family Teams Led by Care Coordinators*

This issue is addressed on multiple levels:

- Within county government, both the Persons in Need of Supervision (PINS) Diversion Family Services Team and the emerging Juvenile Delinquency Services Team are staffed with multidisciplinary teams represented by the Departments of Social Services, Probation and Mental Health. Funding for these activities represent in kind contributions, but with training/ coaching activities for care coordinators that are funded with system of care dollars
- Within the Family Voices Network (FVN), the cross-agency service coordination occurs within the child and family team (CFT) process and is carried out by the care coordinator. Vendor service participation in the CFT process is covered within the rate structure. Barriers to coordination are identified and resolved through one or more of the following: 1) on an individual family level within the CFT; 2) on a Wraparound Supervisor level by the FVN Supervisor Group; 3) on a cross-system operational level by the FVN Management Team represented by key cross systems stakeholders; and 4) on a policy level by the FVN Executive Committee.

### **CO** Project BLOOM, Colorado *Financing Wraparound Facilitators*

Wraparound facilitators are the primary strategy for providing cross-agency services coordination/care management. The role of the wraparound facilitator includes: creating, convening, and facilitating the child and family team; developing the individualized service plan; and serving as the care coordinator and the point person to “coordinate the coordinators.”

### **WI** Wraparound Milwaukee *Financing Care Coordinators*

Child and family teams address issues across systems at the service delivery level, and their functions are financed through Wraparound Milwaukee. Additionally, the system contracts with care coordinators who work with small numbers of children and their families (1:8) and are responsible for outcomes across systems. Care coordinators are financed through Wraparound Milwaukee’s blended funding pool.

## II. Finance Family and Youth Partnerships

A central tenet of the systems of care philosophy is that families and youth are full partners in all aspects of the planning and delivery of services. The concept of family and youth involvement has been strengthened over time, and the new concept of family-driven, youth-guided care is achieving broad acceptance. Family-driven care means that families have a primary decision making role in the care of their own children, as well as in the policies and procedures governing care for all children in the community, state, tribe, territory, and nation. Similarly, youth-guided care means that young people have the right to be empowered, educated, and given a decision making role in their own care and in the policies and procedures governing care for all youth in the community, state, tribe, territory, and nation. Financing strategies are needed to support partnerships with families and youth at the service delivery level in planning and delivering their own care and at the system level in designing, implementing, and evaluating systems of care. In addition, partnering with families and youth requires financing for services and supports not only for the identified child, but also for family members to support them in their caregiving role. Financing to fund program and staff roles for family members and youth also reflects a system of care that is committed to partnerships, as does financing for family- and youth-run organizations. (A related study at the University of South Florida on development of family voice in systems of care through support for family organizations has produced a number of resources, including: A Quick Guide for Self Assessment for Family-Run Organizations in Systems of Care; A National Directory of Family-Run Organizations, which is an interactive web-based resource; and a report on Examining the Relationships Between Family-Run Organizations and Non Family-Run Organization Partners in Systems of Care. These reports are available at: <http://rtckids.fmhi.usf.edu/publications.cfm>.)

### **Financing strategies include:**

- A. Finance Family and Youth Involvement and Choice in Service Planning and Delivery**
- B. Finance Family and Youth Involvement in Policy Making**
- C. Finance Services and Supports for Families and Other Caregivers**

## A. Finance Family and Youth Involvement and Choice in Service Planning and Delivery

### Financing strategies include:

1. Finance supports for families and youth to participate in service planning meetings
2. Finance family and youth peer advocates
3. Incorporate financing policies to provide families and youth with choices of services and/or providers
4. Finance training for providers on how to partner with families and youth

### 1. Finance Supports for Families and Youth to Participate in Service Planning Meetings

The sites studied incorporate financing to support family and youth participation in service planning meetings. They typically pay for such supports as transportation, child care, food, and interpretation on an as-needed basis.

#### ***Financing Transportation, Child Care, Food, and Interpretation to Support Family/Youth Participation in Service Planning Meetings***

- **In Arizona**, family and youth participation on child and family teams is one of the core principles of the system. The managed care system pays for child care, transportation, food, and interpreters as needed.
- **In California**, state code (5600.3 Welfare and Institutions code) tied to the Children's System of Care program requires family and youth involvement at the service level, as does the Mental Health Services Act (Proposition 63) with its emphasis on a wraparound approach. In Contra Costa, the county uses paid parent partners who are county employees to support families in wraparound teams.
- **In Hawaii**, child care may be provided if the family member has to fly to another island to participate in a child and family team meeting. In some instances, a child may be served on another island, for example, if a child needs to be in a different environment or requires hospitalization, which is available only on Oahu. Transportation and food are funded out of ancillary funds. Parent partners can advise families as to the availability of these resources and can help families to obtain them from the Family Guidance Centers when necessary. In addition, Hawaii Families As Allies (HFAA) provides some training for families on how to participate in service planning (such as training in advocacy, communication, how to speak up, how to become informed about what services are available, etc.)
- Michigan enacted legislation in the mid-1990s which was designed to increase individual choice

and responsibility in specialty services. The law requires that the planning process for publicly-funded specialty services be person-centered, based on a person's strengths, individual choices, and preferences. The person centered planning process is largely used for wraparound services for children and families. Family participation is supported by financing child care services with respite providers, financing transportation with gas cards, bus passes, or other payment, as well as providing food.

- **In Vermont**, the participation of parents/family members on child and family teams is fundamental to system of care assessment, service planning and plan implementation. The local team determines the appropriate funding resources for supports, such as child care, interpreter services and/or transportation, that permit and facilitate family participation (and without which the parent/family member might not be able to participate). The funding resources depend on the supports required (e.g., interpreter services would be covered by Medicaid; others by state mental health, other partner agency funding, or available flexible funds.)
- **Choices** attempts to remove all potential barriers to the participation of family members at team meetings, such as transportation, child care, and conflicts with work, to facilitate and maximize their involvement. Depending on a family's needs, payments can be provided for bus passes, reimbursement for gas, and child care – even providing checks for child care in advance of the meeting. If necessary, arrangements can be made for someone at Choices offices to provide child care during child and family team meetings. Staff is empowered to do whatever is needed to remove barriers to participation. Flexible funds are used to cover costs such as these.
- **In Cuyahoga County, Ohio**, parent advocates, funded by the Cuyahoga Tapestry System of Care primarily through the federal SAMHSA grant, offer support for families and ensure that the parent voice is heard in the child and family team meetings. Transportation of families to child and family team meetings is provided, if needed, by parent advocates or through vouchers for public transportation. The child and family team meetings are usually held in the schools or in an office at a settlement house, rather than in a family's home; food is rarely provided during the meetings. No formal child care is provided, although a parent advocate might help occupy the siblings during a meeting.
- **In Erie County, New York**, funding is available from the blended funds allocation given to each wraparound vendor (\$10/meeting) for family and youth participation in child and family team meetings. However, funding is often unnecessary because typically these meetings take place in the home of the caregiver.
- **Project BLOOM, Colorado** uses SAMHSA system of care grant funds to provide a range of supports to support family and youth participation in child and family team meetings as needed, including child care, transportation, and food. In addition, family members are compensated with gift cards for participating in interviews related to the Wraparound Fidelity Index or participating in the evaluation.
- **In Wraparound Milwaukee**, family and youth participation on child and family teams is a core principle. The system pays for child care, transportation, food, and interpreters to ensure that families can participate, using dollars from its blended funds pool.

**Table 7.1** shows the types of supports for family involvement in service planning and delivery that are financed in the sites studied.

Type Of Support	States						Regional/Local Communities					
	AZ	CA	HI	NJ	VT	MI	Central NE	Choices	Cuyahoga County	Erie County	Project BLOOM	Wraparound Milwaukee
Payment		X					X			X	X	
Child Care	X	X	X		X	X	X	X			X	X
Transportation	X	X	X		X	X	X	X	X		X	X
Food	X	X	X		X	X	X	X			X	X

## 2. Finance Family and Youth Peer Advocates

Most of the sites provide financing for family and/or youth peer advocates. The role of these peer advocates typically includes working with families and youth to support them through the service planning and delivery process and providing a variety of types of direct assistance.

### **AZ** Arizona

#### ***Requiring Core Service Agencies to Hire Family Support Partners and Covering Family and Youth Peer Support Under Medicaid***

All Comprehensive Service Providers (core service agencies) are required to hire Family Support Partners (FSPs). In **Maricopa County**, FSPs are recruited, trained, and coached by the Family Involvement Center, though they are employed by the Comprehensive Service Providers. This arrangement enables FSPs to feel part of and supported by a larger family movement. The managed care system also covers family and youth peer support, which is a Medicaid-covered service. A new type of Medicaid provider which the state created, called Community Service Agencies (CSA), employs, trains, and supervises family and youth peer support providers. CSAs are agencies that do not have to be licensed as behavioral health clinics. For example, the Family Involvement Center in Maricopa County is a CSA and provides family-to-family and youth-to-youth peer support directly and bills Value Options for the service.

Also, **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) is working with other child-serving systems to encourage them to fund family-to-family delivered peer support within their own systems and was making some headway with the juvenile justice system at the time of the study.

**CA California*****Covering Youth and Family Peer Support under Medi-Cal and Hiring Parent Partners as County Employees***

Youth and family peer support services can be billed to Medi-Cal if they are focused interventions that are consistent with the mental health service plan and meet medical necessity criteria. Peer support staff may facilitate support/education groups, provide 1:1 support services, teach individualized coping skills, and support the development of and linkage to natural and community support resources. Their work is supervised by a licensed or credentialed person and, typically, they need co-signature on their service notes. In addition, Mental Health Services Act (MHSA) funds can pay for parent and youth peer support.

In **Contra Costa**, parent partners hired by the county provide peer support services. Initially, parent partners were hired as contract employees without benefits and at comparatively low salaries. The county converted these positions to regular county employee slots, which gives parent partners benefits and better salaries. One of the reported downsides to having parent peer partners be county employees, however, is that the county's centralized personnel system can take a long time to process applicant paperwork, during which time the county can lose good candidates who have applied to be parent partners.

**HI Hawaii*****Contracting with Family Organization to Finance Parent Partners***

Financing is provided for parent partners who serve as peer advocates and provide assistance and support to other family members. Parent partners are employees of Hawaii Families As Allies (HFAA) whose role involves supporting parents in advocating for their children and themselves. Parent partners attend meetings such as individual education plan (IEP) meetings and court proceedings with families, conduct workshops and support groups for families, and support families in a variety of other ways. Typically, parent partners work out of their homes, but they are tied to the various Family Guidance Centers, and they serve on Family Guidance Center committees and management teams, representing the interests of and advocating for families. Care coordinators provide a packet of materials about the availability of parent partners and about HFAA to family members receiving services. In addition, Family Guidance Centers make referrals to the parent partners for support. The registration process at Family Guidance Centers was modified to include a review of parent partners and to obtain consent for the parent partner to contact the family to provide support. New work currently is being undertaken to develop youth mentors to provide positive role models to other youth in areas including social and life skills. Some mentors will receive stipends from the new federal system of care grant in Hawaii. Curriculum development to provide training for this role is underway. A new request for proposals issued by the State requires provider agencies to have a Family Specialist and a Youth Specialist. These roles can be assigned to direct service staff, but must be at least half-time positions.

**NJ** **New Jersey*****Financing Family Support Organizations with Family Support Coordinators***

The state funds Family Support Organizations (FSOs) in each region, which provide advocacy, support and education at the system and service delivery levels. They are funded with a combination of state general revenue, Medicaid administrative case management dollars, and federal discretionary grants. FSOs are required to fund Family Support Coordinators to work closely with families served by Care Management Organizations (CMOs), providing peer support and advocacy. The Family Support Coordinators are individuals with children involved in the system or who have been diagnosed with emotional problems and are available for families who request their help. A primary focus is to support the family's involvement in the individualized service planning process to ensure that the plan is supportive of their concerns, values, and preferences.

**VT** **Vermont*****Financing Peer Support and Peer Navigators***

The **Vermont** Federation of Families for Children's Mental Health provides the most extensive family organizational support for the system of care. It is the designated organizational representative in state law and policy and provides an array of services and supports (e.g., peer navigation, parent and provider training, information, and referral to resources). Peer Navigator efforts, initially developed through a statewide collaboration with family organizations (financed through a federal grant from the Administration on Developmental Disabilities and the Administration on Children and Families), offers service participants the support of someone who has experienced the system first-hand. Peer Navigators assist individuals and families with accessing and navigating the health, education and human service systems. System of care principles and practice have brought these systems together to work in an integrated fashion to reduce crises and improve child and family health, mental health and well-being. Peer navigation is supported by state general revenue and federal grant and contract funds.

**NE** **Central Nebraska*****Financing Family Partners and Youth Support through the Family Organization***

To further support families in the formalized service system, a Family Partner, employed by Families CARE, provides support for each family served through the wraparound process. Each Family Partner is recruited from and based within the community in which he/she resides.

In addition, Families CARE coordinates YES — Youth Encouraging Support, a group of 200 – 300 youth in Region 3, who work to educate professionals, families, and peers on mental health issues and to reduce the stigma within their communities. YES also provides support to other youth who have mental health disorders and provides a youth voice within the local systems of care. Youth and

parents who were interviewed applauded the work of YES and indicated that these connections with other youth make a significant difference in the life of each youth. Family Partners and YES are programs that Families CARE operates through its contract with Region 3 Behavioral Health Services (BHS). Funding for the contract comes from the case rate for the Integrated Care Coordination Unit (ICCU), comprised of mental health and child welfare general revenue. In addition, YES applies for small grants for specific activities, and the youth fundraise.

### **Choices** Choices

#### ***Purchasing Family Advocate Services from Family Organization***

Family advocates are paid by **Choices** on a fee-for-service basis, drawing on the blended (braided) funding pool. Every family served has access to a family advocate to accompany them to child and family team meetings and for other sources of support. Family advocates are employed by the family organization (Rainbows) and are available on an as-needed basis. They are funded fee-for-service to provide family mentoring and support.

### **OH** Cuyahoga County, Ohio

#### ***Using System of Care Grant Funds for Parent Advocates and Youth Peer Support***

At the time of the site visit, 11 parent advocates were available to families involved in the county's system of care, with plans to expand parent advocates into four new Neighborhood Collaboratives in October, 2008. Parent advocates are funded by the **Cuyahoga** Tapestry System of Care (CTSOC) and are hired by, assigned to and housed in each of the each of the 10 Neighborhood Collaboratives. All are parents of children with special needs and come from the communities that they serve. In addition to providing support and advocacy for families, the parent advocates serve on the system of care's Parent Advisory Council, and many of them serve on other system of care committees. CTSOC employs a "family involvement lead" who works with all 10 Neighborhood Collaboratives and provides training and support for the parent advocates.

CTSOC also has hired a youth coordinator who is working through the Neighborhood Collaboratives to support youth in the system and to develop youth groups. The Youth Coordinator developed a Youth Advisory Council, which serves as a mechanism for youth planning and decision making. Four monthly support groups are held to provide youth with peer to peer support. SAMHSA grant funds are the primary funding source for the parent lead, the parent advocates, and youth coordinator. CTSOC is exploring use of child welfare and mental health general revenue to sustain this capacity beyond the life of the federal grant and has been in discussions with the State Medicaid agency about the possibility of Medicaid covering peer support services.

**NY** Erie County, New York***Contracting with Family Organization to Provide Family Advocates***

The Erie County Department of Mental Health (ECDMH) contracts with Families CAN to hire, train, and supervise family advocates who offer support to families who are newly enrolled in care coordination through the wraparound agencies. Family advocates are present at intake, the first contact of a family with the system. The family advocate offers to follow up with the parent/caregiver and provide an orientation to the children's mental health system. Family advocates are not ongoing members of child and family teams, except when requested by parents. Three of the wraparound providers have hired their own parent advocates who are embedded in the agency. The family organization would like to move these positions to Families CAN so that family advocates would be independent of the providers. In addition, child welfare and juvenile justice agencies are contracting with Families CAN to provide family advocates. Families CAN views itself as a vendor of family support services.

**CO** Project BLOOM, Colorado***Using Federal System of Care Funds for Family Coordinators***

In each of the **Project BLOOM** communities, the community mental health center (CMHC) has a Family Coordinator on staff, hired by the CMHC using SAMHSA system of care grant funds. The Family Coordinator is a full-time position in El Paso, and part time in the other Project BLOOM communities. The role of the Family Coordinator includes both service-level and system-level functions, although system-level functions are emphasized. The Family Coordinator organizes family support for families served by the system of care, conducts outreach to families, and services as a support person to an individual family if needed. Though it is not required, the Family Coordinator may accompany a family to a child and family team meeting to provide support. Family Coordinators explain the wraparound process to families and provide them with brochures and written information outlining the service delivery process and what they may expect. They also do a lot of work in connecting families informally through a bulletin board, computer, picnics, and other activities. While the Family Coordinator's primary role is not individual peer advocacy, this is done as needed. The Family Coordinator also plays a significant role at the system level, participating on the local governance council, the Early Childhood Council, and various policy groups. Respondents from the Colorado Federation of Families for Children's Mental Health described the role of the Family Coordinator (also referred to as the Family Involvement Coordinator) as serving as the liaison between families and the system of care, bridging that gap and bringing family needs and perspectives to the forefront. It is anticipated that this may be the most difficult position to sustain after the termination of the federally funded grant period, as the Family Coordinators are financed with grant funds. Early Childhood Councils in the various communities may play a role in identifying and providing resources to maintain these positions.

In addition to the Family Coordinator, CMHCs may employ Family Advocates who provide peer advocacy to individual families. Both El Paso and Aurora County mental health centers have Family Advocates on staff. In addition, all Behavioral Health Organizations (in the Medicaid managed care system) have an Office of Consumer and Family Affairs.

### **Wraparound Milwaukee** **Wraparound Milwaukee**

#### ***Purchasing Family and Youth Peer Support***

**Wraparound Milwaukee** pays for family peer support and youth peer support on a fee-for-service basis. Family and youth peer support are provided through individuals and agencies that are part of Milwaukee Wraparound's extensive provider network. They are paid for through Milwaukee's blended funding pool.

### **3. Incorporate Financing to Provide Families and Youth with Choice of Services and/or Providers**

Most of the sites finance an individualized care planning or wraparound process with child and family teams in which the youth and family are integral to decision making about the services and supports that will be provided. In addition, the sites also offer choices of providers to families and youth when possible.

#### ***Financing Individualized, Wraparound Care Planning Processes and Broad Provider Networks***

- **In Arizona**, the managed care structure and the broad benefit design allow families and youth choice of providers and services, and the Child and Family Team process that closely involves families also supports choice. In addition, the system can enter into individual contracts with a provider that is outside the managed care network if there is a need for the service. These are known as "single case agreements". Also, the system uses flex funds (though limited) to support family choice.
- **In California**, the various financing streams that go to counties provide a certain degree of flexibility, along with use of the 1915 b waiver, a wraparound approach, parent partners to help families advocate for what they want, and a broad flexible provider network.
- **In Hawaii**, financing allows for families and youth to have some choice of services and/or providers. For example, options are available for providers of intensive in-home services, and attempts are made to address needs based on gender, ethnicity, language, and others. However, in some remote areas where there are few providers, it is difficult to offer choices. In some areas of the state, providers are flown in to provide services on a weekly basis; ferries are used in cases in which islands are closer, such as between Maui and Lanai. Family members reported that due to limited resources, shortages of providers, and high rates of turnover among providers in many areas, in actuality, few choices of services or providers may be available to families and youth, particularly in rural communities and smaller islands.
- **Michigan** enacted legislation in the mid-1990s which was designed to increase individual choice and responsibility in specialty services. The law requires that the planning process for publicly-funded specialty services be person-centered, based on a person's strengths, individual choices, and preferences. The person centered planning process is largely used for wraparound services for children and families.
- **Choices** offers families options of providers through child and family team meetings if there is a sufficient volume of providers for the services in question. To the extent possible, providers of services are customized to the community or neighborhood in which the family

resides, with the goal of establishing connections with providers that families will be able to maintain independently after their involvement with Choices has ended. Typically, two or three suggestions of providers for a service are brought to the child and family team meeting. The family is able to choose or may rely on the recommendation of the care coordinator.

**In Cuyahoga County, Ohio**, the Cuyahoga Tapestry System of Care (CTSOC) system of care ensures family and youth choice through its wraparound service delivery model integrated with the Family to Family approach in child welfare, which places a high value on making services “family driven” and providing choice for families. Parents are at the center of the wraparound team that meets to develop the plan to address the needs of their family, and parent advocates/parent support partners help ensure that family voice is heard at the child/family team meetings. In addition to its service model of wraparound planning, CTSOC has an extensive and diverse Provider Services Network (PSN) that a family can “shop” when in wraparound care.

**In Project BLOOM, Colorado**, families are active participants in the child and family team process. It is through this vehicle that families are provided with choices about the types of services they will receive and about providers. The extent of choice available to families and youth depends on their location; there are more choices in urban areas that have a wider array of resources than in more rural areas. Despite resource limitations, families and youth are the drivers of the child and family team process and are key decision makers regarding services.

**In Wraparound Milwaukee**, the child and family team, on which the family and youth are key players, determines the array of services and supports for a child and family, drawing from a very broad provider network of over 200 providers and 85 services and supports and access to flexible, individualized (e.g., one-time) supports as well. The plan of care developed by the team details the specific services and supports that will be provided, but not the specific provider. The family itself may choose the provider. This also creates a built-in quality improvement check for the system because if families are not choosing particular providers, the system will have that information and can begin to analyze the underlying reasons.

#### 4. Finance Training for Providers on How to Partner with Families and Youth

The sites use various approaches to finance training for providers on how to partner with families and youth, including using state funds for training through a state mental health institute, contracting with a family organization to provide training, and incorporating this focus in all other training in the system of care approach and practice improvement.

##### **AZ** Arizona

##### ***Financing Training for Families and Providers***

Since the JK settlement agreement, **Arizona** has spent \$7 million of tobacco settlement monies, as well as discretionary and formula grants and Regional Behavioral Health Authority (RBHA) investments, to pay for training and coaching of families, providers and others to develop a statewide practice approach designed to actualize Arizona’s vision of family-centered practice and the 12 system of care principles. In **Maricopa County**, the Family Involvement Center partnered with the Value Options (VO) training department, Comprehensive Services Providers (i.e., core service agencies), and others designated by VO to design a curriculum on how to partner with families and youth. (See [www.familyinvolvementcenter.org](http://www.familyinvolvementcenter.org))

**CA California*****Providing Training through State Institute of Mental Health***

The Children's System of Care program was a source of funding for training providers on various system of care principles, including partnering with families, but the program was de-funded by the current administration due to state deficit issues. Funding did remain, however, for the Cathie Wright Technical Assistance Center at the California Institute for Mental Health, which provides training, consultation, and technical assistance to support county efforts to develop and maintain Children's System of Care. The Center's efforts focus on offering technical assistance that enables counties to utilize core principles of the California Children's System of Care model. The Mental Health Services Act (Prop 63) includes some training resources as well. In Contra Costa County, county general revenue supports an internship program in which interns are trained in partnering with families; the county also has used various grants to pay for some training of providers.

**HI Hawaii*****Incorporating Focus on Partnering with Families and Youth in All Training***

Training for providers always includes a focus on partnering with families. Family members are employed as trainers and provide training on effective partnerships and collaboration with families. There also are resources in the current Hawaii Families as Allies budget from the state's contract with the organization to train providers in how to partner with families and youth. The state points out that just being in the same room does not necessarily result in meaningful family participation and effective partnerships between providers and families. The state plan is for parent partners to provide group and individual training to line staff on partnering with families and youth.

In addition, the second annual Young Adult Support Group Planning Summit will be held this year with the theme of "Why Not Me?" This will be used as a vehicle to share with providers the vision of youth voice and youth involvement and provide training about how to partner with youth.

**VT Vermont*****Financing the Family Organization to Train Providers***

**Vermont's** Department of Mental Health has a long-standing partnership with the Vermont Federation of Families for Children's Mental Health, which was the first state chapter of the national Federation of Families for Children's Mental Health organization. The Federation has received funding from its inception from the Department of Mental Health, as well as significant multi-year federal grant funds, to engage in a variety of ways with parents, providers and policy makers in building the system of care with strong family participation. The Federation's current state contract (\$93,000), along with other resources, funds efforts with the Department of Mental Health to help design and conduct training for mental health, other state agency and local provider agency staff, and to work directly with family members and others in improving mental health services and policies. The Federation conducts extensive family outreach, education and leadership development and serves as the family organization representative on several formal advisory and review bodies.

## **Choices** Choices

### ***Using a Community Resource Manager to Train Providers***

The community resource manager is the designated individual in each site who works closely with providers, including identifying providers to participate in the network; negotiating rates; and arranging for, coordinating, or providing training on best practices, innovations, etc. One aspect of the training for providers in the network is on family-driven care. Community resource managers arrange for training provided by family members; family members employed by the family organization, Rainbows, can provide such training locally or can travel to other sites. The contract with Rainbows financed by Choices covers these costs.

## **OH** Cuyahoga County, Ohio

### ***Providing Training through Local Training Team and Coaching Learning Communities***

The **Cuyahoga** Tapestry System of Care (CTSOC) has developed a local training team to provide the basic wraparound training to partners and providers. This training is held quarterly with smaller targeted trainings offered during the course of the year. Additionally, coaching learning communities were developed for continuous learning purposes. These mechanisms provide extensive training in high fidelity wraparound for care managers, wraparound facilitators, and supervisors by contracting with national experts to do both classroom training and shadowing of care managers as they meet with child and family teams. The goal is to transition away from the national experts and to utilize the local expertise in wraparound. Partnering with families is integral to the wraparound approach and, therefore, is emphasized in all of this training. This is financed with funds from their federal system of care grants from SAMHSA and from the Center for Substance Abuse Services.

## **NY** Erie County, New York

### ***Providing Training through Contract with Family Organization***

Training is provided by Families CAN, the local family organization, and is funded through its contract with Family Voices Network (the **Erie County** system of care). Family Voices Network also provides funding for extensive training of children's providers in care coordination through use of the wraparound process and in cultural competence. Training is supported with federal grant dollars and county general revenue from mental health and child welfare.

### **CO** **Project BLOOM, Colorado** ***Providing Training to Providers through Family Organization and Family Coordinators***

A Family Coordinator is part of the **Project BLOOM** system of care in each of the four communities. In each of these communities, training has been provided by the Colorado Federation of Families for Children's Mental Health on "Partnering with Parents" to child care providers and mental health service providers. The Federation of Families has also provided technical assistance to the four communities on family involvement, creating family organizations, and working with natural supports in a community.

Providers also are included in the ongoing wraparound training that is provided to the communities, which emphasizes family involvement and family partnership in service delivery. Training is supported with federal grant funds.

### **WI** **Wraparound Milwaukee** ***Providing Training to Providers***

**Wraparound Milwaukee** trains all providers in its underlying principles, values and operating procedures, in the child and family team concept and operations, and in the wraparound approach. It also tracks fidelity through its quality improvement (QI) system. Training and fidelity monitoring are supported through Milwaukee's blended funding pool.

## **B. Finance Family and Youth Involvement in Policy Making**

### **Financing strategies include:**

- 1. Finance payment and supports for family and youth participation at the policy level**
- 2. Finance family and youth participation in policy making, including contracts with family organizations**
- 3. Finance training and leadership development to prepare families and youth for participation in policy making**

### **1. Finance Payment and Supports for Family and Youth Participation at the Policy Level**

All of the sites provide payments and/or other supports for family and youth participation at the policy level. The mechanism used most often in these sites is a contract with a family organization which, in turn, provides payments and supports to family members and youth. Typically, supports include stipends and, on an as-needed basis, may also include transportation, child care, and food.

### ***Contracting with a Family Organization to Provide Payments and Supports for Policy-Level Participation***

- In Arizona**, Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) uses federal discretionary and block grant dollars to support family involvement in policymaking. There is not a strong youth involvement effort yet, but family involvement is a major priority. In the space of about four years (since the JK settlement agreement), family partnership has grown considerably at the state level within ADHS/BHS and at the plan level such that Arizona's family leaders are recognized nationally. Both ADHS/BHS and Value Options in Maricopa reported that they would not be as far along in their reform without the family partnership component. They believe that the philosophical shift among providers and plans is due largely to families being "at the table" and to families providing technical assistance to providers and plans. Both the state and Value Options reported that the family organizations taught them how to engage families at system and practice levels and support families, not just as advocates, but as system and service delivery partners. Families served on the committee to select the contracted Regional Behavioral Health Authorities (RBHAs). Providers employ family members as family support partners and as staff, and families serve on agency boards. The state contracts with MiKid (the statewide family organization) and the Family Involvement Center in Maricopa County to provide stipends for family involvement in policymaking and to ensure that families have access to other supports to participate effectively, as needed. The state also paid the first year dues of these organizations to belong to the Arizona Council of Providers to ensure that their voice is heard at that level of the system.
- In California**, at the statewide level, California state code (5855 Welfare and Institutions Code) tied to the Children's System of Care program requires family and youth involvement, as does the Mental Health Services Act (MHSA- Prop 63), which also adds youth involvement. The MHSA (Prop 63) provided \$33,000 in funding to the statewide family organization to pay stipends to families to participate in the hearings on MHSA (Prop 63) implementation. Also, these funds paid family members to be reviewers of county proposals for the Community Services and Supports component of the MHSA, the first component to be implemented. In addition, the state Department of Mental Health uses state general revenue to support an expert pool that includes service recipients, youth and family members. MHSA dollars also supported a small grant to Pacific News Services, which serves transition-age youth, to conduct roundtables to get youth input into MHSA implementation. In Contra Costa, the Parent Coordinator (a county employee who is a parent) serves on the management team of county mental health, as well as on various policy bodies, such as the Children's Policy Council. There were two youth (paid stipends) at one time on the Children's Policy Council. At the time of the site visit, the county was looking at using MHSA funds to hire a Youth Coordinator and support development of a youth group.
- In Hawaii**, most of the supports for family/youth participation at the policy level are provided through a contract with Hawaii Families As Allies (HFAA), the statewide family organization. The Child and Adolescent Mental Health Division (CAMHD) has been a strong advocate and supporter of family and youth involvement. CAMHD's contracts with provider agencies require the submission of youth engagement and family engagement policies that include a statement of the agency's commitment to involve youth and families in all levels of the organization, as well as a means of ensuring that youth and family members are engaged in their direct treatment plan development and evaluation, organizational quality assurance activities, and organizational management and planning activities.

- **In Michigan**, a contract with the statewide family organization, the Association for Children’s Mental Health (ACMH), is used to support family involvement in policy making. ACMH has an annual contract which comes from Block Grant funds.
- **In Vermont**, the state system of care statute prescribes funding for participation for parents/ family members and family organization representatives on local and state interagency teams and various advisory panels. Vermont law (Act 264 – Title 33 Human Services §§ 4301-4305) mandates family participation at all levels of the system of care [individual care/treatment teams, Local Interagency Teams (LIT), State Interagency Team (SIT) and State Advisory Board]. The SIT has a Case Review Committee that provides assistance to local teams as they work to identify, access, and/or develop resources to serve children and youth in the least restrictive settings appropriate to their needs. This review committee has representatives from the lead state agencies and the Vermont Federation of Families for Children’s Mental Health, specifically. Support for individual family member representation is paid by state mental health funds. Financing for the family organization representatives is covered under the state contract with the Vermont Federation of Families for Children’s Mental Health (currently \$93,000), which includes participation in system of care decision-making and support roles.
- **In Central Nebraska**, a contract with the family organization, Families CARE, is the mechanism used to support family involvement in policy making. Families CARE reimburses families for their expenses (provides meals, gas money, and child care).
- **In Choices**, support for family participation at the system level is provided through a contract with Rainbows, the family organization. Additionally, the Governor’s Office in Indiana offers scholarships for families to attend policy meetings, conferences, and training.
- **Project BLOOM**, Colorado provides supports for policy-level involvement through a contract with the Colorado Federation of Families for Children’s Mental Health (FFCMH). Transportation, mileage reimbursement, child care, etc. are provided as needed with Project BLOOM dollars (SAMHSA system of care grant funds) through this contract. Other foundation funding that FFCMH receives is also used for this purpose. Additional Project BLOOM funds have been used for family/youth involvement in policy meetings if the resources needed were beyond what was in the contract.  
The Federation identifies individual family members, trains them and facilitates and supports their involvement in roles on the Blue Ribbon Policy Council and other state-level policy and advisory bodies. At the local level, the four PROJECT BLOOM counties use their contract dollars (SAMHSA system of care grant funds) to support family involvement and participation. Each budgets an amount to support this (typically under \$10,000.)
- **In Wraparound Milwaukee**, a contract with the family organization, Families United for Milwaukee County, provides a vehicle for support of family participation at the policy level. The family organization pays for parent stipends to participate in policy and team meetings and provides other supports.

