HCRTP

Promising Approaches

for Behavioral Health Services to Children and Adolescents and Their Families in Managed Care Systems

1: Managed Care Design & Financing

Sheila A. Pires

A Series of the

HCRTP Health Care Reform Tracking Project

Tracking Behavioral Health Services to Children and Adolescents and Their Families in Publicly-Financed Managed Care Systems

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I. Introduction

Health Care Reform Tracking Project

Since 1995, the **Health Care Reform Tracking Project** (**HCRTP**) has been tracking publicly-financed managed care initiatives and their impact on children with mental health and substance abuse (i.e. behavioral health) disorders and their families. The HCRTP is co-funded by the National Institute on Disability and Rehabilitation Research in the U.S. Department of Education and the Substance Abuse and Mental Health Services Administration in the U.S. Department of Health and Human Services. Supplemental funding has been provided by the Administration for Children and Families of the U.S. Department of Health and Human Services, the David and Lucile Packard Foundation and the Center for Health Care Strategies, Inc. to incorporate a special analysis related to children involved in the child welfare system. The HCRTP is being conducted jointly by the Research and Training Center for Children's Mental Health at the University of South Florida, the Human Service Collaborative of Washington, DC and the National Technical Assistance Center for Children's Mental Health at Georgetown University.[1]

[1] All reports of the HCRTP are available from the Research and Training Center for Children's Mental Health, University of South Florida (813) 974-6271:

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (2001). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 2000 state survey.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #198)

Pires, S.A., Stroul, B.A., & Armstrong, M.I. (2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 1999 impact analysis.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #183)

Pires, S.A., Armstrong, M.I., & Stroul, B.A. (1999). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 1997/98 state survey.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #175)

Stroul, B.A., Pires, S.A., & Armstrong, M.I. (1998). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 1997 impact analysis.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #213)

Pires, S.A., Stroul, B.A., Roebuck, L., Friedman, R.M., & Chambers, K.L. (1996). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — 1995 state survey.* Tampa, FL: Research and Training Center for Children's Mental Health, Department of Child and Family Studies, Division of State and Local Support, Louis de la Parte Florida Mental Health Institute, University of South Florida. (FMHI Publication #212)

The following special analyses related to the child welfare population are available from the National Technical Assistance Center for Children's Mental Health, Georgetown University (202) 687-5000:

McCarthy, J., & Valentine, C. (2000). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — Child Welfare Impact Analysis — 1999.* Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Schulzinger, R., McCarthy, J., Meyers, J., de la Cruz Irvine, M., & Vincent, P. (1999). *Health care reform tracking project: Tracking state health care reforms as they affect children and adolescents with behavioral health disorders and their families — Special Analysis – Child Welfare Managed Care Reform Initiatives.* Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

The **HCRTP Promising Approaches Series** highlights strategies, approaches, and features within publicly-financed managed care systems that hold promise for effective service delivery for children and adolescents with behavioral health treatment needs and their families, particularly for children with serious and complex disorders. The series is comprised of a number of thematic papers, each describing promising strategies or approaches related to a specific aspect of managed care systems as they affect children with behavioral health disorders. The series draws on the findings of the HCRTP to date, highlighting relevant issues and approaches to addressing them, that have surfaced through the HCRTP's all-state surveys and in-depth impact analyses in a smaller sample of 18 states. The papers are intended as technical assistance resources for states and communities as they refine their managed care systems to better serve children and families.

Methodology for Study of Promising Approaches

The strategies and approaches that are described in the series were identified by key state and local informants who responded to the HCRTP's state surveys and who were interviewed during site visits to states for the HCRTP's impact analyses. Once promising approaches and features were identified through these methods, members of the HCRTP team, including researchers, family members and practitioners, engaged in a number of additional methods to gather more detailed information about identified strategies. Site visits were conducted in some cases during which targeted interviews were held with key stakeholders, such as system purchasers and managers, managed care organization representatives, providers, family members, and representatives of other child-serving agencies. In other cases, telephone interviews were held with key state and local officials and family members to learn about promising strategies. Supporting documentation was gathered and reviewed to supplement the data gathered through the site visits and telephone interviews.

The series intentionally avoids using the term, "model approaches". The strategies, approaches, and features of managed care systems described in the series are perceived by a diverse cross-section of key stakeholders to support effective service delivery for children with behavioral health disorders and their families; however, the HCRTP has not formally evaluated these approaches. In addition, none of these approaches or strategies is without problems and challenges, and each would require adaptation in new settings to take into account individual state and local circumstances. Also, a given state or locality described in the series may be implementing an effective strategy or approach in one part of its managed care system and yet be struggling with other aspects of the system.

The series does not describe the universe of promising approaches that are underway in states and localities related to publicly-financed managed care systems affecting children with behavioral health disorders and their families. Rather, it provides a snapshot of promising approaches that have been identified through the HCRTP to date. New, innovative approaches are continually surfacing as the public sector continues to experiment with managed care.

Each approach or strategy that is described in the series is instructive in its own right. At the same time, there are commonalities across these strategies and approaches that can help to inform the organization of effective service delivery systems within a managed care environment for this population.

Each paper in the series focuses on a specific aspect of publicly-financed managed care systems. This paper, which focuses on promising approaches in managed care design and financing, represents the first paper in the series.

HCRTP Promising Approaches 1: Managed Care Design and Financing

This paper describes seven managed care design and financing approaches that were identified through the Health Care Reform Tracking Project (HCRTP) as incorporating features that support effective service delivery for children and adolescents with behavioral health disorders and their families. As **Table 1** shows, they include three statewide approaches focused on a total population of children and four local approaches focused on subsets of the total population. Two of the statewide approaches (New Jersey and Pennsylvania) are behavioral health carve outs, and one (Delaware) is an integrated approach with a partial carve out. Three of the local approaches (Dawn Project, Wraparound Milwaukee, Utah Frontiers Project) are behavioral health carve outs, and one (MA-MHSPY Cambridge-Somerville Project) is an integrated physical/behavioral health design (**integrated** designs are defined by the HCRTP as those in which the financing and administration of physical and behavioral health services are integrated, even if behavioral health services are subcontracted. **Carve outs** are defined as those in which behavioral health services are financed and administered separately from physical health services).

Table 1
Promising Approaches to Design and Financing

Statewide Approaches

- New Jersey Children's System of Care Initiative
- Pennsylvania HealthChoices
- Delaware Diamond State Health Plan's Public/Private Partnership for Children's Behavioral Health Care

Local Approaches

- Wraparound Milwaukee, Milwaukee, WI
- Dawn Project, Indianapolis, IN
- Mental Health Services Program for Youth (MHSPY), Cambridge-Somerville, MA
- Utah Frontiers Project, six rural Utah counties

This paper begins with a brief discussion of the design and financing issues related to managed children's behavioral health care that have surfaced through the Health Care Reform Tracking Project (HCRTP). It then describes the seven approaches and concludes with a summary of common challenges and characteristics across approaches. The paper also includes a list of resource contacts.

II. Design and Financing Issues

Integrated Versus Carve Out Reforms

Since 1995, the Health Care Reform Tracking Project has been studying the design characteristics of publicly-financed managed care reforms to ascertain whether certain design features seem to promote or hinder effective service delivery for children with behavioral health disorders and their families, particularly children with serious and complex disorders. A fundamental area of inquiry has focused on the extent and nature of differences between integrated and carve out designs in their effect on children with behavioral health disorders.

Consistently, the HCRTP has found that carve outs tend to encompass design features that, reportedly, are more advantageous to children with behavioral health disorders and their families than do integrated designs. Consider the findings reported in **Table 2**, for example. These differences between integrated and carve out designs were reported by state child mental health directors responding to the HCRTP's *2000 State Survey;* the sample includes 35 managed care designs, primarily large-scale, Medicaid-managed care initiatives in 34 states. Similar findings were reported as well by the more diverse group of stakeholders that included purchasers, managed care organizations, family members, providers, child-serving systems, and advocates that were interviewed for the HCRTP's impact analyses in a smaller sample of 18 states. Among the differences in design characteristics reported, carve outs were more likely than integrated designs to include: a broad, flexible benefit design for child behavioral health care; specific mechanisms for care coordination for children with serious emotional disorders; clinical management features that support provision of individualized care, such as flexible level of care criteria and individualized service planning teams for children with serious disorders; broad psychosocial medical necessity criteria; and a formal role for family organizations built into the design.

Table 2

Reported Differences Between Carve Outs and Integrated Designs
(Sample of 35 managed care designs in 34 states*)

Characteristic	Carve Out	Integrated
Cover an expanded array of behavioral health services	70%	13%
Increase case management or care coordination for children with serious emotional disorders	79%	42%
Support provision of individualized, flexible care	88%	50%
Incorporate broad, psychosocial medical necessity criteria	82%	40%
Involve families of children with behavioral health problems in planning and implementation in significant ways	48%	0%
Include specialized behavioral health services for culturally diverse populations	48%	0%
Provide training to MCOs on children with serious emotional disorders	62%	29%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

The HCRTP also found reported differences in the financing arrangements of integrated and carve out designs. Carve outs were more likely to utilize multiple funding streams from multiple sources, while integrated designs tended to depend principally on Medicaid dollars contributed by the Medicaid agency. While both integrated and carve out designs left significant dollars for behavioral health care outside of the managed care system, creating potential for fragmentation across systems, carve outs were more likely to include strategies for clarifying responsibility for paying for services across child-serving systems. Carve outs were more likely to use non risk-based financing and case-rates, while integrated reforms primarily used capitation, a "riskier" form of financing, particularly when high-need populations are involved, such as children with serious disorders. Carve outs were more likely to assess the sufficiency of rates for behavioral health services, and more likely to include bonuses or penalties tied to performance related to child behavioral health care.

There were even some significant differences reported between integrated and carve out designs in their fundamental goals, as **Table 3** shows. Survey respondents and key stakeholders reported that, with respect to behavioral health services for children, carve outs were far more likely than integrated reforms to encompass goals beyond cost containment, such as expansion of the service array for children's behavioral health care, improvement in accountability for child behavioral health care, and improvement in the quality of child behavioral health care.

Table 3

Reported Differences in Goals Between Carve Out and Integrated Designs

(Sample of 35 managed care designs in 34 states*)

Goal	Carve Out	Integrated
Cost containment	72%	100%
Expand service array	76%	38%
Improve accountability for children's behavioral health care	92%	38%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

At least as perceived by key stakeholders who responded to the HCRTP's state surveys and who were interviewed on site for the HCRTP's impact analyses, the differences in design and financing characteristics between integrated and carve out approaches were associated as well with differences in impact on children with behavioral health disorders. As **Table 4** shows, integrated designs were far more likely than carve outs to be perceived as having a negative impact across a number of indicators, including access to initial care, access to extended care for children with serious disorders, waiting lists, interagency coordination, the practice of families having to relinquish custody to access services, administrative burden on providers, and reimbursement rates.

Table 4

Reported Differences in Impact Between Carve Out and Integrated Designs

(Sample of 35 managed care designs in 34 states*)

Measure	Carve Out	Integrated
Initial access to behavioral health services is worse than before managed care	10%	33%
Access to extended behavioral health services is worse	4%	60%
Waiting lists are longer	15%	33%
Practice of having to relinquish custody to access services is worse	0%	17%
Administrative burden on providers is higher under managed care	56%	75%
Provider reimbursement rates are lower under managed care	25%	57%
Interagency coordination is worse	4%	14%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

Theoretically, an integrated approach should lead to improved service delivery for children because of the important linkage between primary and behavioral health care. The HCRTP found, however, that if this linkage does occur, it is regardless of integrated or carve out design and far more a function of whether coordination between physical and behavioral health care was attended to in planning, implementation, and financing (e.g., incentives for primary care and behavioral health providers to coordinate). Indeed, the *2000 State Survey* found that carve outs were actually slightly more likely to be reported as improving coordination between physical and behavioral health care than integrated designs (61% versus 57%).

The findings of the HCRTP should *not* be interpreted as suggesting that there is an *inherent* disadvantage for children's behavioral health care in an integrated design approach. Rather, primarily because integrated designs tend to focus almost exclusively on physical health issues, integrated designs end up being disadvantageous because they tend *not* to include design features that have been customized for children with behavioral health disorders, particularly children with serious disorders. In addition, they are less likely than carve outs to draw on or coordinate with the multiple financing streams that exist across child-serving systems for children's behavioral health care, thus aggravating service fragmentation to a greater extent.

The HCRTP found that, in comparison to carve outs, integrated designs were less likely to have had the benefit of involvement in planning and implementation of stakeholders who are knowledgeable about children's behavioral health care, such as family members, other child-serving systems, and behavioral health providers. In addition, the HCRTP found that state Medicaid agencies were the predominant players in designing integrated reforms, whereas carve outs were more likely to be designed jointly by state mental health and Medicaid agencies. The lack of involvement of stakeholders informed about children's behavioral health care, combined with an almost exclusive focus on physical health issues, makes it not surprising that integrated designs tend not to include design characteristics more favorably suited to children with behavioral health disorders.

Most of the promising design and financing approaches that were identified by stakeholders across the country for the *Promising Approaches Series* are carve outs; however, there are some integrated designs as well. What these promising integrated designs have in common with the carve outs are customized design and financing features for children with behavioral health needs, which reflect the expertise and input of key stakeholders with knowledge in this area.

Type and Number of Managed Care Organizations Used in Design

A basic design question concerns the type and number of managed care organizations (MCOs) to use. Stakeholders interviewed for the HCRTP's impact analyses cited pros and cons of using various types of MCOs. For example, commercial MCOs were seen as having managed care technical expertise in such areas as provider profiling, utilization management, and data systems. However, they also were perceived as lacking familiarity and expertise in serving children with serious disorders and other populations dependent on public systems. Nonprofit and government entity MCOs were perceived as having this expertise, but as lacking in experience with managed care. Stakeholders cited the importance of training and orientation for MCOs to understand issues with respect to children with behavioral health disorders, as well as populations involved in the child welfare and juvenile justice systems, where there is a higher prevalence of behavioral health disorders. The HCRTP's *2000 State Survey* found that approximately half of all publicly-financed managed care systems provide training to MCOs related to children's behavioral health and child welfare issues, and about one third related to juvenile justice issues.

