RTC Study 3
Financing Structures and Strategies to Support Effective Systems of Care

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# Effective Strategies to Finance a Broad Array of Services and Supports

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

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

The study of effective financing strategies for systems of care uses a participatory action research approach, involving a continuous dialogue with key users on study methods, findings, and products. The study methodology is based on a multiple case study design; data collection and analysis includes 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*[1] — that addresses seven important areas to assist service systems or sites (states, tribes, territories, regions, counties, cities, communities, or organizations) to develop comprehensive and strategic financing plans for systems of care:

1. Identifying spending and utilization patterns
2. Realigning funding streams and structures
3. Financing appropriate services and supports
4. Financing to support family and youth partnerships
5. Financing to improve cultural and linguistic competence and reduce disparities in care
6. Financing to improve the workforce and provider network
7. Financing for accountability

The critical financing strategies also 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 in 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 the first wave of site visits and interviews.

[1]This publication is available on-line at: **http://rtckids.fmhi.usf.edu/study03.cfm**

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The sample included four states and four regional or local areas:

- **Arizona and Maricopa County**: 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
- **Hawaii**: 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
- **New Jersey**: A behavioral health carve out utilizing a statewide Administrative Services Organization and locally-based Care Management Organizations and Family Support Organizations
- **Vermont**: A statewide mental health system managed by the Department of Mental Health utilizing legislatively-mandated state and local interagency teams and designated provider agencies
- **Bethel, Alaska**: 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
- **Central Nebraska**: 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
- **Choices, Inc**: A nonprofit, community care management organization operating in Marion County, Indiana; Hamilton County, Ohio; Montgomery County, Maryland; 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
- **Wraparound Milwaukee**: A behavioral health population carve-out, operated by the Milwaukee County, Wisconsin 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

Site visits were conducted to Arizona, Hawaii, Vermont, Bethel, and Central Nebraska and involved in-depth interviews with key stakeholders about the various financing approaches in use. 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 in each of the sites were reviewed and analyzed by the study team.

This issue brief presents the results of the first wave of site visits with respect to financing strategies to support a broad range of services and supports. It is intended as a technical assistance document to assist stakeholders to identify strategies and approaches that might be implemented or adapted in their own states and communities.

# Financing an Extensive Array of Services and Supports

By definition, systems of care include a comprehensive array of services and supports that are made available 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 sites studied cover an extensive array of services and use a number of strategies to fund them, including: using resources from multiple systems, expanding the services covered under Medicaid, using multiple options under the Medicaid program, using diverse funding streams in addition to Medicaid, redirecting resources from deep-end services to home and community-based services, blending funds, sharing the costs of services across systems, and investing in service capacity development. Each of these financing strategies is discussed.

## Expanding the Array of Covered Services

The study examined coverage of an extensive list of services and supports, shown on **Table 1**. The states and communities in the sample reported covering virtually all of the services on this list with few exceptions. These sites intentionally expanded the array of services and supports that they cover in order to ensure the availability of a broad array of services and supports to children and youth with emotional disorders and their families.

**Table 1.**
**Array of Services and Supports Examined**

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

Beyond the services listed above, most of the sites also cover additional services and supports. Some examples of additional services covered include the following:

- **Arizona** — Supported employment, peer support, traditional healing, flexible funds
- **Hawaii** — Respite homes, respite therapeutic foster care, independent living services, intensive outpatient services for youth with co-occurring mental health and substance abuse disorders, treatment/service planning, parent skills training, peer support, ancillary support services
- **Vermont** — Family and individual education, consultation, and training; skills training and social support; peer support and advocacy; emergency/hospital diversion beds
- **Central Nebraska** — After school and summer programs, substance abuse prevention, youth development, supported independent living, family care partners, mentor services
- **Choices** — Mentor services, supported independent living, team meetings, camp, discretionary (flexible funds)

The service array covered by Choices in each of its service sites (Marion County [Indianapolis], Indiana; Hamilton County [Cincinnati], Ohio; and Montgomery County and Baltimore City, Maryland) provides an example of the wide range of services and supports covered by the sites studied, as shown on **Table 2**.