**Table 7.2** shows the types of support for participation in policy making that are financed in the sites.

Type of Support	States						Regional/Local Communities					
	AZ	CA	HI	NJ	VT	MI	Central NE	Choices	Cuyahoga County	Erie County	Project BLOOM	Wraparound Milwaukee
Payment (e.g., wages or stipends)	X	X	X		X	X	X	X	X	X	X	X
Child Care	X		X			X	X		X	X	X	
Transportation	X		X			X	X		X		X	
Food	X	X	X			X	X		X		X	

## 2. Finance Family and Youth Participation in Policy Making, Including Contracts with Family Organizations

Contracts with family organizations are the most frequent vehicle used to ensure family participation in policy making. Contracts are used to fulfill a wide variety of policy making and system management roles, including: serving on committees and advisory bodies; participating in evaluation activities; providing training; providing family advocates, peer mentors, and ombudspersons; developing and disseminating information; and organizing and facilitating youth groups and youth councils.

### **AZ** Arizona

#### ***Contracting with Two Family Organizations – MIKID and Family Involvement Center***

The **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) uses both discretionary (e.g., federal State Infrastructure Grant) and formula grant dollars to contract with two family organizations – MIKID, a statewide family organization, and the Family Involvement Center (FIC) in Maricopa County. The family organizations hold both mini-conferences and a statewide conference to reach more families. At the time of the study, ADHS/BHS was issuing a new Request for Proposals (RFP) for consumer and family involvement at the policy level – for example, to support families to serve on committees, to participate in practice evaluation, to create a hotline for families, etc. The RFP includes a priority on establishing a family advocacy center serving Latino families. MiKid and FIC submitted a joint proposal to ensure statewide family involvement at the policy level and to clarify their respective roles. The state also received a federal Center on Substance Abuse Treatment (CSAT) adolescent substance abuse grant and included both MiKid and FIC in the grant.

**In Maricopa County**, at the time of the site visit, the FIC was seen as an “extension of Value Options” (VO) in terms of expanding VO’s capacity to advance system of care goals. (Note. VO is no longer the behavioral health managed care entity — BHO — in Maricopa. The subsequent BHO was Magellan, which continued many of the same types of funding and supports for Arizona’s family organizations.) Initially, FIC got started with a small grant from St. Luke’s Health Initiative and then became funded with system dollars. VO has funded FIC for several years, and FIC has also been a direct service provider within the VO provider network since 2005. VO also funds MiKID. VO’s contract with FIC is for \$900,000 for “system transformation” activities in Maricopa County, including staffing and participating on the Children’s Advisory Committee for VO, family recruitment and training, organizing open education opportunities for families, information and referral, co-facilitation of meetings, recruitment and training of family support partners (who are out-stationed with each of the Comprehensive Service Providers – core service agencies), and technical assistance to providers and others on family partnership. Every family enrolled with VO receives a Family Handbook developed by FIC and is invited to attend orientation sessions conducted by FIC. VO also has several full-time family members on staff, with two devoted to the children’s system at the time of the site visit.

At the time of the site visit, FIC received the following funding:

- Contract with VO for the “system transformation” activities noted earlier, including: recruit family support partners for provider agencies in the VO network, train and coach family members and providers in a family partnership model, train and supervise family members to participate in performance improvement reviews, and pay stipends to families.
- Contract with VO to be a Medicaid Comprehensive Services Agency (CSA) provider (all billable work has to be face-to-face contacts) and to hire eight family support partners to provide family-to-family services as part of the provider network. Also, after the site visit for this study, FIC became licensed as an outpatient behavioral health provider, which allows it to bill for telephone contact and provide case management, in addition to providing respite, peer support and family education as a CSA Medicaid provider.
- Federal State Infrastructure Grant (SIG) funding from the state to expand the family movement.

For more information about the Family Involvement Center, see

<http://www.familyinvolvementcenter.org>

## **CA** California

### ***Contracting with a Statewide Family Organization — United Advocates for California’s Families***

United Advocates for California’s Families (UACF) operates as the statewide family organization in **California** and was launched in 1989 with CASSP funding. At the time of the site visit, it operated as the Statewide Family Networks Technical Assistance Center for SAMHSA and, in addition to federal dollars, in 07-08 it received state Department of Mental Health general revenue (\$160,000) and Mental Health Services Act (MHSA — Prop 63) funds (\$210,000) to develop regional family networks. It also had a private foundation grant to develop a statewide youth organization, which was in early developmental stages at the time of the site visit. UACF was developing 12 family leaders in 12 regions of the state, and there are family organizations in varying stages of development operating in 38 out of 58 counties.

**In Contra Costa**, there is no family organization per se. The county was interested in having parent partners on staff as well as a family organization and had gone so far as to file for a 501 c 3 designation, but it lacked start-up funds sufficient for both an organization and to hire parent partners. The county believes strongly in its model of hiring parent partners as county employees because they feel it helps to build credibility faster within agencies for the role of parent partners, but they also indicated that there can be a watering down of a parent partner advocate role as parent partners become “professional” family members hired by the system. Ideally, the county would like to have both parent partners and a county family organization to broaden advocacy.

## **HI** Hawaii

### ***Contracting with the Statewide Family Organization—Hawaii Families as Allies***

CAMHD contracts with **Hawaii** Families as Allies (HFAA), the statewide family organization, for participation in policy making and system management. The first such contract was executed in 2002. State general fund dollars and federal block grant funds are used to fund the activities of the family organization. Funding levels were at approximately \$722,000 last year. HFAA reports a staff of 17 -18 people who are available to participate on a range of committees and other policy-level activities through the contract resources. CAMHD may finance transportation to support some policy-level participation outside of this contract; this is financed through flexible funds for ancillary services. In particular, assistance is available if transportation to another island is necessary.

The family organization is providing assistance in the newly received federal system of care grant focusing on youth in transition to adulthood. Among other activities, assistance is being provided in establishing a young adult support organization and preparing/mentoring youth to participate in policy making activities. Family members also serve as co-chairs with professionals on the Community Children’s Councils (CCCs); there are 17 of these in the state. These councils meet monthly to plan for and assess the strengths and needs of the children’s mental health system in their respective communities. Quarterly statewide meetings of the CCC chairpersons are held. These councils were initiated as a result of the Felix lawsuit. During the lawsuit, HFAA was used as a vehicle for supporting family involvement on the CCCs.

Parent partners are employees of HFAA whose role involves supporting parents in advocating for their children and themselves. Parent partners attend meetings such as individual education plan (IEP) meetings and court proceedings with families, conduct workshops and support groups for families, and support families in a variety of other ways. Parent partners are tied to the various Family Guidance Centers, and they serve on Family Guidance Center committees and management teams representing the interests of and advocating for families.

HFAA reported initiating a strong marketing campaign to create greater awareness of HFAA and the various supports that the organization offers. The contract with Hawaii Families as Allies specifies a scope of work that involves providing family involvement and support to families with youth experiencing emotional and/or behavioral challenges in the state including:

- Ensure that the family perspective at the community and state level is effectively presented and considered in all policy decisions (including providing representatives for CAMHD Executive Management Team, State Mental Health Council, the children’s policy group of the Governor’s Cabinet, and various CAMHD committees).

- Develop, implement, and coordinate a program on a broad range of topics relevant to enhance attitudes, skills, and knowledge of youth and families
  - Develop, implement, and evaluate a program of training that addresses a broad range of topics including, but not limited to educational issues, health issues, child welfare issues, juvenile justice issues, substance abuse issues, effective parenting, and community collaboration
  - Disseminate information by obtaining or developing documents (flyers, checklists) that provide information using family friendly language
  - Publicize the availability of documents through the newsletter of family-focused organizations
  - Disseminate and distribute documents through all suitable avenues including developing a web site
  - Conduct workshops on specific topics related to families in the community
  - Organize, widely publicize and host at least one conference annually for parents, foster parents, and caregivers of youth with emotional and/or behavioral challenges
  - Organize and facilitate a Youth Council comprised of youth to conduct public awareness and peer support activities developed by youth
  - Operate and publicize a statewide phone line to respond to requests for information and help in accessing services and support for children with emotional and/or behavioral challenges
  - Employ Consumer/Family Relations Specialists to be accessible via the statewide phone line to advise families about appropriate services for children with emotional and/or behavioral challenges
  - Develop and maintain two resource manuals of available services and supports (an Empowerment Resource Manual with information identifying community resources and a Recreational Resource Manual with information about recreational, leisure, and educational resources)
  - Provide comprehensive peer support for families of children with emotional and/or behavioral challenges by recruiting, training, and supervising Parent Partners, who will serve families in the community
  - Assist families seeking help for their children with emotional and/or behavioral challenges to access and navigate through the available services
- Increase social acceptance and reduce the stigmatization and bullying of youth with emotional and/or behavioral challenges on a statewide level.
- Participate in the CAMHD Strategic Plan
  - Collect and report information about activities and outcomes of those activities, and regularly use evaluation results to identify and address areas that need improvement.

**MI Michigan*****Contracting with a Statewide Family Organization — Association of Children’s Mental Health***

The state involves family members at the policy level through a contract with a family organization, the Association for Children’s Mental Health (ACMH), which is a statewide chapter of the national Federation of Families for Children’s Mental Health (<http://www.acmh-mi.org/about.htm>). ACMH has an annual contract that comes from Block Grant funds to do family advocacy and to participate in policy level activities. The family organization provides payment, child care transportation, and food.

**VT Vermont*****Contracting with the Statewide Family Organization — Vermont Federation of Families for Children’s Mental Health***

The state has a contract with the **Vermont** Federation of Families for Children’s Mental Health (currently \$93,000 and indexed for increases) for participating in system of care decision-making and advisory roles, for developing and carrying out parent and provider training activities, for outreach, peer support, and referral, and conducting special projects to strengthen parent/ family awareness about the system of care and its resources. The Federation also serves as a resource to the state and local mental health agencies, and works as well to grow parent leadership on children’s mental health. This includes making connections between family members ready to move into system-level work and policy groups and those committees and groups looking for new members at the regional and state levels.

**NE Central Nebraska*****Contracting with a Local Family Organization — Families CARE***

The behavioral health system for children and families in **Central Nebraska** operates as a “three legged stool”, including 1) Region 3 Behavioral Health Services (BHS); 2) Nebraska Department of Health and Human Services, Central Service Area, Office of Protection and Safety; and 3) Families CARE. When Nebraska received a federal system of care grant in 1997, Region 3 called families together to talk about how to build a system of care and to learn what families needed. Parents told them they needed an independent family organization; thus, Families CARE was created to provide support, advocacy, education and care management services for families who have children with emotional and behavioral difficulties. Region 3 BHS also contracts with Families CARE for certain evaluation components that measure wraparound fidelity and family and youth satisfaction. Initially, federal SAMHSA grant funds were used to fund Families CARE. The organization was initially paid on a cost reimbursable basis. Then, when Region 3 BHS had a better idea of the costs, they began to pay them a flat fee that represented 8% of the overall case rate for the Integrated Care Coordination — ICCU program. At the time of the site visit, Families CARE received \$472,000 annually.

**Choices** **Choices*****Contracting with a Local Family Organization—Rainbows***

Choices contracts with Rainbows, a family organization in Marion County, Indiana in the amount of \$225,000 per year. The contract supports four full-time staff, offices (provided by Choices at a minimal rent), technology, etc. The staff of Rainbows is employed by Choices, and, as such, receives the Choices benefit package. Essentially, the Choices contract supports the infrastructure for the family organization. Although there may be the perception that the family organization is “owned” by Choices, this was felt to be the only viable financing strategy to support the organization. As part of the contract, Rainbows is required to operate a hotline, offer a family support group with monthly meetings, a newsletter, trouble shooting, training, and public speaking. Participation in policy making functions related to Dawn is included in Rainbow’s role, such as participation on the Marion County System of Care Collaborative. In addition to these functions, Rainbows staff is paid for additional services on a fee-for-service basis. These include mentoring—either mentoring a child or an entire family—or serving as a family advocate. Family advocates can bill at the market rate for mentors. They accompany the family to child and family team meetings and provide other supportive services.

**OH** **Cuyahoga County, Ohio**  
***Funding Neighborhood Collaboratives***

The **Cuyahoga** Tapestry System of Care (CTSOC) ensures participation of families and youth in policy decisions by creating a governance and management structure (Neighborhood Collaboratives) that supports family participation and open communication among all levels of the system. In addition, the county has hired a parent lead, parent advocates, and a youth coordinator. The SAMHSA system of care grant budget includes a line item (\$153,000) to support family involvement, and the Neighborhood Collaboratives are the fiscal agents for these monies.

The CTSOC Oversight Committee is a broad representative stakeholder group and has eight workgroups, including a Parent Advisory Council. The parent lead (hired by the CTSOC) chairs the Parent Advisory Council (PAC), which is made up of a parent advocate and a family representative from each of the Neighborhood Collaboratives, as well as agency representatives. A member of the PAC is represented on each of the other seven workgroups of the Oversight Committee, and the Oversight Committee has two parent representatives in addition. This structure is important in fostering a strong family voice in the system. Parent representatives are paid a \$40 stipend for each meeting of the PAC that they attend.

SAMHSA grant funds have also been used to hire a Youth Lead who has developed four youth groups at the Neighborhood Collaboratives and has organized a Youth Advisory Council with a parallel structure to the Parent Advisory Council.

**NY** Erie, County, New York***Contracting with a Local Family Organization — Families CAN***

The **Erie County** Department of Mental Health contracts with Families CAN, the family organization, to offer orientation, training and ongoing mentoring and consultation with caregivers and youth who participate in policy and system management structures, including system-level advisory groups and boards of provider agencies. Two youth serve on the Families CAN Advisory Board. In addition, the local child welfare and juvenile justice systems contract with Families CAN to provide family advocates. Families CAN views itself as a vendor of family support services; its focus now is on building an internal accountability and quality assurance system.

**CO** Project BLOOM, Colorado***Contract with a Statewide Family Organization — Colorado Federation of Families for Children’s Mental Health***

**Project BLOOM** contracts with the **Colorado** Federation of Families for Children’s Mental Health (FFCMH) using SAMHSA system of care grant funds and some Block Grant funds from the Division of Mental Health in addition. The contract amount is \$40,000 to \$50,000. The funding provided through the contract with the Federation covers activities and functions including: a Youth Coordinator, involvement on policy-level bodies, such as the Blue Ribbon Policy Council, co-facilitation of an evaluation advisory group, coordination and support of the Family Involvement Coordinators in each BLOOM community, and helping families to develop leadership on the state level.

A staff person at the FFCMH provides support and coordination for the Family Involvement Coordinators at the four Project BLOOM communities. Training has been provided, and a monthly conference call is held to provide ongoing support. There is a beginning effort on the part of the FFCMH to document the role of the Family Involvement Coordinators to obtain feedback on how this role has made a difference to families, providers, and the communities. It is hoped that this effort will develop information that will support the maintenance of these positions after the termination of the federal system of care grant, since they are currently financed with grant funds.

The Youth Coordinator initially worked with siblings of the young children involved in the Project BLOOM systems of care but currently focuses on teen parents. She works in each community to identify teen parents. A scrapbook project about their children’s development is a vehicle used to infuse information about social-emotional development to these teen parents.

In addition to co-chairing the evaluation advisory group for Project BLOOM, training in evaluation is provided to families by the FFCMH, and family involvement in evaluation activities is promoted and supported. The FFCMH also supports the development of family organizations in communities.

The contract with the Colorado FFCMH includes the following provisions:

- Ensure early childhood issues are included in collaborations with family/advocacy organizations
- Assist teen parents in understanding the social-emotional development of their children
- Assist in ensuring that families are represented at Blue Ribbon Policy Council meetings by identifying potential members, providing training, coaching, and stipend payments
- Identify a family member and support this person in working with the evaluation team

- Demonstrate state level partnerships and coordination regarding social marketing, evaluation, and technical assistance/training
- Outreach to grassroots organizations and networks on issues related to young children’s mental health and systems of care
- Distribute materials and educate stakeholders in early childhood mental health about flexible funds and its significance
- Assist each PROJECT BLOOM community in implementing a work plan with strategies to maintain family and youth representation on community governance teams, evaluation teams, and local system of care work
- Provide material to all PROJECT BLOOM communities regarding family involvement in advocacy, leadership, community organizing, partnering in policy and evaluation and provide technical assistance as resources permit
- Coordinate Community Asset Building that will help connect at least one PROJECT BLOOM family to natural supports and community resources and use this demonstration for other communities as a model
- Provide database ability input and reports about family members, youth, and professional participation in support groups, trainings, policy committees, etc.
- Participate in state level efforts to improve services for children with SED through evaluation team membership and participate in reviews of quality of system of care
- Ensure family involvement in project work groups
- Provide leadership and education to organizations regarding the development of family supportive practices
- Ensure all PROJECT BLOOM family coordinators/family advocates feel supported and have a sense of connection with peers and a greater understanding of family involvement
- Ensure all community partners understand authentic family and youth involvement and distribute guidelines around the skills, supports, and administrative structures needed to support families and youth as members of the workforce
- Ensure the family and youth perspective is represented on all levels of Project BLOOM implementation
- Continue researching and pursuing funding strategies to support family/youth participation in an early childhood system of care

There also has been some foundation funding to support these activities/functions.

### **WI** Wraparound Milwaukee *Contracting with a Family Organization*

**Wraparound Milwaukee** contracts with Families United for Milwaukee County at \$300,000/year. The family organization pays for parent stipends to participate in policy and team meetings, conducts training of care coordinators, employs the education advocate, holds family events, provides family education and support, provides 1:1 family peer support, and publishes a newsletter. There is also a Youth Advisory Committee, but it is not as well established.

### 3. Finance Training and Leadership Development to Prepare Families and Youth for Participation in Policy Making

Leadership development activities are financed in some of the sites to prepare families and youth for participation in policy making and system management activities. **Hawaii, Project BLOOM**, and **Cuyahoga County**, for example, developed curricula for parent advocates, and the statewide family organization in **California** conducts peer-to-peer training.

#### **CA** California

##### ***Financing Peer-to-Peer Training***

At a statewide level, United Advocates for **California's** Families conducts peer-to-peer training for families, and the Mental Health Services Act (Prop 63) includes resources for training families. In **Contra Costa**, training of parent partners is built into the job description of the Family Coordinator, and the county used federal system of care grant funds to bring in consultants to conduct training and to develop a training binder.

#### **HI** Hawaii

##### ***Financing a Curriculum for Family Leadership Training***

Among other activities, the contract with **Hawaii** Families As Allies (HFAA) includes family leadership training. The curriculum developed for this purpose is now used nationally. The Leadership Academy is comprised of three days of training and is held 3 times per year, according to HFAA. The training provides family members with a range of knowledge and skills, including: understanding the legislative system, the structure of the mental health system, how to build relationships with policy makers, how to speak in front of an audience, how to make their voices heard, etc.

#### **OH** Cuyahoga County, Ohio

##### ***Financing the Development of a Curriculum for Parent Advocates***

The **Cuyahoga** Tapestry System of Care (CTSOC) developed a basic training curriculum for parent advocates that is offered during the day, in the evening, and on weekends by the Parent Lead and Senior Parent Advocates. This is a train-the-trainers model curriculum in family leadership which includes a focus on working with families and how to tell/use their own stories. The parent advocates also participate in the training and coaching on the high fidelity wraparound process, in the National Alliance on Mental Illness's Hand to Hand training, which is an eight-week education program designed to foster learning, healing and empowerment among families of children with emotional, mental, or neurobiological disorders, and parent advocates attend local trainings on topics of interest.

**CO** **Project BLOOM, Colorado**  
***Providing Resources for Training on Leadership, Parent-Professional Partnerships, and Family Involvement and Family Advocacy***

**Colorado's** System of Care Collaborative is providing training on leadership and Parent-Professional Partnerships on a statewide basis. A consultant has been brought in to provide training with **Project BLOOM** funds, and BLOOM funds (SAMHSA system of care grant funds) were also used to hold a Family Involvement Conference for the four Project BLOOM communities. Smart Start also includes work on family leadership and is developing a database on family resources, with foundation funding. See <http://www.smartstartcolorado.org/family/leadership.html>. In addition, Project BLOOM has developed a curriculum for family advocacy, called "Bone Deep." This is a skill-based curriculum for family advocates across disciplines.

Training was procured from the national Federation of Families for Children's Mental Health to train both families and providers on family involvement, including a Family Involvement Retreat and an Evaluation Retreat. SAMHSA system of care grant resources were used to finance this training.

***Providing Resources for Leadership Development***

- **Arizona** has spent \$7 million to date in tobacco monies, discretionary and formula grants and RBHA investments to pay for training. This has included training and coaching of families related to policy level participation.
- **In Vermont**, the State Department of Mental Health contract with the Vermont Federation of Families for Children's Mental Health provides training and supports for families and others. These trainings focus on a range of issues, from service-related matters to leadership development. A current SAMHSA grant also supports the Federation as the Vermont Statewide Family and Consumer Driven Leadership Team "to drive the implementation, sustainability and improvement of effective mental health and substance abuse prevention and treatment services for children, youth, young adults and their families."
- **In Erie County, New York**, the Department of Mental Health's contract with Families CAN includes as a deliverable the preparation and mentoring of families and youth for participation on system level policy and advisory boards.
- **In Wraparound Milwaukee**, the contract with Families United includes this type of training for families.

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## C. Finance Services and Supports For Families and Other Caregivers

### Financing strategies include:

1. Cover services and supports to families under Medicaid and other financing streams
2. Finance families, youth, and family organizations to provide services and supports

### 1. Cover services and supports to families under Medicaid and other financing streams

All of sites have incorporated strategies to ensure that services and supports can be provided to families and are not limited to the “identified child.” These include coverage under Medicaid, use of other agencies’ funds, use of flexible funds, and use of blended or braided funding structures supported by case rates.

#### **AZ** Arizona

#### ***Covering Services and Supports to Families Under Medicaid***

Medicaid can pay for family education and peer support, respite, behavioral management skills training and other supports to families if these supports are geared toward improving outcomes for the identified child. The child does not have to be present. Medicaid also can be used to pay for transportation and interpretation services for families. Non-Medicaid allowable services — for example, certain cultural supports, such as Native healers — can be paid for with non-Medicaid dollars in the Regional Behavioral Health Authority (RBHA) capitation. **Arizona** also defines “family” broadly. The Medicaid Covered Services Guide provides the following definition of family and guidance regarding coverage of services to family members —

For purposes of services coverage and this guide, family is defined as:

- (1) ‘The primary care giving unit and is inclusive of the wide diversity of primary care giving units in our culture. Family is a biological, adoptive or self-created unit of people residing together consisting of adult(s) and/or child(ren) with adult(s) performing duties of parenthood for the child(ren). Persons within this unit share bonds, culture, practices and a significant relationship. Biological parents, siblings and others with significant attachment to the individual living outside the home are included in the definition of family. In many instances, it is important to provide behavioral health services to the family member as well as the person seeking services. For example, family members may need help with parenting skills, education regarding the nature and management of the mental health disorder, or relief from care giving. Many of the services listed in the service array can be provided to family members, regardless of their enrollment or entitlement status as long as the

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enrolled person's treatment record reflects that the provision of these services is aimed at accomplishing the service plan goals (i.e. they show a direct, positive effect on the individual). This also means that the enrolled person does not have to be present when the services are being provided to family members. (See [http://www.azdhs.gov/bhs/bhs\\_guide.pdf](http://www.azdhs.gov/bhs/bhs_guide.pdf) for AZ Covered Services Guide)

At the time of the visit, the Family Involvement Center in **Maricopa County** had just agreed to develop for the child welfare system community/family supports for families at risk but whose children are not yet removed from home (in a "Family-to-Family" approach) in one zip code in the county. Child welfare also was launching a "Building Better Futures" initiative that would assign parent mentors who had had involvement with child welfare to at-risk parents. Child welfare is hoping to recruit these parent mentors through its substance abuse providers. Child welfare has used the MAPP training (National Model Approach to Partnership in Parenting out of Atlanta) and indicated that the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) also adapted this model statewide with a therapeutic overlay for its therapeutic foster care providers.

## **CA** California

### ***Using Medi-Cal for Services to Families***

Medi-Cal will support services to family members even if the child is not present as long as the service pertains to the identified child. Medi-Cal also can be used for various aspects of wraparound, such as plan development. Some family peer support services can be billed to Medi-Cal if they are part of the mental health service plan and meet medical necessity criteria. Other funding mechanisms, such as Mental Health Services Act (MHSA – Prop 63), can be used to fund supports to families.

## **HI** Hawaii

### ***Covering Services and Supports to Families Under Medicaid***

Medicaid allows services and support to be provided to families in addition to the identified child, and for which the identified child does not necessarily have to be present. For example, family therapy is billable even if the child is not present, and for young children, the family can receive services to address issues related to the child, even if the child is not present (e.g., substance abuse). For services not covered by Medicaid, funds for ancillary services are used to finance services and supports to families/caregivers. The role of case managers includes helping families to access needed services through the adult mental health system or other systems or agencies as needed.

Additionally, the contract with **Hawaii Families As Allies (HFAA)**, the statewide family organization, is used to provide services and peer supports to families/caregivers. HFAA would like to deliver a parent skills training program as a billable service under Medicaid.

**MI Michigan*****Using Medicaid and Block Grant Funds***

The Medicaid Manual includes wraparound and home-based services, both of which serve the family, not just the identified child. Block grant funds and an annual \$1,000,000 respite allocation in the state budget, which is divided among the Community Mental Health Services Programs based on prior utilization of respite, help to fund one-on-one respite and group respite.

**NE Central Nebraska*****Using Flexible Funds to Finance Services to Families***

The Professional Partners Program includes flex funds that can be used to pay for treatment and services when a family does not have access to a third party payer. When care coordinators request flexible funds, they must show how using the funds will lead to specific outcomes. There is no charge to families for the care coordination they receive when they are enrolled in Professional Partners Program or the Integrated Care Coordination (ICCU) program.

At the state level, \$310,000 has been set aside (\$274,000 from the Division of Protection and Safety [child welfare] and \$36,000 from the Division of Behavioral Health Services) to serve family members of children served through the five ICCUs across the state. The care coordinator and family determine service needs, and use these flex funds to purchase some of these services.

**OH Cuyahoga County, Ohio*****Using Neighborhood Collaboratives to Provide Services and Supports to Families***

By using the Neighborhood Collaboratives network as the base for parent advocates and by pairing Neighborhood Collaboratives with mental health Medicaid providers in the eight Care Coordination Partnerships, Cuyahoga County provides services and supports to families. These services and supports are funded primarily with Department of Children and Family Services (DCFS) funds (\$4.2 million) and SAMHSA grant funds (\$1.1 million). Eventually the county plans to serve more than 3,000 families in 14 Collaboratives by housing 38 wraparound specialists and 14 resource specialists in the Collaboratives. Through the parent advocates, families receive multiple support services and are offered the opportunity to participate in monthly support groups hosted in the Collaboratives. Siblings of identified children can participate in services when the care manager documents in the wrap plan how the services for the siblings will help the identified child, e.g., day camp, respite care, etc.

### **CO** Project BLOOM, Colorado *Using Medicaid and Flexible Funds for Services and Supports to Families*

Some providers identify this as a barrier, while others find a way to provide services to the families, not just to the identified child. There may be some variance in policy across behavioral health organizations, but billing under Medicaid for services to families is allowable under the state plan. The **Project BLOOM** communities are working with families, and wraparound plans address family issues. Some families may have their own therapists and/or their own coverage. If the family's need for services is directly related to the child, services to the parents are covered.

Respondents from the statewide family organization reported that flexible funds from SAMHSA system of care grant resources often are used to provide services and supports to families that are not covered in other ways, such as gift cards for groceries, home supplies, or other items identified in the wraparound plan that would make a difference in the lives of the child and family. A concern is that flexible funding may be difficult to sustain after the termination of the federal system of care grant.

### **Choices** Choices and **WI** Wraparound Milwaukee *Using Case Rates and Blended Funds to Finance Services to Families*

- **In Choices**, the case rate approach offers flexibility to provide whatever services and supports are needed by the child and family with no medical necessity or prior authorization necessary. The child is not required to be present in order to provide services to parents and other family members, including family therapy, alcohol or drug treatment, and others. Choices maintains data on the wide range of services and supports provided to families. Flexible funds can be used to finance supports to families, including transportation (bus, car repairs, etc.), housing, utilities, clothing, food, summer camps (including for siblings), home repairs, and others. The expenditures must be within the care plan structure, and the plan must document how such expenditures will support the service plan goals for the child and family.
- **In Wraparound Milwaukee**, services to family members are financed through its blended funding approach. It also pays for substance abuse services for parents if necessary and has partnered with the adult substance abuse system to adopt a wraparound approach.

## 2. Finance Families, Youth, and Family/Youth Organizations to Provide Direct Services and Supports

In most sites, family organizations can provide specific services and supports, with resources for these services included in contracts with these organizations or by allowing them to bill Medicaid. As an alternative approach to financing family organizations, **California's Contra Costa County** hires family members as county employees to provide direct services, and **Cuyahoga County** uses family members employed by Neighborhood Collaboratives to provide services.

### **AZ** Arizona

#### ***Using Family Organizations as Direct Service Providers***

The family organizations not only receive contracts from the state and from individual Regional Behavioral Health Authorities (RBHAs), but they also can be direct service providers. The Family Involvement Center (FIC) in **Maricopa**, for example, is a Community Service Agency (i.e. a Medicaid-approved rehab service provider — see below) and provides direct services like respite and behavioral coaching. (Subsequent to the site visit, FIC also became licensed as a behavioral health provider, which allows it to provide case management). Medicaid billings thus generate revenue for the organization. In addition, each of the Comprehensive Services Providers (CSPs) in the Value Options network in **Maricopa County** must have family support partners on staff, who are paid for by the managed care system. These family support partners can provide services in any location (e.g., school, court, home, etc.).

As part of the JK settlement agreement, Medicaid expanded covered services to include a new provider type, called a “community service agency,” (CSA) to allow family organizations and others to be funded like a licensed Medicaid provider. Both FIC and MiKid (the statewide family organization) became CSAs, authorized to provide certain rehabilitation services. As a CSA, FIC can bill Medicaid for rehab services, including skills training and development, health promotion, and support services, including peer and family support, respite and personal care services. One challenge noted by families, however, is that they can only provide services to families referred by the CSPs; in other words, they cannot serve walk-ins directly. A need for FIC services has to be documented in the child and family team plan of care, and families access the child and family team process through the CSPs. Families noted that on the adult side, the system funds adult drop-in centers that can serve adults directly, and FIC is advocating for a similar arrangement on the child/family side where FIC and MiKid would get direct service funding.