The design approaches described in this paper, collectively, use a variety of types of MCOs, including government entities, non-profit organizations and commercial companies. What these MCOs have in common is an expertise in serving children with behavioral health disorders, particularly those with serious disorders, gained through prior experience, as in the case of government entities, and/or an active partnership with state purchasers and family members that encompasses training and orientation to create responsive systems.

Another design issue identified through the HCRTP concerned the problems created by the use of multiple MCOs, as opposed to one MCO statewide or one in each region. Stakeholders interviewed for the HCRTP's impact analyses noted that when there are multiple MCOs, each MCO develops different procedures for virtually every aspect of system operation (i.e., billing; credentialing; service authorization; utilization management; reporting, etc.; creating added administrative burden on providers; confusion for families in navigating different systems; and monitoring challenges for state purchasers). Stakeholders noted that families were not so much concerned about choice in MCOs, but, rather, choice in providers. The HCRTP also found that integrated designs were nearly three times as likely to use multiple MCOs statewide or within a single region as were carve outs.

The design approaches identified for the *Promising Approaches Series* utilize one managed care entity statewide or within a single region and do not use multiple MCOs.[2]

[2] Delaware, which uses an integrated approach with a partial carve out, is a kind of hybrid in that a single MCO is used for children with intermediate to extended care needs and multiple MCOs are used for children with only acute care needs.

Coverage of Acute and Extended Care Services

Stakeholders interviewed for the HCRTP's impact analyses strongly advocated inclusion of both acute and extended care in the design of managed care systems. *Acute care* is defined as brief, short-term treatment with, in some cases, limited intermediate care also provided. *Extended care* is defined as care extending beyond the acute care stabilization phase (i.e., care required by children with more serious disorders). The impact analyses found that inclusion of both acute and extended care creates the potential for more integrated service delivery for a total eligible population of children and reduces the potential for fragmentation and cost shifting.

All of the statewide approaches described in this paper, which are focusing on total eligible populations, that is, children with both acute and extended treatment needs, include both acute and extended care within the managed care design. The local approaches described in this paper are focusing on subsets of the total population that encompass only children with extended care needs (i.e., children with serious disorders), who, typically, have exhausted the resources of acute care systems.

Benefit Design

A tenet of effective service delivery for children with behavioral health disorders, particularly those with serious disorders, is that they require access to a broad, flexible array of services and supports, including especially home and community-based services.[3] The HCRTP's *2000 State Survey* explored the extent to which publicly-financed managed care designs are covering the following array of services and supports: assessment and diagnosis; outpatient psychotherapy; medical management; home-based services; day treatment and partial hospitalization; crisis services; behavioral aide services; therapeutic foster care; therapeutic group homes; residential treatment center; crisis residential services; inpatient hospitalization; care or case management services; school-based services; respite services; wraparound services; family support/education; transportation; and mental health consultation.

The HCRTP found that, at least in the case of carve outs, managed care designs are incorporating a broad, flexible benefit design. Seventy percent of carve outs reportedly cover a broad array of services, including "wraparound" services and supports,[4] but only 13% of integrated designs do.

All of the design approaches described in this paper incorporate a broad, flexible benefit design that includes home and community-based services and supports.

[3] Stroul B.A. & Friedman, R.M. (1986). *A system of care for children and youth with serious emotional disturbances* (rev. ed.). Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

[4] Wraparound services and supports are highly individualized, flexible services and supports, such as a behavioral aide, mentoring services, transportation, respite, often used to augment clinical treatment services. Wraparound also connotes an approach to service delivery that flexibly draws on and combines traditional and nontraditional services and supports to support individualized care planning and provision.

Individualized Care Mechanisms

Another premise of effective service delivery for children with or at risk for serious behavioral health disorders is that service design should support provision of individualized care.[5] The HCRTP *2000 State Survey* found that publicly-financed managed care, in general, and as compared to fee-for-service systems, is making it easier to provide flexible, individualized care in many cases. This was particularly, although not solely, reported to be the case with carve outs. An enhanced ability to provide individualized care was attributed to such design features as: more flexible financing arrangements, such as capitation, case-rates and designated pots of "flexible funds"; a broad, flexible benefit design; and required mechanisms for individualized care planning. Where managed care designs have not supported flexible, individualized care, stakeholders pointed to such design features as: rigid billing procedures and service codes; rigid service authorization mechanisms; narrow medical necessity criteria; accounting and reporting procedures that focus on single episodes of care or discrete services; and a narrow benefit design.

The design approaches described in this paper all incorporate a variety of design features that support provision of individualized care.

Care Management and Coordination Features

Children with behavioral health disorders, particularly those with serious disorders, often are involved or at risk for involvement with multiple service providers and multiple child-serving systems. Care management and coordination is important from the standpoint of both quality and cost of care, as well as family satisfaction. The HCRTP's *2000 State Survey* found that, in over a quarter of integrated designs, care management and coordination for children with behavioral health disorders had decreased in comparison to the previous fee-for-service system. This was not the case with carve outs, however, in which it was reported that care management and coordination had increased in over three-quarters of these initiatives. Increased care management and coordination was reported for nearly twice as many carve outs as for integrated designs (79% versus 42%).

All of the design approaches identified for the *Promising Approaches Series* incorporate customized care management features for children with serious disorders.

Clinical Decision Making and Management Mechanisms

Throughout the course of the HCRTP, stakeholders have complained about the impact of narrowly defined or interpreted medical necessity criteria on the ability of managed care systems to provide effective care for children with behavioral health disorders. The *2000 State Survey* found that, while there is some movement across states to broaden the definition of medical necessity criteria to include psychosocial and environmental factors, criteria continue to be interpreted narrowly within integrated designs, though not within carve outs.

The HCRTP also has been tracking the extent to which managed care designs incorporate clinical decision making criteria specific to children's behavioral health care. The *2000 State Survey* found that 70% of carve outs, but only 38% of integrated designs, reportedly incorporate criteria specific to children's behavioral health.

[5] Stroul, B.A. & Friedman, R.M. (op.cit.).

Stakeholders interviewed for the HCRTP's impact analyses often complained about the clinical management mechanisms built into managed care designs, such as prior authorization and concurrent and retrospective review procedures. These features were described as cumbersome, time consuming, confusing, and as creating barriers to access. The *2000 State Survey* found that, in many managed care systems, some steps were being taken to make clinical management mechanisms less rigid, such as pre-authorizing certain services or service amounts.

A common characteristic of the approaches described in this paper is that they all incorporate broad definitions of medical necessity, and they include clinical decision making criteria specific to children's behavioral health care. In addition, they have tried to build flexibility into their clinical decision-making and management mechanisms to support provision of individualized services for children with serious disorders.

Interagency Coordination Mechanisms

Because children with behavioral health disorders often are involved or at risk for involvement with multiple systems, such as the education, child welfare, and juvenile justice systems, in addition to the managed care system, coordination across systems is critical to effective care. The HCRTP found that, in most cases, insufficient attention was paid to cross-system issues in initial managed care designs. The problems that surfaced as a result have led states to focus more attention on improving interagency coordination in system redesign.

The approaches described in this paper incorporate a variety of interagency coordination features both at the systems and the services levels.

Family Involvement Strategies

Table 5 shows the extent to which the *2000 State Survey* found family involvement strategies built into managed care designs. Carve outs, reportedly, were far more likely than integrated designs to incorporate strategies for family involvement at systems and services levels.

Table 5

Extent of Family Involvement Strategies in Managed Care Designs

(Sample of 35 managed care designs in 34 states*)

Strategy	Carve Out	Integrated
Requirements in RFPs and contracts for family involvement at the systems levels	69%	0%
Requirements in RFPs, contracts and service delivery protocols for family involvement in planning and delivering services for their own children	62%	14%
Focus in service delivery on the family and not only the identified child	73%	29%
Coverage and provision of family support services	65%	29%
Use of family advocates	62%	0%
Hiring families and/or youth in paid staff roles	35%	0%
No strategies	0%	29%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

A characteristic of the approaches described in this paper is their focus on family involvement. Some go farther than others in building family partnership structures into the managed care design, but all recognize the importance of a design that incorporates opportunities for partnerships with families.

Provider Networks

Consistent with a broad, flexible benefit design and a goal of individualizing care, effective service delivery systems for children with behavioral health disorders also design provider network parameters to accommodate: nontraditional and culturally diverse providers; families in the role of providers; student interns and paraprofessionals; and providers from other child-serving systems, such as child welfare providers and school-based providers. As **Table 6** shows, the *2000 State Survey* found that many managed care systems are including various types of providers relevant to child behavioral health care, beyond traditional behavioral health providers, such as mental health clinics and psychiatrists. Again, however, carve outs are more likely than integrated designs to have diverse provider networks.

Table 6

Types of Providers in Managed Care Designs

(Sample of 35 managed care designs in 34 states*)

Provider Type	Carve Out	Integrated
Child welfare providers	65%	13%
School-based behavioral health providers	62%	63%
Certified addictions counselors	69%	63%
Culturally diverse and indigenous providers	88%	63%
Family members as providers	42%	0%
Paraprofessionals and student interns	62%	13%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

The design approaches described in the *Promising Approaches Series* all incorporate both traditional and nontraditional providers in their networks, and, in some cases, the range and flexibility built into provider network parameters are extensive.

Related to the issue of provider network design parameters is that of training to ensure that the provider network has the skills, attitudes, and knowledge necessary to serve children with behavioral health disorders, particularly those with serious disorders. **All of the approaches described in this paper incorporate training and technical assistance for providers into their managed care structures, again, in some cases, extensively.**

Accountability Systems

The adequacy of management information systems (MIS) and quality measurement and improvement systems has a critical impact on the effectiveness of managed care systems. The *2000 State Survey* found that over one-third of carve outs and over one-half of integrated designs reportedly did not have adequate data to guide decision making at both services and systems levels related to children's behavioral health care. In about a quarter of cases in which adequate data were not available, it was because the system was not designed to track data on children's behavioral health services. The *2000 State Survey* found that, while most managed care systems are incorporating quality and outcome measures related to children's behavioral health care, most also are in early stages either of development or implementation.

As a result of inadequate data systems and/or not fully developed or implemented quality and outcome measurement systems, a substantial number of publicly-financed managed care systems reportedly do not know the impact they are having on children's behavioral health care. The *2000 State Survey* found that, in over 40% of managed care systems, the impact on penetration rates, service utilization, cost, quality and satisfaction was unknown. In 63%, the impact on clinical and functional outcomes was unknown. While a major goal of managed care systems is to control costs, in nearly three quarters of integrated designs and over a third of carve outs, the impact on cost of children's behavioral health services was unknown. Where cost data existed, the impact was decidedly mixed, with cost increases reported for 24% of managed care systems, no effect one way or the other in 10%, and cost decreases in 7%.

The approaches described in this paper have designed data, quality and outcomes measurement systems specifically relevant to children's behavioral health care. In addition, a number of them have documented improved clinical and functional outcomes, along with cost savings.

Financing Structures

The *2000 State Survey* found that carve outs are more likely to draw on multiple funding streams contributed by multiple systems than are integrated designs, which tend to rely almost predominantly on Medicaid dollars contributed by state Medicaid agencies. In contrast, carve outs are drawing more on Medicaid, block grant, and general revenue dollars from state mental health, substance abuse, and child welfare systems, in addition to state Medicaid agencies.

The significance of the types of revenue and agencies financing managed care systems has to do with the fact that many of the populations of children enrolled in publicly-financed managed care rely on multiple funding streams and agencies for behavioral health services. This is true, for example, of children involved in the child welfare and juvenile justice systems, children receiving Supplemental Security Income (SSI), and those with serious disorders who do not quality for SSI. Historically, there has been fragmentation across these funding streams and agencies, creating cost inefficiencies and confusion for families and providers. Managed care as a technology creates opportunity to blend or braid dollars and "rationalize" the delivery system. The *2000 State Survey* results suggest that states with carve out designs are beginning to experiment with the use of multiple funding streams, engaging multiple agencies in this effort. This does not seem to be the case with integrated designs.

All of the design approaches described in the *Promising Approaches Series* draw on multiple funding streams contributed by multiple agencies.

An aspect of the design of managed care systems has to do, not only with the types of dollars used, but the types of financing arrangements involved. As **Table 7** shows, publicly-financed managed care systems are using a variety of risk-based financing arrangements, as one would expect in managed care. However, carve outs are far more likely than integrated designs to use "less risky" arrangements, such as case-rates and non risk-based administrative services organizations (ASOs); integrated designs are more likely to use full-blown capitation.[6] Less risky financing arrangements may be called for in the case of children with behavioral health disorders, particularly those with serious disorders, to guard against underservice and to give systems time to collect and analyze utilization and cost data to support realistic capitation models.

Table 7

Use of Risk-Based Financing

(Sample of 35 managed care designs in 34 states*)

Type of Financing	Carve Out	Integrated
Capitation	54%	88%
Case-rates	31%	13%
Neither (i.e., no risk)	27%	13%

* Note: This sample includes the three statewide initiatives highlighted in this paper. However, the sample does not include small-scale, local managed care approaches such as the four local initiatives described in the paper.

All but one of the approaches described in this paper are using either case-rates or non risk-based ASO arrangements or a combination of both, rather than full-blown capitation.

[6] Capitation financing pays MCOs or providers a fixed rate per *eligible* user of service, while case-rates pay a fixed rate per *actual* user of service, based typically on the service recipient's meeting a certain service or diagnostic profile. In a capitated system, a potential incentive is to prevent eligible users from becoming actual users. In a case-rated system, there is no such incentive, although case-rates do create an incentive, like capitation, to control the type and amount of service provided.