**Table 2.**
**Choices' Service Array**

| Behavioral Health | Psychiatric | Mentor | Placement |
|---|---|---|---|
| • Behavior management<br>• Crisis intervention<br>• Day treatment<br>• Evaluation<br>• Family assessment<br>• Family preservation<br>• Family therapy<br>• Group therapy<br>• Individual therapy<br>• Parenting/family skills training<br>• Substance abuse therapy (individual and group) | • Assessment<br>• Medication follow up/psychiatric review<br>• Nursing services | • Community case management/case aide<br>• Clinical mentor<br>• Educational mentor<br>• Life coach/ independent living skills mentor<br>• Parent and family mentor<br>• Recreational/social mentor<br>• Supported work environment<br>• Tutor<br>• Community supervision<br>• Intensive supervision | • Acute psychiatric hospitalization<br>• Foster care – non therapeutic<br>• Therapeutic foster care<br>• Group home care<br>• Relative placement<br>• Residential treatment<br>• Shelter care<br>• Crisis residential<br>• Supported independent living |
| **Respite** | **Service Coordination** | **Discretionary Activities** | **Other** |
| • Respite<br>• Crisis respite (daily or hourly)<br>• Planned respite (daily or hourly)<br>• Residential respite<br>• Service Coordination<br>• Case management | • Case management<br>• Service coordination<br>• Intensive case management | • Auto repair<br>• Childcare/supervision<br>• Clothing<br>• Education<br>• Furnishings/ appliances<br>• Housing (rent, security)<br>• Medical<br>• Monitoring equipment<br>• Paid roommate<br>• Supplies/groceries<br>• Utilities<br>• Incentives | • Camp<br>• Team meeting<br>• Consultation<br>• Guardian ad litem<br>• Transportation<br>• Interpretation |

## Using Resources from Multiple Systems

One financing strategy used by the sites studied involves utilizing resources from multiple child-serving systems to finance the array of 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 health systems are included in the financing mix less frequently, but are included in some of the sites. **Table 3** shows the extensive use of cross-system funding to contribute to financing a broad array of services and supports.

**Table 3. Use of Multiple System Resources**

| Source | Arizona | Hawaii | Vermont | Central Nebraska | Choices | Wraparound Milwaukee | New Jersey |
|---|---|---|---|---|---|---|---|
| Mental Health | X | X | X | X | X | X | |
| Medicaid | X | X | X | X | X | X | |
| Child Welfare | X | X | X | X | X | X | |
| Juvenile Justice | X | X | X | X | X | X | |
| Education | X | X | X | X | X | X | |
| Substance Abuse | X | | | X | | | |
| Developmental Disability | X | X | | | X | X | |
| Health | | | X | | | | |

## Expanding Medicaid Coverage

Although resources from multiple child-serving systems are used to finance services, Medicaid is a significant, if not primary, financing stream for services in most of the sites studied. In most cases, state Medicaid plans were amended to add new covered services and/or to change service definitions to expand coverage to a broader array of services and supports.

Arizona, Hawaii, New Jersey, Vermont, and Alaska are examples of states that have included an extensive list of services in their state Medicaid plans, such as respite, family and peer support, supported employment, therapeutic foster care, one-to-one personal care, skills training, intensive in-home services, and many others – including Native healing services in Alaska.

In Arizona, for example, the state Medicaid agency contracts with the Arizona Department of Health Services (ADHS), Division of Behavioral Health Services (DBHS), to manage a behavioral health carve-out. In connection with the settlement of a lawsuit (JK Settlement Agreement), the behavioral health and Medicaid agencies expanded the services covered under Medicaid and revised licensure rules and rates. Though the Medicaid benefit was fairly traditional previously, the state expanded coverage to a broad array of services and supports by either adding new covered services (such as sub-acute step down, respite, case management, peer and family support, supported employment, and therapeutic foster care) or by changing definitions for already covered services. The state added a new provider type — community service agencies — to provide a range of support and rehabilitation services. The state also removed limitations on place of services so that services can be provided in any location and increased the rates for care provided in out-of-office settings in order to change practice.

In Hawaii, through a Memorandum of Understanding (MOU) with the Medicaid agency, the Child and Adolescent Mental Health Division (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. Operation as the prepaid health plan for Medicaid eligible youth began in 2002. The state modified its state Medicaid plan to add the broad array of services provided through the CAMHD system of care. CAMHD's efforts have included identifying services to be added to the Medicaid plan; proposing definitions, rates, and credentialing requirements; and identifying fiscal incentives for the state.