### **CA** California

#### ***Hiring Parent Partners as County Employees to Provide Direct Services***

In **Contra Costa**, county mental health has hired family members as county employees since 1997 to be parent partners, using state Children's System of Care (CSOC) and federal system of care grant monies and Medi-Cal. At the time of the site visit, there were seven family partners and a coordinator position in the process of being filled. At its height, there were 16 parent partners and two coordinators; cuts in CSOC and federal grants have reduced the number. Parent partners are attached to different programs, for example, the regional mental health clinics and the residential

treatment center. The Family Coordinator, whose role includes training, coaching, etc., helps out-stationed parent partners to feel part of a network and avoid feeling isolated. Parent partners provide: one-on-one support to families, resource development for families, help to families with eligibility enrollment, support to families on wrap teams, and help to families with IEPs. They also conduct broader community outreach. At the time of the site visit, the county was exploring the use of Mental Health Services Act (MHSA — Prop 63) dollars to rebuild its parent partner capacity; the community services and supports component of the MHSA builds in use of family partners.

## **HI** Hawaii

### ***Using a Family Organization as a Direct Service Provider***

**Hawaii** Families As Allies is receiving training to provide Common Sense Parenting. However, there is concern that should this organization shift towards being a provider agency, its advocacy and peer support mission may be compromised. Additionally, all provider agencies are now obligated through their contracts to have parent and youth specialists on staff to address issues and partnerships with families and youth. The requests for proposals (RFPs) for provider agencies specify this and request the submission of position descriptions with other application materials.

Consumer and family-run services are supported through Medicaid, block grant, and general revenue funds. Block grant and general funds finance parent partners, parent skills training, peer mentoring services for youth, and parent-to-parent supports. An attempt is being made to have all of these services covered under Medicaid through an amendment to the state plan; approval is pending.

## **Choices** Choices

### ***Using a Family Organization as a Direct Service Provider***

In **Indiana**, the family organization (Rainbows) is a provider of some services. In this role, it is treated like any other service provider and is paid on a fee-for-service basis for services, such as mentoring. Financing comes from the case rates. Services provided include family-to-family mentoring. In addition, members of the organization currently are being trained to offer a family training program, Common Sense Parenting. Currently, the county child welfare system contracts with Rainbows to provide Common Sense Parenting and has begun to provide this service to Dawn families. The trainers will be paid to provide this training. Rainbows also provides parent support groups, financed as part of the contract with the family organization.

## **OH** Cuyahoga County, Ohio

### ***Using Family Members in Neighborhood Collaboratives to Provide Services***

Family members are hired by the Neighborhood Collaboratives as parent advocates. Parent advocates provide multiple direct services and supports.

### ***Using Family Organizations as Direct Service Providers***

- **Vermont's** Department of Mental Health has a contract with the Vermont Federation of Families for Children's Mental Health (currently \$93,000 and indexed for increases) for a range of decision-making and advisory roles, as well as for some direct services. Direct services include developing and carrying out parent and provider training activities and peer support.
- **In New Jersey**, Family Support Organizations (FSOs) are funded via contract with the state in every region and are financed using a combination of state general revenue and Medicaid administrative case management dollars. They are family-run, not-for-profit organizations designed to ensure that the family voice is incorporated at the system and service level. The FSO acts as peer support for families and as a guide for professionals. The Care Management Organizations are required to utilize the services of the FSOs by way of a Family Support Coordinator. The FSOs provide advocacy, information, referral, education, and mentorship.
- **In Erie County, New York**, the family organization (Families CAN) has had success in marketing itself as a vendor of family support services with the local child welfare and juvenile justice systems. The annual budget of Families CAN is \$380,000. Funding sources include the Erie County Department of Mental Health (ECDMH) through system of care grant funds, re-investment dollars that come from local child welfare and juvenile justice funds, and billable services for family support. Currently, there are five FTEs on staff. The roles of Families CAN include system of care training events, education seminars for parents, orientation for parents, and family support activities.
- **In Wraparound Milwaukee**, Families United is contracted to provide family peer support and educational advocacy.

### **III. Finance Improvements in Cultural And Linguistic Competence And Reduction Of Disparities In Care**

A core value of systems of care is that they are culturally and linguistically competent, with agencies, programs, and services that respect, understand, and are responsive to the cultural, racial, and ethnic differences of the populations they serve. In recognition of the unique cultural backgrounds of children and families served within systems of care, financing strategies are needed to incorporate specialized services, culturally and linguistically competent providers, and translation and interpretation. Financing strategies also are needed to support leadership capacity for cultural and linguistic competence at the system level and to allow for analysis of utilization and expenditure data by culturally and linguistically diverse populations, which contributes to the identification of disparities and disproportionalities in service delivery. Systems of care also must incorporate strategies to proactively address the disparities in access to care and in the quality of care experienced by culturally and linguistically diverse groups, as well as in underserved geographical areas.

#### **Financing strategies include:**

- A. Finance Culturally and Linguistically Competent Services and Supports**
- B. Finance Strategies to Reduce Disparities in Access to and Quality of Services and Supports**

#### **A. Finance Culturally and Linguistically Competent Services and Supports**

#### **Financing strategies include:**

- 1. Finance specialized, culturally specific services**
- 2. Finance culturally and linguistically competent providers, nontraditional providers, and natural helpers**
- 3. Finance translation and interpretation**
- 4. Analyze service utilization and expenditures by culturally and linguistically diverse populations**
- 5. Finance cultural competence coordinators and/or other leadership capacity at state and local levels**

## 1. Finance Specialized, Culturally Specific Services

Many of the sites cover “cultural” services, that is, specialized services that are specifically designed to respond to the ethnic and cultural characteristics of children and families served. For example, **Arizona** covers native traditional healing, and other sites use the wraparound child and family team process to identify and purchase culturally specific services.

### **AZ** Arizona

#### ***Covering Cultural Services***

Many covered services within the managed care system, such as counseling, can be provided in any location, including locations that may be more culturally appropriate, such as a sweat lodge. Translation and interpretation are services covered by Medicaid. Certain cultural activities, such as traditional Native healing, can be paid for by the managed care system, though not with Medicaid dollars, but using the other dollars in the system. The managed care system also uses “promotores,” outreach workers and counselors for the Latino community, which it covers in a number of ways, e.g., as “health promotion,” family support, or peer support under Medicaid.

The state used funding from a federal Center for Substance Abuse Treatment grant to develop a cultural competence training curriculum. The state also developed a Practice Improvement Protocol related to cultural competence and requires Regional Behavioral Health Authorities to do cultural organizational self-assessments. For information about Arizona’s Practice Improvement Protocol, see: [http://www.azdhs.gov/bhs/provider/sec3\\_23.pdf](http://www.azdhs.gov/bhs/provider/sec3_23.pdf)

### **CA** California

#### ***Contracting with Multi-Cultural Provider Organizations and Using Wraparound Approach***

The Prevention and Early Intervention Component of the Mental Health Services Act (MHSA - Prop 63) targets \$15 million each year over four years, for a total of \$60 million to address disparities and focus services and supports on racial and ethnic minority communities. Particularly focused on are: Native Americans, African Americans, Latinos, Asian Pacific Islanders, and gay, lesbian, bisexual, transgender and questioning (GLBTQ) populations. In addition, the Community Services and Supports Component requires counties to identify underserved populations and develop strategies to address disparities.

In **Contra Costa**, the county has a number of contracts with community-based multicultural provider organizations and has made an effort to hire diverse parent partners. The Mental Health Services Act (MHSA) Community Services and Supports funding will enable the county to target an area of the county with many immigrant farm worker families, using a culturally competent approach and multicultural provider organizations. The lead agency will be Familias Unidas, now a small agency, in partnership with county mental health and another provider, Asian Pacific Psychological Services. The county is providing technical assistance to Familias Unidas in recognition that the MHSA grant will double this small provider’s size. The service model is intensive wraparound, not clinic based, with close attention to basic supports such as housing, transportation, legal services, as well as mental health and substance abuse services, and natural supports through teen peer mentors, and parent partners. Staff is multilingual, including Tagalog, Vietnamese and Spanish. County public health is partnering to ensure inclusion of primary care.

**HI** Hawaii***Covering Cultural Services***

The entire state is highly diverse with a multi-ethnic and multi-cultural population. There is financing for specialized services to culturally/linguistically diverse populations. For example, interpretative services are provided through flexible funding for ancillary services and supports, as are nontraditional services and supports, such as martial arts provided as a therapeutic service for children. Traditional healer services and other Eastern approaches to treatment (such as Asian healer services) are funded under Medicaid or mental health general fund resources. The state is attempting to integrate Eastern and Western approaches to medicine to meet the needs of the diverse cultural and ethnic groups services, including Chook, Samoan, Micronesian, Chinese, and other cultures.

**AK** Bethel, Alaska***Covering Cultural Services***

Yukon – Kuskokwim Health Corporation (YKHC) sponsors the following projects that are designed to offer and support culturally competent services and supports:

**Family Spirit Project**

Family Spirit Project is a collaborative effort of the communities of the Yukon – Kuskokwim region, the Department of Health and Social Services, Division of Alcohol and Drug Abuse, the Office of Children's Services, the YKHC and other community providers in the Delta. Emphasizing traditional family life and values, the collaboration builds a community development model to strengthen families so that children will be safer in their homes. Parents who could lose their parental rights due to abuse and neglect of their children are encouraged to enter substance abuse treatment in a culturally appropriate and supportive manner. These parents are a priority population for YKHC's substance abuse treatment services.

**Community Holistic Development**

Drawing on local resources, the Holistic Development Program conducts presentations on grief processes, youth conferences, healing circles, "Spirit Camps," and other health promotion activities. This program integrates the cultural, traditional, and spiritual values of the people in partnership with other family-based counseling services.

**Choices** Choices***Covering Cultural Services***

In **Choices**, any service can be provided within the case rate structure, depending on the child and family's need and what is included in the individualized care plan. If the child and family team identifies a service need that is not readily available, it is the responsibility of the care coordinator and community resource manager to look for an appropriate resource. Culture and language are considered by child and family teams in developing the service plan and identifying resources to provide services and supports. For example, some African American youth have attended a camp program that uses a retreat approach for rituals around the transition from boys to men.

**OH Cuyahoga County, Ohio*****Financing Neighborhood-Based Services and Using the Wraparound Approach***

The fundamental structure of the **Cuyahoga** Tapestry System of Care (CTSOC) promotes culturally competent services in that the pathway to services and supports is through Neighborhood Collaboratives that are comprised of providers who are representative of the family's culture and ethnicity and the emphasis is on culturally appropriate services. CTSOC values the importance of social networks, natural supports, the faith community, and neighborhoods where children and their families live. The wraparound team approach used in the CTSOC helps families find "creative solutions based on the family's strengths, needs and culture and the uniqueness of your neighborhood and your team." All personnel in CTSOC (e.g., care coordinators, care managers, wrap specialists and parent advocates) are trained in a strengths-based approach, and use an assessment tool (Strengths, Needs, Cultural, Vision and Discovery) that helps them develop individualized plans with families to ensure culturally responsive services.

The population served by CTSOC is primarily from ethnically diverse communities. Approximately 80% are African American and 7% are of Hispanic origin (on the West Side of Cleveland), and the CTSOC staff is representative of the demographics of the community. In the West End area, most providers are bilingual (Spanish/English). The CTSOC employs two Spanish speaking FTEs. One parent advocate is of Hispanic origin. CTSOC also hired a male parent advocate to work with families in Central Neighborhood Collaborative (primarily young African American men). Applewood Center, one of the Care Coordination Partnership lead agencies, has a program (Project Manzanita) designed specifically to serve Latino Children. They have used very creative approaches to recruit Latino staff, providing a model for programs that are struggling with this type of recruitment.

**CO Project BLOOM, Colorado*****Using the Wraparound Process and Purchasing Culturally Specific Services***

Culturally and linguistically competent services are provided through the development of an individualized wraparound plan. For example, when Fremont County served a Native American family, the entire wraparound plan was culturally based. SAMHSA system of care grant funds are being used to purchase nontraditional, culturally specific services. Respondents indicated these services could also be purchased with block grant funds.

## 2. Finance Culturally and Linguistically Competent Providers, Nontraditional Providers, and Natural Helpers

Sites have incorporated financing and various types of incentives for culturally and linguistically competent providers, including natural helpers and traditional healers.

### **AZ** Arizona

#### ***Incorporating Requirements in Contracts***

There are clear expectations in Regional Behavioral Health Authority (RHBA) contracts with providers related to serving culturally diverse populations, and fiscal penalties may be attached to serving an inadequate number of culturally diverse members. These are specific to each RBHA contract. There also are requirements for recruitment and retention of Latino providers, and RBHAs are required contractually to have specialized Native American providers in their networks.

Value Options (VO) in **Maricopa County** indicated that the state will be conducting cultural competence assessments of providers and may implement direct incentives to providers and/or to RBHAs in the future. VO also indicated that it has implemented both incentives and sanctions for the Comprehensive Service Providers (i.e., core service agencies) in its network related to access for the Latino population. Providers could receive up to \$10,000 a month depending on their meeting certain access standards (e.g., \$2500 per month if reaching 40% of Latino eligibles).

The state also reported that it is working on a program for various types of behavioral health staff, including racially diverse staff. (Note. The legislature approved funding for this in fiscal year 2007).

Nontraditional providers, paraprofessionals and natural helpers can be included in managed care networks as community service, or direct service, agencies. For example, the Family Involvement Center (FIC) in Maricopa County is a provider. Also, FIC is developing a teaching video and toolkit as part of its contract with the state (financed through federal State Infrastructure Grant dollars) on use of natural supports. (Note. This video and toolkit are now available. Contact: <http://www.familyinvolvementcenter.org>.)

Also, providers reported that there are “informal incentives” provided by VO in Maricopa. For example, VO loaned a staff person for a year to the People of Color Network in Maricopa to help them develop the infrastructure needed to join the VO Medicaid network.

### **CA** California

#### ***Requiring Cultural Competence Plans***

**California** counties are required to submit cultural competence plans to the state Department of Mental Health that address access, quality, management, workforce, and utilization issues of racial and ethnic minority populations. Also, the Prevention and Early Intervention component of the Mental Health Services Act (MHSA) is intended to invest in racially and ethnically diverse communities’ developing community-generated strategies that are culturally competent and is providing \$15 million a year over four years (\$60 m.) to reduce disparities and support more culturally competent service strategies.

In **Contra Costa**, the county pays higher rates for bilingual providers.

**HI** Hawaii***Using Financial Incentives***

Financial incentives are offered for culturally and linguistically competent providers, and provider agencies generally have culturally diverse staff and staff able to speak many languages. The Child and Adolescent Mental Health Division (CAMHD) pays higher rates if the clinician is fluent in the needed language. Providers under contract with CAMHD are required to submit a cultural competence policy to ensure that all employees and subcontractors are trained and supervised in providing services in a culturally aware manner, including requirements for cultural assessment and cultural considerations in the treatment planning process. There also are financing mechanisms for nontraditional services and natural helpers such as native **Hawaiian** healers and Asian healers, both funded with Medicaid and mental health general fund resources.

**MI** Michigan***Allocating Budget Funds for Nontraditional Multi-Cultural Providers***

The state has a \$3 million line item in the budget for smaller, nontraditional, multicultural providers. This money is filtered through the Community Mental Health Services Programs to specific ethnic groups, usually through contracts with private, nonprofit agencies that provide an array of services, including services to children and families.

**NE** Central Nebraska***Providing Language Classes for Providers***

Region 3 Behavioral Health Services funds and hosts a weekly Spanish language class for its Region 3 staff, Families CARE staff and providers.

**Choices** Choices***Recruiting and Developing Culturally Appropriate Providers***

**Choices** has worked with minority communities to identify culturally and linguistically competent providers, as well as nontraditional providers appropriate for particular racial and ethnic populations. Work with the African American community has resulted in the identification of African American treatment foster parents who serve predominantly African American youth. In addition, Choices collaborates with a church, paying for an additional staff person to enable the provision of after school care for youth in this natural, culturally appropriate community setting. Often, culturally appropriate providers are developed on an individual case basis. For example, collaboration with a Korean church was undertaken to meet the support needs of a Korean youth and family. The resources developed for individual youth and families become part of the database and are shared among staff; these resources can then be enlisted in the future on behalf of other clients.

**Choices** has engaged consultants both in **Indiana** and **Ohio** to assist in doing cultural assessments and in developing strategies to improve cultural and linguistic competence. Consultants also have worked with providers in the provider network (including mentors, therapists, therapeutic foster care agencies, and others) to provide training related to cultural and linguistic competence. In addition, Choices has worked internally to add diversity to its own staff. The staff now is 40% African American.

### **OH** **Cuyahoga County, Ohio** ***Including More Culturally Competent Providers in Provider Network***

**Cuyahoga** Tapestry System of Care (CTSOC) contracts with the Care Coordination Partnerships (i.e., Neighborhood Collaboratives and lead provider agencies) require cultural and linguistic competence in the execution of contract services. The Provider Services Network includes vendors from culturally diverse backgrounds, and at the time of the site visit, CTSOC was planning to expand the network to include more culturally and linguistically competent service opportunities for families; this was a goal for 2008.

### **NY** **Erie County, New York** ***Improving the Cultural Competence of Providers***

The Family Voices Network system of care conducted a cultural competence survey of providers, including the six care coordination/wraparound providers and 68 vendors of children's services. The survey instrument is the Agency Narrative and Self-Evaluation Tool which focuses on six domains: needs assessment, information exchange, services, human resources, policies, and outcomes regarding cultural competence. Findings are being shared with the CEO of each agency and its cultural competence committee. Some general findings are: There are few minorities in key leadership or upper management positions. In addition, some staff have a discomfort in asking about ethnicity or using the information to improve outcomes. Currently, no information is being collected on the lesbian and gay community that will allow for data analysis specific to this population

Family Voices Network offered Spanish classes for Care Coordinators and staff from the Mobile Crisis Unit. The delivery mode was three segments, seven classes each. At the time of the site visit, an evaluation was being conducted to determine whether to repeat the course, and/or make revisions.

In addition, **Erie County** was awarded a one-time supplemental grant by SAMHSA to focus more intensely on network development that reflects the engagement and use of services that demonstrate cultural competence reflective of the communities where children reside, ensure the flexibility and emerging capacity needed, and support transference of skills and access to natural supports for families. This targeted funding will provide financial support to address barriers to vendor development of culturally and linguistically competent providers, nontraditional providers, and natural helpers.

### **CO** Project BLOOM, Colorado *Financial Incentives for Bilingual Staff*

Providers reported that financial incentives are offered for bilingual staff.

### **WI** Wraparound Milwaukee *Including Diverse Providers in Network*

There are over 40 racially and ethnically diverse providers in Milwaukee's provider network. Also, the system will pay for interpretation and translation services and uses nontraditional providers. It also tracks use of informal helping supports through its management information (MIS) system. Wraparound Milwaukee believes that its fee-for-service structure does allow diverse providers to compete effectively and that lack of a "guarantee" for a certain service amount has not been an impediment to diverse providers' participating in the provider network.

## 3. Finance Translation and Interpretation

All of the sites finance translation and interpretation services either with Medicaid, managed care system resources, or with flexible funds.

### *Financing Translation and Interpretation with Medicaid, Managed Care System Resources, or Flexible Funds*

- **In Arizona**, translation and interpretation are paid for by the managed care system and are a covered Medicaid benefit. The staff of the Family Involvement Center in Maricopa is 35% Latino and often provides translation services.
- **In California**, 40% percent of California's population speaks a language other than English at home. At the time of the site visit, the state Department of Mental Health in partnership with the state Medi-Cal agency was developing a proposal to the Governor to cover interpretation services under Medi-Cal. (This work was being done under the auspices of the Medi-Cal Language Access Services Taskforce.) Contra Costa uses county general funds to finance interpreter services.
- **In Hawaii**, there is financing for translation and interpretation services through flexible funding for ancillary services and supports. The most common languages include Mandarin, Korean, Ilocano, and Tagalog. The child mental health division also produces documents in large print and on CD for people with vision impairments.
- **In Michigan**, the community mental health centers are required to have translation and interpretation services for culturally/linguistically diverse populations.
- **In New Jersey**, translation and interpretation are paid for by the Contracted Systems Administrator and are a covered Medicaid benefit.
- **In Vermont**, the system of care financing mix supports translation and interpretation services as needed. Local agencies typically subcontract for these services. Medicaid pays for them.
- **In Bethel, Alaska**, the Yukon-Kuskokwim Health Corporation provides and pays for translation and interpretation services using a mix of funding sources.

- **In Central Nebraska**, Medicaid reimburses for interpretation services during treatment. Region 3 maintains a list of interpreters and translators they can call upon.
- In Choices**, translation and interpretation are financed on a fee-for-service basis as needed, including interpretation for persons with hearing impairments. Choices has staff members who are Hmong and Hispanic and, thus, has internal capability in Hmong and Spanish.
- In Cuyahoga County, Ohio**, 7% of the families served are of Hispanic origin. Most of these families reside on the West Side of Cleveland, and in this area, most providers are bilingual. The system of care uses interpreters at child and family meetings when needed. Most materials are translated into Spanish, and the website includes a Spanish page.
- In Erie County, New York**, translation and interpretation services are funded with flexible service dollars.
- Project BLOOM, Colorado** uses Medicaid funding for interpreters, as well as SAMHSA system of care grant funds and other resources. Interpretation services are required by law when needed and are covered under Medicaid. There is a push to acquire bilingual interviewers for the Wraparound Fidelity Index (WFI). A bilingual evaluator was hired.
- In Wraparound Milwaukee**, the system will pay for interpretation and translation services, using its blended funding pool.

#### 4. Analyze Service Utilization and Expenditures by Culturally and Linguistically Diverse Populations

Analysis of utilization, expenditure, and outcome data by culturally and linguistically diverse populations allows systems of care to identify potential problems or disproportionalities in access to services, in service utilization, and in the quality and outcomes of care. Most sites have the capacity to analyze data by racial/ethnic group (e.g., penetration rates), and California and Arizona conduct special studies.

##### **AZ** Arizona

##### **Analyzing Data by Racial/Ethnic Groups**

The system is able to analyze utilization and costs by racial/ethnic breakdown but does not run this analysis regularly. Instead, it engages in special studies, for example, a study looking at under-utilization of services by the Latino community, and another long term project involving juvenile justice and Value Options to look at over representation of youth of color in the juvenile justice system.

**CA** California***Tracking Indicators by Cultural Group and Special Studies***

The state data system has the capacity to track utilization and expenditures for children by racial and ethnic breakdown, and routinely tracks certain indicators, such as penetration rates by racial/ethnic breakdown. These are for adults and children. The state has the capacity to disaggregate these data by children, but does not routinely do so; rather, it engages in special studies. The state has disparity data on some child/adolescent programs, such as Assembly Bill 3632 (special education), but not on all programs.

**HI** Hawaii***Analyzing Data by Racial/Ethnic Groups***

Service utilization, expenditures, and outcomes are analyzed by culturally/linguistically diverse populations. No differences in outcomes by specific groups have been found; the entire state's population is culturally/linguistically diverse, and most youth and their families are multi-ethnic. However, better outcomes have been found for youth eligible for the Medicaid program than non-Medicaid eligible youth, regardless of cultural group. This is attributed to the richer service array available for the Medicaid eligible population.

**CO** Project BLOOM, Colorado***Analyzing Data by Cultural Group***

Community mental health centers are provided with data on the population they are serving and how this matches up with the general population. Utilization data are analyzed by cultural group, including data from the TSOC (Tracking System of Care) data system and the state's mental health management information system (Colorado Client Assessment Record).

**WI** Wraparound Milwaukee***Analyzing Data by Racial/Ethnic Groups***

The system does analyze utilization and costs by racial/ethnic breakdown and analyzes disproportionality and disparity issues. It has been able to tap into federal Disproportionate Minority Confinement (DMC) dollars through its partnership with the juvenile justice system. Specifically, **Wraparound Milwaukee** has reduced placement of African American youth in corrections facilities, which enables the juvenile justice system to draw down DMC monies, which, in turn, it uses to pay Wraparound Milwaukee.

## 5. Finance Cultural Competence Coordinators and/or Other Leadership Capacity at State and Local Levels

Some of the sites finance leadership for cultural and linguistic competence — either cultural competence coordinators at state and/or local levels or various types of cultural competence advisory committees or teams.

### **AZ** Arizona

#### ***Using a Cultural Competence Advisory Committee and Requirements for Behavioral Health Organizations***

The Chief of Substance Abuse Prevention in the **Arizona** Department of Health Services (ADHS) reportedly is a leader in the cultural competence field and has served in an ad hoc position as coordinator for cultural competence activities. At the time of the study visit, the state was looking at use of discretionary grant dollars to fund a cultural competence coordinator position. There is a three-year old Cultural Competence Advisory Committee, which the Chief of Substance Abuse Prevention chairs, and which has developed a framework for cultural competence in the behavioral health system. The committee includes representation from child welfare, juvenile justice, families, etc. The committee devoted its first foundational year to looking at research and data on utilization, disparities, etc. There are three committees: one on data, one on translation/interpretation, and one on training (chaired by the ADHS training coordinator). Each Regional Behavioral Health Authority (RBHA) also is required to have a cultural expert and to conduct a cultural competence organizational self-assessment that leads to a plan for each RBHA. The committee is developing a tool to measure cultural competence at the RBHA level.

RBHA Cultural Competency Plans, at a minimum, must address the following:

- Identification of diverse population groups in the service area
- Determining and addressing any disparity in access and utilization
- Outreach strategies to diverse communities
- Recruitment and retention strategies to attract and develop culturally competent staff
- Obtaining input and consultation from diverse groups in its service area
- Collaboratively working with local diverse groups to review service delivery to individuals, families, communities
- Receiving consultation on planning, providing, evaluating and improving services to diverse individuals, families and communities
- Regular quality monitoring program with indicators that evaluate both the quality and outcomes of services with respect to culturally diverse populations
- Use multi-faceted approaches to assess satisfaction of diverse individuals, families and communities
- Monitoring service delivery to diverse individuals
- Ensuring identification of minority responses in the tabulation of client satisfaction surveys
- Ensuring cultural competency training is required and obtained by all staff at all levels of the organization(s) providing behavioral health services
- Ensuring persons' and families' cultural preferences are assessed and included in the development of treatment plans.

**CA California*****Funding an Office of Multicultural Services***

The state Department of Mental Health (DMH) has financed the Office of Multicultural Services for the past nine years, which has six staff. As part of Mental Health Services Act (MHSA) planning, the state also began a concerted planning effort with Tribal communities and funded Native American Partnership Strategies in 06-07 and in 07-08. The state has also funded two training curricula and pilots. The first was a 40-hour Mental Health Interpreter training curriculum (\$100,000), the second was a 32-hour Brief Multicultural Competency Training curriculum and pilot (\$137,000). The state office has provided the leadership to ensure that cultural competence is embedded into state policy and management requirements. There is also a Statewide Cultural Competence Advisory Committee, and each county funds an Ethnic Services Manager (either full time or part time, depending on the size of the county), who meet regularly. All counties are required to implement cultural competence training, and while there are not bonuses or penalties tied to cultural competence, awareness has been raised and most counties do pay attention to this issue. In addition, the **California** Institute of Mental Health has a Center for Multicultural Development (partly funded by state DMH general revenue and MHSA funds) that provides technical assistance to the counties. DMH has worked with the California Mental Health Directors Association and the county Ethnic Services Managers on annual Statewide Mental Health Cultural Competence Summits for the past 14 years.

**OH Cuyahoga County, Ohio*****Financing a Cultural Competence Coordinator and Committee***

The **Cuyahoga** Tapestry System of Care (CTSOC) has created a governance and management structure that promotes ongoing attention to cultural and linguistic competence and strengthens leadership capacity in this area. In 2008, CTSOC hired a cultural competence coordinator to lead these efforts. CTSOC has an active Cultural and Linguistic Competence Committee (CLCC) that meets monthly and is part of its governance structure and reports directly to the SOC Oversight Committee. Its members include major providers, child welfare, neighborhood collaboratives, families and others. The CLCC is working with the site evaluation team to establish current baseline information about the cultural and linguistic competence of service delivery, with future plans to assess level of cultural and linguistic competence and strategize for improved capacity. The CLCC is empowered to determine its budget needs and make decisions about how to spend budgeted funds. The annual budget for this committee, which comes from federal SAMHSA grant funds, is \$150,000. These funds are used to enhance cultural and linguistic competence initiatives for the system of care and to implement core elements of a culturally competent system. The county is developing a cultural and linguistic competence plan to guide its efforts. This plan was not yet complete at the time of the site visit.

### **CO** **Project BLOOM, Colorado** ***Using Federal System of Care Funds for Coordinator, Work Group, and Consultant***

Initially, **Project BLOOM** hired a cultural competence specialist as part of the Project BLOOM leadership team. An inventory was completed and a resource guide was produced including consultants, translators, advocates, organizations, services, resources, etc. that relate to cultural and linguistic competence. A work group also was created that focused on cultural and linguistic competence, examined assessments, and identified the core elements of a cultural assessment. Each of the four Project BLOOM communities could choose an instrument but was required to conduct a cultural competence assessment of their system of care. A second person was later hired to work with each of the four communities on the development of their plans to enhance cultural and linguistic competence. Project BLOOM no longer has a cultural competence coordinator. Currently, a cultural competence consultant provides consultation and technical assistance in this area to the four Project BLOOM communities. This is financed with SAMHSA system of care grant funds.

### ***Financing Other Cultural Competence Leadership Capacity***

- **In Hawaii**, as of July 1, 2006, in the Child and Adolescent Mental Health Division's (CAMHD) new request for proposals (RFP), agencies were asked to establish positions for cultural coordinators/specialists. There is no formal cultural competence coordinator at the state level, although a staff member within CAMHD plays that role.
- **In Choices**, there was a cultural competence coordinator during the time that Choices had a federal system of care grant. Currently, Choices has a "cultural competence team" that is ongoing and meets quarterly with an outside consultant. The team, currently comprised of Choices staff and representatives of a number of community agencies, receives training, shares resources, discusses diversity challenges, and offers support and suggestions to each other. Choices hosts a Diversity Team list serve so that members can ask questions or share resources electronically.
- **In Erie County**, New York, funds from the federal system of care grant are used to support activities related to cultural competence.
- **In Wraparound Milwaukee**, there is a cultural competence committee.

## B. Finance Strategies to Reduce Disparities In Access To And Quality Of Services And Supports

### Financing strategies include:

1. Finance strategies for reducing racial and ethnic disparities
2. Finance strategies for reducing geographic disparities
3. Finance the use of technology to reduce geographic disparities
4. Finance outreach to culturally and linguistically diverse populations and transportation

### 1. Finance Strategies for Reducing Racial and Ethnic Disparities

Several sites incorporate financing strategies directed at reducing disparities in care. For example, **Arizona** has implemented strategies including outreach, service provision in culturally appropriate sites, special studies to identify and elucidate disparities, and requirements for Regional Behavioral Health Authorities to serve under-served populations (such as the Latino population). **California** funds a Center for Reducing Health Disparities.