III. Description of Promising Design and Financing Approaches

Statewide Approaches

A. New Jersey Children's System of Care Initiative

Overview

The New Jersey Children's System of Care Initiative 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 previously fragmented system in which each child-serving system (i.e., child welfare, juvenile justice, mental health, and Medicaid) provided its own set of behavioral health services. The New Jersey (NJ) Department of Human Services is the state purchaser, and the Initiative is being rolled out by county or groups of counties over a five-year period. The goals of the Initiative 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 core values of individualized service planning, family/professional partnership, culturally competent services, and a strengths-based approach to care.

Key Design and Financing Features

- **Contracted Systems Administrator** (**CSA**). The design utilizes a statewide ASO-type entity to coordinate, authorize, and track care for all children entering the system and to assist the NJ department of Human Services to manage the system of care and improve quality. A non risk-based contract was awarded to Value Options, a commercial behavioral health managed care company, to perform the CSA role. The State opted to use a non risk-based, ASO contract to discourage rationing of care and encourage management of care. The CSA provides coordinated 24-hour access to care, operates a toll-free Access to Care line, and supports utilization management, quality management, and information management functions. It also facilitates a single method for paying providers of behavioral health care and maintains one electronic record of behavioral health care across child-serving systems (for all children, both Medicaid and non Medicaid).
- **Contracted Care Management Organizations** (**CMOs**). The design utilizes newly-formed, nonprofit entities at the local level (one per region) that provide individualized service planning and care coordination for children with intensive, complicated service needs. Currently, contracts are non risk-based, with the goal of moving to a case-rate arrangement as the Initiative produces reliable data on utilization and cost. Care Management Organizations use **Child and Family Teams** to develop individualized service 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 in the child welfare system. 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 also are supported by *Family Support Coordinators* (see **Provider Network**, page 17) and *Community Resource Development Specialists*, whose job it is to identify and develop informal community supports and natural helpers to augment treatment services.

- **Family Support Organizations** (**FSOs**). The design incorporates a partnership with families through many mechanisms and at all levels of the system. The NJ Department of Human Services funds Family Support Organizations at the local level (one per region), and requires Care Management Organizations to utilize the resources of FSOs. The FSOs are required to fund Family Support Coordinators to work closely with families served by Care Management Organizations. More broadly, FSOs ensure that the family voice is incorporated at the systems and services levels, develop peer mentors, provide education and advocacy, information and referral, and host peer support groups. The state also supports the statewide family organization to provide technical assistance to the local FSOs. The Initiative governance structures (see **Interagency Governance Structure**, page 16) all include family representation. The CSA is required to recruit family members as staff and to establish a family panel to assist with complaints and grievances. In addition, the State's Quality Improvement Process (see **Quality Assessment and Performance Improvement Program** [**QAPI**], page 17) involves families through committee structures in monitoring system performance.
- **Broad Benefit Design**. The design incorporates a broad, flexible benefit design that includes a range of traditional clinical services, as well as nontraditional services and supports. To achieve a broad benefit design, the Initiative expands services covered under Medicaid through the Rehabilitation Services Option and covers other services using non-Medicaid dollars. The array of covered services includes: assessment (screening, evaluation, and diagnostic services)†[7] mobile crisis/emergency services†, out-of-home crisis stabilization services†, acute inpatient hospital services‡, residential treatment center care‡, group home care†, treatment homes/therapeutic foster care†, intensive face-to-face care management†, outpatient treatment†, partial care‡, intensive in-home services†, behavioral assistance†, wraparound services, and family support.
- **Uniform Screening and Assessment Protocols**. The design incorporates uniform screening and assessment protocols developed specifically for children with behavioral health disorders. The protocols are used across child-serving systems to determine appropriateness for referral and within the Initiative to determine appropriate level of care and to support the individualized service planning process for children referred to CMOs. The instruments address strengths and needs of both children and their caregivers, cut across life domains, and address multisystem issues, such as child welfare, juvenile justice, and school issues. In particular, the Initiative utilizes a series of **Information Management and Decision Support Tools** (**IMDS**), developed specifically for the Initiative, to support the practice model (i.e., individualized,

[7] A single dagger † denotes that the service is a current Medicaid service; a double dagger ‡ indicates that the service is a new Medicaid service; no †/‡ indicates that the service is covered by non-Medicaid dollars.

strengths-based services and supports across systems and life domains). The tools include a Crisis Assessment instrument, an Initial Assessment instrument, and a Comprehensive Assessment tool, and were developed with the input of families, providers, clinicians, and other stakeholders across systems, supported by outside expert consultation. Over 500 local mental health, child welfare, and juvenile justice staff in six counties have been trained in use of the protocols.

- **Interagency Governance Structure**. The design involves an interagency governance structure that includes: an Interagency Policy Body comprised of key Executive Branch heads and a statewide advisory council with broad stakeholder representation; a State-level Implementation Team comprised of interagency management staff, family representatives, and designated representatives from local implementing teams; and local Children's Initiative (i.e., local implementation) Teams comprised of interagency regional and local managers and family representatives.
- **"Pooled" Resources and Maximization of Medicaid Revenue.** The Initiative is financed by existing dollars supporting child behavioral health care from child welfare, juvenile justice, mental health, and Medicaid systems; new dollars approved by the legislature; and expansion in Medicaid covered services facilitated by conversion from the Medicaid Clinic to the Rehabilitation Services Option. The Initiative pooled $85 million in mental health and child welfare dollars alone to leverage federal Medicaid dollars. Initiative funds support services and system infrastructure and availability of **flexible funds** allocated to Care Management Organizations to facilitate a wraparound service approach. The Initiative also uses the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) to screen children for the Initiative. The use of EPSDT and the Medicaid Rehabilitation Option provides federal participation in services previously funded by State dollars alone.[8] The New Jersey Initiative creates a **single payer system** by lodging all Initiative dollars (Medicaid and non Medicaid) with the State Medicaid agency and having the Medicaid agency handle all reimbursements through its existing financial management system. By integrating financing and payment mechanisms, the Initiative can mitigate the effects of categorical funding streams on children with serious disorders, eliminate a child's need to go on the DYFS caseload to obtain residential services, and allow for service continuity across eligibility status. The Initiative in effect creates a single enrollment and payer system for families and providers, with eligible children receiving a "Children's System of Care Initiative (CSOCI)" card (see **Figure 1**, page 17).
- **Presumptive Eligibility Enrollment**. The design allows for presumptive enrollment for children needing behavioral health care if they are Medicaid eligible, eligible for NJ Family Care (State Children's Health Insurance Program), or eligible as a Children's System of Care Initiative child (i.e., 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,

[8] As part of its State plan amendments to support the Initiative, NJ is "Medicaiding" care management, residential treatment, therapeutic group homes, family care homes, intensive in home services, behavioral assistance, and crisis response and stabilization services. To date, due to retroactive Medicaid reimbursement for previously unclaimed residential services, the Initiative has expended three federal dollars for every one state dollar.

juvenile justice, etc.), 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.

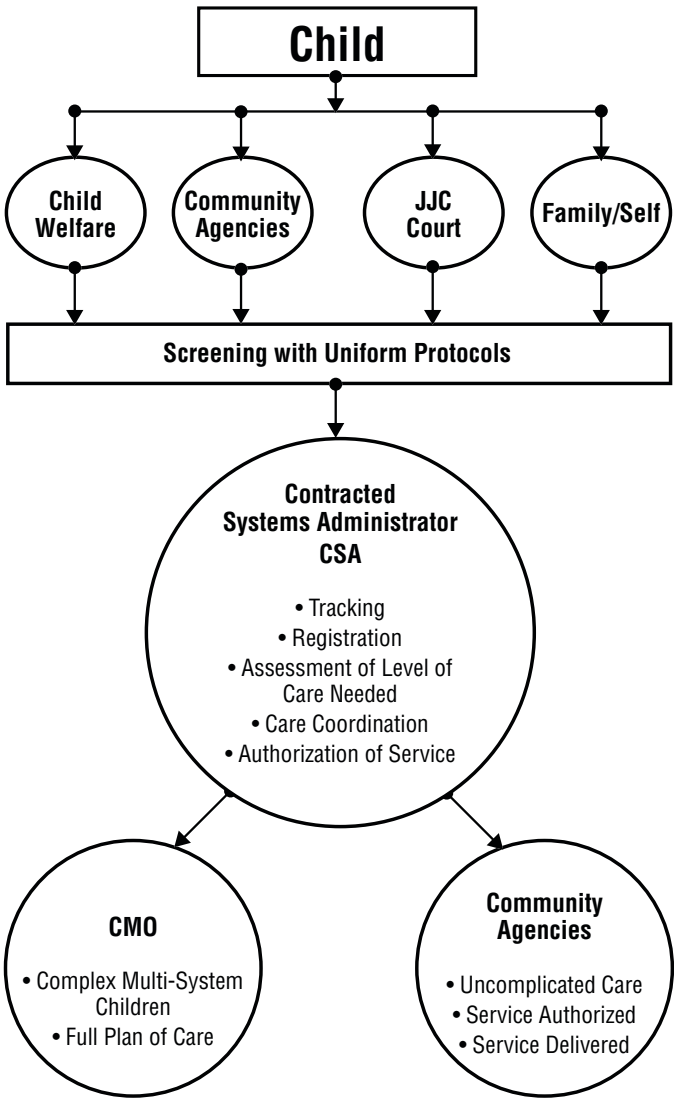
- **Provider Network**. All providers under contract with the NJ Department of Human Services are eligible to participate in the Initiative. Providers must meet Division of Youth and Family Services (DYFS) licensing requirements. Contracts are on a fee-for-service basis through a combination of cost reimbursable and fixed price arrangements. In addition, Care Management Organizations utilize flexible funds to buy individualized services and supports to augment provider capacity. Through a combination of Medicaid expansion and some new dollars, the State is developing needed, **new service capacity**, such as care management, mobile crisis services, and family care homes.
- **Training and Technical Assistance**. Training and technical assistance are built in as an ongoing system cost and are targeted to key players at all levels of the system. The Initiative has developed a training and technical assistance strategic plan and contracts with a university-based entity to be the fiscal agent for training and technical assistance dollars by creating a **Training and Technical Assistance Institute**. This arrangement allows for flexibility in allocating resources to meet emerging training and technical assistance needs. In addition, the Initiative has developed ongoing, structured **Orientation** to the system of care for all new participants and utilizes a website,[9] community forums, and targeted mailings to keep the large community of stakeholders informed about the Initiative.
- **Quality Assessment and Performance Improvement Program** (**QAPI**). The Initiative incorporates a quality improvement program specifically targeted to ensuring quality individualized service planning (ISP) at the local level for children with serious disorders. The QAPI establishes performance benchmarks and assesses quality of system performance. It is supported by an information management system at the CMO level that gathers and organizes information for ISP design and implementation, including QAPI methodology needed to track and monitor critical indicators of successful implementation of structure and process. For example, QAPI includes indicators of family involvement and satisfaction, interagency collaboration, access to community-based services, improved stability in family and other living arrangements, and improved child status in key life domains.

[9] www.njkidsoc.org

- **Management Information System** (**MIS**). The Initiative is supported by an MIS at the CSA level that is capable of supporting individualized service planning at the local level and of identifying a single payer for each identified service and support (thereby avoiding duplicated payments and inefficiencies). The system creates a single electronic record that is connected to the DHS eligibility files.

  Figure 1 provides a design overview of the NJ system from the perspective of a child and family accessing care.

Figure 1
New Jersey System of Care Flow Chart



B. Pennsylvania HealthChoices

Overview

HealthChoices is Pennsylvania's statewide Medicaid managed care program for adults and children that is being rolled out across the state incrementally. Behavioral health services are administered and financed separately from physical health care through a behavioral health carve out in which counties have the right of first opportunity to contract with the State Office of Mental Health and Substance Abuse Services to act as their own managed care entity. Counties, in turn, may choose to subcontract MCO functions to commercial or nonprofit organizations. State contracts with counties are risk-based, and counties, in turn, may enter into risk-based arrangements with managed care organizations. As a result of the strong role for counties in the design of HealthChoices, there is variation across the state in the types of managed care entities used, with some counties using government entities as MCOs, some contracting with commercial or non-profit organizations and some using hybrids of these arrangements.[10] However, there is only one Behavioral Health Managed Care Organization (BH-MCO) per county (or cluster of counties in the case of sparsely populated areas). The goals of HealthChoices are to improve access to care, quality of care, continuity of care, and management of scarce Medicaid resources.

HealthChoices serves children (and adults) eligible for Temporary Assistance to Needy Families (TANF), Healthy Beginnings (pregnant women and/or low income children), Healthy Horizons (low income Medicare consumers), Supplemental Security Income (SSI), General Assistance-State Only, and federally assisted General Assistance.

Key Design and Financing Features

- **Incorporation of CASSP Principles**. Pennsylvania has a long history of efforts to develop local systems of care for children with or at risk for serious disorders, following the principles and values of the federal Child and Adolescent Service System Program (CASSP).[11] These values call for family involvement, cultural competence, interagency coordination, individualized service planning, and provision of services in normalized (i.e., home and community-based) settings. For many years, Pennsylvania has worked to institutionalize in every county a CASSP infrastructure to serve children with or at risk for serious disorders, including a CASSP Coordinator, a range of services, and interagency collaboration at the service and system levels. The state consciously built on its CASSP history in designing HealthChoices. Requests for Proposals (RFPs) and contracts require incorporation of CASSP values, principles and infrastructure. HealthChoices' performance monitoring system (see **Performance/Outcome Management System** (**POMS**), page 21) has indicators tied to CASSP principles, and the state's Readiness Assessment Instrument (see **Family Involvement**, page 20) incorporates criteria based on CASSP principles. In addition, the state underwrites the Pennsylvania CASSP Training Institute, based at Penn State University, to provide ongoing orientation and training in CASSP principles to support HealthChoices implementation.

[10] Because of local variation in capacity, there is also variation in the quality of implementation of HealthChoices across the state. This paper, however, focuses on basic design features of the Initiative.