The services included under Arizona's Medicaid benefit are displayed on **Table 4**, and under Hawaii's rehabilitation benefit on **Table 5**. 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**. More information about Hawaii can be found at **http://www.hawaii.gov/health/mental-health/camhd/index.html**.

**Table 4**
**Arizona's Medicaid Benefit**

- 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

**Table 5**
**Hawaii's Medicaid Rehab Benefit**

**Covered Services**

- Crisis management
- Crisis residential services
- Biopsychosocial rehabilitative programs
- Intensive family intervention
- Therapeutic living supports
- Therapeutic foster care supports
- Intensive outpatient hospital services (partial hospitalization)
- Assertive community treatment

**Approval Pending**

- Peer supports
- Parent skills training
- Intensive outpatient independent living (co-occurring)
- Community hospital crisis stabilization
- Multi-Systemic Therapy (MST)
- Multidimensional treatment foster care (MTFC)
- Functional family therapy (FFT)
- Community-based clinical detox

## Using Multiple Medicaid Options and Strategies

The states 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, EPSDT, and several different types of waivers. **Table 5** demonstrates the extensive use of multiple Medicaid options.

**Table 6.**
**Use of Multiple Medicaid Options**

| Source | Arizona | Hawaii | Vermont | Central Nebraska | New Jersey |
|---|---|---|---|---|---|
| Clinic Option | X | X | X | X | X |
| Rehab Option | X | X | X | X | X |
| Targeted Case Management | | X | X | X | X |
| Psych Under 21 | X | X | X | X | X |
| EPSDT | X | X | X | X | X |
| Katie Becket (TEFRA) | | | X | X | |
| H & CB Waiver (1915C) | DD* | DD* | X** | DD* | DD* |
| 1915b Waiver | | | X | | |
| 1115 Waiver | X | X | X | | |
| Family of One | X | | | | |

* DD = Developmental Disabilities
** X=For Children with Developmental Disabilities and Serious Emotional Disturbances

The local communities studied also implemented various strategies to maximize the use of Medicaid to finance care. Choices uses several strategies to maximize the use of Medicaid to finance service delivery. In both Indiana and Ohio, the case rates used by Choices do not necessarily finance all of the services included in the child and family plan of care. 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 Choices.

In this way, Medicaid can be billed for care coordination services under the Rehabilitation Option. In Ohio, Choices became a Medicaid provider, thereby allowing care coordination staff employed by Choices to receive Medicaid reimbursement under Ohio's Medicaid regulations.

Wraparound Milwaukee utilizes Medicaid dollars through a capitation from the state Medicaid agency of $1,589 per member per month (pm/pm). These resources are blended with case rate financing from the child welfare and juvenile justice systems to finance the broad array of services and supports provided to youth and their families.

## Using Diverse Funding Streams in Addition to Medicaid

The states and communities studied identify and utilize diverse funding streams in addition to Medicaid to contribute to financing systems of care and their component services. Typically, these resources are used to finance services and supports that are not covered by Medicaid and/or to pay for services for non-Medicaid eligible children. Behavioral health general revenue funds and federal mental health and substance abuse block grant dollars are the most frequent funding streams used in these sites. In addition to these dollars, resources from other child-serving systems (most frequently child welfare, juvenile justice, and education) are used either to support specific services, such as therapeutic foster care, group homes, or school-based services, or general revenue from these systems is used to increase match for Medicaid-covered services. In addition, these systems may contribute support in the form of a case rate for youth referred for services.

Hawaii provides an example of the use of diverse funding streams, including:

- **Mental health general revenue** — Funds staff, services and supports not covered by Medicaid, and payments to providers above the Medicaid rate
- **Medicaid** — through a carve out operated by CAMHD's children's mental health system
- **Block Grant** — Funds screening and assessment of children in family court, screening and assessment of children in 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 Grants** — Fund system of care development, alternatives to seclusion and restraint, data infrastructure development. A grant from the federal 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.
- **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

## Pooling or Braiding Funds

Pooling or braiding funds is a strategy used in Central Nebraska, Choices, and Wraparound Milwaukee. In Central Nebraska, a case rate created with blended funds serves as a primary funding strategy to support and sustain intensive care management and a number of services within the system of care, as well as the work of the family support organization. Funds blended in the case rate for the Integrated Care Coordination Unit (ICCU) include child welfare and juvenile services general revenue, and Title IV-E resources, as well as small amounts of other funds. The case rate for the Professional Partner Program (PPP) blends funds from state general funds and federal mental health block grant funds. Use of case rates has provided the flexibility to offer individualized care and develop new services. The case rate methodology has expanded to other areas of the state and is now used by five of the six regional behavioral health authorities in Nebraska.