#### **AZ** Arizona

#### ***Using Managed Care System, Practice Improvement Protocol, and Outreach to Address Disparities***

The managed care system pays for various outreach activities, uses general revenue and block grant dollars to pay for services that are not Medicaid-covered, allows provision of Medicaid services at sites that may be more culturally appropriate, conducts special studies in an effort to identify and reduce disparities, and incorporates contract requirements for Regional Behavioral Health Authorities (RBHAs) to serve under-served populations, such as the Latino population. Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), as part of its “New Freedom” transformation agenda, issued a new advocacy request for proposals (RFP) that called for structured outreach to all culturally diverse populations, including, for example, development of a new Latino family organization and the involvement of faith-based organizations to reach out to the African American community. Value Options (VO) in Maricopa County has implemented both incentives and sanctions for Comprehensive Service Providers (i.e. core service agencies) related to access for the Latino population. Providers can receive up to \$10,000 a month depending on their meeting certain access standards (e.g., \$2500 per month if reaching 40% of Latino eligibles). The state also has developed practice improvement protocols (PIPs) and a curriculum on cultural competency. (See: <http://www.azdhs.gov/bhs/policies/cd1-2.pdf>)

**CA California*****Funding a Center for Reducing Health Disparities***

Outreach to racial and ethnic minority populations is a required element of planning and service implementation related to the Mental Health Services Act (MHSA). Racial and ethnic minority populations are included as one of seven underserved populations in the Act. The Prevention and Early Intervention Component of the Act funded the Center for Reducing Health Disparities at the University of California-Davis (at \$300,000) to identify culturally competent and effective outreach strategies related to prevention and early intervention. At the time of the site visit, the state Department of Mental Health was in the process of planning a 2008 summit on eliminating disparities using \$140,000 in MHSA funding. Under the MHSA, all of the counties have new monies to fund outreach and engagement, and counties are being funded to implement community stakeholder processes.

**CO Project BLOOM, Colorado*****Using Foundation Funds for Addressing Health Disparities***

While there are no financing strategies specific to mental health that are directed at reducing disparities, there is a health disparities office in the Colorado Department of Health and Environment, largely funded through a Robert Wood Johnson Foundation grant. One product of this effort was a health disparities tool kit. Toolkit to Promote Cultural Proficiency is a training program designed to increase the cultural proficiency of health care providers. Funding is available to develop and implement this training over a two-year period. The training program entails two courses: Introduction to Cultural Proficiency for Care Providers and One-Day Intensive Training on Cultural Proficiency for Care Providers. Information on this training was shared with mental health providers across the state.

**2. Finance Strategies for Reducing Geographic Disparities**

Strategies to reduce geographic disparities were found in several sites. For example, *Hawaii* provides incentive pay for providers to work in underserved areas.

**AZ Arizona*****Establishing Higher Rates for Home and Community-Based Services***

The behavioral health managed care system's fee-for-service rate schedule intentionally pays more for home and community-based versus clinic-based services in an effort to get services to rural areas, among other goals. Also, there is flexibility in the capitation paid to Regional Behavioral Health Authorities (RBHAs) that allows them to pay more for getting providers to rural areas.

**CA California*****Focusing on Underserved Rural Populations***

The Mental Health Services Act includes a focus on underserved rural populations, and Rural Mental Health Directors at the county level meet regularly.

**HI Hawaii*****Providing Incentive Pay to Work in Underserved Areas***

There are special financing mechanisms to provide services in underserved geographic areas. Incentive pay that is 10% above the standard pay scale is offered as an incentive to work in underserved areas. In addition, transportation is paid for providers to fly to the Islands, and travel time is considered billable time. Service utilization patterns and expenditures are analyzed by geographic areas. According to providers, the provider array is different on the smaller islands, and there is a cost differential in providing care in remote areas or areas with a smaller population base. These factors create geographic disparities in the availability of professionals and services.

**AK Bethel, Alaska*****Using Village Health Clinics***

The entire region is an underserved geographic area. The Yukon – Kuskokwim Health Corporation (YKHC) has put extensive resources into the building and development of village health clinics offering both health and behavioral health services. YKHC's finance system is set up by village and type of service. The system has the capacity to analyze service utilization and expenditures by villages.

Like YKHC, the school districts and the Department of Juvenile Justice struggle to recruit and retain staff to work in the villages. Currently in Bethel, the probation agency is offering incentives for people to get a college degree with an internship that provides needed work experience. The goal is that these individuals will return to Bethel and become probation officers.

### 3. Finance the Use of Technology to Reduce Geographic Disparities

Examples of financing the use of technology to address geographic disparities were found in the sites, including telemedicine, video-conferencing, web-based technology, and teleconferencing for services including medication management, psychological and psychiatric evaluation, consultation, and education.

#### ***Financing Telemedicine and Video-conferencing:***

- **Arizona** has set up a telemedicine system serving remote areas, using federal grant dollars. Medicaid can then be used to pay for certain services provided through the telemedicine system, such as medication management, psychological evaluation, and health promotion and education (for example, teaching parents about attention deficit-hyperactivity disorder). At the time of the site visit, Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), MiKid (the statewide family organization) and Family Involvement Center in Maricopa County were developing an issue paper for the state Medicaid agency on the potential of covering telephone support services.
- **In Hawaii**, teleconferencing for medication management is used in some of the Islands and is financed by General Fund and Medicaid resources. The state has not been as successful in using video-conferencing due to some of the logistical and technical issues involved. The state has a statewide video-conferencing system. This requires participants to go to specific locations (typically in health centers); advance scheduling is required. The system is used for interviewing, training, meetings of providers, provision of psychiatric consultation, etc. The only direct service that is provided through this system is medication management. Participants indicated that a two-second delay involved in video-conferencing has been problematic.
- **In Michigan**, telemedicine is covered under the specialty services (i.e. home and community-based) waivers. Video conferencing is available for families with children in state hospitals though it is not utilized in some counties.
- **Vermont** is experimenting with the delivery of psychiatric consultation services using technology (e-mail and web-based “face-to-face” encounters) to provide services in underserved geographic areas. A Department of Labor grant supports links for telemedicine in three northern very rural and underserved Vermont counties. The state is exploring ways to do more using technology and create additional funding options.
- **Nebraska** was one of the first rural telemedicine sites funded by the federal government. Through funding from the Nebraska Office of Rural Health, the Richard Young Hospital is able to conference in families from 23 counties. They also do medication checks via teleconference. South Central Behavioral Services soon will have telemedicine capacity in two sites.
- **Project BLOOM, Colorado** uses federal system of care grant funds for teleconferencing and video-conferencing, primarily for training and consultation. These strategies have not as yet been used for service delivery through Project BLOOM, but are used by some mental health centers for service delivery.

## 4. Finance Outreach to Culturally and Linguistically Diverse Populations and Transportation

The sites finance outreach to culturally diverse populations and transportation to increase access to services and reduce disparities. For example, **Arizona's** managed care system includes “structured outreach” to culturally diverse populations and uses “promotores” (health promoters) to reach out to the Latino population.

### **AZ** Arizona

#### ***Requiring Outreach to Culturally Diverse Populations and “Promotores” Financed by Managed Care System***

Outreach activities can be paid for out of the managed care system. **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS), as part of its “New Freedom” transformation agenda, issued a new advocacy request for proposals (RFP) that called for structured outreach to all culturally diverse populations, including, for example, development of a new Latino family organization and the involvement of faith-based organizations to reach out to the African American community. The managed care system also uses “promotores,” health promoters, to reach out to the Latino community. At the time of the site visit, Value Options in Maricopa had set a target for itself of reaching 40% of the eligible Latino youth population.

#### ***Financing Transportation for Families and Providers***

- **In Arizona**, transportation is a covered service in the managed care system. The system can either pay a family for its transportation costs, or pay to bring the service to the family, or pay a transportation provider.
- **In California**, transportation is addressed in the Mental Health Services Act (MHSA), and MHSA funds can be used to pay for transportation costs, including purchase of vans/vehicles.
- **In Hawaii**, transportation is paid for families to attend child and family team meetings or for services only available on another island. Additionally, transportation is paid for providers to fly to the Islands, and travel time is considered billable time.
- **In Erie County, New York**, transportation is financed through the use of flexible service dollars.
- **In Project BLOOM, Colorado**, most agencies reimburse the costs of transportation for providers. On an individual basis, transportation is financed for families. Transportation for Medicaid clients to and from a medical provider is a benefit when the medical service provided is a benefit of the Colorado Medicaid Program and transportation is prior approved by the county. County transportation benefits are prior authorized and administered by the county. Some community mental health centers provide this service through a contract with a company.

## IV. Finance Improvements in the Workforce and Provider Network

Systematic attention is needed to develop a workforce with the attitudes, knowledge and skills needed to administer systems of care and to provide services within them. Financing strategies are needed to support a broad, diversified network of providers that is capable of providing the wide ranges of services and supports offered through systems of care and is committed to the system of care philosophy underlying service delivery, such as accepting and valuing the inclusion of families and youth as partners in service delivery and the shift from office and clinic-based practice to an individualized home and community-based service approach. In addition to supporting a broad provider network, workforce development strategies are needed to address pre-service training programs to prepare individuals for work within community-based systems of care, as well as to implement in-service training strategies to help the existing workforce to infuse the new philosophy, values, approaches, and evidence-based practices into their work. The payment rates established for providers must allow systems of care to attract and retain qualified providers within their provider networks and must create incentives for providers to develop and provide home and community-based services.

### Financing strategies include:

- A. Finance a Broad, Diversified, Qualified Workforce and Provider Network
- B. Provide Payment Rates that Incentivize Qualified
- C. Providers for Home and Community-Based Services

### A. Finance a Broad, Diversified, Qualified Workforce and Provider Network

#### Financing strategies include:

1. Finance a broad array of providers
2. Finance workforce development activities

#### 1. Finance a Broad Array of Providers

The sites have implemented several strategies to finance a broad array of providers. Arizona created a new type of provider called a “community service agency” to offer a broader array of services. Other sites have built extensive provider networks including agencies, individual practitioners, nontraditional providers, families as providers, and specialty providers.

**AZ** Arizona***Creating New Types of Providers***

Development of a new “community service agency” designation within the managed care system opened up the provider network to new provider types, including family organizations and community agencies, who do not have to be licensed as an outpatient mental health clinic to provide certain Medicaid services. These services include: respite, peer support, habilitation, skills training, and crisis services. Also, there is a category of outpatient provider called a paraprofessional, whose services also can be reimbursed under Medicaid. There also is a category called, habilitation workers, that was derived from the developmental disabilities long term care system.

As **Maricopa County** redirected spending from residential treatment centers, it has been able to expand its use of community service agencies, with over 20 contracts currently providing such services as mobile crisis, behavioral coaches, family peer support, etc. To support involvement of these community and family-run organizations, Value Options (VO) in Maricopa County pays them 1/12 of their payment on a prospective basis each month; eventually, VO wants to move them to a fee-for-service basis.

**CA** California***Financing a Broad Array of Providers***

The provider network in **Contra Costa** includes both specialty mental health and rehab services managed by county mental health, as well as independent Medi-Cal (non rehab) practitioners providing more traditional assessment, individual and group therapy. County mental health providers (in-house and contracted) tend to serve children with serious mental health challenges and who are multi-system involved, whereas independent practitioners tend to serve children who do not have complex, intensive service needs. The 1915b waiver has led to considerable broadening of the provider network. For example, in Contra Costa, prior to the waiver, Medi-Cal covered primarily Ph.D psychologist and M.D. psychiatrist mental health services, and there was no “organized” network per se. Today, on “both sides of the house” (i.e. specialty mental health/rehab services managed by county mental health and independent Medi-Cal providers, who are credentialed by county mental health), there are over 50 organizations, nine group practices, and over 200 individual practitioners. All are Medi-Cal providers. The county indicated it gets calls every day from new providers wanting to join the network. There is no cap on the number of providers in the network, but there are contract caps. While there are shortages of certain types of providers, such as child psychiatrists on both sides, there is fairly ready access to services in general. The county utilizes a single point of access, which triages children to county (clinic) services or to network providers, based on severity (although children also can access individual practitioners in the network independently). Children typically can access non-emergency county-managed services within 10 days and network providers within a week. The county describes the provider network as “always evolving.”

**HI** Hawaii***Financing a Broad Array of Providers***

The state finances a broad array of providers, including nontraditional providers (such as Native **Hawaiian** healers) through Medicaid and General Fund resources. Supporting a broad, diversified provider array is more challenging on the smaller islands, as there is a cost differential in providing care in remote areas or areas with a smaller population base. These factors create geographic disparities in the availability of professionals and services.

**Choices** Choices***Building an Extensive Provider Network***

The flexibility in service delivery is supported by an extensive provider network comprised of both agencies and individual practitioners under contract with **Choices**. Some providers may offer a single service, while large agencies may offer multiple services. The network as a whole offers a unique blend of traditional and formal services coupled with nontraditional and alternative services and supports. Providers are not at risk, but rather are paid on a fee-for-service basis. For each individual youth and family, providers are identified to provide the services specified in the service coordination plan. Private psychiatrists or psychiatrists from the affiliated community mental health centers are used for psychiatric assessment and for medication trials and follow-up. (Choices resources cover the cost of medications for children who do not have coverage through Medicaid or through private insurance, or for those whose insurance coverage is exhausted.) In addition, Choices may contract for specialized services to meet a particular need. In this way, the provider network can be expanded and enhanced in a flexible and timely manner in response to the service needs presented by children and their families. The role of the community resource manager in each location is critical in developing and managing the provider network.

**OH** Cuyahoga County, Ohio***Financing a Broad Provider Services Network***

The **Cuyahoga** Tapestry System of Care (CTSOC) organizes and operates the Provider Services Network (PSN), consisting of both informal and formal services that are contracted directly through the provider or affiliated group of providers. CTSOC awards PSN memoranda of understanding (MOUs) based on an open application process, meaning that the agency offers a PSN MOU to every applicant that applies for and meets the qualifications set by the CTSOC. In 2008, the PSN included approximately 81 providers. CTSOC's legal services administrator (an attorney) handles negotiations, contracts and agreements with providers. The legal service administrator is funded by the Board of County Commissioners (BOCC), rather than with federal grant funds.

Prior to creation of the PSN, the county and providers entered into contracts for set amounts of funding and services. However, because CTSOC is trying to expand the number of providers and the array of services, it did not want to limit the amount of services a provider could offer. Instead it intended for services to be driven by family needs and wanted to give families both a voice and a

choice in selecting their providers. CTSOC looked at other county contracts for precedents and then got the county Office of Management and Budget and the county auditor to agree to enter into MOUs with providers rather than traditional contracts. MOUs indicate the specific types of services providers will offer and at what rate. The county agrees to pay the agreed upon rate for the types of services that are provided by the agency during the contract year while MOU is in effect. If providers want to add new services while the MOU is in effect, they can do this. In order not to limit itself to a few providers, the MOU between CTSOC and each provider indicates that the county assumes no obligation to purchase a minimum amount of services from any provider and does not guarantee that any specific volume of referrals will be made to the provider. The PSN is funded at \$1,000,000 annually through a contract between CTSOC (as the Administrative Services Organization - ASO) and the Board of County Commissioners. The Funders Group has to approve this continued funding each year.

### **NY** Erie County, New York

#### ***Finance Expanded Array of Vendor Services***

Two children's providers have been given contracts for a total of \$5.5- 6 million to develop vendor services. The intent is that these provider agencies will identify, recruit, and supervise vendors who will provide services that cannot be funded by Medicaid or other traditional funding streams. Vendor services include flexible and individualized support services such as respite, tutoring, in-home behavioral aides, and mobile crisis and response services.

### **CO** Project BLOOM, Colorado

#### ***State Financing of Early Childhood Mental Health Specialists***

**Project BLOOM** created an early childhood mental health specialist position within community mental health centers (CMHCs) to augment specialized capacity for the early childhood population. The position was conceptualized as a combination of providing direct services, consultative services to families and early care and education providers, and cross-system program development. Located at each CMHC, these specialists conduct screening, provide consultation, and train other practitioners in the skills needed to serve young children and their families. State funds are used to support these positions. In addition, they provide direct services to non-Medicaid-eligible children and their families. The early childhood specialists are intended to significantly increase the capacity of the public mental health system to provide early intervention services, many of which will be provided in conjunction with existing programs, such as Part C of IDEA.

## **WI** Wraparound Milwaukee *Building an Extensive Provider Network*

**Wraparound Milwaukee** has a very large provider network of over 200 providers, which is diverse and meets the qualifications Milwaukee has developed. Included in the provider network are both individuals and agencies, including over 40 racially and ethnically diverse providers. The network includes clinical treatment providers as well as providers of supports, such as respite and mentoring. No formal contracting with providers is used. Wraparound Milwaukee develops service definitions, rates and standards for 85 different services and supports. Community agencies and individual practitioners are invited during the first 90 days of each calendar year to apply to provide one or more of the services. Wraparound Milwaukee then credentials providers to be part of a qualified provider pool. Child and family teams that develop plans of care and families can draw from any providers on the list. Providers are paid on a fee-for-service basis. For certain high cost and restrictive services, such as psychiatric hospitalization, residential treatment and day treatment, prior authorization is required. For most services, authorization to a provider to provide services is simply based on a care coordinator's entering the requested services (based on the plan of care developed by the child and family team), units needed, and name of provider into the automated information system. Providers are immediately notified on-line of units of service approved for the upcoming month. The broad provider network is overseen by Wraparound Milwaukee's Quality Assurance Office.

## 2. Finance Workforce Development Activities

A variety of workforce development activities is financed in the sites, including training, coaching, and learning communities on the system of care approach and on evidence-based and promising practices. Some sites have financed centers to provide training, such as the **California** Institute of Mental Health and the **New Jersey** Behavioral Research and Training Institute.

## **AZ** Arizona *Financing Training and Coaching*

The state has used general revenue, block grant, tobacco funds, and federal State Infrastructure Grant (SIG) discretionary dollars to pay for training and coaching. Much of the training has focused on **Arizona's** vision and implementation of the 12 system of care principles, for example, partnering with families, implementing a child and family team (i.e., wraparound) approach, cultural competence, and the requirements of the reformed system of care. There also has been training related to particular subpopulations, such as children in child welfare and the 0–3 population.

The Arizona vision states: "In collaboration with the child and family and others, Arizona will provide accessible behavioral health services designed to aid children to achieve success in school, live with their families, and become stable and productive adults. Services will be tailored to the child and family and provided in the most appropriate setting, in a timely fashion and in accordance with best practices, while respecting the child's and family's cultural heritage."

The 12 Principles include:

- Collaboration with the child and family
- (Priority on) Functional outcomes
- Collaboration with others

- Accessible services
- Best practices
- Most appropriate setting
- Timeliness
- Services tailored to the child and family Stability
- Respect for the child's and family's cultural heritage
- Independence
- Connection to natural supports.

In the first year couple of years of implementation after the JK agreement, the state contracted directly for training and coaching. Beginning in the third year, it gave training dollars to the Regional Behavioral Health Authorities (RBHAs), and RBHAs have taken the lead in getting certain training curricula developed. For example, in Maricopa County, Value Options (VO) took the lead in developing 18 hours of pre-service training for foster parents wanting to be therapeutic foster parents. The state also has developed statewide training in a number of areas. For example, at the time of the site visit, the state had formed a workgroup with child welfare to develop training related to trauma and permanency, and was in the process of retaining a national consultant to help develop training curricula. The state also used the SIG grant to bring up telemedicine for a number of the tribes, identified substance abuse leads in each RBHA and sent them to a week of training, and sponsored a conference related to methadone maintenance. Also, child welfare training for new workers in the child welfare system includes training provided by the Family Involvement Center and VO on the child and family team process; at the time of the visit, the two systems were working on a more in-depth training.

Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) also indicated that it is looking at ways of trying to build stronger coaching and supervision into the behavioral health system to shore up training gains. This is a current priority.

## **CA** California

### ***Using Mental Health Services Act Funding for Workforce Development***

The Mental Health Services Act (MHSA - Prop 63) includes Education and Training (workforce requirements) as one of its major components, funded at \$200 million through June 2009 (\$100 million for statewide activities and \$100 million for counties). Counties receiving these funds will be required to develop workforce, education, and training plans. Counties also will be required to conduct workforce needs assessments, which will provide the state with a baseline of workforce requirements. The state Mental Health Planning Council has a Human Resource Development Committee, which, at the time of the site visit, was in the process of developing requirements related to the Workforce component of the MHSA. Several statewide initiatives already were underway, including: funding for the California Institute of Mental Health to provide technical assistance to counties on effective practices; funding to a contractor to support statewide assessment of workforce requirements; and implementation of a stipend program by the California Social Work Education Consortium, which is leading to more social work graduates working in the public mental health system.

**HI Hawaii*****Implementing a State-Level Practice Development Focus and Contracting with Universities***

The Child and Adolescent Mental Health Division (CAMHD) finances a Provider Relations Liaison position within CAMHD to serve as a communication linkage with providers and to promote positive relationships with CAMHD. The broad goal of the Provider Relations Liaison is to strengthen the relationship between CAMHD and its network of contracted providers. General Fund and Title IV-E resources are used to finance workforce development activities.

A Practice Development Section of CAMHD's Clinical Services Office oversees a range of activities on evidence-based clinical practice and care coordination practice for CAMHD staff, contracted providers, staff of other state agencies, and families of children and youth with special needs. The section's focus includes care coordination and provider practice in areas including evidence-based interventions, evidence-based practice components, core practice elements such as assessment and engagement, measurement tools such as the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child and Adolescent Level of Care Utilization System (CALOCUS), now known as the CASII (Child and Adolescent Service Intensity Instrument), etc. Practice development specialist positions are financed within CAMHD through general funds to provide consultation, training, and supervision to staff and contracted providers. Training on "parents as partners" is part of most training, and family members participate as trainers. Consultants are contracted to provide training as needed. Materials, training, supervision, consultation, practice guidelines, and other resources developed or identified by the Practice Development Section are disseminated to Family Guidance Centers, provider agencies, partner agencies, and families through courses, consultations, small group discussions, case reviews, conferences, or written materials. A Practice Development/Clinical Training Plan for 2006–2007 includes goals with objectives and specific strategies that will be implemented by practice development specialists and other CAMHD staff and consultants. Goals focus on: supporting the implementation of evidence-based practices among clinicians; improving practice within CAMHD contracted residential programs; improving the transition to adulthood for CAMHD youth; improving planning for crisis prevention and intervention; identifying youth in need of intensive mental health services at younger ages; strengthening family involvement in treatment and in planning and policy throughout the system of care; implementing strong models of clinical supervision throughout the system; strengthening core components on children's mental health in higher education curricula; developing a comprehensive system of care for youth with sexualized behavior; developing standards of practice for the CAMHD system; and developing policies, procedures, and plans that reflect clinical best practices and commitment to system of care principles.

Pre-service education is provided through significant contracts with the state university and small contracts with some private universities. Through these agreements, university faculty teach courses on systems of care, evidence-based practices, and other subjects critical to the public children's mental health system. University faculty members also serve on various CAMHD committees. In addition, the contracts provide a mechanism for trainees across mental health disciplines to rotate through the children's mental health system to obtain real life experience. Contracts range in size from under \$200,000 to about \$600,000. These contracts have been strategically used as mechanisms to shape university curricula to support the priorities and needs of the public children's mental health system. An example of a contract with the University of Hawaii specifies that the University will:

- Collaborate on the development of opportunities for interdisciplinary seminars, lectures, and/or discussions when appropriate with the Schools including Psychiatry, Psychology, Social Work, and Nursing
- Provide interdisciplinary seminars and lectures on system of care principles and values, family-driven services, youth-guided services, cultural competency in mental health, evidence-based services (psychosocial interventions, prevention programs, and psychopharmacology), public child-serving systems (child welfare, education, mental health, and juvenile justice), community mental health, and core components of intensive clinical case management services
- Provide youth and family-led visits, discussions, and lectures
- Trainees shall attend and participate in the monthly Evidence-Based Services Committee
- Provide quarterly reports of services provided by trainees and progress with interdisciplinary lectures/seminars
- Participate in Case-Based Review training and observations

A contract with the University enlists psychiatrists experienced in child and adolescent psychiatric services to provide clinical and administrative services within the state's Family Guidance Centers, youth correctional facility, and other sites, including medical and clinical supervision. In addition, the contracting mechanism is used to secure psychiatric residents to perform services in child and adolescent psychiatry in the Family Guidance Centers, including: diagnostic evaluations, ongoing psychiatric treatment, psychotherapy (individual, family, and group), prescribing and monitoring medications, maintaining medical records, consultation to provider agencies, educational seminars and case consultation to Family Guidance Center staff, mental health education to the community (including police departments), and research in community and cultural child psychiatry. Similarly, a contract with the University's School of Social Work provides trainees at the Master's level to work in the children's mental health system, and a contract provides graduate level psychology students to participate in CAMHD's evaluation activities. Doctoral level psychology students also are contracted to provide services in Family Guidance Centers. Another contract with the University establishes an Advance Practice Registered Nurse (APRN) program in child and adolescent mental health nursing for qualified students to prepare them to integrate with CAMHD's children's mental health system to provide services.

## **NJ** New Jersey

### ***Creating a Behavioral Research and Training Institute***

Financing for these activities is built into all aspects of the children's behavioral health system. Training and technical assistance are available to key staff at all levels and are ongoing. The state contracted with the University of Medicine and Dentistry of New Jersey to be the fiscal agent for training and technical assistance resources, and the University created the Behavioral Research and Training Institute to provide such services. Choosing this design allowed flexibility in using dollars to meet the technical assistance and training needs of staff. The state also has built in certain requirements for workforce development activities. All new staff has to go through training or orientation on the system of care, and the state also provided work specific training, e.g. all Care Management Organizations are trained to use the assessment and screening tool relevant to their job. New Jersey also has web-based certification in use of the Child and Adolescent Needs and Strengths (CANS) screening and assessment tools.

## **AK** Bethel, Alaska *Creating a Health Education Center*

Yukon–Kuskokwim Health Corporation (YKHC) has a strong recruitment program for Native hires and a number of workforce development activities. Currently at YKHC, 71% of the staff is **Alaskan** Native or Native American. YKHC has a formal commitment to increasing this number and placing more tribal members in professional positions.

For the past year, YKHC has planned and developed a new Yukon-Kuskokwim Area Health Education Center (AHEC) in collaboration with the University of Alaska, Anchorage (UAA) School of Nursing and internal partners. YKHC’s corporate training and development functions and current staff, formerly known as the Learning Center @ YKHC, will be incorporated into the YK AHEC. This new partnership provides an opportunity for YKHC to enhance staff development as well as sustain its Career Pathways program. AHECs create formal relationships between universities and community partners to strengthen the health workforce in underserved communities. They encourage youth in underserved areas to go to college and pursue a health career, encourage health professions students to go to work in underserved areas, and support continuing education opportunities for health professionals who are working in underserved areas.

The Rural Human Services program is operated by a strategic partnership between the University of Alaska-Fairbanks and YKHC. The State of Alaska Department of Health and Human Services funds the program. Rural Human Services graduates and students deal with crisis situations; their strengths are enhanced by completion of the Rural Human Services program. They learn about resources available and the processes involved in their line of work.

Yuut Elitnaurviat or “The People’s Learning Center” is another workforce development resource implemented through a partnership between YKHC, Lower Kuskokwim School District, the Association of Village Council Presidents, City of Bethel, Coastal Villages Region Fund, Bethel Native Corporation, AVCP Regional Housing Authority, and the Kuskokwim Campus of the University of Alaska at Fairbanks. These organizations have come together to construct a vocational training center that will focus on those in the 8th to 14th grades and lead them into career paths in the construction, health, education, and childhood development fields. The Learning Center is playing a key role in this project by developing the health careers curriculum and providing resources to the partnership in many ways.

## **Choices** Choices *Using Community Resource Managers and Training Coordinators*

Prior to contracting with providers to become part of the network, efforts are made to assess their competencies, as well as their values and beliefs regarding the care of children, family involvement, strengths-based practice, cultural issues, and the like to ensure consistency with **Choice’s** philosophy and approach. The community resource managers provide training opportunities for providers in a variety of forums, including brown bag “lunch and learns.” Quarterly forums are held with providers in the network to discuss themes, trends, the philosophy of care, the wraparound approach, and other topics to enhance their ability to work with children and families. Training topics may include cultural competence, wraparound, the role and functioning of child and family teams, and others. Clusters

of providers also may meet periodically for training purposes and to maintain positive provider relations. Additional support to providers is provided through Choice's care coordinators who are considered "ambassadors" to the providers and who consistently communicate Choice's philosophy and approach to care.

Choices has training coordinators in both Indiana and Ohio to provide in-house training to Choices staff. These coordinators, in collaboration with the site director, provide or arrange for 90-minute weekly training sessions that are mandatory for all staff. Attendance is taken at these trainings and participation in training is examined in performance reviews. New staff is provided with a checklist of required training and mentoring from veteran staff. Training is provided on TCM (The Clinical Manager management information system) and computer systems, as well as on the philosophy and process of providing individualized care. Though not fully developed as yet, Choices is working on developing "manuals" or written documents that detail its philosophy, service approach, and administrative processes.

Many Choices staff have Master's Degrees or obtained them while working. Universities often ask staff to return to the university and speak to graduate students. Professionals from Choices give presentations at various universities at least four or five times per semester. Topics include strengths-based care planning, what is wraparound, what is a system of care, etc. In addition, Choices provides placements for student interns in both Indiana and Ohio and often hire interns after they have completed their professional training programs.

Choices has a contract from the State of Indiana to operate a technical assistance center (TA Center) that provides training to other counties on the development and operation of systems of care. The current contract is for approximately \$402,000/per year and covers a director and three coaches. The TA Center works with all communities currently funded and many previously funded to build systems of care, as well as communities that have never received funding for this purpose. Communities may apply for a \$50,000 planning grant from the state; one of the TA Center's roles is to support them in the planning process to develop a viable, sustainable strategy to build a system of care. The participating communities have access to Choices database to assist in developing case rates, as well as to job descriptions and other structures and processes used by Choices that can be adapted in their respective communities. The TA Center has provided training and consultation to more than 60 of Indiana's 92 counties.

### **OH** Cuyahoga County, Ohio ***Financing Training, Human Resource Activities, and Learning Communities***

All **Cuyahoga** Tapestry System of Care (CTSOC) approved providers must use *Synthesis*, a web-based management information system leased by CTSOC from Wraparound Milwaukee. CTSOC provides training on how to utilize the system. Also, to ensure high fidelity to the wraparound model, CTSOC trains providers in how to adapt the wraparound model to meet Medicaid requirements. CTSOC finds that it is not easy to translate high fidelity wraparound to Medicaid billing; provider and care coordinator documentation must meet Medicaid standards. To assist providers, CTSOC created a cross walk from high-fidelity wrap to Medicaid.

Additionally, the CTSOC recently conducted a forum on recruitment and retention. The forum was an opportunity for agencies new to care coordination to discuss with some of the "veteran" partners

the barriers encountered in trying to recruit and retain the right people. Human resource personnel and recruitment personnel were invited to listen, learn and participate.

Learning Communities are also used to help retain the staff in the jobs. Through the Learning Communities, staff can ask for support on especially difficult cases, request feedback on their performance, and learn how to manage the work load. Currently, the Data Committee of the Wraparound Fidelity Task Force (WAFT) is attempting to link Learning Community attendance with length of stay on the job. The WAFT is in the beginning phases of gathering information. The theory is that the more a worker attends a Learning Community, the longer the length of stay on the job will be. CTSOC also provided \$43,500 to the “council” of Neighborhood Collaboratives to hire a business consultant to assist the Collaboratives in their business model.

### **NY** Erie County, New York

#### ***Financing Coaching Tools for Care Coordinators and Supervisors***

One workforce development strategy is a redefinition of the role of case management supervisors. The Erie County Department of Mental Health (ECDMH) has procured the services of a consultant to work with the management team and the wraparound provider agencies to develop a set of coaching tools that will be implemented with supervisors by their supervisors (Supervisor Coaching Tool) and with care coordinators by their supervisors (Care Coordinator Supervisory Coaching Tool). These tools are tied to individual child outcomes, as measured by the Child and Adolescent Functional Assessment Scale (CAFAS), any differences in CAFAS progress for children and families of color, and the set of critical clinical indicators that are on the dashboard. These indicators include: timely family engagement, a reduction in use of inpatient and other out-of-home options, whether services on the treatment plan are authorized and/or utilized, and the use of family and community supports.