[11] See Stroul, B.A., & Friedman, R. (1996). Values and principles for the system of care. In B.A. Stroul (Ed.), *Children's mental health: Creating systems of care in a changing society*. Baltimore, MD: Paul H. Brookes Publishing.

- **Local Management Control**. The design feature of giving counties the first option to act as their own MCOs builds on the historical structure and experience in the State, which since the 1960s has given the counties the authority for behavioral health care delivery. The design gives counties a population-based responsibility that has the potential to improve accountability for care and acknowledges that many counties in the State have invested considerable resources over the years in building behavioral health services, which could have been undermined by a centralized design. The design also allows for localities to adjust system parameters to reflect local differences.
- **Broad Benefit Design**. HealthChoices covers a broad array of mental health and substance abuse services and covers both acute and extended care. Services include: *hospital-based services* (inpatient mental health treatment, inpatient detoxification, inpatient rehabilitation services, partial hospitalization); *behavioral rehabilitation services for children and adolescents* (designed to keep families together and children in school and community, including therapeutic staff support services, such as behavioral aides, behavioral specialist consultation, family support services, neuropsychological evaluations, summer therapeutic activities, mobile therapy, therapeutic group and foster care, and residential treatment); *emergency services* (telephone, walk-in, mobile crisis, in-home crisis support, and crisis residential services); *community-based outpatient* (individual, family, group therapy, psychiatric evaluation, medication monitoring, case management and intensive case management, methadone therapy, outpatient drug and alcohol clinic, halfway house services, nonhospital detoxification and rehabilitation treatment; and, *wraparound services through EPSDT.*
- **Interagency Service Coordination**. RFPs and contracts require that, for children with serious disorders who are involved in multiple systems, BH-MCOs must serve on interagency (i.e., CASSP) service planning teams. In addition, BH-MCOs are required to have letters of agreement in place with county child welfare, juvenile probation, and substance abuse agencies and with local school districts that address coordination of service planning and delivery.
- **Guidelines for Mental Health Medical Necessity Criteria for Children and Adolescents**. With the input of stakeholders, including families, the State developed clinical decision-making criteria specifically for children, "Guidelines for Mental Health Medical Necessity Criteria for Children and Adolescents". These guidelines act as broad admissions and level of care criteria for certain services in the benefit package, including: inpatient, residential treatment, partial hospitalization, outpatient, behavioral health rehabilitation services under EPSDT, including home and community-based services, and family-based mental health services. In addition, the State requires use of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for determining medical necessity for substance abuse services for children and adolescents.
- **Family Involvement**. As noted, RFPs and contracts incorporate CASSP values and principles, which stress the importance of family involvement in service planning. RFPs and the State's Readiness Assessment Instrument, which gauges the readiness of counties for managed care prior to the implementation of the HealthChoices program, have standards related to family involvement in a wide array of systems-level activities, including: grievance and appeals process, quality assurance, program oversight,

development of member handbooks, development of satisfaction surveys, and participation on consumer satisfaction teams. Families also are required to be involved in decision-making as to how reinvestment dollars are spent. Families participate on readiness assessment reviews with the State. They also were involved in initial design of the system, participate on State-level advisory bodies and are involved in performance monitoring. The State provides funding for family organizations in various regions of the State. Also, the Pennsylvania CASSP Training Institute works closely with families in developing training relevant to the managed care system.

- **Provider Network**. The HealthChoices design allows for inclusion of providers who had contracts with the county and Medicaid fee-for-service providers. The design also encourages the use of nontraditional providers through designation under Medicaid of a so-called "Type 80" provider. These nontraditional providers provide services not covered historically by Medicaid in Pennsylvania, such as nonhospital detoxification and rehabilitation services. The State requires that BH-MCO contracts with providers include requirements for participation on interagency teams and coordination of behavioral health services with other child-serving systems, such as child welfare, juvenile justice, and the schools. Also, the state design includes requirements that BH-MCOs must orient and train providers in CASSP principles.
- **Blended Financing.** HealthChoices is funded with a blend of Medicaid, mental health, and substance abuse dollars. HealthChoices also provides for reinvestment of savings generated by the system back to the county of origin. Counties must develop reinvestment plans, with input from key stakeholders, including families, and plans must be approved by the State. Counties receive capitated contracts from the State purchaser; the average, statewide capitation rate for both adults and children and adolescents in 2000 was $56 per member per month (pmpm).
- **Performance/Outcome Management System** (**POMS**). The state Office of Mental Health and Substance Abuse Services has created a performance monitoring system, tied to a **Continuous Quality Improvement** (**CQI**) process. The county/BH-MCOs must submit for approval their quality management plans, their QI structure, plans for including consumers/families in the QI process, specific areas their QI will track and monitor, QI policies and procedures, and areas of special study. Each year the State selects key areas for review and sends monitoring teams on site to meet with counties and BH-MCOs around priority issues. The state's POMS system draws on multiple data sources, including encounter data, enrollee eligibility and demographic data, consumer/family satisfaction reports, a consumer registry file that BH-MCOs are required to maintain that is a minimum data set on behavioral health service utilizers, a quarterly file that BH-MCOs must maintain concerning the status of priority populations (which includes children with serious emotional disorders), and performance indicator reports. POMs tracks the following "outcome dimensions": (1) increase community tenure and less restrictive services; (2) increase vocational and educational status; (3) reduce criminal/delinquent activity; (4) improve health care; (5) increase penetration rates; (6) increase consumer/family satisfaction; (7) implement CQI activities; and (8) increase the range of services and improve utilization patterns. Under each of these larger headings are indicators pertaining specifically to children and adolescents. In addition, the State instituted an **Early Warning System** to provide data across a select number of clinical and administrative indicators to identify quickly potential areas of concern and issues needing immediate attention.

- **Management Information System** (**MIS**). The State placed a priority on having an adequate MIS system in place at the State level to track children using the system by geographic location, program involvement, system involvement, and outcome measures. The State MIS system is capable of tracking utilization across the full continuum of children's services within HealthChoices and of tracking use by the 0–5, 6–12, 13–17, and 18–21 age groups.

C. Delaware Diamond State Health Plan's Public/Private Partnership for Children's Behavioral Health Care

Overview

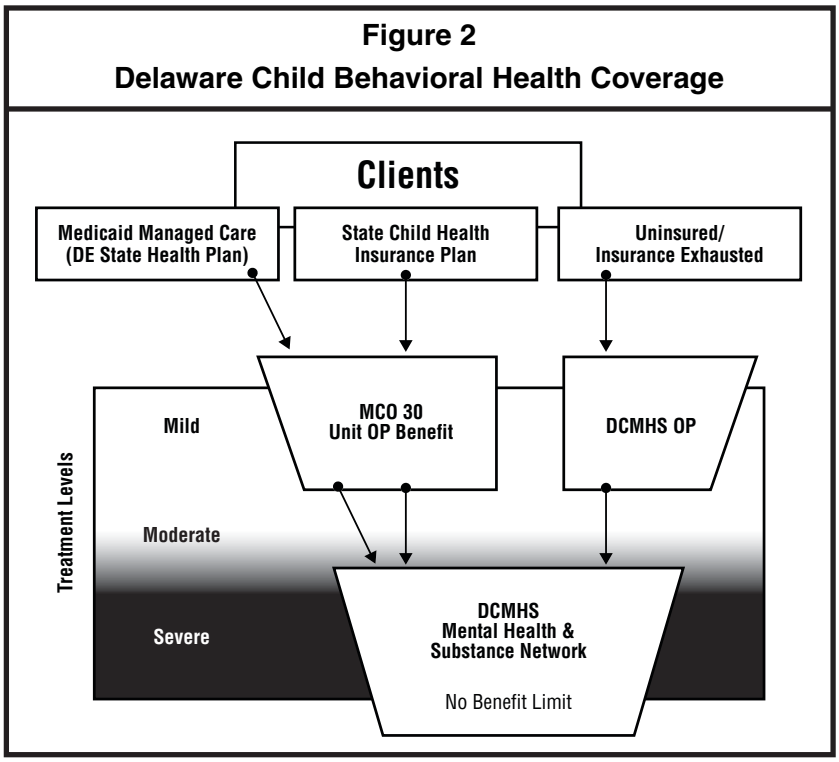
The essential design feature of Delaware's statewide Medicaid managed care initiative, the Diamond State Health Plan, is a partnership between commercial managed care plans and the State Division of Child Mental Health Services (DCMHS) for the delivery of children's behavioral health services. Delaware's approach is an integrated design with a partial carve out. The purchaser is the State Medicaid agency. Commercial managed care companies under contract to the State Medicaid agency manage the physical health benefit and a basic behavioral health benefit, defined as 30 hours of mental health and/or substance abuse outpatient services, or its equivalent, renewable annually. The State Division of Child Mental Health Services (located in the Department of Services for Children, Youth and Their Families), acting as a public MCO, manages all behavioral health services beyond the basic behavioral health benefit, utilizing, in effect, a case-rate from the State Medicaid agency, as well as mental health and some child welfare dollars. This Partnership between commercial MCOs on the physical and acute behavioral health side and DCMHS on the intermediate-severe behavioral health side serves all children requiring behavioral health services from the public sector, including children eligible for Medicaid and SCHIP, children without health insurance, and children with serious disorders who exhaust private coverage. The commercial MCOs must include DCMHS outpatient providers in their networks to facilitate coordination, and DCMHS has explicit level of care criteria governing service referrals from commercial MCOs to the carve out. The public MCO role of DCMHS has three unique design features: (1) a care assurance model (i.e., no pre-ordained benefit limit); (2) a clinical services management model for care coordination; and (3) an MIS system that includes mental health, substance abuse, child welfare, and juvenile justice system data. The goals of the Partnership are to increase access to behavioral health care, improve quality and appropriateness of services, contribute to Medicaid cost containment, and avoid duplication (that is, avoid having commercial MCOs create a service delivery system that would duplicate what is already in place through DCMHS).

Key Design and Financing Features

- **Public-Private Partnership Management Structure**. Commercial MCOs (currently, there are two operating statewide) manage an integrated benefit covering physical health care and brief, short-term behavioral health care (the equivalent of 30 outpatient visits), and the State Division of Child Mental Health Services, acting as a public MCO, manages behavioral health care for children with moderate to severe disorders. The boundary between the commercial MCOs and DCMHS is governed by level of care

criteria developed by DCMHS (see **Level of Care Criteria**, page 25). This management design builds on the strengths of both sectors. It gives to the commercial sector responsibility for expanding access to brief, short-term care, and gives to DCMHS responsibility for managing care for children most dependent on public services, whom DCMHS historically has served. DCMHS spent several years preparing for its role as a public MCO by developing level of care criteria and an effective management information system, upgrading provider performance standards and monitoring capacity, expanding its continuum of services, divesting itself of publicly owned services, and developing sound working relationships with Medicaid. In addition, DCMHS has a long history of working to develop a system of care throughout the state, modeled on system of care principles, and the part of the managed care system for which it is responsible is built on its system of care infrastructure and principles. The management design lessens cost shifting from the commercial MCOs to the public system and creates an experienced locus of accountability for children with serious disorders that is critical in a managed care environment. DCMHS is accredited by the Joint Commission on Health Care Organizations as a managed behavioral healthcare organization. DCMHS has signed affiliation agreements and designated contacts with each of the commercial MCOs. The **Figure 2** depicts the basic design.

Figure 2
Delaware Child Behavioral Health Coverage

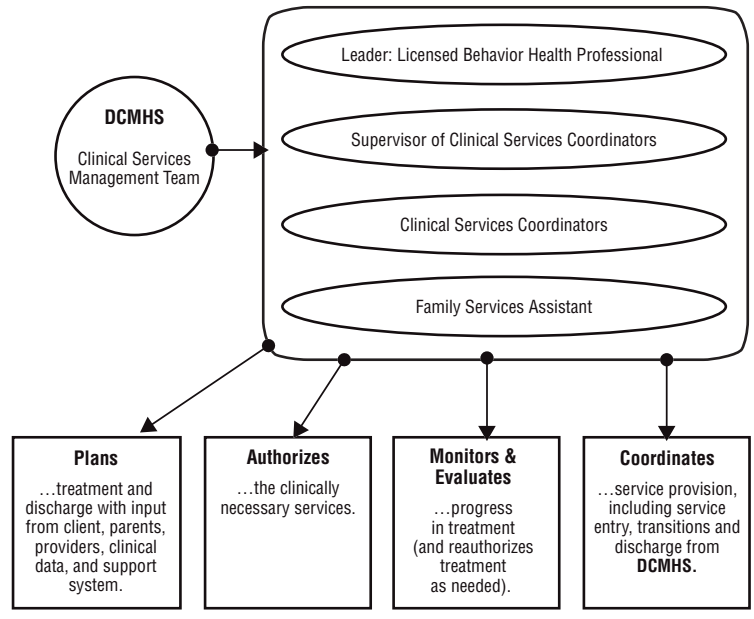


- **Broad Benefit Design**. The Partnership covers a broad array of services, including: 24-hour, statewide mobile crisis services and crisis residential; intake and assessment; clinical service team functions, including treatment planning and monitoring and case management; outpatient services; behavioral aides; intensive outpatient services; wraparound services and supports; in-home services; day treatment and partial hospitalization; therapeutic foster care; therapeutic group homes; residential treatment;

inpatient hospitalization; and family support and education. In addition, the public MCO (DCMHS) embraces a **Care Assurance Model**, meaning that there are no predetermined benefit limits. The benefit design encompasses both acute care (managed by the commercial MCOs) and extended care (managed by DCMHS).

- **Clinical Services Management Model**. DCMHS utilizes eight **Clinical Services Teams** (**CST**) located throughout the State and including one statewide CST for substance abuse. The specialized CST for substance abuse has a somewhat different function than the other CSTs; it provides best practice, clinical consultations to the other teams, and provides training in substance abuse treatment Department-wide. The regional CSTs are responsible for treatment planning and monitoring and serve as the primary point of contact for families who have children with more serious disorders. The CSTs have a great deal of flexibility and can offer, when needed, support services, such as transition assistance, school re-entry help, transportation, clothes, one-time purchases, records retrieval, and the like. The CSTs have strong clinical supervision and also play the primary case management role in the system. **Figure 3** depicts the structure of a CST.