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 pays the case rate for each child referred for care. Funds are provided by the child welfare, juvenile justice, and education systems, each paying the case rate for children they refer for services. (A four-tiered case rate system was recently adopted. The highest rate is $6,500 per child per month for youth likely to require residential treatment, the second tier is $4,290 for youth in or at risk for out-of-home care, the third tier is $2,780 to support community-based care, and the lowest tier is $1,565 to cover care coordination and home-based supports.) The case rates establish a fixed and predictable cost for payers and allow greater flexibility in using funds for individualized services. 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. In Ohio, 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 both in Indiana and in Ohio. The case rates cover all services and supports that are not covered by Medicaid.

Wraparound Milwaukee blends several funding streams: Medicaid dollars through a capitation from the state Medicaid agency of $1,589 per member per month (pm/pm); child welfare dollars through a case rate of $3,900 pm/pm; mental health block grant dollars; and both contract dollars and case rate dollars from the juvenile justice system. Blending of funds for youth is based on target populations of youth who would otherwise be placed in residential treatment centers or correctional facilities. The blended funds support an array of flexible, individualized services delivered through a wraparound approach. In addition, Wraparound Milwaukee bills Medicaid for services provided by its Mobile Urgent Treatment Team and other crisis services.

## Sharing Costs for Services Across Systems

Arizona, Hawaii, Vermont, Central Nebraska, and Wraparound Milwaukee provide examples of sharing costs for specific services. In Arizona, funding for therapeutic foster care, in-home services, and others is shared between the mental health and child welfare system. The mental health system in Hawaii shares costs with the child welfare, juvenile justice, and education systems for specific services, such as therapeutic foster care and mental health services in the detention facility. Vermont, Central Nebraska, and Wraparound Milwaukee also demonstrate cost sharing among partner agencies for a range of services including care coordination, Multisystemic Therapy (MST), school wraparound, family support, and crisis services.

## Redirecting Dollars from Deep-End Placements to Home and Community-Based Services

In Arizona, 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, rates were restructured to better correspond to system goals of encouraging 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 reports that in 2003, 39% of the child behavioral health budget went to 3.6% of enrolled children served in residential treatment centers and inpatient hospitals. In 2005, this had been reduced to 29%. The use of therapeutic foster care has increased significantly as an alternative to other types of out-of-home care; approximately 40% of out-of-home placements are now therapeutic foster care.

In Hawaii, 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; 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 state also has had a focused initiative on bringing children back from out-of-state placements. The initiative represents a collaboration among the mental health, education, and court systems. In 1999, there were 89 children out of state. Individualized service plans were developed child by child to bring these children back, and currently there are only six children in out-of-state placements. Attempts are made to bring children from out-of-state placements back to therapeutic foster care rather than residential treatment centers. Now, 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. 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.

New Jersey committed to move dollars from deep-end placements to community-based services by implementing its system of care reform that created entities including Care Management Organizations (CMO) in each region that serves as a locus of care management and accountability for high-need children and adolescents. The CMOs partner with Family Support Organizations in each region. Through a combination of Medicaid expansion and some new dollars, the state is developing needed service capacity, such as care management, mobile crisis response and stabilization services, and family care homes that have provided community-based alternatives to residential treatment. 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.

Vermont used its Home and Community-Based Services Medicaid waiver as one mechanism for shifting resources. Another mechanism for redirection is Vermont's Case Review Committee that assists local teams to identify, access and/or develop less restrictive alternatives to deep-end placements. The Case Review Committee reviews all requests for intensive residential placement.

In Central Nebraska, the creation of an individualized system of care for children in state custody who have extensive behavioral health needs has resulted in reduced out-of-home placements and an increased percentage of children who live in the community. The system of care reported reducing out-of-home placements from 36% in group home or residential treatment settings at enrollment to 5.4% at discharge. One of the core principles of the system of care calls for the reinvestment of cost savings to allow for more preventative, front-end, community-based services.