### **CO** Project BLOOM, Colorado

#### ***Using Multiple Financing Sources for Train the Trainer Approach and Early Childhood Mental Health Training***

The state uses a “train the trainer” approach for all of the training provided related to early childhood mental health services. In addition, the Early Childhood Mental Health specialists at the community mental health centers (CMHCs) in each community in **Colorado** provide training to other providers on early childhood mental health. SAMHSA system of care grant resources have been used to provide extensive training and follow-up coaching on the DC: 0–3R diagnostic system for early childhood mental health to build capacity in this area, as well as for training in the wraparound approach (including extensive training for wraparound facilitators), early childhood mental health consultation, and parent-professional partnerships on a statewide basis. Training has been offered at no or little cost to communities.

To further the development of a workforce prepared to deliver early childhood mental health consultation, a resource and sustainability tool kit for providers was developed on “Mental Health Consultation in Early Care and Education.” It includes:

- Section I. Program Implementation and Workforce Development, including a mental health consultation brief, mental health consultation competencies, and a monograph

- Section II. Funding, including a funding source overview, and a funding fact sheets series
  - Section III. Issues and Advocacy, including landscape and opportunities, talking points, funding perspectives, and a mental health consultation Colorado survey report.
- Partners in training and workforce development related to early childhood mental health include:
- Harris Fellowship in Infant Mental Health at the University of Colorado – Some staff have gone through this program at the University of Colorado for in-depth training on infant mental health. This program also co-sponsors training on DC: 0-3R and has done an early childhood mental health track at the mental health provider organization’s annual conference and other conferences, using their own resources. This was funded by the Colorado Behavioral Healthcare Council, the sponsors of the conference.
  - Part C – The Part C program (of the Department of Developmental Disabilities) has provided resources for wraparound training.
  - The Center on the Social and Emotional Foundations for Early Learning (CSEFEL) — A collaborative entity including the University of South Florida and University of Colorado at Denver Health Sciences Center focused on promoting the social emotional development and school readiness of young children birth to age 5. CSEFEL is a national resource center funded by the Office of Head Start and Child Care Bureau for disseminating research and evidence-based practices to early childhood programs across the country. Extensive, user-friendly training materials, videos, and print resources have been developed that are available to help early care, health and education providers based on the Pyramid Model.
  - Training on the Pyramid Model — The Pyramid Model for Promoting the Social and Emotional Development of Infants and Young Children is a conceptual framework of evidence-based practices developed by two national, federally-funded research and training centers: CSEFEL and the Center for Evidence-Based Practices: Young Children with Challenging Behavior (CEBP). These centers’ faculty, including faculty at the University of Colorado at Denver and Health Sciences Center (UCDHSC), represent nationally recognized researchers and program developers in the areas of social skills and challenging behavior. Colorado has offered two, four-day trainings-for-trainers in the Pyramid Model, with over 200 people trained. Attendees paid a fee to support the training.
  - Smart Start Colorado, Office of Professional Development — Operated out of the Community College of Denver, the Office of Professional Development has a charge to implement professional development programs for the state in four domains to establish core knowledge and competencies – health, mental health, family support, and early care/education. The office will house a training registry. The effort is funded by the Colorado Division of Child Care and a Colorado foundation. It is based at a community college in Denver which trains a lot of early care and education providers in an associate’s degree program.
  - A Project BLOOM Professional Development Committee has worked on pre-service training issues. Faculty in graduate programs and community colleges have been surveyed to determine what currently is being taught in early childhood mental health and system of care development and what needs they identify. At the time of the site visit, a webinar was planned to discuss the core elements of early childhood mental health and system of care development that need to be incorporated into curricula for the different disciplines (clinical providers, educators, etc.). An ultimate goal is to create a credential or endorsement for staff in early childhood mental health and system of care development. Subcommittees of the Professional Development Committee have worked on identifying competencies in several areas:
    - Early childhood mental health consultation (a self-evaluation checklist)

- Early care and education (e.g., child care, preschool, Head Start)
- Clinical competencies
- Family members have been a part of this work and will “vet” competencies.

**WI** **Wraparound Milwaukee**  
***Providing Training on the Wraparound Approach***

**Wraparound Milwaukee** provides training to providers in all aspects of the wraparound approach and Wraparound Milwaukee’s operations. It also provides close supervision and coaching for care coordinators. Care coordinators must be certified by completing 40 hours of mandatory training, and there are mandatory, monthly in-service trainings on clinical and program issues. Wraparound Milwaukee partners with parent co-trainers and has a contract with Families United to provide training. It also has a contract with the child welfare system to train all 400 child welfare workers in the county on the wraparound approach and other elements of the program.

**B. Provide Payment Rates that Incentivize Qualified Providers for Home and Community-Based Services**

**Financing strategies include:**

- 1. Incorporate payment rates and policies that incentivize providers to develop and provide home and community-based services**
- 2. Incorporate payment rates and policies that incentivize recruitment and retention of qualified staff**

**1. Incorporate Payment Rates and Policies that Incentivize Providers to Develop and Provide Home and Community-Based Services**

To create incentives for providers to develop and provide home and community-based services, sites have implemented strategies that establish higher rates for home and community-based services, as in **Arizona** and **Michigan**. Others, such as **Choices** and **Wraparound Milwaukee**, purchase primarily home and community-based services, in effect, creating a strong market for these services and incentives for providers to develop home and community-based service capacity.

**AZ** Arizona***Establishing Higher Rates for Services in Out-of-Office Settings***

The state established higher rates for out-of-office than for in-office services to encourage therapists to provide services in homes and schools and not just in offices. Also, it pays a tiered system of rates for out-of-home care, with rates decreasing with longer stays. In addition, there are multiple levels of case management provided by paraprofessionals, mental health techs and licensed professionals. The system pays the lowest rate to paraprofessionals in office-based settings and the highest rate to licensed professionals in out-of-office settings.

Value Options says that being able to be a provider in the network is an incentive to provide home and community-based services (since that is the thrust of the system reform). Also, the size and growth of the provider is contingent on the provider's performance in providing home and community-based services.

For out-of-home services, there is a tiered rate structure. The longer the length of stay in a level one placement (i.e., hospital or residential treatment center), the rate drops (with the exception of level one programs serving youth with sex offenses).

**CA** California***Negotiating Higher Rates for Community-Based and Cultural Services***

In **Contra Costa**, the county can negotiate for a higher rate for specialty services and for cultural or linguistic capacity. The county also is able to do "single case agreements" for a particular type of service not in the network but needed by a given child.

**MI** Michigan***Establishing Higher Reimbursement Rate for Home and Community-Based Services***

The state Medicaid agency provides higher reimbursement rates and lower case load sizes for providers of home and community-based services than for providers of traditional outpatient services.

**Choices** Choices***Purchasing Primarily Home and Community-Based Services***

**Choices** purchases primarily home and community-based services; 80% of the dollars go to community providers. The rates paid by Choices are comparable to the rates paid by public sector agencies. Choices has, in effect, created new home and community-based services, such as mentoring. Its demand to purchase this service resulted in the establishment of a new "industry."

## **OH** Cuyahoga County, Ohio *Incentivizing Home and Community-Based Services*

**Cuyahoga County** has engaged in a number of strategies to incentivize providers to develop home and community-based services, for example:

- **Creating a “soft landing”** for providers when the number of referrals for residential treatment centers (RTCs) drops off—The county child welfare agency (DCFS) traditionally has had a strong relationship with a group of residential care providers through contracts for services and dollars. As DCFS reformed its system and reduced the number of children entering child welfare custody (e.g., due to front end services and supports through Family Team Decision Making), the number of children needing residential care dropped. However, rather than immediately reducing its contracts with the RTCs, DCFS held the RTC providers harmless for two years and allowed them to develop community based services with the extra funds that resulted from serving fewer children in residential care. In the third year, contract amounts with the residential providers dropped, and DCFS invested these dollars into the greater system of care. This process helped many of the RTCs to survive the change and to develop the kind of community-based services that children and families served by DCFS needed. At one point, DCFS was spending \$105 million for board and care. It now spends \$54 million.
- **Establishing a process for determining rates**— Uniform service descriptions are provided by Cuyahoga Tapestry System of Care (CTSOC). Service providers who belong to the provider services network (PSN) propose a unit rate (subject to negotiation with CTSOC) for each of these services. Rates for certain services (e.g., Medicaid services) have been previously established. Once approved by CTSOC, each provider’s rates are applicable for the calendar year. The PSN application process allows providers to list the services they plan to offer from the uniform list and the rates they propose for those services. Providers also can propose to offer new services, not currently listed in the uniform service descriptions. They must provide a brief description of the new services and a proposed rate/unit. In the future, CTSOC intends to move toward a uniform rate schedule for specific services. (see <http://cuyahogatapestry.org/pdf/Partners/ExhibitAServiceDesList.pdf>).
- **Not capping the amount of funds that any single provider can receive**— CTSOC does not cap the amount of funds that an individual provider can receive. The system of care wants to reward providers who offer effective services needed by children and families. There are no “not to exceed” clauses in the provider memoranda of understanding (MOUs). The plans of care developed by child and family (wraparound) teams determine which services get used from which providers.
- **Allowing the six Care Coordination Partnerships (CCPs) to request advances** against future billings— The contracts with the six Care Coordination Partnerships (CCPs) allow them to request advances from CTSOC against future billings. The contractor proposes a schedule for recoupment of the advances at the time of the request. The recoupment is offset against payments for billings for contracted services rendered within the terms of the contract. This policy was put in place to cover the start up year of the system.

**NY** Erie County, New York***Providing Incentives for Residential Providers to Shift to Home and Community-Based Services***

One deliberate strategy of Family Voices Network is to encourage traditional residential providers to shift towards offering home and community-based services and to reduce lengths of stay in residential care. For those providers who are willing to do so, the **Erie County** Department of Mental Health (ECDMH) offered them fiscal incentives, including new contracts for wraparound services. The two providers who participated in the pilot and were successful in reducing lengths of stay were asked to manage large pots of flexible dollars and to develop vendor services that are accessed by the child and family teams.

One innovative CEO of a large children's agency is partnering in a number of ways with the Family Voices Network by moving 30 staff, including his executive team, from a suburban location to an urban, high-risk neighborhood. The agency has recently opened a Family Resource Center on the East Side of Buffalo, another high-risk area. The Family Resource Center is inviting other agencies to locate staff and services in the building and is hiring community members for specific roles and tasks.

**WI** Wraparound Milwaukee***Purchasing Primarily Home and Community-Based Services***

Milwaukee's entire orientation is toward home and community-based services. It has systematically conveyed that message to providers and has made clear the types of services it is most interested in buying. **Wraparound Milwaukee** developed definitions and rates for over 85 specific services and supports in its system. It sets its own uniform rates for all of the services/supports in its network, except residential treatment, the rates for which are set by the state.

## 2. Incorporate Payment Rates that Incentivize Recruitment and Retention of Qualified Staff

Payment rates and policies to help recruit and retain qualified staff were found in several sites. For example, **Arizona** pays off college loans of some professionals entering the behavioral health system as an incentive.

### **AZ** Arizona

#### ***Paying College Loans for Behavioral Health Professionals***

Arizona stakeholders reported that the system (as in a lot of states) has difficulty recruiting and retaining staff. Legislation had been passed to pay off college loans of some professionals going into the behavioral health system, which Regional Behavioral Health Authorities (RBHAs) are using as an incentive for recruitment.

### **Choices** Choices

#### ***Paying Usual and Customary Rates***

**Choices** pays providers their “usual and customary” fee, as documented in existing contracts for the service in question. Choices must pay comparable rates that providers receive for the service from other payers. The community resource manager looks at the average rates for particular services and then negotiates with individual providers and provider agencies. For new services, such as mentoring, Choices enters into negotiation with providers and establishes a new scale for payments. Small providers tend to get a greater share of Choices business. Larger provider agencies often are more demanding of higher rates, and, thus, may not receive the volume of referrals. The system is based on competition. Providers with favorable rates, and who consistently demonstrate positive outcomes, will receive the most consistent rate of referrals.

### **WI** Wraparound Milwaukee

#### ***Paying Providers Promptly***

Given the breadth of the Milwaukee network, the system pays rates that are sufficient to attract and retain providers. At the same time, **Wraparound Milwaukee** pays its providers very quickly, which is another incentive for providers to participate (and which can help to offset concerns about rate sufficiency). Providers are able to bill every week for services rendered, and they get paid within five days.

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## V. Finance Accountability Processes

Systems of care need reliable, practical data and accountability mechanisms to guide decision-making and quality improvement in the provision of services to children and adolescents and their families. The development of strong accountability and continuous quality improvement procedures requires a financial investment in good information systems, as well as financing to support the collection, analysis, and use of data by administrators and other stakeholders to build on system strengths, remediate deficiencies, and make decisions about resource allocation. Accountability and quality improvement procedures require data on the populations being served, service utilization, service quality, cost, and outcomes at multiple levels (the system level, service level, and child and family level). Use of performance-based or outcomes-based contracting allows systems of care to incorporate accountability procedures in contracts with providers. In addition, financing is required for a focal point of accountability for systems of care, that is, an agency, office, or entity that is responsible for policy and management of the system of care.

### **Financing strategies are:**

- A. Finance Mechanisms to Track and Manage Utilization, Quality, Cost, and Outcomes**
- B. Utilize Performance-Based or Outcomes-Based Contracting**
- C. Finance a Leadership, Policy, and Management Infrastructure for Systems of Care**

## A. Finance Mechanisms to Track and Manage Utilization, Quality, Cost, and Outcomes

### Financing strategies include:

1. Finance mechanisms to track utilization, quality, cost, and outcomes and to use data to guide financing and service delivery policies
2. Collect and use data on cost-benefit, cost avoidance, and cost savings
3. Use care managers to play a role in accountability
4. Incorporate financial incentives or sanctions associated with utilization, quality, cost, or outcomes
5. Finance the development of electronic medical records systems

### 1. Finance Mechanisms to Track Utilization, Quality, Cost, and Outcomes and to Use Data to Guide Financing and Service Delivery Policies

The sites studied make financial investments in mechanisms for tracking information related to service utilization, quality, cost, and outcomes and use this information for system improvement.

#### **AZ** Arizona

#### ***Financing a Quality Monitoring System Tied to Principles***

At the time of the study visit, **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) was in the early stages of implementing a new quality monitoring (QM) system driven by the JK settlement agreement and is interested in using data to drive quality and effectiveness. In the past, quality monitoring was driven by Medicaid and focused on generic practice standards, such as access to care and physical/behavioral health coordination. Now, there is a QM children's subcommittee. The new quality system is tied to the 12 principles in the JK settlement agreement and includes both process and outcome measures. This includes a Child and Family Team Practice Review and reporting requirements related to outcomes.

Each Regional Behavioral Health Authority (RBHA) now undergoes an intensive review of the child and family team processes throughout its provider network. This is done through chart reviews and interviews with families conducted by independent teams of family members and wraparound specialists. This Practice Review is looking at process issues, not outcomes. In **Maricopa County**, 110 case reviews in one quarter were conducted. At the time of the visit, ADHS/BHS had just received the first round of data from RBHAs and will use the data to inform quality improvement efforts. For example, areas needing improvement identified by the first round of practice reviews included: a need for better use of natural helpers; a need for better crisis and safety plans; an issue with

timeliness of service provision; and concerns about the adequacy of provider networks. Strengths included cultural competence and family involvement. As part of quality improvement, the Best Practices Committee is recommending a focus on supervisory-level training and coaching.

With respect to the new reporting requirements related to outcomes, for every child in the system, RBHAs are required to report outcomes in several areas – success in school; safety; preparation for adulthood; decreased criminal justice involvement; lives with family; and, increased stability in family and living conditions. There is a different set of outcomes for the 0-5 population, which include: emotional regulation, readiness to learn, safety and stability. Outcomes are reported by child and family teams at enrollment and at six months in response to “yes or no” questions, or by clinical liaisons for children who do not have a child and family team, who have to document a process involving children and families to answer the questions. These data can be found on the ADHS/BHS website under “What’s New: JK Measures.”

The system also tracks cost by funding source and cost by rate group (e.g., child welfare population) – there are 22 different funding categories. The cost data are broken out by child/youth and adult. These cost data are part of RBHA deliverables.

Arizona uses independent quality monitoring teams that include family members; also, there is a quality monitoring process mandated by Medicaid that involves independent case reviews of 1500 cases (adult and child) a year. ADHS/BHS also has access to 16,000 sets of data representing over 50,000 children and youth, and the data can be cut by age, ethnicity, region and whether a child has a child and family team, to support special analyses. Penetration rates of the child welfare population can be tracked as can their use of out of home placements (but not of counseling services). Reportedly, the system is experiencing better outcomes for children who have child and family teams.

In terms of utilization management, this is a managed care system in which there are utilization management mechanisms at state, plan and program levels. Value Options monitors utilization in Maricopa County and must pre-authorize higher levels of care, such as residential treatment. Child and family teams manage utilization at an individual child/family level.

## **CA** California

### ***Using System of Care Grant Funds to Assess Outcomes***

The state Department of Mental Health requires counties to measure family and youth satisfaction, and it will be using funds from the Mental Health Services Act (MHSA-Prop 63) to help counties strengthen infrastructure to track outcomes. Contra Costa does family and youth satisfaction surveys twice a year. In addition, Contra Costa has outcome data related to children served through its federal SAMHSA and ACF system of care grants because funding from the grants allowed them to study the impact. Their data show reduced lengths of stay in child welfare, reduced juvenile justice recidivism, and improved school functioning for children served through a wraparound approach. The county indicated that when county and state funds were cut due to deficits (and federal grants ended), infrastructure was the first to go, including the capacity to track utilization, quality, costs and outcomes. The Mental Health Services Act (MHSA – Prop 63) funds will enable them to rebuild this capacity, beginning with populations served through the Community Services and Supports (CSS) Component (i.e., transition age youth and families in the underserved far eastern part of the county). Over time, MHSA’s current restrictions to limit infrastructure to CSS issues will be lifted. Currently, the

county does ad hoc data inquiries, including looking at high users. For example, at the time of the site visit, the county had identified 50 “high users,” 35 of whom were children and youth. The county also noted the difficulty in recruiting and retaining IT staff with the county’s proximity to Silicon Valley where corporate employers pay higher salaries. Also, the county IT division serves both health and mental health, and physical health tends to consume a far greater share of IT’s time. Contra Costa noted that in some other counties, IT staff are directly assigned to mental health, which works better. (Centralized support systems, such as IT, personnel, and contracts, in general, are problematic at the county level as it takes time to navigate these systems, and they are not necessarily knowledgeable about mental health’s particular issues.)

## **HI** Hawaii

### ***Financing a Quality Assurance and Improvement Program***

The system has utilization, cost, quality and outcome data, managed by the Child and Adolescent Mental Health Management Information System (CAMHMIS) through its various modules. The Child and Adolescent Mental Health Division (CAMHD) has a Quality Assurance and Improvement Program (QAIP) operated by its central office and guided by a Performance Improvement Steering Committee. The types of data used to inform the quality improvement process include: utilization review, sentinel events, grievances and appeals, monitoring, caseloads and vacancies, access, credentialing, facilities certifications, training, and other aspects of CAMHD’s performance. Each Family Guidance Center has an internal structure for reviewing performance data and managing performance improvement initiatives (an interdisciplinary Quality Assurance Team); a Quality Assurance Specialist at each Family Guidance Center manages these efforts.

In addition, each provider agency with which CAMHD contracts is required to have a continuous quality improvement system. Contractors are required to submit quarterly reports on the agency’s Quality Assurance and Improvement Program. Providers also are required to submit the following quality data to CAMHD on a quarterly basis:

- Access data — number and percentage of referrals reviewed within 48 hours, number and percentage of youth accepted upon referral, number and percentage of youth seen within five days of referral, number and percentage of youth ejected from program
- Quality of service provision measure — number and percentage of staff fully credentialed
- Least restrictive measure — average length of treatment
- Treatment measure — number and percentage of youth that have met treatment goals
- Outcome data are collected on each child served by CAMHD to enable evaluation of the performance of the system and its providers. Measures tracked include:
- Number and percentage of youth with improved functioning as measured by CAFAS or PE CAFAS, Achenbach and CALOCUS
- Number of youth served in an out of state setting
- Number and percentage of youth served within the community setting
- Number and percentage of youth with good school attendance
- Number and percentage of youth arrested
- Number and percentage of youth involved in school and community pro-social activities
- Satisfaction

An example of tracking quality is the quality review focused on the Coordinated Service Plans (CSPs). A number of indicators were identified and defined operationally regarding this individualized service planning process, resulting in a “review scale.” The indicators specify that:

1. The plan includes all relevant stakeholders including the child and family as evidenced by signature and/or explanation.
2. The plan provides evidence that there is a clear understanding of what the child needs.
3. The plan is individualized and clearly identifies and links strategies to the preferences and strengths of the child, family and community.
4. There is evidence that informal/natural supports are indicated and infused into the plan.
5. Evidence-based strategies/interventions are included in the plan and are appropriate to the diagnosis.
6. Focal concerns and priority needs are addressed.
7. The plan conveys a long-term view that will lead the child toward desired goals and outcomes.
8. Services and strategies are accountable (includes persons responsible for implementation, timeliness, and resource provision.)
9. A contingency and crisis component is evident.
10. Transitions/discharges are adequately addressed.
11. If child is in an out-of-home placement, conditions and strategies for return home or appropriate least restrictive setting are clearly indicated.

CAMHD studied the rate of child improvements during fiscal years 2002-2004, including analyses across measures of functioning, service needs, and symptomatology. The study found youth were improving more rapidly at the end of the study than at the beginning. This time period coincided with performance improvement initiatives within CAMHD, including the dissemination of evidence-based practices, improvement of care coordination practice, increased information feedback to stakeholders, improved utilization management, adoption of the use of statewide performance measures, restructuring quality improvement operations, and the integration of practice-focused performance management (i.e., quality assurance efforts that are discretely focused on specific practices, such as youth/family engagement, individualized planning, or coordination of services) at various levels of the service system. It was suggested that these system improvements may have an impact on improved youth outcomes.

The state routinely collects system performance information, including information on: the population served, service utilization data on the type and amount of direct services provided, financial information about the cost of services, system performance information about the quality and operation of the infrastructure that supports services, and outcome information regarding functioning and satisfaction of children, youth and families.

A statewide performance improvement committee reviews data and provides the data along with recommendations to the governing body. In addition, data are provided to the quality assurance (QA) teams at each of the Family Guidance Centers for review. Two Family Guidance Centers have emerged as being the most efficient while achieving the same outcomes as others. The state plans to study these centers to determine the strategies used by these centers to maintain both cost-efficiency and outcomes.

Utilization management efforts may suggest special studies that are then conducted in particular areas to focus on a systemic issue. For example, a study was conducted on utilization of therapeutic group homes to determine why utilization of this service was decreasing statewide. It

was determined that schools did not refer youth to therapeutic group homes because there was no educational component. This led to identification of the need for an alternative school component to some therapeutic group homes to avoid placement in a residential treatment center.

A number of performance measures for the children's mental health system operated by CAMHD are tracked to monitor the functioning of the system. For each of these performance measures, CAMHD has specified "statements" that break them down into specific indicators, thresholds for achievement, data to be used to derive the performance information, data source, and benchmarks, as follows:

1. CAMHD will maintain sufficient personnel to serve the eligible population
  - 95% of mental health care coordinator positions are filled
  - 90% of central administration positions are filled
  - Average care coordinator caseloads are in range of 15-20 per full time coordinator
2. CAMHD will maintain sufficient fiscal allocation to sustain service delivery.
  - Sustain within quarterly budget allocation
3. CAMHD will maintain timely payment to provider agencies.
  - 95% contracted providers are paid within 30 days
4. CAMHD will provide timely access to a full array of community-based services.
  - 98% of youth receive services within 30 days of request
  - 95% of youth receive the specific services identified by the educational team plan
5. CAMHD will timely and effectively respond to stakeholders' concerns.
  - 95% of youth served have no documented complaint received
  - 85% of provider agencies have no documented complaint received
  - 85% of provider agencies will have no documented complaint about CAMHD performance
6. Youth will receive the necessary treatment services in a community-based environment within the least restrictive setting.
  - 95% of youth receive treatment within the State of Hawaii
  - 65% of youth are able to receive treatment while living in their home
7. CAMHD will consistently implement an individualized, client and family centered planning process.
  - 85% of youth have a current Coordinated Service Plan (CSP)
  - 85% of Coordinated Service Plan review indicators meet quality standards
8. There will be a statewide community-based infrastructure to ensure quality service delivery in all communities
9. Mental health services will be provided by an array of quality provider agencies.
  - 85% of performance indicators are met for each Family Guidance Center
  - 100% of agencies will maintain acceptable scoring on internal reviews
  - 100% of provider agencies are monitored annually
  - 85% of provider agencies are rated as performing at an acceptable level
10. CAMHD will demonstrate improvement in child status.
  - 60% of youth sampled show improvement in functioning since entering CAMHD as measured by the CAFAS or Achenbach
  - 85% of those with case-based reviews show acceptable child status

11. Families will be engaged as partners in the planning process.  
85% if families surveyed report satisfaction with CAMHD services
12. There will be state-level quality performance that ensures effective infrastructure to support the system.  
85% of CAMHD Central Office performance measures will be met

Data are used for system improvement. For example, data from the Annual Evaluation Report for fiscal year 2005 showed that disruptive behavior disorders comprised the most common problem among youth registered in the CAMHD system, with 48% having a primary or secondary diagnosis in the disruptive behavior category. Two evidence-based interventions with demonstrated effectiveness for youth with disruptive behaviors have been increased in the system – Multisystemic Therapy—MST (utilization increased in FY 2005) and Multidimensional Treatment Foster Care (an RFP for this service was recently released). In addition, the annual report showed that the growth in utilization of community residential services was contained, which was a system goal, although costs for this service increased. Data showed that evidence-based practices were not being used to the extent desired among CAMHD providers, prompting actions to increase their use in therapeutic interventions. Data also pointed to the need for further exploration of the factors that have resulted in youth being discharged from the CAMHD system with more problematic functioning and greater service needs than youth discharged in prior years, despite the fact that they showed improvement with services at a more rapid pace. Similarly, although out-of-state placements remained low, the report found an increase in the use of hospital services, suggesting the need for more aggressive strategies to reduce hospital utilization.

## Michigan

### *Financing a Data System to Track Utilization, Costs, and Outcomes*

The Community Mental Health Services Programs (CMHSP) cost report provides the data that are necessary for the Department of Community Health (DCH) to manage the CMHSP contracts and provide reports to the legislature. The data describe and represent the support activities provided to or on behalf of all recipients of CMHSP services regardless of funding stream (Medicaid, general fund, grant funds, private pay, third party pay, contracts). The cost reports provide information on:

1. **Total units, cases, and costs per procedure code.** This includes: number of units that were provided during the period of this report for each eligibility group (individuals with a developmental disability, adults with mental illness, and children with mental illness); peer-delivered units, costs, and peer-delivered expenditures (typically drop-in center activities); residential room and board; pharmacy; unique number of cases per procedure code; total expenditures per procedure code; substance abuse procedure codes.
2. **Prevention- Indirect Service-** total expenditures (staff, facility, equipment, staff travel, contract services, supplies and materials) for indirect prevention activities.
3. **Mental Health/Developmental Disabilities Medicaid Administration by PIHP Hub for its Affiliate CMHSPs:** The CMHSPs who are Prepaid Inpatient Health Plans (PIHPs) for affiliate CMHSPs report administrative costs where the PIHP/CMHSP retained Medicaid funding to assist with the administration of affiliated programs.
4. **Mental Health/Developmental Disabilities Administration by CMHSP.** Total expenditures for managed care administration performed by the CMHSP for all services.

5. **Substance abuse services and administrative costs.** This includes the total expenditures (services + administration) for substance abuse services managed or provided by the CMHSP to individuals with substance use disorders in the CMHSP catchment area.

6. **Total MH/DD Cases and Costs.** This includes the total unduplicated number of cases and costs for each group.

The Prepaid Inpatient Health Plan (PIHP) cost reports provide the Medicaid service data that DCH needs to manage the PIHP contracts, and it is also used to set rates by the actuary. If the PIHP is affiliated with a CMHSP and other services providers, the PIHP must report this data as an aggregation of all Medicaid services provided in the service area by its affiliates. The data in this report describe and reveal the support activities provided on behalf of or to Medicaid recipients. However, this does not include Children's Waiver beneficiaries. The information reflected is for mental health and substance abuse coverage for the state plan, services provided under the authority of Section 1915(b)(3) waiver, and the Habilitation Supports Waiver.

In addition, in order to monitor expenditures, provided services, and consumer outcomes, Michigan requires the CMHSPs and the PIHPs to provide data on costs, services, consumer demographics, and administrative activities. The Michigan Mission-Based Performance Indicator System was first implemented in fiscal year 1997 and is written into the state's contract with the 18 PIHPs and 46 CMHCs. Since 1997, the system has undergone changes based on feedback from consumers, families, advocates and mental health professionals. In the early stages of the systems there were 51 indicators. The list was shortened, and there are currently 15 indicators. The indicators measure the performance of PIHPs for their Medicaid beneficiaries, including those that received substance abuse services, and the CMHSPs for all persons with mental health and developmental disabilities. The system measures indicators in four domains:

- **Access**, including the percent of children and adults receiving a pre-admission screening for psychiatric inpatient care for whom the disposition was completed within three hours, the percent of new persons receiving a face-to-face assessment with a professional within 14 calendar days of a non-emergency request for service, the percent of new persons starting any needed on-going service within 14 days of a non-emergent assessment with a professional, the percent of discharges from a psychiatric inpatient unit who are seen for follow-up care within seven days, the percent of Medicaid recipients having received PIHP managed services, the percent of face-to-face assessment with professionals that result in decisions to deny services
- **Adequacy/ appropriateness**, including the percent of Habilitation Supports Waiver (HSW) enrollees during the quarter with encounters who are receiving at least one HSW service per month other than supports coordination
- **Outcomes**, including the percent of children and adults readmitted to an inpatient psychiatric unit within 30 days of discharge, the annual number of substantiated recipient rights complaints per thousand persons served, in the categories of Abuse and Neglect I and II, the semi-annual number of sentinel events per thousand Medicaid beneficiaries served (sentinel events include death, injuries requiring emergency room visits and/or admissions to hospitals, physical illness requiring admissions to hospitals, arrests, convictions, serious challenging behaviors and medication errors), the number of suicides per thousand persons served
- **Efficiency**, including the percent of total expenditures spent on managed care administrative functions for CMHSP and PIHPs.

The Michigan Department of Community Health (MDCH) contracts with Eastern Michigan University (EMU) for a project entitled Level of Functioning (LOF). The purpose of the project is to assist the state and Community Mental Health Service Programs (CMHSPs) in studying client level

outcomes using the Children and Adolescent Functional Assessment Scale (CAFAS). Participation is voluntarily and collaborative between MDCH, EMU, and the CMHSPs. The providers send outcome data monthly to the University, and in return, receive data profiling their site monthly as well as a yearly report using comparison statistics for a pooled dataset for the State. The purpose is to encourage providers to earnestly engage in self-scrutiny so that they can assess their strengths and weaknesses and improve the latter. Meetings are held twice a year where data are shared and analyzed with all of the participants. Training and technical assistance are provided in CAFAS rater reliability, use of the automated version of the CAFAS, as well as in how to produce reports that are useful clinically as well as administratively. Data from this project have been used for a variety of purposes. Some of these include the following:

- Identify evidence based practices and evaluate the impact the training has had on therapists
- Establish objective eligibility criteria for home-based services to ensure efficient use of limited resources
- Identify exemplary programs and to study those programs so others can learn from their service approaches
- Assist CMHSPs in a variety of quality improvement projects
- To improve the quality of the services provided by the CMHSPs

The impact of all of these efforts has been to improve the quality of the mental health services provided to the children and families served by the public mental health system in Michigan.