Figure 3
Delaware Components of Clinical Services Management



- **Level of Care Criteria**. DCMHS developed level-of-care criteria specific to children's behavioral health, which guide clinical decision-making between the commercial MCOs and DCMHS and guide the CST treatment planning process. In addition, DCMHS has developed other clinical guidelines related to such areas as the definition of urgent care and requirements for physicals for children involved in the child welfare system. Also, the State Medicaid agency funded DCMHS to develop a behavioral health screening instrument for children, which is used by providers as a screen to trigger assessments for mental health and substance abuse treatment services.
- **Provider Networks**. To further promote continuity of care between the commercial MCOs and DCMHS, Medicaid requires the MCOs to enroll DCMHS providers in MCO networks. This requirement created an issue initially in that the MCOs had to revise their credentialing and privileging processes to include community agencies, as opposed to their standard practice of credentialing only individual practitioners. In addition, Medicaid requires that providers in MCO networks cannot discriminate between serving commercial and Medicaid-insured consumers. DCMHS provides an ongoing series of training/workshops for MCOs and providers, among others. Trainings have been held on such topics as cultural competency in behavioral health care, mental health and substance abuse integration, and performance improvement in behavioral health care.
- **Service Continuity and Coordination**. In the Delaware system, once a child becomes eligible for Medicaid, he/she automatically remains eligible for six months, unless incarcerated or moves out of state. This helps to prevent disruptions in behavioral health care, particularly for children involved in the child welfare system who experience multiple placements. Children may access behavioral health services directly without having to go through their primary care physician (PCP). When children are admitted to services provided through DCMHS, their primary care providers are sent a letter (with consent of parents or guardians) and given the name of the clinical services management team leader and care coordinator. PCPs also are notified when children leave DCMHS care. The State Medicaid agency holds quarterly meetings with DCMHS, the child welfare and juvenile justice agencies to address service continuity and coordination issues.
- **Bundled Rate Financing**. The commercial MCOs receive a capitation from Medicaid for both physical and behavioral health services (the statewide average rate is about $100 per member per month). Medicaid and DCMHS worked out an agreement for a bundled rate for the DCMHS service population, (i.e., those with intermediate to severe behavioral health needs). Medicaid pays the Department of Services for Children, Youth and Their Families a bundled rate of $4,239 per Medicaid-eligible client served per month, a rate that was based on actual DCMHS client service and expenditure data. Mental health general and block grant revenue and some child welfare dollars also help to finance the system. DCMHS and Medicaid share the risk. EPSDT is built into the system as the screening process for behavioral health services.

- **Performance Measurement**. DCMHS has developed a performance monitoring system with indicators at both the system and child/family (i.e., clinical and functional outcomes) levels. Examples of indicators include: psychiatric hospital length of stay; "service load", that is periodic snapshots of the extent of utilization of each service component; system admissions; crisis activity; and others.
- **Information Management System**. DCMHS' data system provides real time data on every child in the system across service components. It allows for client and service tracking and provides the range of data needed to support the performance monitoring system. The data system meets MHSIP standards, is fully relational and provides crucial service data to support development of DCMHS' bundled rate. The DCMHS data system is linked to the Department-wide automated client record and decision making support system – Family and Child Tracking System (FACTS) — which includes both the child welfare and juvenile justice systems. It allows for 24-hour online accessibility by departmental staff, a particularly unique feature of the system.

Local Managed Care Systems[12]

A. Wraparound Milwaukee, WI

Overview

Wraparound Milwaukee is a behavioral health carve out, serving several subsets of children and families in Milwaukee County, Wisconsin. Its primary focus 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 600 children a year. 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 is managed by Wraparound Milwaukee, housed within the Milwaukee County Mental Health Division, Child and Adolescent Services Branch, which acts as a public care management entity. Wraparound Milwaukee organizes an extensive provider network and employs, directly or by contract, 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.

[12] While these local managed care systems are focusing on relatively small subsets of children, they represent customized approaches to managing care for children with serious, complex and historically costly disorders – approaches that could be integrated into larger managed care designs serving total eligible populations.

Key Design and Financing Features

- **Publicly-Operated Care Management Organization**. Wraparound Milwaukee is a publicly-operated managed care system, with the Child and Adolescent Services Branch of the County Mental Health Division acting as the managed care entity. The Branch 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 Branch, however, utilizes managed care technologies, including a management information system designed specifically for Wraparound Milwaukee, capitation and case-rate financing, service authorization mechanisms, provider network development and management, accountability mechanisms, and utilization management, in addition to care management.
- **Broad Benefit Design**. Wraparound Milwaukee covers a very broad array of services and supports, including: case management; referral assessment; medication management; outpatient individual/family; outpatient group; outpatient/drug and alcohol; psychiatric assessment; psychological evaluation; mental health assessment/evaluation; inpatient psychiatric; nursing assessment/management; consultation with other professionals; daily living skills-individual; daily living skills-group; parent aide; child care; housekeeping; mentoring; tutor; life coach; recreation; after school programming; specialized camps; discretionary (i.e., flexible) funds; supported work environment; group home care; respite; respite foster care; respite-residential; crisis bed-residential; crisis home; foster care; treatment foster care; in-home treatment; day treatment; residential treatment; and transportation. The system provides over 80 core services (see **Provider Network and Consumer Choice**, page 28). The ability to cover an extensive array of services and supports is made possible by the diverse funding streams that support the system.
- **Mobile Urgent Treatment Team** (**MUTT**). Wraparound Milwaukee has a 24-hour mobile crisis team attached to it; it is one of the few service components directly staffed by the Child and Adolescent Services Branch itself, rather than contracted. It also is the one component of Wraparound Milwaukee that serves not only the 600 enrolled youth but the community at large, handling about 4,000 calls a year and 1,500 face-to-face contacts. Its primary purpose is to respond when a child's behavior threatens his or her removal from home, school, etc. The team goes to where the crisis is occurring, assesses the situation, identifies alternatives to hospitalization whenever possible, and makes referrals as needed. In addition to crisis intervention, the team can provide access to short-term case management, intensive (30-day) case management, 60-day family preservation services, and crisis group home care. The team acts as a first-line response to prevent unnecessary hospitalization and improve families' access to care in crisis situations. The team operates from 9 a.m. to 10 p.m. on Monday through Friday and from 1:30 p.m. to 10 p.m. on Saturday and Sunday. After hours, MUTT can be reached by telephone through an on-call system. The team is staffed by child psychologists, psychiatric social workers, and case managers and serves all children in the County, including those enrolled in Wraparound Milwaukee.
- **Care Coordinators Working in a Wraparound Approach**. As a care management organization, Wraparound Milwaukee utilizes care coordinators, largely on a contracted basis, who are responsible for convening a **Child and Family Team** to develop a

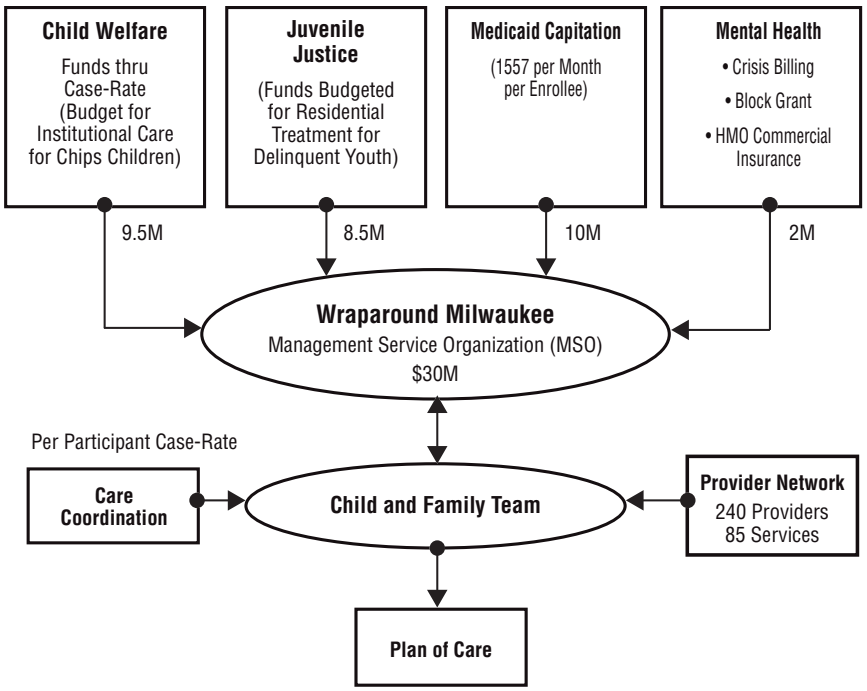
wraparound plan of care for each child referred to the system. The Child and Family Team is comprised of the child and his or her family, other key people in the child's life, including providers, teachers, family advocate, etc., and the care coordinator. Care coordinators meet the child and family, conduct a strengths-based inventory, convene the Child and Family Team, and work with the team to develop a wraparound plan, including goals, identification and prioritization of needs, and identification of formal services and informal supports within the family's support system. The wraparound process also is used to create community-based **safety networks** for certain adjudicated youth with "high risk" behaviors, such as fire-setting and sexual offenses. A safety network is comprised of responsible, competent adults who contractually agree to supervise the offender while he or she is in their care. In addition, the wraparound process creates **safety plans** for children who have been the victims of sexual or physical abuse, and each plan of care includes a crisis plan. Care coordinators obtain the commitments needed to implement the plans of care developed through the wraparound process and ensure that plans are evaluated and modified as needed over time. At a minimum, plans are reviewed every 90 days. Care coordinators prepare and submit service authorizations, collect outcomes data and assume some of the administrative and legal functions previously performed by a child's probation officer or child welfare worker, for example, court reports. Care coordinators have very small caseloads (1:8 or 9 families), and, in the Wraparound Milwaukee model, are primarily individuals with bachelor's degrees in the human services field. Supervision of care coordinators and access to specialized clinical expertise also are important in this approach. For example, care coordinators have access to specialized expertise related to victims of sexual abuse, and they receive specialized training in this and other areas (see **Training**, page 31).

- **Family and Youth Advocacy and Natural Supports**. Wraparound Milwaukee is committed to partnering with families in all aspects of service design and delivery. It funds Families United of Milwaukee to provide family support and advocacy services, run support groups and activities, conduct satisfaction surveys, serve on committees and boards, train care managers, and provide information and educational materials for families. Wraparound Milwaukee also is committed to inclusion of natural supports to enhance service delivery and reduce families' dependency on formal services. It includes a wide array of natural support services, such as mentoring, in its provider network and actively seeks to identify friends, family members, peers, faith-based organizations, schools, and civic groups that can be integrated into individual plans of care. As discussed more fully below, Wraparound Milwaukee seeks to increase parent choices in selecting services and providers and promotes family independence, rather than system dependency. Wraparound Milwaukee also has developed a youth advocacy group, which to date has sponsored fundraisers, recreational outings, and volunteer activities, and is designing peer mentoring services to support youth involved in Child and Family Teams.
- **Provider Network and Consumer Choice**. In preparation for developing a broad, diverse provider network, Wraparound Milwaukee developed service descriptions, standards, and rates for over 80 core services. It has no formal contracts with providers but rather utilizes a comprehensive fee-for-service approach. Community agencies are invited to apply to provide one or more core services. Wraparound Milwaukee then credentials providers who will participate in the network. There are over 240 providers

(individual and agency) involved in the provider network. Certain high-cost services, such as residential treatment and psychiatric hospitalization, may require prior authorization, and outliers are reviewed; however, most vendors 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 for services provided, and the MIS system matches actual services provided against the authorized plan of care. The system links with another system to cut checks and enter payments on the ledger. The system has streamlined previously cumbersome, multiple contracting and payment systems. Because typically there are multiple providers enrolled in Wraparound Milwaukee's network offering the same types of services, families and youth have a **choice** in providers as long as the type of service or support is called for in their plan of care. For example, if family counseling is part of the plan of care, a family may choose any family counseling provider from within the network. This provides another way of creating greater control for families over their services and creates an accountability mechanism for Wraparound Milwaukee. The system can continually examine which providers are being under- or over-utilized by families and explore underlying causes, such as quality issues, location, cultural sensitivity, etc.

- **Blended Funding**. **Figure 4** illustrates the major funding streams that support Wraparound Milwaukee. Note that the financing design includes a capitated payment from Medicaid and a case-rate payment from the child welfare system, along with funding from the mental health and juvenile justice systems.

Figure 4
Wraparound Milwaukee Pooled Funds



In 2001, the average cost of care in Wraparound Milwaukee was $4,100 per month, compared to $6,700 per month for the cost of residential treatment. Because savings earned by Wraparound Milwaukee are reinvested in the program, the system is able to serve more children with the same amount of funds. For example, in 2001, Wraparound Milwaukee served 600 children and their families, over 200 more children than could have been served with the same amount of dollars in the old system.