Similarly, the philosophy of Choices, and how its services are marketed, is built on the concept of redirecting care from deep-end placements to home and community-based services. This forms the basis for service delivery. Wraparound Milwaukee also has achieved significant reductions in the use of deep-end placements, namely in use of inpatient hospitalization, residential treatment, and juvenile corrections facilities. The wraparound approach and mobile crisis response and stabilization services are key in reducing deep-end services. Over time, inpatient average length of stay has been reduced from 70 days to 1.7 days, and utilization has declined from 5,000 days per year to 200. The average residential treatment center population has been reduced from 375 to 50. Significant cost savings per child served have been achieved by reducing use of inpatient and residential care, and improved outcomes have been achieved.

## Investing Funds to Build Home and Community-Based Service Capacity

Arizona, Hawaii, New Jersey, Vermont, Central Nebraska, and Wraparound Milwaukee have invested funds to develop home and community-based service capacity. In Arizona, for example, the behavioral health and Medicaid agencies worked in partnership to invest in expanding the availability of home and community-based services by spending increased dollars, adding new service types, and restructuring rates to encourage the provision of home and community-based services. In addition, a new type of provider (community service agencies) was created specifically to increase the availability of these services. Arizona includes state general revenue and block grant funds in the capitation given to regional behavioral health authorities, 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.

In Hawaii, capacity building and start-up funds come from the existing state budget for children's mental health. Resources from the Child and Adolescent Mental Health Division have been used to build capacity to provide services such as MST and Multi-Dimensional Treatment Foster Care. In New Jersey, state funds also have been used for capacity building and start-up resources, and in Vermont, multiple sources of funding (including state general revenue, federal grants, and foundation grants) have been used to create new service capacity, particularly for early childhood mental health services. In both Central Nebraska and Wraparound Milwaukee, savings generating by avoiding deep-end services are reinvested in the system of care to expand service capacity. Wraparound Milwaukee now 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."

# Financing Individualized, Flexible Services

The system of care philosophy and approach 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, such as incorporating flexible funds for individualized services and supports, financing staff participation in individualized service planning processes (child and family teams), and incorporating care authorization mechanisms that support individualized, flexible service delivery.

## Incorporating Flexible Funds

The sites incorporate flexible funds that can be used to pay for services and supports that are not covered by Medicaid or other sources. Arizona, Hawaii, New Jersey, and Vermont designate funds for this purpose. Typically, child and family teams can access these funds to provide these ancillary services and supports as needed. For example, in Arizona, the behavioral health system distributes about $850,000 in discrete flexible funding to the regional behavioral health authorities (RHBAs), using general revenue and block grant dollars. RBHAs have flexibility

in how they spend these dollars for individual children. In Hawaii, flexible funds are provided by the state's Child and Adolescent Mental Health Division 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. The CMOs have the ability to use flexible funds to purchase individualized services and supports. 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, based on decisions by the individual child and family teams and local lead agencies.

In other sites, such as Central Nebraska and Wraparound Milwaukee, the managed care financing approaches make the resources within the system inherently flexible and available to meet individualized needs. Choices also uses its case rate financing to provide flexible funds. Eleven categories of flexible funds have been established that allow child and family teams to finance supports, 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 such as 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.

## Financing Staff and Provider Participation in Individualized Service Planning Processes

Child and family teams often are the vehicle used to plan and deliver individualized services. These teams typically 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 to jointly develop and reach consensus on service goals and an individualized plan for services and supports that addresses all significant life domains.

In Arizona, child and family teams are mandated in and covered by the managed care system, and the state has given direction to providers as to how to bill for participation on these teams. Essentially, the child and family team process is billed as case management. Elements of the process also can be billed as assessment, transportation, family or peer support, and interpretation services.

Hawaii's child and family teams are organized as part of the Coordinated Service Plan (CSP) process. 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. MHCCs are state employees who are attached to the Family Guidance Centers that are part of the state Child and Adolescent Mental Health Division's system of care. 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. Agencies are committed to participating in the individualized care/ wraparound process. For contract providers (such as outpatient therapists), participation in individualized service planning process is billable time under a service code for "treatment planning."

In Vermont, payment for participation in child and family team planning can be billed as case management under Medicaid. In addition, provider participants not located as the local lead agency (Designated Agency) can bill the Designated Agency for their time participating on child and family teams for individualized service planning.

In Central Nebraska, case rates cover the cost of staff time for facilitating child and family teams, which are integral to the work of the Professional Partner Program and the Integrated Care Coordination Unit (ICCU) that comprise the region's system of care.