## **VT** Vermont

### ***Reporting State and Local Performance Information***

At local and state levels, the system of care incorporates a variety of utilization, quality, cost, and outcomes management mechanisms. Local agencies have a schedule of reported utilization and cost data to the state, and these are routinely reported. The state tracks:

- Quality of child behavioral health services
- Costs of child behavioral health services in total
- Costs of services by child served
- Outliers (i.e., high utilizers of services)
- Utilization and cost by type of population served

The state publishes many of these data in a statistical information resource from the Department of Mental Health and in periodic reports issued by the Vermont Performance Indicator Project, which issues brief reports on a weekly basis providing information about different aspects of the behavioral healthcare system (<http://healthvermont.gov/mh/docs/pips/pip-reports.aspx>). These reports (PIPs) are available on the state's site and investigate indicators such as:

- Access to care
- Practice patterns
- Treatment outcomes
- Concerns of criminal justice involvement
- Employment
- Hospitalization

These reviews often examine the relationship of mental health services with other programs and state agencies. Cross-agency data analysis is facilitated by the use of a statistical methodology that provides unduplicated counts of the number of individuals served by multiple agencies, without reference to personally identifying information, thus protecting confidentiality and complying with HIPAA.

In addition, the local Designated Agencies receive periodic reviews and a comprehensive review at least every four years to ensure quality performance. Every two years, agency staff and members of the State Program Standing Committee conduct a separate program review as part of the state's continuous quality improvement plan. Detailed data are gathered on four quality domains: access to care; practice patterns of care; results of care; and agency structure/administration. The findings of this review form the basis for ongoing discussions and planning for program development, resource allocation, and budgeting. The state tracking and monitoring also has developed and relies on regular measurements of how caseloads overlap across agencies and on satisfaction with services by adolescents served and by parents of children served.

### **NE** Central Nebraska *Tracking Utilization, Outcomes, Quality, and Costs*

**Tracking Utilization**—The cooperative agreement between the Nebraska Department of Health and Human Services and Region 3 Behavioral Health Services (BHS) to establish an individualized system of care for high need youth who are in state custody included a joint responsibility for utilization management. The Care Management Team (CMT), funded jointly by Region 3 BHS and the Central Area Office of Protection and Safety, serves this function. The CMT ensures that children/youth are cared for in the least restrictive, highest quality, and most appropriate level of care.

The Care Management Team (CMT) provides utilization management and review through a systematic process using the CAFAS, risk assessment tools, caregiver and youth interviews, psychological evaluations and other clinical and education/vocational information. It conducts pre-admission screening and ongoing review of children in higher levels of care. The CMT maintains an up-to-date database which tracks youth placement and monitors length-of-stay information. The CMT is staffed by licensed mental health clinicians. This is very helpful in the negotiations with Magellan for access to services for individual children. In FY 2005, 210 youth were referred to the CMT.

**Tracking Outcomes**—While families are receiving services, Professional Partners and Care Coordinators receive management information reports incorporating scores from the variety of assessment tools that are administered at intake and at regular intervals during service delivery. Integrated Care Coordination (ICCU) program directors are provided an executive summary which describes the children who have been accepted into an ICCU each month and the children who have been disenrolled. Areas tracked for accepted youth include: diagnosis, CAFAS scores, types of behavior displayed by the youth accepted, levels of care, assessment of parental behavioral health issues, each child's permanency plan, and status of adjudications. The report also summarizes the placement status for each child who is disenrolled.

**Tracking Quality**—The contract with Families CARE, the family support and advocacy organization in Central Nebraska, includes monitoring fidelity to the wraparound model. Families CARE staff collect information from parents, youth, and care coordinators to measure fidelity and to assess satisfaction. The results are aggregated and distributed to the various wraparound based programs. This feedback allows for continual improvements of the programs and builds capacity for parent-to-parent support by using family members as evaluators. Team members who participate on child and family teams are also asked to assess wraparound fidelity on a semi-annual basis.

**Tracking Costs**—To track utilization and account for how the Integrated Care Coordination (ICCU) program spends its case rate, Region 3 Behavioral Health Services (BHS) administrators prepare a monthly report that identifies, by child, direct service costs (including services provided, flex funds spent, and concrete expenditures such as transportation or rent) and non-direct service costs. This monthly report shows the extent to which the case rate was under- or over-spent for each child. From these reports on individual children/families, Region 3 BHS is able to track trends over a period of time such as: average cost per family, average cost of direct services, costs for youth who are in placement compared to costs for youth who are not in out-of-home placements, average monthly costs for different types of placements, and monthly associated non-service costs (including staff personnel costs). Yearly and monthly increases and decreases in expenditures by placement type also are tracked.

## **Choices** Choices

### ***Financing an Integrated Management Information System***

An integrated management information system, called The Clinical Manager (TCM), was developed as a tool for system management in both the clinical and fiscal arenas. Encompassing all aspects of Choices' data requirements, TCM includes clinical information and plan of care, claims adjudication, service authorization, service utilization, tracking progress, tracking outcomes, tracking costs, medication management, historical information, and contract management. Clinical and fiscal records for a child and family can be viewed together, affording team members prompt access to both types of data and resulting in more efficient care management. Data are analyzed by: payers, team, and individual care coordinator. The Child and Adolescent Needs and Strengths (CANS), measuring clinical and family outcomes, has been integrated into the TCM process and is now a part of the software package.

Utilization is tracked based on service authorizations. Services are authorized prospectively and then authorization is compared with actual utilization. Monitoring utilization allows for an understanding of service utilization patterns, costs, and outcomes, and helps to identify team dynamics, training needs, provider management needs, and fiscal issues needing attention.

Choices contracted with the Indiana Consortium for Mental Health Services Research to conduct evaluation activities relative to Dawn in areas including profiles of Dawn Project participants, patterns of service use, the dynamics of the service coordination teams, client outcomes and service effectiveness, system-level functioning (the implementation of system of care principles within the managed care system), and the functioning of the family support and advocacy organization.

Recent evaluation data on Dawn demonstrated:

- Dawn was able to maintain the majority of its participants within community-based care settings.
- Ratings of functional impairments improved significantly as rated by the Child and Adolescent Functional Assessment Scale (CAFAS), Child Behavior Check List (CBCL), and Behavioral and Emotional Rating Scale (BERS)
- Number of delinquent offenses committed by youth in Dawn declined over time
- Youth showed significant improvement over time in school attendance, level of discipline problems, and academic performance
- 65% of youth leave the program by meeting goals established by their child and family team
- Majority of caregivers (and youth) are either satisfied or very satisfied with services provided, level of cultural competence, and their level of involvement in planning treatment
- Caregivers reported significant improvement in their overall functioning and perceived level of caregiver strain
- Dawn provides a diverse mix of services.
- Two services most closely related to less positive outcomes and increased expenditures are crisis/respite and residential treatment services
- Dawn increased collaboration among child-serving systems in Marion County, highlighted importance of family involvement, and drew attention to family strengths as basis of treatment planning.

## **OH** Cuyahoga County, Ohio

### ***Leasing a Web-Based Multipurpose Information System and Using Data to Drive Decision Making***

*Synthesis* is **Cuyahoga County's** web-based multipurpose management information system, which it leases from Wraparound Milwaukee, which developed the system. *Synthesis* enables the county to track utilization, quality, cost and outcomes. It is used also for service authorization, case management, and invoicing. The county uses SAMHSA grant funds to lease *Synthesis*, to pay for web hosting and to cover the necessary consulting fees.

The county child-serving systems have agreed upon the following outcomes that are tracked for children and families served by Cuyahoga Tapestry System of Care (CTSOC). These include:

- Children are with their families in the community
- Children have increased rates of attendance at school
- Children have improved performance in school
- Children show improvement in Ohio Scales Scores (problem severity and functioning)
- Family assessments indicate improved family functioning
- Reduced length of stay in residential settings
- Reduced length of stay in psychiatric settings
- Reduced recidivism in referrals to juvenile court
- Reduced recidivism and reduced penetration in child welfare
- Children needing to be placed are placed with kin or in the same neighborhood as their home
- Treatment is provided for children and youth who continue to cycle through system involvement because their needs for treatment are not being met

CTSOC was selected as a pilot site and development partner with the federal Center for Mental Health Services to implement the Continuous Quality Improvement (CQI) protocol for systems of care. According to the report of the federal site visit, Cuyahoga County also has done an excellent job in implementing the national system of care evaluation. Enrollment and retention rates are high for the evaluation, and there is a well thought out longitudinal plan to continue the national evaluation.

The county uses data to drive decision making and to improve its system of care. As data are collected, data are shared on the website ([www.CuyahogaTapestry.org](http://www.CuyahogaTapestry.org)), sent to the System of Care Oversight Committee, especially to the subcommittees on evaluation, the Funders Group, and to the Parent Advisory Council. Data are shared with system of care supervisors as information impacts their practice. The Learning Communities receive data, and family stories are woven with data in the Cuyahoga Tapestry System of Care (CTSOC) electronic newsletter, Threads. The culture in Cuyahoga County is now an “addiction to data.” Funders in Cuyahoga County are “data dependent”. The child-serving systems all agreed upon which outcomes to track, and they analyze data to determine if they are achieving them and to guide decision-making. When the national evaluation ends, the county will keep tracking data via Synthesis and the Ohio Scales. A system administrator noted that “a month without data is a month without sunshine.” The county tries to be transparent in everything it does, and data enable them to do this.

The June 2007 federal site visit report noted several examples of how CTSOC uses a data driven approach:

- When the county noticed that referrals to the Cuyahoga Tapestry System of Care (CTSOC) from juvenile justice were low, they trained probation officers to boost their referral rates.
- When the CQI data showed there was an issue in providing timely services, changes were made in the intake process so that families would not have to wait.
- The county used the data from its 2004 study of the costs of mental health services for children placed by DCFS to get approval from the Board of County Commissioners to invest county funds (\$9.5 million) in the SOC (thru 12/09).

Two additional examples of how the county has used data to guide financing and service delivery and to obtain additional resources involve the following:

- The county felt that its parent advocates were a positive force in changing its system of care and ensuring family voice. To examine this, the evaluators developed the Parent Advocate Activity Form (PAAF) to track activity and effectiveness. The PAAF began as an administrative management tool and became an outcomes based assessment tool. They learned that 92% of caregivers are very satisfied or satisfied with their parent advocates, 88% agreed that parents advocates were “there when needed”, and 84% saw their parent advocates at least twice a month. They also learned that parent advocate services were giving caregivers the confidence and skills necessary to obtain employment. Data from the PAAF were used to: increase family voice in the system of care; to demonstrate the need for more parent advocates; to increase collaboration between parent advocates and care managers; and to demonstrate the need for training, coaching and fidelity to the wraparound model. Parent advocates and family members used these data with the Board of County Commissioners to request more parent advocate positions. The county also used the data to support its application to SAMHSA for supplemental funds to develop a pilot parent coaching program.
- One of the first assignments for the system of care evaluators was to do a baseline study in 2004 (2nd yr of SOC grant) to look at duplication of costs across child welfare and mental health. The study looked at children’s utilization of services over their lifetimes, not just at a point in time.

They discovered high rates of cross-system involvement. This made a strong case for cross-system service delivery and building a county-wide system of care. Having local cost data was critical for the decision-makers. Similar national data were not good enough. The county also learned from this study that they were spending four times as many Medicaid dollars on mental health services for youth in the Department of Child and Family Services (DCFS) Levels 3–6 placements as they were for the general population of children/youth receiving mental health services. They learned that child welfare was driving the system. The data showed that DCFS needed CTSOC’s help to reduce costs and to keep children in their own homes. The county believes that the 2004 baseline data will help them make the case for a system of care line item in 2009 after SAMHSA grant funds have ended. The 2004 data were obtained “on a handshake.” County leaders believe that trust and partnership between the child welfare director, the Mental Health Services Board, and the Kent State University evaluators enabled them to gather data on duplicated costs.

### **NY** Erie County, New York *Tracking Milestones Achieved in System of Care*

Milestones achieved to date regarding increasing system capacity, reducing system penetration and the use of institutional care include each of the following:

#### **Increased Systems Capacity:**

1. Identify in a timely manner, utilizing objective criteria, individuals at risk of significant system penetration:
  - The implementation of a Multidisciplinary Persons in Need of Supervision (PINS-i.e. youth with status offenses) Diversion Family Services Team (FST) to identify at risk PINS Youth, utilizing objective screening and assessment tools and structured decision making practices to ensure the optimal service linkage to effective community services for at risk youth;
  - Reducing the time to link youth and families to services by 66%, from six weeks to two weeks in 2007, through Family Voices Network’s single points of access
  - Next Step is to establish a Juvenile Delinquent Service Team applying the emerging practices of the PINS FST to a new multidisciplinary team of Probation, Detention and Mental Health practitioners.
2. By integrating the efforts of the above Single Points of Access, Erie County has initiated the process to establish a virtual overall Single Point of Entry for all residential placements.
3. Development of sufficient capacity in Wraparound and other Evidence Based/ Emerging Community Services to interrupt system penetration and provide effective alternatives to institutional placement:
  - Entering 2008, Wraparound capacity was funded at a capacity of 469 slots with approximately \$4.8 Million of flexible service dollars.
  - Additional funded capacity in the service continuum that includes 24/ 7 Mobile Crisis Response Team, overnight respite, Functional Family Treatment, Multisystemic Therapy, Urgent Access Intensive In Home, Family Support, Youth Advocacy, Juvenile Justice Tracking and Monitoring, Integrated Alcohol and Substance Abuse Clinic with Family Supports, PINS Diversion Early Intervention, Preventive Services for Educational Neglect, Community Resource Center, and PINS Family Mediation.

4. Shortened Length of Stay Initiative:
  - Reforms to be Implemented in the next six weeks include: linkage to Wraparound prior to Court Placement decision; flexibility by Court to extend Shortened Length of Stay (SLOS) to a broader group of Youth; expansion of designated Wraparound Slots to accommodate increases in SLOS Enrollment;
  - Dedicated Quality Improvement capacity to ensure increased effectiveness and the achievement of valued outcomes.
5. Real time data and management structures:
  - Development of Performance Dashboard to monitor the achievement of critical milestones in improving fidelity to practice standards and its impact on the achievement of valued outcomes.
  - Application of the dashboard tool to redefining supervision, learning community, and management functions;
  - Improving the capacity to identify emerging challenges and establish system and service/ practice adjustments to address challenges.
6. 2008 Total Investment in Community SOC Services is \$16.1 Million.

#### **Reduced System Penetration and Use of Institutional Care:**

1. Reductions in Juvenile Justice System Penetration:
  - 44% Reduction in PINS Petitions from the 2004/05 Base (i.e., from 808 to 453);
  - 76% Reduction in PINS Youth Placed on Formal Probation from the 2004/05 Base (i.e., from 299 to 68);
2. Reduced Placement in Institutional Care:
  - Psychiatric Inpatient Beds normatively operating at approximately 56% of Licensed Capacity;
  - 37% Reduction in Average Daily Census for Secure Detention from the 2004 Base (i.e., from 38 to 22);
  - 70% Reduction in Average Daily Census for Non- Secure Detention from the 2004 Base (i.e., From 56 to 19); and,
  - 33.6% Decrease in Annual Residential Treatment Center Bed Days from the 2005 Base (i.e., from 80,556 to 53,517).
3. Annual Savings in Absolute Residential Treatment Center (RTC) Expenditures from the 2005 Base is \$5.1 Million (i.e., from \$22.1 Million to \$17 Million).
  - Investments to date in the System of Care from the 2005 Base Funding Levels include each of the following:
    - Blended SOC Funding @ \$5.81 Million;
    - Reinvestment of RTC Savings @ \$2.95 Million; and
    - Expansion of the NYS Office of Mental Health Home & Community Based Waiver @ \$1.67 Million.

In addition, the Erie County Department of Mental Health (ECDMH) has a contract with a consultant to redefine a software system as a management tool. He has added a critical data dashboard of clinical indicators for the wraparound agencies, which displays by provider agency. The indicators include:

- Current enrollees with length of stay less than 14 months.
- Engagement, as measured by families assigned but not opened or discharged in less than 90 days
- Changes in CAFAS score at 6 months and 12 months
- Successful discharges as measured by objectives met
- Enrolled youth who are discharged without an RTC or inpatient placement

The indicators are reviewed monthly by the management team of Family Voices Network, the local system of care. Data from the dashboard are updated on a monthly basis and shared with the management team of Family Voices Network, the family roundtable, and with care coordinators. A similar data dashboard is under development for other vendors of children's services.

The Wraparound Fidelity Index is used by Child and Family Teams at the six wraparound agencies. Data are reviewed and used to inform system change. For example, data indicate that when families are discharged, there is insufficient transition to informal supports and services. The CAFAS is used to assess child and family progress. Specific issues have been examined, for example, why some families leave before services are complete and how to better engage families.

### **CO** Project BLOOM, Colorado *Financing a Web-Based Data System and Providing Information to Leadership Committee and Communities*

The primary tracking mechanism at **Project BLOOM** is through the TSOC (Tracking System of Care) web-based data system, which tracks the following:

- **Quality**—The Wraparound Fidelity Index is used to assess the quality of services as well as the national evaluation's CQI report card
- **Cost**—The Services and Cost Study of the national evaluation, cost data from the TSOC system, and the Smart Start financial modeling project are used to determine and track costs
- **Outcomes**—The TSOC tracks outcomes (e.g., movement from placements, expulsions from child care, changes in assessment scores). In addition, some system of care outcomes are tracked through Smart Start, such as family involvement. The Early Childhood Specialists track outcomes through the CCAR (Colorado Client Assessment Record, the state's mental health management information system) and the Parenting Stress Index (PSI) which can be found at: [www.friendsnrc.org/download/outcomeresources/toolkit/annot/psi.pdf](http://www.friendsnrc.org/download/outcomeresources/toolkit/annot/psi.pdf). The CCAR and the PSI are used to measure: child's mental health symptoms (CCAR overall symptom severity at admission and discharge), level of functioning (CCAR overall level of functioning at admission and discharge), social skills (CCAR interpersonal domain and/or socialization domain ratings), change in rate of child care expulsions (CCAR outcome section out of school, defined as childcare or preschool), school readiness (CCAR outcome section for under age six), family relationships (CCAR family domain ratings at admission and discharge and parent/child interaction on the PSI), changes in rates of out-of-home placements (CCAR update for current living arrangement when placement changes), family stress (overall score on PSI), family

isolation/social supports (CCAR social support domain rating), family sense of competence (CCAR empowerment domain). In addition, trainings attended and delivered are tracked for early childhood mental health professional development, and the number of screenings/assessments completed is tracked to assess the extent to which mental health is being infused into early childhood systems. Another example of outcomes tracked is the reliable change index of child behavior and emotional problems for young children (Child Behavior Checklist -CBCL). This has shown that for both internalizing and externalizing behaviors, about 30% of the children improved from intake to 12 months, about 54% remained stable, and about 15% deteriorated.

- **Utilization** — TSOC tracks services used. Findings indicate that the support services most frequently used by children in Project BLOOM systems of care between intake and six months include: case management (60%), followed by informal supports (31%), behavioral/therapeutic aides (20%), family support (20%), after school programs (23%), transportation (17%), respite (17%), and flexible funds (17%). For clinical services, 86% received some type of therapy, including family, play and group; 24.6% received medication and medication monitoring; and 3.5% received inpatient treatment.
- **Outliers** — Outliers are tracked through TSOC by tracking service utilization and frequency. Information is brought to the Project BLOOM leadership committee. A workshop was held for Project BLOOM communities, including families, by the Project BLOOM evaluation staff on how to present data to communities and how data can be used.

Data from the system-level assessment that are part of the national evaluation were provided to each of the Project BLOOM communities. Each community developed an improvement plan based on these results. Findings from the Wraparound Fidelity Index (WFI) also have been used to implement improvements. For example, it was determined that the use of natural supports was not as high as desired. A consultant was hired to work with the communities to increase the use of natural supports.

A study was conducted by a contractor on enrollment into wraparound and to identify issues needing attention. One change implemented based on this study was the development of an eligibility definition including Axis 2 diagnoses as some children could not get services based on their diagnoses. Additionally, training for wraparound facilitators was improved and efforts were implemented to train additional wraparound facilitators.

A newsletter, the "Code PROJECT BLOOM Courier," provides highlights of evaluation data to communities. Materials are provided to the PROJECT BLOOM coordinator in each community, and the evaluation team has gone to the communities to provide evaluation information and consultation. Each of the Project BLOOM communities has assigned a Quality Coordinator, who is responsible for examining TSOC data and using it to recommend and implement needed improvements.

## **WI** Wraparound Milwaukee

### ***Using a Web-Based Management Information System***

**Wraparound Milwaukee** is a data-driven system that is supported by Synthesis, a web-based management information system, built and owned by Wraparound Milwaukee. Synthesis allows the system to capture real time, as well as retrospective, data. For example, progress notes on individual children are automated through Synthesis so that the MIS system is used, not only by managers and policymakers, but by clinicians and care managers. Synthesis captures all care planning, crisis plans, safety plans, and progress notes. It tracks all services/supports provided, for which youngsters and at what cost. It captures demographic data and outcome data. It is used for billing and claims adjudication and links to a system for automatic check writing. Providers are able to bill every week for services rendered, and they get paid within five days. Synthesis data also are used by Wraparound Milwaukee's quality improvement (QI) staff. Over 300 people use Synthesis; Milwaukee uses a "train the trainers" approach to build capacity to use *Synthesis*.

Wraparound Milwaukee tracks program, clinical, fiscal, system and safety outcomes. It addresses the following:

- Is there improved clinical functioning as measured by the Child and Adolescent Functional Assessment Scale – CAFAS? (Note: Wraparound Milwaukee is considering abandoning use of the CAFAS, perhaps moving to use of the Child and Adolescent Needs and Strengths –CANS.)
- Has there been a reduction in the restrictiveness of living environment?
- Is there a reduction in juvenile justice contacts?
- Has school attendance improved?
- Are the wraparound costs comparable to or less than residential treatment costs?
- Are families and youth satisfied with services?

In terms of utilization management, this is a managed care system, in effect, in which there are utilization management mechanisms at the care coordinator and system management levels. Certain high-cost services, such as residential treatment and inpatient hospitalization, may require prior authorization, and outliers are reviewed. However, most providers are notified of units of services approved for the upcoming month based on the plans of care and service authorization requests submitted by care coordinators. Providers invoice online, and Synthesis matches services provided with those authorized under the plan of care.

**Table 7.3** shows the types of information tracked by the sites.

Information Tracked	States						Regional/Local Communities					
	AZ	CA	HI	NJ	VT	MI	Central NE	Choices	Cuyahoga County	Erie County	Project BLOOM	Wraparound Milwaukee
Quality of child behavioral health services	X	X	X	X	X	X	X	X	X	X	X	X
Costs of child behavioral health services in total	X	X	X	X	X	X	X	X	X	X	X	X
Costs of services by child served	X		X	X		X	X	X	X	X	X	X
Outliers (i.e., high utilizers of services)	X		X	X		X	X	X	X	X	X	X
Utilization by type of population served (e.g., children in the child welfare and juvenile justice systems)	X	X	X	X	X	X	X	X	X	X	X	X
<b>Second Wave Only</b>												
Utilization by racial and ethnic subgroups		X				X			X		X	
Outcomes of services		X				X			X	X	X	

## 2. Collect and Use Data on Cost-Benefit, Cost Avoidance, and Cost Savings

The use of data on cost-benefit, cost avoidance, or cost savings can provide powerful evidence of the efficacy of the services provided within a system of care approach. Several of the sites collect these types of data. For example, **Hawaii** collects and uses cost-benefit data through a process referred to as Data Envelope Analysis (DEA), and **Wraparound Milwaukee** collects and uses data on cost savings for youth who would otherwise be in residential treatment or correctional facilities. **Project BLOOM** undertook an analysis to document the costs that could be avoided in the future by investing in the early childhood population.

**HI** **Hawaii*****Collecting and Using Cost-Benefit Data from Data Envelope Analysis (DEA)***

Cost-benefit data are used by the **Hawaii** system. Information from Data Envelope Analysis (DEA) analyses is provided to the system of care governing body. DEA is a linear programming methodology that examines the relative efficiencies of six mental health centers (Family Guidance Centers). The methodology is considered to be an important decision support tool for focusing quality and financial improvement efforts within a mental health service delivery system. The method involves examining multiple resource inputs (such as costs of operating expenses, staffing patterns, etc.) along with multiple quality outputs (such as youth outcomes, quantity of services, etc.). These multiple input and disparate input and output (cost and quality) measures are converted to a single comprehensive measure of “efficiency.” In an example of the application of this methodology, indicators of quality outputs were compiled from the Child and Adolescent Mental Health Division’s (CAMHD) usual performance monitoring reports. Quality indicators included the percentage of youth receiving intensive in-home services/not removed from their homes, percentage of youth with Coordinated Service Plans meeting quality standards, percentage of youth showing improvement on the Child and Adolescent Functional Assessment Scale (CAFAS) or Achenbach System for Empirically Based Assessment, and percentage of youth with no documented complaint or grievance. Input indicators were taken from CAMHD’s routine staffing and financial summary reports and included office expenses per average client day per month, salary expenses per average client day per month, number of full time equivalents of care coordinators per average client day per month, selected summary costs of therapeutic services per average client day per month, and selected costs of out-of-home treatment services per average client day per month. The results showed that five of the mental health centers could be considered “efficient,” but one of the six mental health centers had the lowest percentage of clients showing improvement on the CAFAS or Achenbach System for Empirically Based Assessment, as well as the highest input of resources per client day for three of the five resource inputs. The application of the DEA methodology allowed managers to compare themselves to those with the lowest costs and highest outputs. The analysis also indicated the need for additional data or operational evaluations to clarify results.

**WI** **Wraparound Milwaukee*****Collecting and Using Data on Cost Savings***

Milwaukee does not have cost/benefit data per se, but it does have data available showing the cost savings for youth who would otherwise be in residential treatment or correctional placements and for children in child welfare who are in more permanent living arrangements. Wraparound Milwaukee contracts for a full-time evaluator who can conduct analyses using data directly from the Synthesis management information system. The system also has a strong quality improvement infrastructure.

Wraparound Milwaukee outcomes include the following:

- Decrease in daily residential treatment center (RTC) population from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days to less than 200 days per year
- Average monthly cost of \$4,200 (compared to \$7,200 for RTC, \$6,000 for juvenile detention, \$18,000 for psychiatric hospitalization)

- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- School attendance for child welfare-involved children improved from 71% of days attended to 86% days attended
- Reduction in placement disruption rates in child welfare from 65% to 30%
- 91% of families reported that they and their child were treated with respect
- 91% of families reported that staff were sensitive to their cultural, ethnic and spiritual needs

### 3. Use Care Managers to Play a Role in Accountability

Care managers play important roles in managing utilization, quality, cost, and outcomes in the sites. Some sites provide data on a regular basis to care managers to monitor their assigned children and families and to enable them to compare their practice patterns with those of other care managers. For example, Choices provides data to child and family teams, team leaders, and care managers enabling them to assess their approaches, costs, and outcomes and to make appropriate adjustments.

#### ***Providing Data to Care Managers***

- **In Arizona**, Child and Family Team facilitators must ensure that child and family teams review all outcome domains at least every six months.
- **In California**, state-level yearly reports are made available to everyone in the system.
- **In Hawaii**, care managers facilitate the child and family team process. The Coordinated Service Plan developed by the child and family team serves as the mechanism for service authorization, as all services and supports included in the plan are considered to be authorized. Care managers receive data reports on their practice, documenting services they are authorizing through the child and family team process and comparing their service utilization patterns with those of other care managers and with statewide patterns.
- **In Wraparound Milwaukee**, care coordinators and child and family teams have a responsibility to monitor outcomes and costs for individual children and families and receive real time and retrospective data through the Synthesis management information system to support this function.

#### **Choices Choices**

#### ***Providing Data to Child and Family Teams, Team Leaders, and Care Managers***

Child and family teams can review and respond to trends in service provision and cost data among the populations assigned to their team, enabling them to assess their approach more globally and plan their service strategies. The management information system (The Clinical Case Manager or TCM) helps to link process, outcome, service utilization, and cost data in a way that assists Choices to assess what services work, in what ways, for which children, and at what cost. Data reports are produced by worker and by team so that team leaders can review how workers use particular services and trends of teams. Inquiries focus on: 1) number of children in out-of-home placements, 2) types of out-of-home placements used, 3) four-month trends regarding out-of-home placements, 3) overall cost per child, and 5) mentoring costs.

#### 4. Incorporate Incentives and/or Sanctions Associated with Utilization, Quality, Cost, or Outcomes

Some sites establish incentives or sanctions associated with utilization, quality, or cost. For example, in *Arizona*, incentives are included in contracts with Regional Behavioral Health Authorities related to standards for access, functional improvement, satisfaction, consumer and family involvement, and others. In other sites, sanctions primarily involve discontinuing the participation of the provider if appropriate corrective actions are not taken in response to identified problems associated with utilization, quality, cost, or outcomes.

##### **AZ** **Arizona** **Using Incentives**

Contract requirements with the Regional Behavioral Health Authorities (RHBAs), to which incentives are attached, relate to: access standards; measurement of functional improvement; consumer and family satisfaction; coordination of care; cultural competence; and consumer and family involvement. These are also the measures used for quality improvement. The incentive pool represents 1% of the entire capitation pool. If RBHAs meet performance standards, they may receive funding from the incentive pool.

##### **Using Sanctions**

- **In Hawaii**, referrals to a provider agency may be stopped if there are concerns about utilization, quality or cost. Typically, data highlighting problems with utilization, quality, or cost are shared with the agency and corrective action is requested. In some cases, a provider agency may be closed for continued substandard performance. First, admissions at the agency could be closed for a period of time; then, children could be moved to other providers and the agency closed temporarily; then, the agency could be closed permanently. This has occurred once in a six month period prior to the site visit.
- **In Vermont**, the process of agency reviews results in a rating that indicates quality performance, may identify areas for improvement that are detailed in a corrective action plan, or begin a process to cut the agency from the contractor network because it failed to meet standards.
- **In Choices**, sanctions available for providers involve primarily declining to make new referrals based on feedback from families and staff. Providers receive feedback from the community resource manager.
- **In Wraparound Milwaukee**, the system has an incentive to pay attention to cost and quality issues among providers, since the bulk of its funding is risk-based (either capitation or case rates). Providers are paid on a fee-for-service basis, and Wraparound Milwaukee monitors their performance closely. If a given provider is not providing the types of services or quality care the system wants, it will not be used. Wraparound Milwaukee believes that its use of a “qualified provider panel,” from which providers are paid on a fee-for-service basis if they are used, gives it the mechanism to better manage quality and cost of care provided.

## 5. Finance the Development of Electronic Medical Records

Electronic medical records will eventually be required through federal mandate, and most of the sites have begun preparing. In Cuyahoga County, Wraparound Milwaukee, and Choices, the electronic management information system includes electronic clinical records.