- **Interagency Collaboration**. Both with respect to funding and policy, as well as day-to-day operating procedures, care planning and coordination, interagency collaboration is a key ingredient of Wraparound Milwaukee. The system has identified some key challenges to effective collaboration across child-serving systems and strategies to address them. The need to understand the *differences in the language* used by juvenile justice, child welfare, and mental health is one critical area. The system has designed training and informational materials to help break down barriers created by language differences. *Role definition*, that is deciding who is in charge in a collaborative endeavor, is another area of focus. In the first instance, Wraparound Milwaukee emphasizes that families are in charge in a family-driven system; in addition, they do team development training and job shadowing across systems to ensure understanding of the multiple roles across systems. *Information sharing* is another area where the system has focused attention, setting up a common database for shared access to information, sharing organizational charts and phone lists, sharing paperwork responsibilities with other systems, for example, preparation of court reports, and promoting flexibility in schedules to support attendance at meetings. Because Wraparound Milwaukee is serving children involved in the child welfare and juvenile justice systems, it also pays close attention to the *safety* concerns that are the purview of these systems. Child and Family Teams, for example, document safety plans, protocols are developed for particularly high risk youth, and the system demonstrates adherence to court orders. Wraparound Milwaukee stresses the importance of *relationship-building* with other key stakeholders, such as judges and teachers, and the importance of *documenting outcomes* that have meaning to these stakeholders. Finally, the system seeks to infuse its *values base* into all of its meetings, trainings and interactions with other systems as the “glue” that holds stakeholders together.
- **School Partnership**. Wraparound Milwaukee and Milwaukee public schools have developed a variety of ways of supporting each other to strengthen the overall system of care. In addition to the on-site crisis intervention provided by the Mobile Crisis team discussed above, Wraparound Milwaukee also provides technical assistance to the schools in such areas as behavioral change programs, school wraparound plans, and supervision/observation. The system also has funded and arranged after-school programs, tutors, and in-home academic support for individual children. It has secured child care before school and/or to enable parents to attend school meetings. It has funded day treatment services, arranged and funded clinical services and medication management, and facilitated and funded neurological and psychiatric evaluations. For its part, the schools have participated in Child and Family Teams and in transitional planning for youth returning from residential treatment. They have supported wraparound plans by allowing half-day or otherwise modified school schedules, by supporting certain teacher or classroom reassignments, and by allowing behavioral aides in classrooms. Teachers have served as mentors and tutors for children.

In addition, the schools play an important role in developing transition plans for youngsters returning to regular education, for youth transitioning to vocational services, and in the area of academic testing.

- **Training**. Wraparound Milwaukee builds training into all aspects of its system. Care coordinators, for example, must be certified by completing 40 hours of mandatory training, and there are mandatory, monthly in-service trainings on clinical and program issues for all care coordinators. Wraparound Milwaukee's training program is based on the system's values of partnering with families, and it utilizes paid parent trainers as co-trainers. The system also partners with Families United of Milwaukee to provide trainings for families. Trainings are conducted by and for providers and by and with other systems, such as education and child welfare. For example, Wraparound Milwaukee is contracted to train all 400 child welfare workers in the county on the wraparound approach and other elements of the program.
- **Quality Assurance/Improvement and Outcomes Monitoring**. Wraparound Milwaukee utilizes a comprehensive quality assurance/quality improvement program and has established outcome indicators to measure program effectiveness. Its outcomes address program, fiscal, clinical, and safety issues. The system examines the following outcome indicators:
  - Is there improved clinical functioning as measured by scores on the Child and Adolescent Functional Assessment Scale (CAFAS)?
  - Has there been a reduction in restrictiveness of living environment?
  - Is there reduction in juvenile justice contracts?
  - Has school attendance improved?
  - Are the wraparound costs comparable to or less than residential treatment costs?
  - Are families satisfied with services?

  Wraparound Milwaukee uses the Child Behavior Checklist and the Youth Self Report, creating a quality improvement system in which there are three different raters of change — parents, youth, and care coordinators.

  The system has achieved: better clinical outcomes, reduced recidivism of delinquent youth served, improved school attendance, reduction in the use of residential treatment and psychiatric hospitalization, and reduction in the cost of care, as noted above.
- **Information Management System**. Wraparound Milwaukee partnered with management information specialists to design an Internet-based clinical and financial management software package that integrates family service plans with service data, allows providers to bill online (reducing reimbursement times from five weeks to about five days), and maintains provider contract data. The MIS system supports integration of cost and quality outcomes and facilitates a flexible, responsive service delivery approach. Some 300 people — care coordinators, administrators, providers, evaluators, etc. — use the system, which is reducing paperwork processing time enormously. Access safeguards are built into the system. A "train the trainers" approach is used to build capacity within the system to use the MIS capability effectively.

B. The Dawn Project — Marion County, Indianapolis, IN

Overview

The Dawn Project is a behavioral health carve out serving a subset of children in Marion County (Indianapolis, Indiana). It focuses on Marion County children who have serious emotional or behavioral disorders, are involved in multiple systems, and are in or at risk for residential placement. Dawn serves about 150 children on any given day and has served over 600 youth and their families since its inception in May 1997. The average length of stay in care is 14 months. Several state and county agencies finance the project, including the State Mental Health Agency, the state special education agency, the county child welfare agency, and the juvenile court, creating a case-rate of $4,254 per member per month. Indiana Behavioral Health Choices (Choices), a nonprofit care management organization, acts as the managed care entity. The Dawn Project was created to integrate care for children involved in multiple systems and their families, including the child welfare, mental health, juvenile justice, and education systems, and draw on the strengths of families to reduce long-term system dependency and improve outcomes. Choices employs service coordinators, who are responsible for organizing and facilitating Child and Family Teams, which develop individualized service plans using a wraparound, strengths-based approach. The Dawn Project partners with families at all levels of the system and actively monitors quality and outcomes. It adheres to a values base that emphasizes the resiliency of children and families and their capacity for positive development when provided with family-centered, community-coordinated support.

Key Design and Financing Features

- **Nonprofit Lead Agency Care Management Organization**. Indiana Behavioral Health Choices, a nonprofit entity, acts as the lead agency for managing the care of children enrolled in the Dawn Project. It employs over 26 service coordinators and case managers, who coordinate Child and Family Teams. It utilizes an extensive network of providers in the community and has developed rates for a broad array of services and supports. Like Wraparound Milwaukee, Choices utilizes a variety of managed care technologies, including case-rate financing, service authorization mechanisms, quality improvement, utilization management, and care management. In addition to the Dawn project, Choices operates a **youth emergency services** component that provides immediate in-home crisis intervention and follow-up services for children and families who come to the attention of child protective services for reasons of abuse or neglect. It also operates a **24-hour crisis counseling and in-home support program** for families struggling with children who have a history of running away or are at risk of running. Choices also operates a **school truancy prevention component**, a program serving families who are **homeless** or are at risk for homelessness, and a program serving adults who are **homeless with a co-occurring disorder of mental illness and addictions**. The Dawn Project draws on these in-house components of Choice, in addition to over 500 community providers.
- **Broad Benefit Design**. The Dawn Project covers a broad array of services and supports, which it has organized under nine major headings: (1) behavioral health services (e.g., individual and family therapy, day treatment, etc.); (2) psychiatric services (e.g., assessment, medication management); (3) mentor services (e.g., educational mentors, case aides, parent and family mentor, life coach/

independent living skills mentor, etc.); (4) placement services (e.g., residential treatment, therapeutic foster care, supported independent living, etc.); (5) respite services (e.g., crisis respite, planned respite); (6) supervision services (e.g., intensive supervision, community supervision); (7) discretionary (e.g., child care, clothing, groceries, etc.); (8) other services (e.g., camp, consultation with other professionals, team meetings, etc.); and (9) care management and service coordination. A diversified funding base and case-rate financing structure support the Dawn Project's broad, flexible benefit design.

- **Interagency Governance**. The Dawn Project utilizes a cross-system governing and oversight body for the Dawn Project, called the Dawn Project Consortium. It is comprised of the payor agencies, families, referring agencies, the managed care entity (i.e., Choices), advocates, and additional representatives from the public schools. The Consortium meets monthly. At the service-delivery level, Child and Family Teams work across agencies to integrate school plans, court orders, probation requirements, and mental health plans into one coordinated plan that is manageable for families.
- **Partnership with Families**. One of the Dawn Project's first initiatives was to establish a family support group, which over time has developed into a family support organization, Families Reaching for Rainbows, the Marion County chapter of the national Federation of Families for Children's Mental Health. The organization provides support and advocacy for families enrolled in Dawn and also provides general advocacy, information, and education for families in Marion County. Family members participate as partners on Child and Family Teams and, as noted above, also serve on the governance body for the Dawn Project.
- **Service Coordination and Clinical Management**. Children are referred to the Dawn Project from the child welfare, juvenile probation, or special education systems based on established eligibility criteria (i.e., child has a serious emotional disorder and is in or at risk for residential treatment or hospitalization). A child's enrollment in Dawn activates assignment to a **Service Coordinator** who organizes and facilitates a **Child and Family Team.** This team, comprised of the child, family members, other natural supports, and relevant providers and agencies, develops a services plan that draws on the child's and the family's strengths and integrates action steps across life domains (e.g., school, home, etc.). Every service plan also contains a clearly defined crisis plan that includes 24-hour response and clearly-defined roles for team members, including family members and youth. The Dawn Project has the philosophy that "families don't fail, plans do", so it aggressively manages service plans by having teams meet monthly. Service Coordinators carry very small caseloads (1:8). They are able to authorize funds for agreed upon services. They are supported by Indiana Behavioral Health Choices clinical management software, called **The Clinical Manager (TCM)**, which has integrated clinical and fiscal data capabilities. TCM maintains the following information: consumer demographics; comprehensive intake assessment information; family/team member data; contact management; medication management; education/ health/placement histories; treatment planning information, including needs and problems, goals and outcomes, interventions and strategies, authorizations, and strengths and supports; cost approval and analysis data; and claims adjudication.

- **Extensive Provider Network**. The Dawn Project utilizes over 500 vendors, and has established rates for an extensive array of services. Residential, group, and foster care programs that it uses are licensed by the child welfare agency in Marion County. The provider network encompasses both clinical treatment services and informal support services.
- **Training**. Training is a key component of the Dawn Project. Service Coordinators receive initial and ongoing training. Dawn uses a training format in which service coordinators, supervisors, and managers receive 90 minutes per week of training covering a variety of topics to support and enhance performance. In addition, supervisors participate in meetings/trainings with Choice management every two weeks. Family members are involved both as recipients of trainings and as trainers. Trainings are also available to providers in the network.
- **Case-Rate Financing and Flexible Funds**. As noted earlier, the Dawn Project is financed by several state and county agencies, whose dollars support a case-rate of $4,254 per member per month (the project started with a case-rate of $4,130; it increased by 2% after three years of implementation). **Figures 5** and **6** show how Dawn is funded and its cost allocation breakdown.

Figure 5
How Dawn Project is Funded

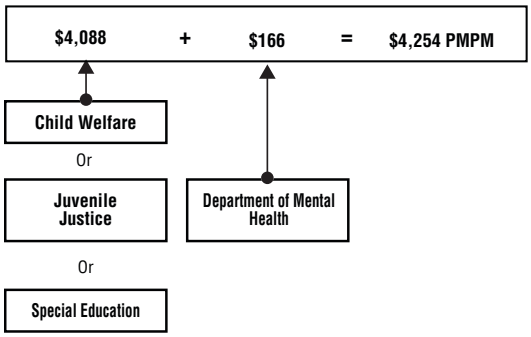
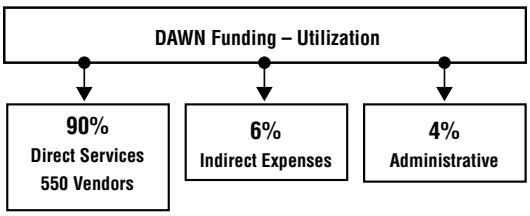


Figure 6
DAWN Project Cost Allocation



The case-rate structure and Dawn's internal financial management structure allow for flexible funding of services and supports, with service coordinators having access to **flexible dollars** in a quick turnaround mode.

- **Outcomes Monitoring**. The Dawn Project Consortium created an Outcomes Committee to develop a set of performance indicators for the Dawn Project. Current outcome measures include the following:
    1. improved child and family functioning, including improved school functioning, improved records with the child welfare and juvenile justice systems, improved records for community supervision for Department of Corrections youth, improved CAFAS scores, progress on service coordination plans, and fewer days in out of home placement;
    2. increased family autonomy, measured by a decrease in the number of paid providers and a Caregiver Strain Questionnaire;
    3. parents/families feel more effective, as measured by a Family Assessment Device;
    4. commitment of caregivers to the plan of care, measured by team meeting attendance;
    5. services meet the real needs of the child and family, measured by narrative reports based on service coordinator focus groups;
    6. decreased cost per child; and
    7. child and family receive cost-effective services.

    In addition to monitoring outcomes for clinical and financial accountability to guide project management and service coordinators, an interdisciplinary team of researchers, partnering with family members, providers, and administrators is implementing a comprehensive evaluation plan. The Evaluation Study focuses on six general areas: (1) profile of Dawn project participants; patterns and costs of service use; (2) dynamics of service coordination teams; effectiveness; family involvement; and (3) system level functioning. Cost data to date indicate that the Dawn project, at a cost of $4,130 per child per month is less costly to Marion County than standard treatment at a cost of $6,017 per child, and that clinical functioning of children enrolled in Dawn improves between enrollment and six months. The cost differential appears to be related to reduced reliance on residential treatment in the Dawn Project. In addition, the management mechanisms in place at the Dawn Project have reduced significantly double and duplicate billings for services rendered.
- **Management Information System**. The Dawn Project is supported by a customized management information system that provides real time clinical and cost information. The system supports Service Coordinators in making quick plan adjustments as needed and in readily accessing flexible funds. It also supports the outcomes monitoring process and Evaluation Study.

C. Massachusetts — Mental Health Services Program for Youth (MA-MHSPY) Cambridge, MA

Overview

The Massachusetts-Mental Health Services Program for Youth (MA-MHSPY) in Cambridge, Massachusetts, is an integrated physical-behavioral health managed care initiative serving a subset of children and their families. It focuses on Medicaid-eligible children in the Cambridge and Somerville communities and has recently expanded to the communities of Malden, Everett, and Medford, MA. It focuses on children and adolescents who have persistent symptoms of serious emotional disturbance, risk of out-of-home placement, significantly impaired functioning, and multi-agency involvement. The purchasers are several State agencies, including Medicaid, Child Welfare, Mental Health, Juvenile Justice, and Education. These child-serving agencies have agreed to "blend" their dollars, which combine to create a case-rate of $3,283 per member per month.[13] The managed care entity is Neighborhood Health Plan, a nonprofit health maintenance organization, which manages the system and provides directly or contracts for medical, behavioral health, and social support services. With the recent expansion to Everett, Malden, and Medford, the system has the capacity to serve 100 children at any given time, and the average length of stay is 16 months. It is unique in its integration of primary care with behavioral health in a "system of care" approach. The MA-MHSPY philosophy stresses individualized, comprehensive, culturally appropriate, strengths-based, and coordinated services designed and implemented in partnership with families. It stresses the importance of continuity in settings and relationships and the quality of the relationship between the clinician and child and family.