In Choices, 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. Wraparound Milwaukee contracts with care coordinators who coordinate the child and family team process. Therapists and other providers are paid to participate in team meetings using Milwaukee's blended resources pool.

## Incorporate Care Authorization Mechanisms that Support Individualized, Flexible Service Delivery

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 services specified by the plan are considered to be authorized.

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 – CSP) and all services in the service plan are authorized; the mental health care coordinator completes needed written service authorizations. The team is the decision maker regarding care authorization.

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. Similarly, 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 (with the exception of residential and hospital care, which must be authorized by Wraparound Milwaukee).

# Financing Evidence-based and Promising Practices

Financing strategies also are needed to support the incorporation of evidence-based and promising practices to improve the effectiveness of services. These include incorporating financing and incentives for using evidence-based and promising practices and incorporating financing for development, training, and fidelity monitoring.

The sites studied are involved in promoting and financing the implementation of evidence-based 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 are supported in the sites. For example in Arizona, MST, Functional Family Therapy (FFT), Multidimensional Treatment Foster Care, and Dialectical Behavior Therapy currently are provided, and there is interest in developing others for substance abuse treatment, such as Stages of Change, Motivational Interviewing, Seven Challenges, and the Matrix Model. The development of evidence-based practices is financed both through the state Division of Behavioral Health Services, using primarily grant funding and some block grant monies, as well as through other state agencies. For example, MST and FFT were developed initially by the juvenile justice system using state general revenue funds, and then these providers became part of the regional behavioral health authorities' networks. MST is funded on a single day rate of $65 per day, as a partial day program. At the time MST was instituted (2004), this was the only option for coding the service; currently, ADHS/BHS is looking at using the federal MST code. In general, rates are negotiated for each evidence-based practice, and quality supervision is built into the rate. Providers indicated that the managed care structure provides more flexibility to tailor rates to individual evidence-based practices  The state agency also has used grant dollars to fund consultants and trainers and has subsidized providers so they can participate in training (i.e., paying them for lost billable time).

One of the goals in Hawaii's strategic plan was to consistently apply current knowledge of evidence-based practices to service delivery. The state Child and Adolescent Mental Health Division has an Evidence-Based Services Committee comprised of academicians, state agency 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. A coding system was developed and an accompanying code book 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. The state has promoted the use of these evidence-based practice components among providers and now collects information from providers about their use as part of the clinical intervention process in service delivery.

Hawaii also has "practice development specialists" who have provided training and technical assistance to supervisors and clinicians, and the state invests resources in 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 MST, Functional Family Therapy, Parent Skills Training, Multidimensional Treatment Foster Care, and others. 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 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

The use of MST is integral to Central Nebraska's system of care. MST was seen as a therapeutic intervention with good outcomes for youth in the juvenile justice system. Federal system of care grant funds were used for the development phase of MST, for clinical consultation, and to train two mental health centers to become MST providers. 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. MST providers are paid a case rate based on outcomes achieved with each youth and family. Within the case rate, Medicaid pays for intensive outpatient services. Approximately 226 youth and families participate in MST each year.

In addition, 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 (the lead agency for the system of care) contracts with the family organization (Families CARE) to collect Wraparound Fidelity Index information from parents, youth and care coordinators. This feedback allows for continual improvements of the intervention.

Nebraska's State Infrastructure Grant (SIG) has enabled the state to review evidence-based practices from a statewide perspective; to study the "real" costs for implementing evidence-based practices, including development, training, monitoring, licensing; and to make decisions about how to proceed. 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 state mental health agency in Indiana 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) and strategies for "building a culture" supportive of implementation. MST and FFT can be billed under the current Medicaid plan in Indiana. The TA Center currently is assembling a group of stakeholders to explore what evidence-based practices 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.

# Conclusion

As these sites demonstrate, financing a broad array of services and supports in systems of care requires a number of strategies, including: broad coverage under Medicaid and use of multiple Medicaid options; using resources from multiple systems and diverse funding streams; pooling, braiding or intentionally coordinating cross-system funding streams; cost-sharing among systems for specific services; redirecting spending from restrictive levels of care to home and community-based services and supports; investing in home and community-based service expansion; incorporating financing mechanisms for flexible funds; financing staff and provider participation in individualized service planning processes (e.g., child and family teams); allowing child and family team decisions to govern "medical necessity;" and, financing for evidence-based and promising practices.

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