### **Developing Electronic Medical Records:**

- **In Michigan**, the Community Mental Health Service Providers are moving in this direction and it is covered by their budgets.
- **In California**, this is in early developmental stages but the effort will be strengthened by Mental Health Services Act (MHSA - Prop 63) funds, which include information technology (IT) as a major component. The IT systems in the counties reportedly need major upgrading, and the state is working with them. The state's plan for the technology component of MHSA was in late developmental stages at the time of the site visit. In anticipation of MHSA technology support funding, **Contra Costa** was in discussions with behavioral health IT vendors for web-based systems that would include a personal health record and tie cost to outcome by client.
- **Wraparound Milwaukee and Cuyahoga County, Ohio** use *Synthesis*, a system developed by Wraparound Milwaukee, as their system of care information technology systems, database web application case management, and service authorization system. *Synthesis* includes electronic clinical records. (Cuyahoga County leases the system from Milwaukee.) Wraparound Milwaukee integrates behavioral health and social services information into the electronic record, as well as information on the child's primary care provider and use of medications prescribed by primary care providers.
- **Choices** uses *The Clinical Manager (TCM)* as its IT system, which incorporates an electronic clinical record.
- **In Colorado**, some initial work is being undertaken on electronic medical records. Community mental health centers are participating in this.

## B. Utilize Performance-Based or Outcomes-Based Contracting

Performance or outcomes-based contracting is not utilized widely in the sites studied. However, some of the sites are working towards implementing performance-based contracting through a "score card," pay for performance contracts, or financial incentives for fidelity to practice models and/or positive outcomes.

### **AZ** Arizona

#### **Using Performance Standards in Contracts with Regional Behavioral Health Authorities**

The **Arizona** Department of Health Services, Division of Behavioral Health Services' (ADHS/ BHS) contracts with Regional Behavioral Health Authorities (RBHAs) include penalties for poor performance, but the state is interested in pay for performance arrangements in the future. The state does allot extra funds to plans that meet access to care standards. Value Options (VO) reported that they met the standards to receive the extra funding and then had to decide how to allocate the monies to providers in the network. None of the providers met all standards, but some met several of them so VO decided to give funds to all of the providers who met at least one standard.

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VO also indicated that it has implemented both incentives and sanctions for Comprehensive Service Providers (i.e. core service agencies) related to access for the Latino population. Providers can receive up to \$10,000 a month depending on their meeting certain access standards (e.g., \$2500 per month if reaching 40% of Latino eligibles).

### **Choices** Choices

#### ***Developing a “Score Card” for Provider Outcomes***

Choices is working to develop a “score card”, which would provide indicators for providers regarding the outcomes of particular services by provider. One aspect of this would involve tying Child and Adolescent Needs and Strengths (CANS) data to providers to assess whether behavior is improving with a given service, such as individual therapy.

### **NY** Erie County, New York

#### ***Piloting Performance-Based Contracts***

The **Erie County** Department of Mental Health (ECDMH) is piloting performance-based contracts with two of the wraparound agencies that include fiscal incentives for fidelity to practice and emphasize the relationship between practice and outcomes. There are milestones in the contracts for implementation of an administrative infrastructure and implementation of a real-time evaluation process that measures fidelity to practice and the connection between practice and outcomes. Provider agencies are assessed to determine whether they achieve one of four levels:

1. Below Level 1: Not fully reimbursed for expenditures
2. Level 1: Fully reimbursed for expenditures/actual costs
3. Level 2: Reimbursed up to full contracted amount, even if expenditures are lower than anticipated
4. Level 3: Performance premium of \$30,000.

The methodology for the incentive system does not include the funds for care managers or wraparound dollars. The domains that are assessed to determine level achievement are: 1) Management oversight structures and practice, such as management of capacity through recruitment and retention of staff, a data reporting infrastructure, successful engagement of children and families, the integration of training and coaching into the agency culture, 2) Effective practice, as measured by fidelity to standards for evidence-based and/or emerging local practices and supervisory relationships that promote effective practice, 3) Short term, interval events that indicate achievement of service outcome milestones, and 4) Achievement of long-term family and system outcomes.

## **CO** Project BLOOM, Colorado *Providing Incentive Payment for Positive Outcomes*

Community mental health centers (CMHCs) will soon be able to get incentive payments for meeting outcomes. The Division of Mental Health will be re-instituting a program that pays for positive outcomes such as receiving high marks on consumer satisfaction surveys. Regarding the Project BLOOM systems of care, there are contractual obligations for the communities for number of enrolled children, maintaining a local governance council, and specific tasks, etc., though there are no specific financial incentives or penalties associated with these.

## **C. Finance a Leadership, Policy, and Management Infrastructure for Systems of Care**

### **Financing strategies include:**

- 1. Finance a focal point for policy and management of systems of care**
- 2. Finance leadership development for system of care leaders**

### **1. Finance a Focal Point for Policy and Management of Systems of Care**

To ensure accountability, a designated focal point of responsibility for policy and management of systems of care is essential along with committed and skilled leaders. All of the sites finance some type of focal point for management of the system of care. In most cases, this involves a state-level focal point of responsibility, as well as a local agency or entity for local system management.

#### ***Financing a Focal Point for System of Care Management at State and Local Levels***

- **In Arizona**, state-level leadership is provided by the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) in partnership with its sister agencies. Leadership for the system at the county level in Maricopa County, at the time of the site visit, was provided by Value Options and the Family Involvement Center, working with other child-serving systems and stakeholders on an ad hoc basis.
- **In California**, there is a Child and Adolescent Chief at the state level. There is also a Mental Health Oversight and Accountability Commission for the Mental Health Services Act, which includes multiple stakeholders and individuals with system of care expertise. In Contra Costa, the County Administrator's office has a Director of the Office of Children's Services, county mental health has a children's system of care manager, and there is a System of Care Policy Council.

- **In Hawaii**, the Child and Adolescent Mental Health Division (CAMHD), within the Department of Health, serves as the focal point for system management for the public children’s mental health system. A governing body oversees all policy making and management related to systems of care; this body does not involve cross-agency representation. The governing body is comprised of the CAMHD Division Chief, Medical Director, Performance Manager, the Executive Director of Hawaii Families As Allies, Branch Chiefs, and the Provider Relations Specialist. An interagency quality assurance committee plays a monitoring and advisory role to the system. Community interagency quality assurance committees play a similar role at the local level. Leaders for systems of care are positions within CAMHD at the state level, and within Family Guidance Centers at the local level.
- **In New Jersey**, the Division of Child Behavioral Health Services, Department of Children and Families, is the focal point for management of the statewide system of care initiative. The state contracts with an Administrative Services Organization-type entity (the Contracted Systems Administrator) to coordinate, authorize, and track care for all children entering the system and to assist in managing the system of care and improving quality. Locally, a Care Management Organization (CMO) in each region provides care coordination and accountability for children with intensive service needs. The CMO partners with a Family Support Organization (FSO) whose role is to provide education, support, and advocacy for caregivers and family members of children with serious emotional problems.
- **In Vermont**, the Department of Mental Health is the lead state office for children’s mental health. Vermont’s system of care legislation (Act 264) identifies agency partners and their responsibilities, as well as the fundamental partnership with families. A lead agency (Designated Agency) in each region is responsible for local management and operation. These structures are supported by local interagency teams and a state interagency team, which provide technical assistance and consultation on individual cases and a vehicle for problem-solving on systemic issues. The system level work is enhanced by a state level Advisory Board whose nine members are appointed by the Governor to advise the stakeholders on annual priority recommendations to further improve the interagency system of care.
- **In Central Nebraska**, when a federal grant was received in 1997, the system of care was based on an existing infrastructure. Region 3 Behavioral Health Services (BHS) is the entity with a statutory responsibility to administer behavioral health services in Central Nebraska. This greatly enhanced the chances for sustainability. A cooperative agreement exists between the Nebraska Department of Health and Human Services (DHHS) and Region 3 BHS to create an individualized system of care for children in state custody who have extensive behavioral health needs. Within Central Nebraska, the system of care is managed as a “three legged stool” including Region 3 BHS (behavioral health) the Nebraska DHHS Central Service Area Office of Protection and Safety (child welfare) and Families CARE (family support and advocacy organization).
- **Choices** is the focal point for system management for high-need sub-populations of youth in Marion County, Indiana; Hamilton County, Ohio; and Montgomery County and Baltimore City, Maryland.
- **The Cuyahoga** Tapestry System of Care (CTSOC) office serves as a public Administrative Services Organization (ASO) and reports to the Deputy County Administrator for Health and Human Services and the county’s interagency Funders Group. The ASO manages multiple braided funding streams and provides planning, communications, and operational and fiscal management for the system of care. The ASO manages Continuous Quality Improvement (CQI) and tracks outcomes (through Synthesis, a web-based management information system). The

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ASO handles care authorization and enrollment for the 900 children and families enrolled by the ASO and assigned to Care Coordination Partnerships. The ASO is funded with SAMHSA grant funds and county levy funds.

- **In Erie County**, New York, the focal point for system management is the management team of Family Voices Network (FVN) of Erie County, the local SAMHSA-funded system of care. Currently, FVN is situated within the Erie County Department of Mental Health, and the department also provides administrative support services for the system of care, including the management of the flexible funding pool. The long-range plan is that the local point of accountability will be a contracted Administrative Services Organization (ASO), rather than a county-based agency.
- **For Project BLOOM, Colorado**, at the state level, the focal point for system of care policy and management is within the Division of Mental Health. At the local level, the focal point for system of care management is within the four community mental health centers. These are both funded with SAMHSA system of care grant resources. In addition, the Early Childhood Mental Health Councils in each community fulfill policy and advisory functions for the systems of care.
- **Milwaukee County** has created a focal point for the management of high-need youth through Wraparound Milwaukee, which is financed through multiple cross-system funding streams.

## 2. Finance Leadership Development For System Of Care Leaders

The sites have implemented strategies to finance leadership development and training for systems of care, such as leadership academies, leadership development programs, training, and coaching.

### *Financing Leadership Development and Training*

- **Arizona** has used tobacco monies, discretionary and formula grant funds to support leadership development across stakeholder groups (such as children's systems, families, providers, and behavioral health organizations) in support of the JK settlement agreement.
- **In California**, the California Institute of Mental Health sponsors a Leadership Academy for county mental health directors, which includes a focus on systems of care. The Children's System of Care program also made dollars available to the counties for leadership development activities (but is now ended). Contra Costa used federal SOC grant monies for leadership development activities.
- **In Hawaii**, a ten-week leadership development program was sponsored by the state agency within the last year, focusing on both the theory and practice of leadership. The comprehensive leadership development course involved a full day of participation each week for the duration of the program. Families from Hawaii Families As Allies participated along with mental health system representatives, including branch chiefs and one level below branch chiefs throughout the agency. The goal was to create "empowered teams" throughout the system.
- **In Central Nebraska**, the state has assumed a leadership role in developing systems of care across the six regions in Nebraska. Once Region 3 began to show positive results and a cost savings, its system of care leaders were encouraged by the Nebraska Department of Health and Human Services (DHHS) to provide technical assistance to other regions/service areas to

implement similar systems. Five of the six regions in Nebraska now have a care coordination system in place for children with significant mental health needs. One of the regions (Lincoln) also benefited from a federal system of care grant. However, the other three regions have implemented systems of care with some additional DHHS funding and the technical assistance provided with Region 3 cost savings.

- **Choices** has been a key technical assistance resource for other areas of Indiana working to develop systems of care. In 2002, Choices was officially funded by the state as a technical assistance center (Technical Assistance Center for Systems of Care and Evidence-Based Practice) to provide assistance in developing systems of care throughout the state. The training and coaching provided through this center has been an important strategy for developing knowledgeable and skilled leaders for systems of care in Indiana.
- **Wraparound Milwaukee**, through its funding of Families United, training of providers, and staff development in system of care principles and operations, is creating leaders among stakeholder groups, for example among care coordinators, family members, judges, and others.

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## Chapter 8. Financing Behavioral Health Services to Children in the Child Welfare System and Their Families

Research and experience have confirmed that children and youth involved with the child welfare system and their families have high rates of behavioral health disorders. Medicaid's costs for children in foster care are disproportionately large in comparison to this population's enrollment in Medicaid. Children in care often change placements frequently. Collaborative relationships among systems — child welfare, mental health, Medicaid, etc. — and strategies for meeting the behavioral health needs of this population are critical for systems of care. The recently enacted Fostering Connections to Success and Increasing Adoptions Act requires state child welfare systems and state Medicaid agencies to develop plans to ensure appropriate and coordinated attention is paid to the health, behavioral health and dental needs of children in child welfare. Coordination of care, establishment of a medical/clinical home, attention to overuse of psychotropic medications, inclusion of an array of appropriate home and community-based supports, timely screening and assessment, inclusion of appropriate providers and of effective practices for this population, a focus on the family as well as the child, incorporation of risk-adjusted rates within managed care systems serving this population — these are all strategies that various of the sites in the study sample are employing to better serve this population.

The sites have implemented a number of strategies to provide behavioral health services to children involved with the child welfare system and their families, recognizing this population as a particularly high-risk group. **Table 8.1** summarizes the strategies used by the sites in the second wave of site visits. Specific financing strategies used in some sites follow. For example, children and families involved with the child welfare system are a target population in Erie County; the mental health system has liaisons in child welfare offices in **Contra Costa County**, and **Project BLOOM** co-locates staff with child welfare.

<b>Strategies</b>	<b>CA</b>	<b>MI</b>	<b>Cuyahoga</b>	<b>Erie</b>	<b>Project BLOOM</b>
Financing community-based behavioral health services and supports for children and families in their own homes that might prevent them from entering more restrictive placements	X	X	X	X	
Financing behavioral health services and supports for family members of children who are in custody, especially if the family members are not eligible for Medicaid	X		X	X	X
Funding behavioral health screening and comprehensive assessments for children in custody	X	X		X	X
Funding behavioral health services for children in custody who do not meet medical necessity criteria	X		X	X	X
Funding to meet the mental health needs of very young children	X		X		X
Financing child and family team service planning meetings	X		X	X	X
Funding individualized and culturally appropriate services that are targeted to meet the needs of each child	X		X	X	X
Funding the expansion of the pool of qualified behavioral health providers	X		X		X
Funding the development, provision, and monitoring of evidence-based practices for children in the child welfare system	X			X	X
Continuing to fund behavioral health services for children and families after reunification	X		X		X
Funding behavioral health services for youth who age out of the foster care system and into the adult system	X				
Funding for co-location of child welfare and mental health staff	X		X	X	X
Funding family-run organizations to provide child/family services and supports	X			X	X

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**CO** **Project BLOOM, Colorado**  
***Core Services Funding and Co-Location of Early Childhood  
Mental Health Staff***

Core services funding from the child welfare system is used to finance services that keep children in their homes and avoid out-of-home placements. In Mesa County, **Project BLOOM** staff are housed in the child welfare agency.

***Financing Mental Health Liaisons in Child Welfare Regions, Screening, Team Decision Making, Wraparound, and Mobile Response Team***

In **Contra Costa**, county mental health partners with the child welfare system in a number of ways. County mental health has mental health liaisons in each of the three child welfare regions (which correspond to the three mental health regions), who participate in Team Decision Making (TDM) meetings and with Neighborhood Collaboratives. The Annie E. Casey Foundation is partnering with the Stuart Foundation in California to develop Family-to-Family Neighborhood Collaboratives, and Contra Costa is an anchor site (i.e., a site that has shown sufficient promise to provide technical assistance to others in the state). Neighborhood Collaboratives are financed with foundation grants, SB 163 wraparound funds, Aid to Families with Dependent Children-Foster Care (AFDC-FC), and federal Promoting Safe and Stable Families (PSSF) funds. The federal Children's Bureau system of care grant (which piggybacked on the SAMHSA system of care grant) expanded use of TDM and parent partners in child welfare and has had a focus on transition-age youth. Overall, this grant has targeted children in multiple placements, transition age youth, and "dual-jacketed" youth (i.e., involved in child welfare and juvenile justice). Expansion of TDM has been facilitated by foundation grants (Stuart Foundation, Hedge Fund), federal system of care grants, and some county general revenue. The county started TDM with children 0-5 and African American families coming to the attention of CPS, then expanded to children with five or more placements, then to those exiting placements, then across the board to all children/families involved in child welfare. If all grants end, the county will try to sustain TDM with county general revenue and some PSSF funding, but TDM is principally grant-funded at present. At the time of the site visit, the county had applied for a federal Children's Bureau grant to improve case planning, and TDM was built into that proposal as well. There is some coordination between TDM and Wraparound facilitated by the mental health liaisons, although at the time of the site visit, TDM was being used primarily with very young children, and mental health wraparound teams were working mainly with older children and youth. Wraparound is seen as one of several resources available to TDMs, along with family preservation, domestic violence programs, substance abuse programs, and case management.

County mental health screens every child entering non relative placement; screenings are financed with Medi-Cal and county child welfare general revenue for non Medi-Cal children. County mental health has worked with child welfare to develop the same network of behavioral health providers for both Medi-Cal and non Medi-Cal children, paying the same rates. Child welfare also pays for a clerk at the county mental health agency to handle credentialing of new providers for child welfare; Medi-Cal administrative case management dollars cover some of these administrative costs. Of the 3,000 children seen through county mental health clinics, 65% are children in child welfare.

Contra Costa also is one of 11 sites in the state to implement differential response working with at risk families coming to the attention of Child Protective Services (CPS). This includes a network of 14 community based (indigenous) providers and faith-based organizations that can provide choice to

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families, case management and supportive services. Forty percent of CPS referrals of families who are not removed are diverted to this differential response system, and, in addition, emergency response workers can refer to this system, which incorporates a strengths-based approach.

In addition, the county received state Department of Social Services (DSS) kinship dollars to link children with behavioral health problems and low school performance in relative care to a case manager, who can link children to wraparound.

Child welfare services are financed with 70% state and 30% county dollars. California has a IV-E waiver, but Contra Costa is not a waiver county. The Title IV-E waiver is a capped allocation model in which funds go to the county in the form of a block grant based on an agreed upon special funding methodology developed by the state, Federal Children's Bureau and participating counties. Contra Costa felt it was too much risk since the county population is growing.

Senate Bill 163 is a major child welfare wraparound initiative in the state, with the authorizing legislation based on work done by Santa Clara County and Eastfield Ming Quong Children and Family Services. It targets wraparound alternatives for children in child welfare who are in or at risk for residential treatment. In Contra Costa, county mental health partners with child welfare to serve about 40 youth using SB 163 funds, which are AFDC-FC monies. Most services provided to children in the initiative are financed using Medi-Cal; AFDC-FC is paying for non Medi-Cal services such as respite and for non Medi-Cal children. In Contra Costa, SB 163 has provided a mechanism to pay for wraparound approaches that were in danger of being cut with the ending of the federal system of care grant. Counties can keep savings generated by reducing lengths of stay or admissions to residential treatment centers (RTCs). Contra Costa saved \$800,000 in 06-07, with three-quarters of the youth served staying in the community. To move it further, the county noted that it needs to recruit more therapeutic foster parents. The county has an Interagency Placement Resource Expansion Team to develop both high-end and low-end services.

The federal Children's Bureau system of care grant, which targets transition age youth exiting foster care or who are at risk of homelessness, also is a partnership between child welfare and mental health (and juvenile justice). The Mental Health Services Act -MHSA (Prop 63) Community Services and Supports funding also will support transition-age youth programming.

County mental health also operates a Mobile Response Team that is helpful to child welfare workers at the front end, as well as for runaway youth. The foster families' newsletter has carried articles about mobile response, and county mental health has oriented child welfare workers to its use.

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**NY** **Erie, County, NY**

***Establishing Child Welfare Population as a Target Population***

Family Voices Network, the local system of care in **Erie County**, is jointly managed by the county departments of child welfare, juvenile justice, and mental health. Children and families within the child welfare system represent a target population for Family Voices Network, and are screened by the Family Services Team. Consistent with standardized risk criteria, these children are eligible for mental health and other services within the system of care service continuum.

**OH** **Cuyahoga County, Ohio**

***Bringing System of Care and Family-to-Family Together***

The Department of Child and Family Services (DCFS, the child welfare agency) has been a driving force and active partner in developing and expanding the system of care in **Cuyahoga County** and in bringing together two related reforms – system of care and Family-to-Family (F2F). F2F is a national initiative sponsored by the Annie E. Casey Foundation that partners child welfare systems with neighborhood collaboratives to wrap supports around families that are at risk for involvement with child welfare. Cuyahoga County is one of the oldest Family-to-Family sites in the country, with 14 Neighborhood Collaboratives. In addition, Cuyahoga County has two federal system of care grants, one from the federal Center for Mental Health Services and one from the Center for Substance Abuse Treatment. DCFS in partnership with the county mental health agency and Board of County Commissioners provided the leadership to bring these related reforms together to strengthen the overall system of care approach and increase access to community- and neighborhood-based behavioral health services for children in child welfare, as well as other populations of children. The director of DCFS has redirected child welfare funds (especially the more flexible local funds) to assist in making this happen.

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## Chapter 9. Financing Strategies For Tribal Systems of Care

Financing systems of care and their component services is extremely challenging in tribal communities. The complications that arise when attempting to coordinate across multiple jurisdictions (for example, multiple states, tribal governments, and the federal government) are complex and can be difficult to navigate. Systems of care in tribal communities may differ significantly from other systems of care due to the complexities of managing multiple jurisdictions and bureaucracies. Strong leadership coupled with political, financing, and policy finesse are critical factors in developing and implementing effective financing strategies for tribal systems of care. In addition, system of care development in tribal communities often occurs in the context of historical trauma and in the context of a non-Western view of mental health challenges and treatment. Thus, application of the system of care approach must be adapted to consider the conceptualization of illness and traditional healing approaches found in Native American communities. These differences in philosophical approach to treatment and healing require cross-system education and negotiation to create or adapt funding mechanisms that support tribal services. Effective financing strategies in tribal communities involve understanding, trust, and collaboration among states and tribes, as well as coordination of federal, state, local, and tribal financing streams. A report from a recent study devoted exclusively to tribal financing — *Exploratory Description of Financing and Sustainability in American Indian and Alaska Native System of Care Communities* — is now available on-line at the Technical Assistance Partnership website ([www.tapartnership.org](http://www.tapartnership.org)).

### Tribal Financing and Sustainability Study

Fifteen American Indian and Alaska Native communities were funded between 1994 and 2006 through the Comprehensive Community Mental Health Services for Children and Their Families Program to develop tribal systems of care (see **Table 9.1**). They represent the broad diversity of tribal people and reflect rural reservations, urban Indian communities, and Alaska Native villages. Their cultures and languages are as diverse as their geographic locations and political environments, both of which have impacted the development of their systems of care. Half of the tribal communities were previous recipients of three-year Circles of Care planning grants which provided financial and technical assistance to plan a culturally respectful mental health system of care.

<b>System of Care</b>	<b>Population of Focus</b>	<b>State</b>	<b>Funding Period</b>
<b><i>Graduated Communities</i></b>			
Restoration of K'e: The Navajo Nation Child Mental Health Project	Navajo Nation	New Mexico	1994–1999
Sacred Child Project	North Dakota Tribes	North Dakota	1997–2003
Kmihqitahasultipon ("We Remember") Project	Passamaquoddy Nation	Maine	1997–2003
With Eagles' Wings Project	Northern Arapaho and Shoshone Tribes	Wyoming	1998–2004
M'no Bmaadzid Endaad Program	Sault Ste. Marie Tribe of Chippewa Indians and Bay Mills Tribe of Chippewa Indians	Michigan	1998–2004
People Working Together Project	Yup'ik Eskimo and Athabaskan Indians	Alaska	1999–2005
Nagi Kicopi—Calling the Spirit Back Project	Oglala Sioux Tribe	South Dakota	1999–2005
Ak-O-Nes Project	Northern California Tribes	California	2000–2006
<b><i>Currently Funded Communities (at the time of the study)</i></b>			
Choctaw Nation CARES Project	Choctaw Nation	Oklahoma	2002–2008
"Ch'eghutsen" A System of Care	Alaska Native Community	Alaska	2002–2008
Urban Trails Project	Urban Indian Community	California	2003–2009
The Po'Ka Project	Blackfeet Nation	Montana	2005–2011
Tiwahe Wakan (Families as Sacred)	Yankton Sioux Tribe	South Dakota	2005–2011
Seven Generations System of Care	Urban Indian Community	California	2005–2011
Sewa Uusim Systems of Care	Pascua Yaqui Tribe	Arizona	2006–2012

An exploratory study was conducted between July 2007 and January 2008 in order to examine the unique financing opportunities and challenges of tribal systems of care in relation to sustainability. Telephone discussions were conducted with the tribal system of care project directors and fiscal managers in all 15 communities, and additional discussions were held with tribal governing boards and state funding source representatives during site visits at five locations. Thematic areas discussed included perspectives on sustainability; the economic, social, and political environment; infrastructure; services; and funding.

The study revealed that the financing of tribal systems of care is particularly complicated. This is due to many factors, including the lack of financial resources in remote tribal communities, the impact of tribal-state history on the willingness and ability to pursue financial partnerships, and the potential funding sources' lack of knowledge about the advantages of working with tribes. Additional factors add to this complexity: the meaning of federally recognized tribes' sovereign status as it relates to financing; the role of tribal self determination; the history of confusing policies guiding support for tribal services; the financing options of tribes that are recognized by states, but lack federal recognition; and the unique financial situation faced by urban Indian communities. These challenges become especially difficult to resolve when there is a lack of cross-cultural and cross-system problem solving.

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Findings from the study included specific recommendations in several categories: 1) planning for financial sustainability, 2) interaction with political entities (including state and county funding sources), 3) developing sustainable culture-based services, 4) role of technology and billing infrastructures, 5) use of tribal data in the development of data-driven financing strategies, 6) assessing and mobilizing available funding including coordination with tribal business plans, 7) developing cost formulas that reflect the true cost of culture-based and rural service delivery, 8) understanding state Medicaid plans and tribal financing implications, and 9) strategies for developing win-win financing partnerships with state, county, and private funding resources.

The exploratory study found that relationships between tribal and state governments are critical for financing tribal services to children and their families. In addition, a review of data from the national evaluation of the federal Community Mental Health Services for Children and Their Families program (the federal “system of care program”) identified issues related to the sustainability of tribal systems of care, with a specific focus on fiscal sustainability. Each of these areas is discussed below.

## Relationships between Tribal and State Governments

The tribal study included discussions with state funding sources during site visits. The state funding source representatives stressed the importance of creating and strengthening relationships between state and tribal representatives, and characterized these relationships as being mutually beneficial. Although historical tribal-state relationships present unique challenges to overcome, state representatives revealed a wealth of structured processes available to develop partnerships with tribes. Each state representative had a formal tribal consultation policy in place within their department. In addition, states can use the Block Grants of the Social Security Act (Title IV-E funding), which include a formal process for working with tribes that can serve as a model for tribal-state relations. Some states have created a senior-level tribal liaison who serves as a direct conduit to tribal leadership, and some have created tribal-state boards for relationship building that are institutionalized through legislation.

State governments also have a range of methods available to them to support tribal services and tribal financial sustainability. Some of the approaches used by states to increase partnerships with tribes and tribal organizations include: committing state and/or county time and resources to developing and problem-solving tribal financing strategies; developing flow charts on how tribes and tribal organizations can access state and/or county funding; developing tribal sections in state billing manuals; developing a state agency accreditation process for tribes as an alternative to the costly national accreditation services; providing Title IV-E administrative funds to tribes to support the development of five-year plans; reviewing the licensing and provider certification portions of state mental health plans and removing barriers for tribal services; and collaborating with tribes to develop alternatives for provider qualifications that not only build on paraprofessional resources but also address tribal workforce shortages and tribal career advancement opportunities. Several state representatives discussed alternatives to state laws that act as barriers to financing tribal services. If the law cannot be changed, state managers can promote regulatory changes instead, including recommending the certification of alternative providers, lessening the paperwork for documenting service provision, and reaching parity in payment for mental health and substance abuse services.

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## Sustainability of Tribal Systems of Care

The national evaluation of the federal system of care program assessed the ability of federally funded sites to sustain key components of their systems of care beyond the grant period. Data were collected from sites that had received funding between 1999 and 2003. Six tribal communities were included in the sample, and data were collected regarding sustainability, with a specific focus on financing.

Regarding specific financing strategies used to sustain their systems of care, tribal respondents reported that the most frequently used strategy was “operating more efficiently through cutting costs” (83% of respondents). “Leveraging funding sources” and “increasing the ability to obtain Medicaid reimbursement for services” were the next most frequently reported strategies (75% and 67% of respondents, respectively). Although these strategies were reported as being used most frequently, respondents did not rate them as highly effective.

“Administrative claiming” (that is, using available child welfare and Medicaid funds to cover administrative costs), “de-categorizing funding streams,” “charging fees for services,” and “creating new revenue by pursuing an activity unrelated to the system of care mission” (e.g., rental income, charging parking fees, enterprises) were the financing strategies rated as least used and also as least effective. These four specific financing strategies rated as least used and least effective by respondents seem to reflect the tribal priority of focusing human resources on the immediate provision of services in high-need communities rather than on building the infrastructure needed to sustain the provision of services.

In addition to financing strategies, results indicated that “cultivating strong interagency relationships” and “involving stakeholders” were strategies reportedly used by most of the tribal communities. The selection of these strategies seems to reflect tribal cultural norms of community engagement and relationship building. In contrast, making policy or regulatory changes that support the system of care approach was reported as being one of the least-often used strategies for sustainability (47.6% of respondents), and it was rated as no more than moderately effective by 77% of the respondents. This stands in contrast to the state representatives who mentioned policy or regulatory changes as strategies to increase resources for tribal communities.

The finding that infusing the system of care approach into the broader system was one of the lesser used sustainability strategies could reflect the struggle of some tribal communities to broadly infuse the system of care philosophy throughout the full range of tribal health service and economic development programs. Another general sustainability strategy reported as being used by relatively few respondents – “using evaluation/accountability results” – could reflect tribal mistrust of data and the lack of tribal-developed data systems.

## Implications

Implications of findings from the Exploratory Description of Financing and Sustainability in American Indian and Alaska Native Communities include next steps such as the need for financing-focused training and technical assistance; broader dissemination of tribal best practices; and increased peer-to-peer learning opportunities on a range of topics such as accreditation, tribal-state agreements, Medicaid negotiations, third-party billing systems, and other tribal financing-related topics.

## Specific Tribal-State Examples

**Arizona** and **Bethel, Alaska**, provide examples of effective financing strategies for tribal systems of care from the study sample. In Arizona, Tribal Regional Behavioral Health Authorities (TRBHAs) operate within the state’s managed care system. In Bethel, Alaska, a tribal organization (the Yukon Kuskokwim Health Corporation – YKHC) administers a comprehensive health care delivery system for the 56 rural communities comprising this area. Both approaches involve problem solving and collaboration between the state and tribes, coupled with coordination of multiple federal, state, local, and tribal financing streams.

### **AZ** Arizona

#### ***Using Tribal Regional Behavioral Health Authorities (TRBHAs)***

At the time of the FIN site visit, only two of Arizona’s 21 tribes were opting to provide their own behavioral health services as Tribal Regional Behavioral Health Authorities (TRBHAs) through the Arizona Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) managed care system. The TRBHAs may serve any tribal member; that is, they are not restricted by geography, which is one of the reasons that the TRBHAs are not capitated. Tribal members also may receive services through the Indian Health Service (IHS). Native Americans who live off the reservation, and are tribal members of a community that operates a TRBHA, can choose to enroll in the community’s TRBHA or enroll in the regular RBHA in their geographic area.