Key Design and Financing Features

- **Health Plan as Home Base**. MA-MHSPY is, in effect, a small, customized service delivery and care management program housed within a large health insurance plan, Neighborhood Health Plan, which serves as the managed care entity for MA-MHSPY. This is a rather unique arrangement in that, historically, MHSPY-like initiatives[14] have not utilized health plans as care management entities, but instead, like the Dawn Project and Wraparound Milwaukee, which have many similarities to this project, have used government, quasi-government, or community-based nonprofits in care management roles. Unlike traditional HMOs or MCOs, however, Neighborhood Health Plan (NHP) specializes in coverage for Medicaid populations, particularly special needs populations, such as persons with HIV/AIDS and adults with disabilities. Many of its staff come from public systems or community health centers. An advantage to using

[13] Note. Readers are cautioned against making direct comparisons between case-rates in different initiatives. There are many reasons for differences, (e.g., benefit structures and service costs). Benefit designs typically differ. For example, MHSPY's case-rate of $3,283 encompasses both physical and behavioral health care, but it has a 30-day stop-loss on respite and residential services. The Dawn Project's case-rate of $4,130 does not include physical health care, but it must support as much residential and respite care as a child and family uses.

[14] In the early to mid 1990s, the Robert Wood Johnson Foundation (RWJ) launched the Mental Health Services Program for Youth (MHSPY), which funded eight states and cities initially to implement MHSPY projects; Wraparound Milwaukee was one of these projects. RWJ then funded 12 more "replication" sites, of which the MA-MHSPY and DAWN projects are two.

a health plan as the management entity is that it allows MA-MHSPY to have increased contracting power compared to its small membership base and facilitates access to an established primary care network.[15] However, MA-MHSPY still has had to develop specialty services and supports not found in NHP's customary network, and there remains a certain "culture clash" and tension between the health plan structure and approach that supports provision of usual and customary care and MA-MHSPY's highly individualized approach and need for flexibility in system structures. The health plan's policies and procedures, (e.g., claims processing) all have required some customization to accommodate MA-MHSPY, a reality that creates challenges for both NHP and MA-MHSPY.

- **Broad Benefit Design**. The MA-MHSPY project covers a very broad array of services and supports, including: primary and specialty medical care through the enrollment of children in Neighborhood Health Plan; traditional and nontraditional mental health and substance abuse services; wraparound family, educational, and community supports; mentoring, care coordination, and care management. Children enrolled in MA-MHSPY are eligible to receive MassHeath (i.e., Medicaid) standard services plus enhanced mental health and substance abuse and social support services for the child and family, delivered in the home, school, or community. Services and supports include: short-term residential treatment; therapeutic after-school day treatment; respite; crisis intervention services; family support services, such as parent training, behavior management training, parent aides, parent support, and in-home respite care; education, training, and clinical consultation; recreation services; day and overnight camping; individual programming in developmental skill areas; case aides; mentors; transportation; care coordination; direct clinical services; case consultations; family consultations; case administration; flexible funds; and nontraditional supports. The broad array of services is supported by "blended" funding from multiple state agencies.
- **Interagency Governance and Coordination**. MA-MHSPY is governed by an interagency steering committee that sets policy. The MA-MHSPY Steering Committee is comprised of senior staff from the central and regional offices of the state Departments of Education (DOE), Mental Health (DMH), Social Services (DSS), Youth Services (DYS), and Medical Assistance (DMA), parents of children with serious emotional disorders, and senior managers from NHP/MA-MHSPY. In addition, MA-MHSPY is supported operationally by an Area Level Operations Team (ALOT Team). The ALOT Team reviews enrollments, serves as an interagency management and problem-solving resource for MA-MHSPY's Care Planning Teams (discussed below), and facilitates collaboration. It is comprised of: DMH Children's Case Management Supervisor; DSS Area Program Manager; DYS Day Reporting Center Director; DMA MA-MHSPY Project Manager; special education designees from each local school department; MA-MHSPY Enrollment Coordinator; NHP/MA-MHSPY Medical Director and Clinical Supervisor. MA-MHSPY's Care Planning Teams develop individualized plans of services and supports that are integrated across these systems.

[15] While another potential advantage to using a health plan is the ability to spread the higher costs of a special population like MA-MHPY's across a much larger membership base, that is not what occurs in this situation. Costs for MA-MHSPY are borne almost solely by the MA-MHSPY budget.

- **Care Planning and Clinical Supervision**. MA-MHSPY/NHP directly employs **Care Managers**, who are masters-level, licensed mental health clinicians with experience and training in family therapy and team facilitation. They provide care coordination, leading the care planning process, and direct clinical services, working directly with family members, and case administration, authorizing services and documenting care planning processes and outcomes. Care Managers carry small caseloads of 1:8. Every child and his/her family that is enrolled in MA-MHSPY is assigned a Care Manager, who organizes and facilitates a **Care Planning Team** (CPT). These teams are family-focused and engage in a structured process to identify strengths and concerns and establish goals and timeframes to create an **Individualized Care Plan**. CPTs include parents, including parent advocates (see below), all relevant providers and agency/school staff, and significant support people in the family's life, in addition to MA-MHSPY's Care Manager. It is a goal of MA-MHSPY that the family and nonprofessionals invited by the parents make up 50% of the MA-MHSPY CPT, reinforcing a value that the family is at the center of the care planning process. All Individualized Care Plans include detailed crisis plans. Care Managers have the authority to authorize services agreed upon by the CPT and monitor implementation of the plan. CPTs meet at least monthly to review implementation of care plans and evaluate progress toward treatment goals. Senior licensed mental health clinicians supervise Care Managers, providing weekly individual supervision, and a child psychiatrist leads the overall MA-MHSPY program and provides weekly group supervision. In addition, MA-MHSPY stresses ongoing training opportunities for Care Managers, as well as for parent partners (see below).
- **Parent Partners**. MA-MHSPY employs two full-time equivalent **Parent Coordinators** and part-time parent partners, who support parents of children enrolled in MA-MHSPY at Care Planning meetings, school meetings, court appearances, etc. In addition, MA-MHSPY is allied with the statewide family advocacy organization, Parent-Professional Advocacy League (PAL), which organizes recreational and education and support activities for parents in general. MA-MHSPY's Clinical Manager sits on PAL's Board, and the two organizations collaborated on developing a training curriculum on family collaboration. As noted, there also is parent representation on the MA-MHSPY Steering Committee, the governance body for the project. MA-MHSPY stresses a family-focused approach, having families at the center in the care planning process and building on family strengths to improve outcomes and reduce system dependency.
- **Enrollment Process and Integration with Primary Care**. MA-MHSPY enrollment is handled by the state Medicaid agency, which receives referrals from the child welfare, juvenile justice, mental health, and education systems. When families enroll their children with MA-MHSPY, they, in effect, are enrolling in Neighborhood Health Plan, and their primary care providers either must have an existing relationship with NHP or be added to the network. MA-MHSPY has had the advantage of an existing primary care relationship by virtue of its being housed in NHP; in addition, the pediatric group used by NHP had a history of working in the community. However, MA-MHSPY has also had to develop relationships with primary care providers outside of NHP's network. MA-MHSPY stresses that integration with primary care requires either an

established relationship with primary care providers or the means (time and appropriate staff) to develop those relationships, and the program must be able to offer payment to primary care providers, if necessary, to participate in meetings. Ironically, MA-MHSPY has yet to have to spend dollars to enlist the cooperation of primary care providers in service planning. However, the program believes that its ability to pay providers for their time spent in meetings is essential, that it creates a positive climate for collaboration.

- **Case-Rate Financing Structure**. As noted earlier and as illustrated by **Figure 7**, several State agencies "blend" dollars to finance a $3,283 case-rate for the MA-MHSPY project.

Figure 7
MA–MHSPY Case-rate Breakdown

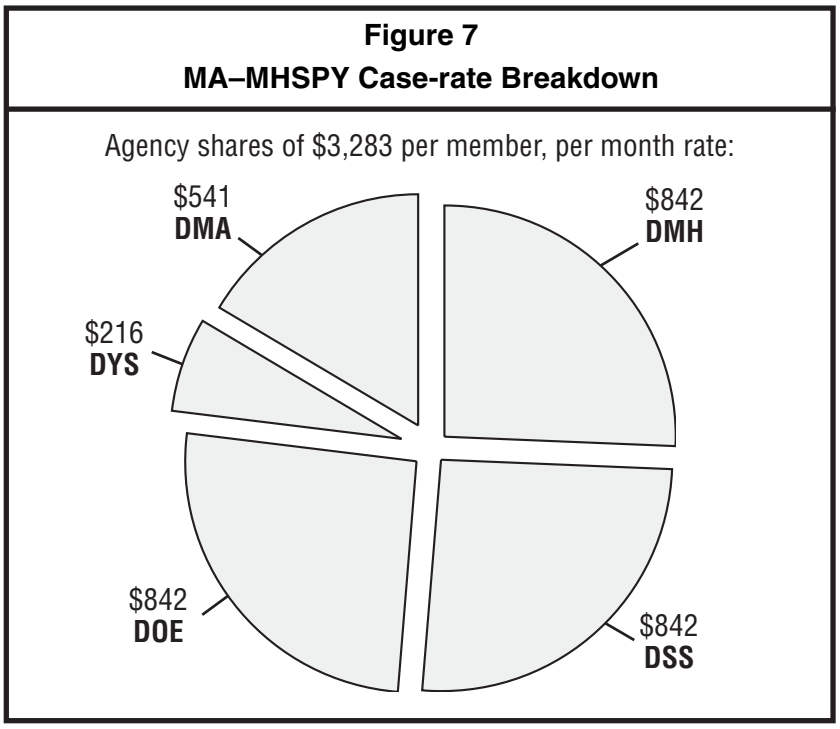
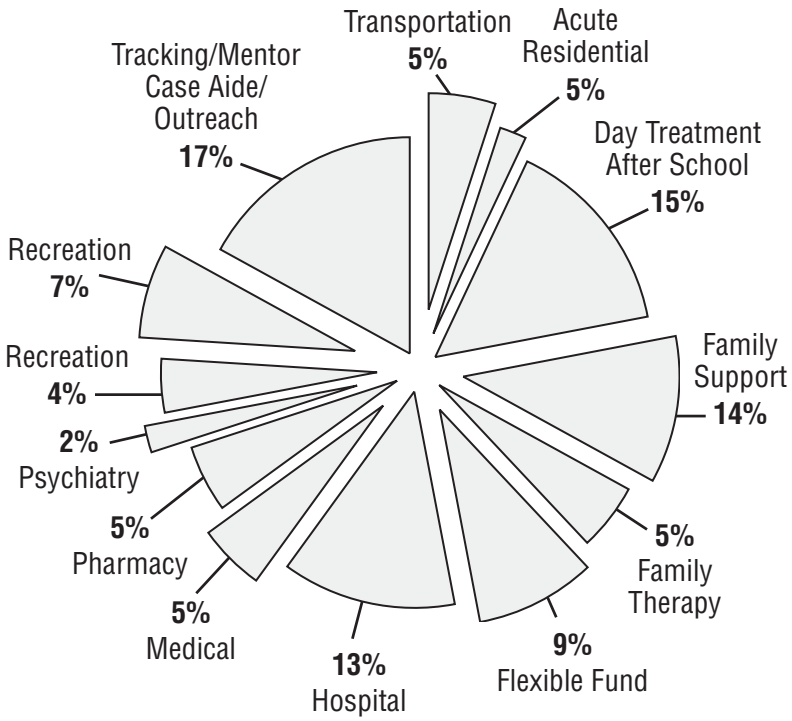


Figure 8 shows the distribution by cost of clinical services supported by the case-rate.

Figure 8
MA–MHSPY Distribution of Total Clinical Service Types by Cost



Family Support — includes crisis intervention, family support, family advocacy, and parent support, family stabilization, team and parent education.

Therapy — includes individual and group therapy.

Tracking/Mentor/Case Aide/Outreach — is composed of tracking, mentor, case aide, and outreach counseling service.