Those tribes that have chosen to set up a TRBHA have typically had the infrastructure and diversified revenue (including, for example, revenue from the gaming industry) and were already making significant investments in tribal health care. They have seen the TRBHA as a means to maximize their ability to use Medicaid and improve access to and coordination of services. Health and behavioral health services provided by Indian-run facilities are eligible for 100% federal Medicaid contribution, known as the federal pass-through program. In effect, Arizona tribes must deal with a bifurcated Medicaid system — the 1115 waiver in the state *and* the federal pass-through for tribes. The federal pass-through benefit is more traditional than the array of services covered under the 1115 waiver, but the federal rate ends up being higher than state rates, and there is 100% federal funding. For example, case management is not a covered service by the pass-through, but it can be paid for through the 1115 waiver. The TRBHA will “pick and choose” whether to bill the federal pass-through or the 1115 waiver. The federal pass-through can only be used for services directly provided by the tribe. For example, there are over 60 providers – adult and child – in the Gila River TRBHA network. Only those that are Gila River community providers can be billed through the federal pass-through, while the off-reservation providers are billed through the 1115 waiver. The Gila River TRBHA is actively working to integrate TRBHA and IHS behavioral health services to achieve more coordinated, comprehensive services and maximize Medicaid financing.

An issue for the TRBHAs is that, unlike the non-tribal RBHAs, they must use the state rates for services, since they are not capitated. (The RBHAs may establish their own rates within broader state guidelines.) At the time of the site visit, the RBHA in Maricopa County was paying higher rates for some services in short supply, such as therapeutic foster care, which was aggravating the Gila River TRBHA’s ability to expand capacity within some of the same geographic area since they could not pay as high a rate. This issue also affects service utilization, since home and community-based alternatives are in short supply and, thus, more restrictive services may end up being used. One example provided by the Gila River TRBHA was the rate paid for sub-acute care. The Maricopa County RBHA’s rate

was \$595/day, compared to the state rate of \$240/day. Sympathetic to the TRBHA's argument, and cognizant of the changing market, the rate was increased by the state to \$700/day; and ADHS/BHS was looking at increasing the state rate for therapeutic foster care as well.

The Gila River TRBHA indicated that it started with the basics – crisis services and counseling services in home and at schools. It is now developing more home and community-based services, such as family support. It is recruiting family members as peer support providers (paying \$9-13/ hour). Since job opportunities are very scarce on the reservation, they feel they will not have difficulty recruiting and adequate workforce.

The Indian Health Service (IHS) behavioral health clinic was not part of the TRBHA network at the time of the site visit. The IHS clinic was described as having long waiting lists and as generating referrals for services to the TRBHA. The TRBHA would like to move the IHS BH clinic into its network, which would also allow it to manage the quality of care. IHS operates a drug and alcohol program at Gila River, and the tribe is building a residential substance abuse program. Those services have also been outside of the TRBHA network; but since the site visit, the TRBHA has made progress. The IHS behavioral health clinic is in the process now of enrolling in the TRBHA network, and the residential substance abuse facility will become part of the TRBHA network once the facility is open.)

Since the time of the site visit, the TRBHA has moved more to a "staff model" of owning its own services and clinical staff, rather than exclusively contracting out for services. For example, it has implemented an intensive outpatient program (IOP) for women recovering from methamphetamine use that it operates directly. The TRBHA has also hired its own in-home therapist so that it does not have to rely solely on county providers; as well as an aftercare therapist for substance abuse services. Most of this new service capacity has been made possible with funding from the state (ADHS/BHS). The TRBHA believes that this approach will accomplish several goals: a higher degree of culturally relevant care; easier access to care; greater continuity and coordination of care between therapists and case managers (who are employed by the TRBHA); and, generation of revenue from the staff model (i.e., through Medicaid billings) that can be used to expand services. The state does prior authorization for all out of home placements for the TRBHA, but the TRBHA indicated that this is not an adversarial process.

### **AK** Bethel, Alaska *Using a Tribal Health Corporation*

At the state level, Alaska has been a national leader in collaboration among tribes, tribal health programs, and the Alaska Department of Health and Social Services. Collaboration between the state and tribes is demonstrated by joint work around Medicaid and SCHIP. The Medicaid authority has dedicated staff at the state level for administration of the Tribal Health System. Further, a Tribal/State Medicaid Task Force was implemented that, among other functions, was responsible for the design of Alaska's SCHIP program and development of a uniform set of billing policies. Agreements are in place between Medicaid and Tribal Authorities, and a Medicaid Tribal billing manual has been produced.

A reorganization of services to Tribes (referred to as "638 compacting") began in the mid-1960s and resulted in the 1994 All Alaska Tribal Compact. Under the statewide compact, the Tribal organizations took over the operations of health care facilities formerly operated by the Indian Health Service (IHS), as well as certain centralized services. Each of the Tribal organizations negotiates a

funding agreement with the IHS annually, although federal IHS funding is available for only 40% of the need for health care services. Today, 12 regional Tribal health corporations administer seven hospitals, 28 clinics, and 176 village clinics. The Tribal corporations are the sole health and behavioral health provider in many areas of the state, and the state is dependent on these Tribal health providers to offer a variety of programs and services funded with state grants. The Tribal corporations are funded by state grants, Medicaid, Indian Health Service, federal and private grants. One hundred per cent of costs for dental, health, mental health, and substance abuse services for Medicaid eligible individuals are reimbursed to the Tribes by Medicaid funds through the federal pass-through program for eligible services. Medicaid administration and training related costs are matched at the 50% federal match level.

Operational costs of the rural health care corporations are high, due to the challenges of offering services in vast remote areas, difficult transportation challenges, harsh weather, and constant workforce shortages.

Health and behavioral health services in the southwestern region of Alaska are the responsibility of the Yukon Kuskokwim Health Corporation (YKHC), a tribal organization which administers a comprehensive health care delivery system for the 56 rural communities in southwest Alaska. YKHC has put extensive resources into the building and development of village health clinics offering both health and behavioral health services. In addition to the community health clinics in the villages, the system includes four sub-regional clinics, a regional hospital, dental services, behavioral health services including substance abuse counseling and treatment, health promotion and disease prevention programs, and environmental health services. The programmatic approach for children's mental health services was adopted with a federal system of care grant and is comprised of core teams of licensed mental health professionals and behavioral health aides that are responsible for service delivery in the rural villages of the Delta area. Behavioral health aides are indigenous practitioners specially trained to provide behavioral health services to individuals living in the widely scattered villages in Alaska. The core service teams were developed and organized around the existing four sub-regional clinics and currently include an itinerant clinician and behavioral health aides. The core teams are financed by Alaska's Medicaid authority in the Department of Health and Human Services, Tribes, Tribal health programs, and the Indian Health Service.

To illustrate, the clinician who covers Upper Kalskag lives in Aniak (the sub-regional clinic location) and is responsible for 15 villages and 5 behavioral health aides. She flies from village to village three to four days a week. The clinician's supervisor is located in Bethel. The child protection office for Upper Kalskag is also located in Aniak. The child welfare system has a worker who gets involved with families where child abuse has occurred and makes referrals to the behavioral health aide for both children and parents. The referral is often for substance abuse issues, but the clinician and behavioral health aide look at the whole person and family. The clinician has a small caseload in Aniak. Typically, she sees people once in the villages as part of the assessment to make a diagnosis; she is not the primary counselor except when there are complex family issues. Services are provided by behavioral health aides receiving supervision from the clinician.

Emergency on-call mental health services are operated from Bethel. Emergency Services clinicians and complex care managers are available 24 hours a day to respond to behavioral health crises. The clinicians are master's level with both experience and specialized training in mental health and substance abuse treatment. The complex care managers are experienced counselors whose specialty area is working in the field of substance abuse treatment. If there is a crisis, the crisis clinician in Bethel talks with the behavioral health aide about what to do. The crisis counselor sometimes provides crisis intervention counseling by telephone.

Behavioral health aides typically have strong partnerships with schools. Coordination of funding at the village level primarily takes place with the school district. For example, a request for a neurological assessment may be on a child's individual education plan (IEP). If the request is on the IEP, the school district pays for the assessment. If the request is not on the IEP, the request would be referred to a physician and a medical facility; Medicaid would likely be the payer.

YKHC sponsors several projects that are designed to offer and support culturally competent services and supports. The Family Spirit Project, for example, is a collaborative effort of the communities of the Yukon-Kuskokwim region, the Department of Health and Social Services, Division of Behavioral Health, Office of Children's Services, the YKHC, and others. Emphasizing traditional family life and values, the collaboration builds a community development model to strengthen families so that children will be safer in their homes. Parents who could lose their parental rights due to abuse and neglect of their children are encouraged to enter substance abuse treatment in a culturally appropriate and supportive manner. These parents are a priority population for YKHC's substance abuse treatment services. A Community Holistic Development Program conducts presentations on grief processes, youth conferences, healing circles, "Spirit Camps," and other health promotion activities. This program integrates the cultural, traditional, and spiritual values of the people in partnership with other family-based counseling services.

YKHC experiences significant challenges in several areas including: capacity and administrative infrastructure, such as billing, business technology, and data; staff recruitment and retention; enrollment and re-enrollment of children into Medicaid; transportation to and from the villages; and a lack of service capacity. However, a number of strategies have been implemented to address some of these challenges. For example, YKHC finances the education of behavioral health aides as a strategy for recruiting and retaining qualified staff to provide children's behavioral health services. The Tribal Community Health Aide Certification Board finalized certification standards for Behavioral Health Aides in 2008. These standards have been under development for a number of years, and will create a career ladder for behavioral health professionals to serve rural populations. Certification of the first groups of Behavioral Health Aides will occur in the summer of 2009. The training curriculum is also under development; YKHC as a health aide training center has developed the first three modules of the BHA training program. The health aide training process is comprised of training components provided in the classroom with a period of mentored practice in which the trainee is assisted in achieving required competencies before moving on to the next level of training. YKHC pays staff while they are being trained and covers the cost of transportation, housing and meals while they attend sessions in the classroom. YKHC installed communication lines and equipment to facilitate telehealth services to 48 villages in December of 2008. Live interaction through technology permits assessment, diagnostic and treatment services from distant clinicians, supervision and mentoring of behavioral health aides, and opportunities for staff meetings and group training.

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# Chapter 10. Conclusion

## Technical Assistance Needs

The sites reported a number of common technical assistance needs to help them to further develop and improve their financing strategies for their systems of care. The technical assistance deemed necessary for progress includes the following:

- **Medicaid** — Several of the sites indicated that technical assistance related to Medicaid is an increasingly urgent need. Technical assistance is needed to understand the Medicaid program, avoid pitfalls with the program in the current economic climate, and improve documentation in preparation for federal audits. Concern was raised by several sites about the potential impact of federal audits, as well as administrative rulings requiring unbundling of program costs, on their systems of care and behavioral health services that are funded by Medicaid. For most sites, Medicaid financing is the foundation of their systems. Partnership and technical assistance from the state Medicaid agency was considered essential by a number of the sites.
- **Developing a Comprehensive, Cross-Agency Financing Plan** — Although many of the sites studied have numerous effective financing strategies in place, they identified a need for assistance in developing a comprehensive financing plan that takes an even greater cross-agency view of financing children’s behavioral health services.
- **Pay for Performance Arrangements** — Several sites indicated a need for technical assistance on pay for performance arrangements or performance-based contracting.
- **Determining Costs and Setting Rates** — Several sites expressed a need for technical assistance on identification of “true” (interagency) costs for various subpopulations of children and for establishing appropriate case rates for different populations.
- **Financing Early Childhood Systems of Care** — Many of the financing strategies for systems of care focus on redirection of funds from deep-end placements, a concept that does not work for the early childhood population. Technical assistance on financing early childhood systems of care is needed, including a focus on Part C is needed, as well as establishing future cost offset justifications.
- **Translating Financing Strategies to Individual States and Communities** — Sites indicated that there is a continuing need for technical assistance related to financing both because of turn-over and because of the complexity and frequent changes in financing streams. Some of the issues noted by sites included: most rational funding approaches for systems of care, opportunities for revenue maximization, how to develop braided funding for multi-system involved children and their families, how to develop reimbursement processes to reduce hindrances to access to care, feasibility of expanding the 1915 (a) Medicaid waiver, how to maximize flexible funds, how to use Medicaid for child welfare population, and others.

## Contextual, Environmental, and Fiscal Factors that Will Influence Financing of Systems of Care

The sites identified a number of factors that are likely to influence financing policies and strategies for their systems of care. These include a host of contextual, environmental, fiscal, and other factors that may impact the sites in the future:

- Leadership changes at the state level and resultant changes in policy that leave system of care reforms vulnerable
- Shifts in Medicaid financing federally
- Increased scrutiny of states' use of Medicaid
- End of lawsuit and accompanying court monitoring and potential difficulty in maintaining state's financial and policy investment in the children's mental health system
- Reductions in or loss of federal grant funding, e.g., federal system of care grants
- Shrinking psychiatric services and qualified providers
- Need to better link health care and behavioral health care
- Emerging new populations (e.g., child and adolescents with co-occurring conditions, such as autism) and burgeoning existing populations (juvenile corrections) that increasingly compete for scarce resources

In the second wave of the study, additional attention was devoted to further identifying and understanding the impact of contextual, environmental, fiscal, and other factors on their financing policies and strategies for systems of care. The three most common factors cited were:

- Changes in state budget or fiscal policy
- Changes in state or local leadership
- Changes in Medicaid policy

The potential impact of state budget crises and deficits resulting in deep cuts in budgets and programs was a major concern, along with leadership changes that can change policy and direction. Changes in the federal Medicaid program that restrict the use of Medicaid for system of care services and supports also were a source of concern. Given the current economic crisis, these concerns become even more prominent.

**Table 10.1** summarizes the factors identified by the sites in the second wave as potentially affecting the financing of their systems of care. Explanations of the specific factors that will affect financing in the individual sites follow.

**Table 10.1**  
**Contextual Changes that May Affect Future Financing**

Contextual Changes	CA	MI	Cuyahoga	Erie	Project BLOOM, Colorado
Deficit Reduction Act of 2005		X			
Changes in Medicaid Policy	X	X	X	X	
Changes in SCHIP Policy		X			
Financial Audits	X		X		
Changes in mental health or substance abuse block grants		X	X		X
Law suits and consent decrees	X				
Changes in child welfare policy or funding	X		X	X	
Changes in TANF funding			X		
Changes in state budget or fiscal policy	X	X	X	X	X
Changes in state or local leadership	X	X	X	X	X
Changes in funding for family organizations			X		
Changes in leadership of family organizations					X
Changes in status of federal grants	X			X	X
Changes in managed care vendors or managed care organizations			X		X
Changes in state laws on mental health parity					X

### **CA** California

There is concern that with the economy as it is, realignment dollars (sales tax and vehicle licensure fees) may shrink; there is also concern about rate of growth in Medi-Cal and whether the state will increase the county share of Medi-Cal costs. **Contra Costa** expressed concern about the pending federal rehabilitation option regulations, which, if implemented, would “cut the system in half”.

Specific factors influencing future financing include:

- Lawsuits are expected to change Medicaid policy.
- As a result of audits, the state had to unbundle day treatment rates. The county reports that as a result, a child can only receive day treatment and no other services on a given day, which creates problems for residential treatment centers (RTCs) that have day treatment programs. There is concern that RTC providers will try to increase rates for other aspects of their programs to compensate for this. At the time of the site visit, the California Association of Group Homes was in the process of filing suit against the state Department of Social Services for higher room and board rates.

- EPSDT lawsuits led to co-financing of Medi-Cal services by counties (formerly was all federal and state financed). This also led to the incorporation of Therapeutic Behavioral Services, and with Katie A. (more recent lawsuit), there also is negotiation about adding wraparound and therapeutic foster care, but there are no dollars attached for this expansion. At the time of the site visit, the lower court had found for the plaintiffs, but the higher court had overturned the decision on the grounds that it was an unrealistic scope, that wraparound and therapeutic foster care needed better definition. The plaintiffs will go back to court on this issue; there has been a 133% growth in EPSDT since the lawsuits.
- Changes in child welfare policy/funding are anticipated due to capping group home rates and SB 163 wraparound legislation.
- The elimination of Children’s System of Care (CSOC) funding is expected to have an impact in the future. The state indicated that data were not there to show children got better in systems of care, but advocates report that the CSOC funding was eliminated due to larger state deficits and because of the rationale that children had broader access to EPSDT due to lawsuits. At the time of the site visit, there also was talk of cuts in Mentally Ill Offenders Criminal Reduction Act (MIOCR) funding. At the same time, state corrections was dismantling juvenile corrections beds and moving these youth to county responsibility with dollars attached to them. Also, at the time of the visit, there was a push to have AB 3632 (special ed) dollars stay with school districts and not go to mental health. Contra Costa noted that would lead to two systems, with county mental health serving Medi-Cal and school districts serving non Medi-Cal – except in counties like Contra Costa where there are strong partnerships between the schools and mental health. (In Contra Costa, 17 mental health staff and half of its case managers are financed with AB 3632 funds). Parent advocates reportedly oppose the change because they fear that the schools will under-identify children to keep costs down. School districts have supported the change where there are not good relationships with mental health.
- Contra Costa noted that they lost a “friendly” county supervisor to the State Assembly.
- The loss of federal system of care grant funds makes it difficult to sustain some initiatives at full capacity.

### **OH** Cuyahoga County, Ohio

**Cuyahoga** Tapestry System of Care’s (CTSOC) sustainability will undoubtedly be affected by the county’s current fiscal condition. Facing a declining population, a shrinking tax base and sitting as one of the areas most ravaged by the foreclosure crisis, Cuyahoga County’s Office of Budget and Management is projecting significant deficits in the foreseeable future.

The county’s health and human services (HHS) levy funds make up a major portion of CTSOC fiscal support. Over the past year, the county’s Office of HHS began a strategic process to set priorities and parameters by which HHS levy monies will be spent. This effort was spurred by a similar process undertaken by the local United Way, which resulted in major changes in service funding. With its emphasis on cross-system collaboration, real-time program and data fiscal tracking and outcome measurement, however, CTSOC is poised to serve as a model for the type of HHS priorities expected to be set.

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At the same time, all offices under the authority of the Board of County Commissioners have embarked on an Integrated Policy Development (IPD) process which will likely result in fundamental changes in the way the county does business in the future. IPD is reviewing all county operations, mission, goals, performance measures, budgets, personnel, etc., asking serious questions about how to conduct business in a way that is responsive to citizen needs and fiscally accountable. The IPD process is asking departments to look for ways to optimize and leverage resources, promote synergy, and incorporate incentives for performance. CTSOC is already modeling some of the behaviors demanded by the IPD process.

### **NY** Erie County, New York

There are a number of environmental, fiscal, and political factors that influence whether the financing strategies and structures that have been implemented in **Erie County** will be disseminated to other counties in **New York State**. First, the mental health leadership in other counties and at the state level would need to revise their vision about the role of mental health in a system of care and move towards a viewpoint of mental health as a support for the other systems (child welfare, schools, juvenile justice). In addition, there would need to be movement towards purchasing services that produce outcomes. Second, “size matters.” Smaller counties that only serve 40–50 children cannot sustain the infrastructure that is needed (i.e., management information systems, a vendor system, quality assurance). Rather than having 67 local governmental units that function as the county-based mental health authority, there would be a need for regional authorities. At the local level, counties would need to make the decision that the local governmental unit (LGU) will not be an operator of services.

### **CO** Project BLOOM, Colorado

Changes that will have an impact on financing for early childhood mental health services include:

- **Block Grant** — There is additional money in the block grant due to a change in the formula, and there may be an opportunity to use that for early childhood mental health services
- **State Budget** — There was an amendment that restricted growth in the budget and extra monies had to be returned to the taxpayers. This amendment specifies that government can only be grown by a certain percent regardless of population growth and growth in economy. Therefore, extra tax dollars were to be returned to taxpayers. In 2005, Referendum C allowed the government to keep the tax revenue that was over and above the allowed rate of growth. This made it possible for the state to fund the Early Childhood Mental Health Specialists in each CMHC
- **Leadership Changes** — This has had a positive impact since the new administration is much more supportive of mental health than the previous administration. There is now increased visibility and increased policy level support.
- **Change in Family Organization Leadership** — The new director of the statewide family organization was formerly the director of the CHP+ (SCHIP) program and brings new knowledge and expertise to the role.

- **End of Federal System of Care Grant**—The termination of the federal system of care grant’s funding period will result in a less concentrated focus on early childhood mental health at the state level. A number of the positions at the state and community levels will be in jeopardy with the loss of federal funding.
- **Changes in Medicaid**—The change in responsibility for the Medicaid mental health managed care program from the Division of Mental Health to the Department of Health Care Policy and Financing has resulted in less mental health expertise in oversight of the system.
- **Health Care Reform**—The “208” Health Care Reform Commission is interested in integrating health care and mental health care. This may have an impact in the future.

## Areas for Additional Study

As the information derived from this study on effective financing strategies for systems of care was synthesized, the study team identified a number of areas requiring additional exploration in the future. Some of these areas represent aspects of financing that have not been sufficiently addressed by states and regional/local areas in the study sample. Others have emerged more recently as new directions, subsequent to the delineation of areas that would be explored through this study. Each is discussed briefly below.

### I. Under-Addressed Financing Strategies Requiring Further Attention

The following represent areas in which only half or fewer than half of the sites in the study sample were engaged in specific financing strategies.

#### Identifying Behavioral Health Expenditures and Utilization Across Child-Serving Systems

Only 42% of sites in the study had engaged in a financing analysis that identified behavioral health expenditures and utilization across child-serving systems. This type of analysis is critical to ascertain, from a systemic standpoint, how much is being spent, by which systems, on which populations of children, on which types of services and with what types of dollars (e.g., Medicaid, general revenue, grant). This type of analysis also can identify disparities in service use by demographics, diagnosis, region, etc.; opportunities for redirection where dollars are being spent on restrictive levels of care; and clarify service shortage areas. It is a critical analysis for a state or community to undertake to get a clear sense of what is actually occurring in the delivery system.

#### Developing and Updating a Strategic Financing Plan

Only a third of the study sample has developed a specific strategic financing plan for its system of care, and even fewer (17%) review and update plans on an ongoing basis if they do have one. Without having a specific and dynamic strategic financing plan in place, state, local, and tribal systems of care are even more vulnerable to the sea changes that characterize public financing for children’s systems.

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## **Utilizing Resources from State and Local Health, Substance Abuse, and Developmental Disabilities Systems**

Although all of the sites in the study draw on multiple funding streams from multiple state, local, and tribal agencies, few of them utilize funds from public health, substance abuse, and developmental disabilities systems. This may be because these systems have few resources available to support children and adolescents with behavioral health challenges, or they may be primarily adult-focused. However, given the prevalence of co-occurring substance abuse and mental health problems, and of developmental disabilities and mental health challenges, and the importance of integrating primary and specialty mental health care, this is a finding that warrants additional attention.

## **Generating New Revenue through Taxpayer Referenda or Local Tax Levies**

A quarter of the sites were using local levies for systems of care or were benefitting from taxpayer referenda that created a new source of funding for mental health services. In general, however, and particularly during periods of economic hardship, generation of new revenue sources is not a widely used strategy, leaving redirection of existing resources and/or maximizing federal match dollars as more viable strategies, which virtually all of the sites are employing.

## **Coordinating Funding Across Child-Serving Systems**

Half of the sites systematically coordinate funding across child-serving systems, including tracking cost shifting. Given that multiple systems finance child behavioral health services, with multiple opportunities for duplication and fragmentation, the need for states, tribes and localities to better coordinate funding strategies across systems remains high.

## **Coordinating Procurement of Services Across Child-Serving Systems**

Half of the sites had put in place strategies to coordinate procurement of services across systems, such as developing uniform rates for services and a common contracting process or creation of a purchasing collaborative, in effect, by using case rates from multiple systems to purchase services. These strategies can create efficiencies in procurement and help to support more consistent and coordinated service delivery practices.

## **Maximizing Medicaid in Lieu of 100% General Revenue and Generating Sufficient Medicaid Match**

While all of the sites in the sample try to maximize use of Medicaid in various ways, only a third of the sites in the sample systematically look for ways to utilize Medicaid in lieu of spending 100% state or local general revenue for Medicaid-eligible services and children. While a higher percentage (42%) report good success in generating Medicaid match, these findings also indicate opportunity for greater use of Medicaid, particularly for home and community-based services on which other systems, such as child welfare, spend significant amounts of general revenue dollars and are primarily serving Medicaid-eligible children.

## **Maximizing Title IV-E and Special Education Funding**

Only a quarter of the sites engage in strategies to maximize use of Title IV-E, and only 17% maximize use of special education funding within the system of care. These are both federal entitlement dollars that could be used more creatively in systems of care. States and localities may need technical assistance, including peer technical assistance, on maximizing use of these dollars.

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## **Financing Strategies to Support Early Childhood Mental Health Services**

Forty-two to 33% of the sites in the study are implementing specific financing strategies related to early childhood mental health services. This is an area requiring further attention and one in which states and localities could benefit from the experience of sites that have a customized focus on infants and young children.

## **Financing Behavioral Health Screens Through EPSDT**

Only 25% of the study sample reportedly incorporates financing strategies to ensure that behavioral health screens occur through the Early Periodic Screening, Diagnosis, and Treatment program in Medicaid. Given that behavioral health screens should be occurring through EPSDT and that certain subpopulations of Medicaid-eligible children, such as those in foster care, are at particularly high risk for behavioral health problems, this is an area that requires further attention.

## **Financing Linkages with Primary Care Providers**

Only 42% of the study sites are financing strategies to better integrate primary and behavioral health care. This is an issue that will be very much in the forefront in national health care reform discussions, with greater attention to integrated approaches.

## **Strategies to Prevent Relinquishment of Custody to Access Services**

While all of the sites employ strategies to finance services and supports for non-Medicaid, non-SCHIP eligible families to help them access behavioral health services, funding is not sufficient in most cases, and families may still be faced with having to obtain services through the child welfare or juvenile justice system with a requirement for relinquishing custody to do so. Only a third of the study sample use specific strategies, such as legislation to allow voluntary access to services without relinquishing custody. The issue of an adequate benefit package for families who have children with serious disorders, who exhaust their private coverage or who are uninsured, is a critical one in the national health care reform debate, as well as for states.

## **Strategies to Encourage Private Insurers to Cover a Broad Service Array**

Only a quarter of the study sites are working with private insurers to cover a broader service array for children with behavioral health challenges. This, too, is a critical issue for national health care reform and very much related to the issue of families' having to relinquish custody to access services through child welfare or juvenile justice.

## **Financing Support for Analyzing Utilization and Expenditures by Racially and Culturally Diverse Children**

Only 42% of the sites finance analysis of behavioral health utilization and expenditures by racially and culturally diverse children. National research (as well as given state studies) point to the disparities in access to behavioral health services by racially and culturally diverse children and the disproportionality in their use of more restrictive services. It is difficult to finance specific strategies to reduce disparities and disproportionality without analyzing one's own state or local data (as the following finding corroborates.)

## **Financing Strategies to Reduce Racial Disparities**

Although half of the study sites finance outreach to culturally diverse populations, only a third are employing specific financing strategies to reduce racial disparities. This is a critical national issue that requires greater attention.

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### **Financing Strategies to Reduce Geographic Disparities**

Only a third of the sites are utilizing specific strategies to reduce geographic disparities in access to children's behavioral health services. The lack of services in rural and frontier communities has been well documented. There remains a compelling need for specific financing approaches to reduce geographic disparities.

### **Financing the Use of Technology to Reduce Disparities**

Half the states are using various telemedicine and related technology approaches in behavioral health care, though not necessarily targeted to children and adolescents. The use of technology to expand service access can be expected to grow and warrants further attention.

### **Payment Rates and Policies to Incentivize Recruitment and Retention of Staff**

Only 25% of study sites were employing specific financing strategies to recruit and retain staff for systems of care. Staff recruitment and retention problems in children's behavioral health are well documented. This, too, is a critical national issue that requires greater attention.

### **Financing Cost Benefit, Cost Savings, and Cost Avoidance Analyses**

Half of the study sites have financed cost benefit, cost savings or cost avoidance analyses. Given that there is intense competition for limited children's services and healthcare dollars, and given the focus of national health care reform on effective practices, including cost-effective practices, it is imperative that more comprehensive data are available supporting the value of systems of care.

### **Incorporating Financial Incentives, Sanctions, and Performance Based-Contracting**

Half of the sites utilize financial incentives or sanctions tied to utilization, cost, or outcomes, but only a third of the study sites utilize some type of performance-based contracting, though virtually all expressed interest in doing so. This is an area where technical assistance, including peer technical assistance, would be helpful.

## **II. New Directions Requiring Further Study**

The following represent areas that were not a specific focus of the current study, but which have emerged as important aspects in the financing of systems of care.

### **Relationship Between State and Local Financing**

The sample of sites in the current study included both states and regional/local areas to examine the financing approaches used to support systems of care from each of these perspectives. An area that has not yet been sufficiently investigated, however, is the relationship between state and local financing. Clearly, financing policies and strategies adopted at the state level have a dramatic impact in shaping the financing approaches that can be implemented at regional and local levels. It is also likely that financing strategies designed and tested locally can influence financing policy at the state level. Given the importance of state financing to take systems of care to scale on a statewide basis, the relationship between state and local financing and how both can be leveraged to promote broader implementation of systems of care is an area of interest.

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## Financing Improvements at the Practice Level

There is no disagreement in the field that the effectiveness of interventions provided to children and their families is the major determinant of clinical and functional outcomes that are achieved within systems of care. The disconnect between the growing evidence base on effective interventions and the approaches used by providers in the field has become increasingly apparent and underscores the need to improve practice. The study identified some financing strategies used by the sites to improve practice, however, additional study is needed to explore more fully the types of financing strategies that can be applied to provide incentives for improved practice. These may include enhanced payment rates for improved practice; financing the creation of specialty provider networks; and financing the adoption and provision of evidence-based, evidence-informed, and promising practices including finding development, training, coaching, fidelity monitoring, and other activities involved in improving practice.

## Financing Youth Partnerships

The sites have implemented various strategies to finance partnerships with families and family organizations. However, the importance of partnerships with youth and youth organizations has more recently been recognized, and many states and communities are strengthening their efforts to support partnerships with youth. Future studies should explore effective financing strategies for partnerships with youth that support and strengthen youth-guided systems of care.

## Financing a Public Health Approach

Attention has increasingly been devoted to exploring the concept of a public health approach to children's mental health services – an approach that would provide services to youth with serious emotional disorders and their families, as well as address mental health promotion activities and the prevention efforts directed at high-risk populations. Such an approach also would track incidence of child mental health problems. The implications for financing of adopting a public health approach warrants investigation, given the movement in this direction and the recognition that public mental health systems cannot limit their attention to only those children with already diagnosed disorders.

## Financing Workforce Development and Improvement Efforts

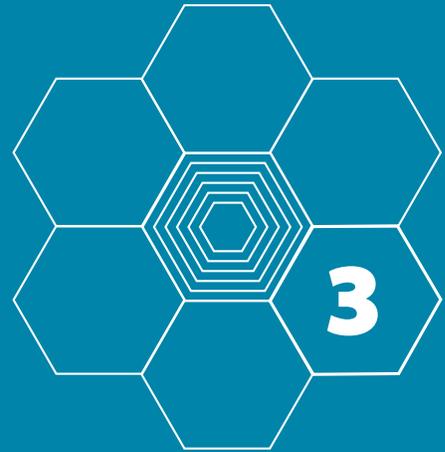
Systems of care will not be developed or sustained without a workforce that is prepared to work with the system of care philosophy and approach. Some of the sites have implemented financing strategies to better prepare the workforce. Additional study in this area is needed to identify financing approaches that can support workforce development activities, including pre-service and in-service training, recruitment and retention of qualified staff, and incentivizing providers to deliver home and community-based services and evidence-informed interventions.

## Financing Children's Behavioral Health Services Within the Context of National Health Care Reform

National health care reform obviously has major implications for financing child behavioral health services. As options are debated related to coverage, quality and efficiency particularly for high utilizing populations, use of electronic health records, the role of Medicaid and other publicly financed plans, and the like, there is a need to ensure that the unique financing issues related to children's behavioral health care are part of the equation.



The Research and  
Training Center for  
Children's Mental Health



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