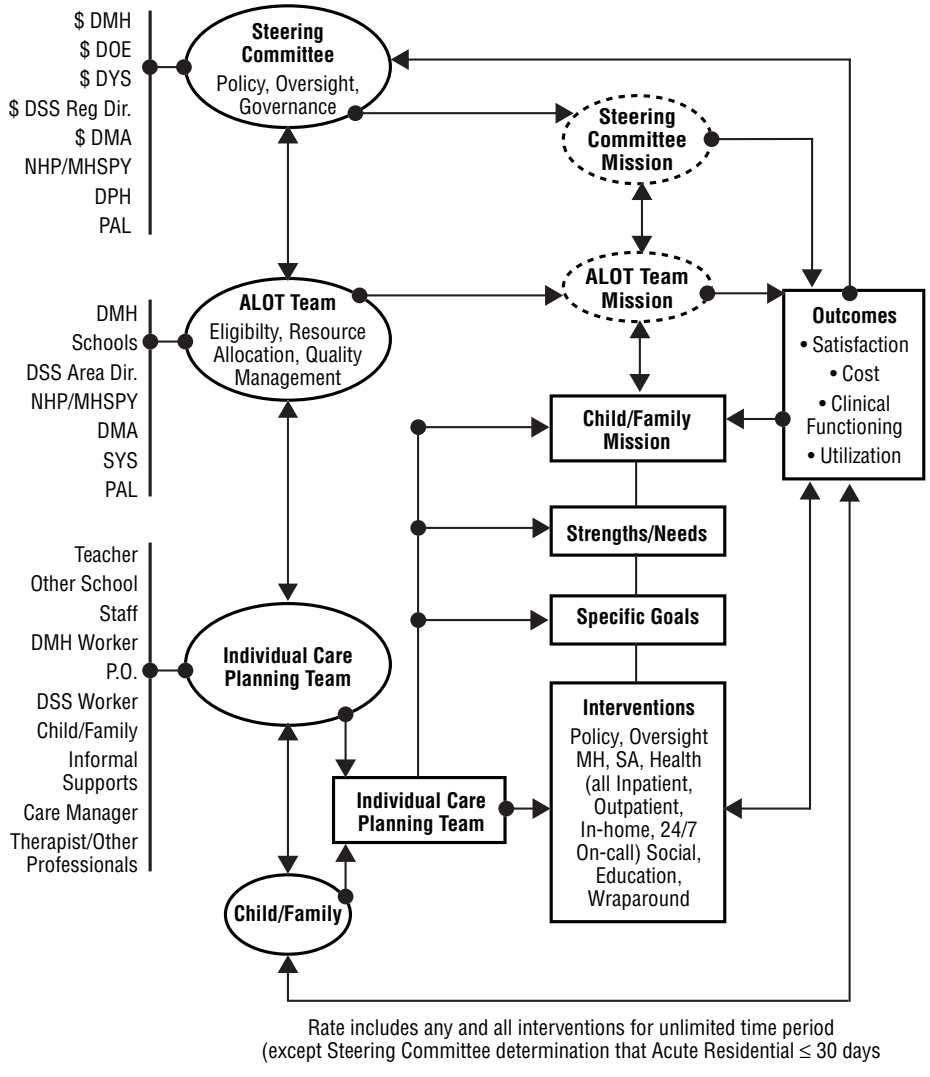
Recreation — includes both day and overnight services, activities therapy, and family night.

MA-MHSPY costs have run at about 92% of the case-rate on average over the past three years and, reportedly, significantly less than the cost that "usual and customary" care would have run. Particularly as compared to the costs of residential treatment, MA-MHSPY is demonstrating significant cost savings.

- **Outcomes Accountability**. MA-MHSPY tracks clinical and functional outcomes, using a variety of measures, including the Child and Adolescent Functional Assessment Scale (CAFAS) and the Child Global Assessment Scores (CGAS). It also tracks the cost of care and family satisfaction. Their family satisfaction rating is 93%, and their program retention rate is 98%. Their data also indicate that, across school, home, and community domains, there has been a 38% improvement in level of functioning, on average, at 6 months after enrollment in the program and a 43% improvement at 16 months. As noted above, data also show cost efficiencies, particularly in comparison to the cost of residential treatment.

  Figure 9 provides a graphic overview of the MA-MHSPY project:

Figure 9
MA–MHSPY Overview



D. Utah Frontiers Project

Overview

The Utah Frontiers Project is an interagency initiative that includes support from the Utah Medicaid Prepaid Mental Health Plan, a behavioral health carve out serving Medicaid-eligible children. The Utah Frontiers Project (Frontiers) serves six counties in areas of the State that are so remote and sparsely populated that they are characterized as frontier communities. Frontier counties have a population density of less than seven persons per square mile. As an interagency initiative that draws on resources from across existing child-serving systems, Frontiers is able to serve not only Medicaid-eligible children but also non Medicaid-eligible children. The target population includes children with serious emotional disorders, ages birth to 17 (or up to age 21 if receiving special education services), who live in the designated frontier communities. Frontiers serves about 200 children and their families at any given time. Frontiers utilizes an interagency governance and management structure based on the Families, Agencies, and Communities Together (FACT) structure that was mandated by State legislation in 1993. The FACT legislation, which was based on system of care values and principles, required interagency, community, and family collaboration to improve outcomes for children and families. Clinical management for Frontiers is provided by interagency service planning and monitoring teams, called WRAP Teams. The Utah Prepaid Mental Health Plan pays for many of the services needed by Medicaid-eligible children involved in Frontiers. FACT legislative requirements were built into Prepaid Mental Health Plan contracts.

Family partnership and extensive use of natural and community supports are critical to the Frontiers Project as these communities are characterized by severe shortages of clinical services, vast distances that separate people, limited dollars, and misconceptions about mental health services. Frontier values that stress self-reliance, conservatism, distrust of outsiders, religion, work-orientation, and individualism make it essential that families and trusted community figures are partners in care planning and delivery. Thus, engaging families and drawing on community supports is a major element of the Frontiers Project. The specific goals of the project are to: develop comprehensive and quality wraparound services, utilizing natural supports and community/family members as service providers; develop effective and accountable clinical and governance structures to monitor and manage the process for service planning and delivery; provide culturally competent and clinically sound services to the target population by fully involving children and families in project planning, development, implementation, management, and evaluation; and maximize existing fiscal and human resources to enhance and sustain services.

Key Design and Financing Features

- **Interagency Governance and Management Structure**. Frontiers utilizes an interagency governance and management structure that grew out of the FACT legislation. Each county has a Local Interagency Council, comprised of family and community members and agency representatives. The Local Interagency Council meets at least monthly to determine which children will be referred to Frontiers and to oversee service planning (i.e., WRAP) teams. At a minimum, the Local Interagency Councils conduct reviews of children in care every 90 days. The Local Councils also have flexible funds available to purchase nontraditional supports for children and families. The Community Mental Health Centers (CMHCs) in each county play an

additional management role (in addition to participating on the Local Interagency Councils). CMHCs are the managed care entities for the Utah Prepaid Mental Health Plan, which covers many of the services and supports provided to Medicaid-eligible children involved with Frontiers. CMHCs in the Frontiers counties have created administrative teams, which meet monthly to review utilization and administrative issues that arise in connection with Frontiers. CMHC administrative teams help to inform the work of the Local Interagency Councils.

- **Benefit Design**. Frontiers covers a broad array of services and supports, virtually anything that a WRAP Team identifies, because the project draws on the existing resources of all child-serving systems and resources within the community and family as well. The Utah Prepaid Mental Health Plan can cover many nontraditional services and supports for Medicaid-eligible children involved in Frontiers, in addition to more traditional clinical services, through a "**Creative Interventions**" service category that was built into the benefit design specifically with the needs of rural and frontier communities in mind. The Creative Interventions category can cover such services and supports as respite, home- and school-based services and supports, collaborative consultation, telephone consultation, and culturally responsive services, such as traditional Native healers. Prior to the introduction of managed care, which allows for flexibility in the types of services and types of providers covered, it would have been very difficult, if not impossible, for the Medicaid fee-for-service system to support a Frontiers-type of project, with its highly individualized approach that relies heavily on use of natural helpers and nontraditional services and supports.
- **Individualized Service Planning and Delivery**. The FACT legislation mandated that child-serving systems collaborate to provide needed services and supports through a single coordinated Individualized Service Plan (ISP). The legislation emphasized that the ISP must be culturally competent, family-focused, and community-based. Under the auspices of the Local Interagency Councils in each Frontiers county, individualized service planning teams, called WRAP Teams, identify strengths, resources, and needs of children and their families and develop plans of care in a wraparound approach. WRAP Teams are comprised of families and youth, other natural helpers and community supports, and relevant providers and agencies. Because of the scarcity of traditional services as well as the culture in frontier communities, WRAP Teams rely heavily on natural helpers, such as family members, and nontraditional supports in a child's community as a basic element of care. Plans of care also include defined crisis plans, which again involve natural helpers in specific ways because the long distances in frontier communities to formal crisis intervention systems preclude overreliance on those systems. Plans of care typically also designate a case manager. Frontiers does not directly hire or contract for case managers; instead, it draws on existing resources from all of the child-serving agencies, including schools, and family members as well, to be case managers. As noted earlier, Frontiers utilizes a case review system, in which the Local Interagency Councils review cases every 90 days at a minimum. In addition, the CMHC administrative team reviews service utilization of children in care who are eligible for the Utah Prepaid Mental Health Plan.

- **Parent Partnership**. The Utah Federation of Families is a partner in the development, implementation, and evaluation of Frontiers. Family representatives participate in the key governance and management structures for the project, as noted earlier, and are very much part of the WRAP Team process. Parents are paid by the State to provide technical assistance and on-site monitoring to Frontiers (and other) counties. Frontiers also uses paid family facilitators, whose role it is to reach out to and support families of children with serious emotional disorders in the Frontiers communities. These facilitators work closely with the WRAP teams. Family members play a critical role in outreach to families who may be reluctant to seek services because of stigma about mental health services or a distrust of government systems. The Frontiers communities are home to diverse cultures, including American Indian and Latino families, and to political and religious subcultures, such as polygamists, who have distinct cultural beliefs and practices. The Frontiers Project relies heavily on family members to reach out to diverse populations and help to dispel myths and misconceptions related to mental health services.
- **Financing**. Managed care has enabled the State to broaden the array of services and supports paid for by Medicaid and incorporate greater flexibility in service provision. In addition, the FACT legislation provided Local Interagency Teams with flexible dollars. Frontiers also has used federal Center for Mental Health Services grant dollars creatively to finance, among other elements, significant training (see **Training and Technical Assistance**, page 44). For the most part, however, Frontiers is based on a financing strategy of maximizing *existing* resources — from across all child-serving systems and within the community — and of creating a culture in which the question of efficacy is continually asked to avoid ineffective use of scarce dollars.
- **Training and Technical Assistance**. Frontiers views training as a fundamental strategy for achieving sustainability. It embraces a unified training approach across child-serving systems and with families and has focused on training related to evidence-based practices, such as Functional Family Therapy. In addition, Frontiers draws heavily on training related to utilizing and supervising a wraparound services approach.
- **Evaluation**. The State emphasizes the importance of evaluation and partners with families in monitoring and evaluating activities. Families, for example, are involved in monitoring Prepaid Mental Health Plan contracts as members of the state Department of Mental Health's Child Team, which visits MCOs annually; these visits also are used as opportunities to identify areas for technical assistance. Families also have been involved in developing instruments to measure families' perceptions of care and burden of care. Frontiers builds on these efforts to create a participatory evaluation process that measures:
    1. outcomes at the child/family level, measuring change in presenting symptomatology, functional status at home, school and community, stability of living arrangements, and family function;
    2. outcomes at the systems level, measuring such elements as service capacity and competence of staff as a result of training; and
    3. process measures that evaluate satisfaction, experience of care, perception of collaboration, and the integrity of the wraparound process.

IV. Concluding Observations

While the seven design and financing approaches described in this paper are unique each in its own way, they also share certain challenges and characteristics, which are summarized in this concluding section.

Major Common Challenges

- **Lack of service capacity** is a frustrating reality across all these sites, particularly lack of nontraditional types of services, such as therapeutic foster care and respite, and of highly-specialized expertise, such as child psychiatry. The lack of service capacity has to do with structural underfunding that pre-dated managed care in many cases, a lack of providers, or an unwillingness of providers to develop different types of services.
- **Cultural inertia**, that is, the difficulty of moving deeply entrenched agencies and providers to adopt new skills, knowledge, and attitudes, is challenging across sites. This seems particularly true with respect to areas such as partnering with parents, adopting a strengths-based perspective, incorporating natural supports, learning new evidence-based practices, and embracing a wraparound services approach.
- **Scale** is an issue in both directions. When the scale is large, such as in the three statewide initiatives, quality control is a challenge. When the scale is small, such as in the locally managed systems, "taking the project to scale" is a challenge. When the scale is small, as in the locally managed systems focusing on subsets of children, having sufficient purchasing power, clinical capacity, and system impact is a challenge. This creates a special burden on pilots since size impacts efficacy, and efficacy impacts sustainability.
- **Time and complexity** are related challenges. Because they involve multiple agencies, funding streams, and stakeholders and are undertaking major systems changes, all of these approaches are complex with many implementation challenges. They require time to implement effectively, and time often is a precious commodity in public systems that must demonstrate results within relatively short-term budget and legislative cycles and under the spotlight of public view.

Common Characteristics

- **Values-based designs** are characteristic of these initiatives. Values are similar to the principles of systems of care, and are relevant to children and their families. All of these approaches build family-friendly core values into their designs, using managed care technologies as a means to operationalize their values.
- **Partnerships with family members at all levels of the system** characterize these approaches. Family partnerships are a fundamental design feature that are deliberately structured at policy, management, and service delivery levels with resources devoted to building the capacity of families and other stakeholders to partner effectively.
- **Use of multiple resources**, **including blended or braided financing**, is a key characteristic of these approaches.
- **A broad**, **flexible benefit design** is another common characteristic, made possible by drawing on multiple resources and by managing care to avoid cost overruns.

- **Incorporation of individualized services planning** for children with serious disorders, often using a "wraparound" approach and utilizing clinical decision-making tools and criteria designed for children and adolescents, is common across these initiatives. These approaches create, in effect, a customized approach to care for children with the most serious, complex disorders.
- **Use of a single care management entity** statewide or within a region to create a locus of accountability, particularly for children with serious disorders, is a characteristic of these approaches.
- **Incorporation of intensive care management for children with serious disorders** is a feature across these approaches.
- **Inclusion of both clinical treatment services and natural supports** is a characteristic of these approaches. Some go further than others in drawing on natural supports, but all build into the design the capacity to incorporate indigenous, community supports as part of the plan of care, particularly for children with serious disorders.
- **Attention to training and technical assistance** characterizes these approaches, including **attention to evidence-based and best practices.** Training and technical assistance built around effective practices is an important design feature that is deliberately structured in an ongoing fashion.
- **Quality improvement processes relevant to children and data-based decision-making** are common elements of these approaches. Typically, these approaches track outcomes and process measures relevant to children and families at both the services and systems levels and use data to guide policy and service decision-making.

V. RESOURCES

More detailed information about each of the design and financing approaches described in this paper can be obtained by contacting the following individuals:

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