# 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.

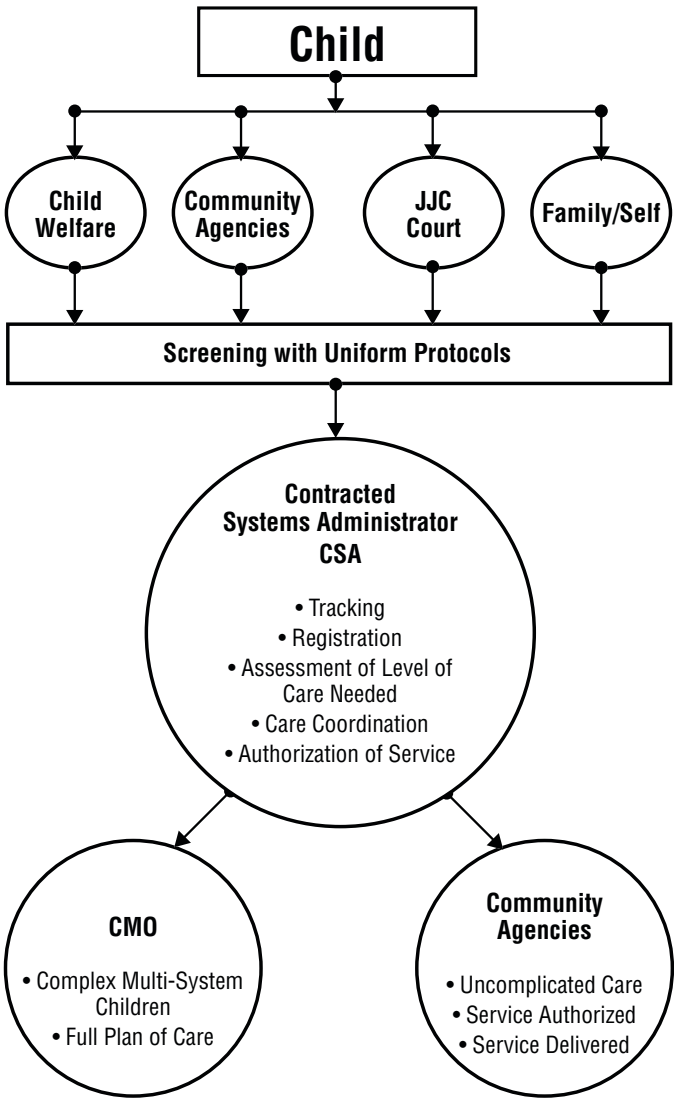
- **Provider Network**. All providers under contract with the NJ Department of Human Services are eligible to participate in the Initiative. Providers must meet Division of Youth and Family Services (DYFS) licensing requirements. Contracts are on a fee-for-service basis through a combination of cost 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

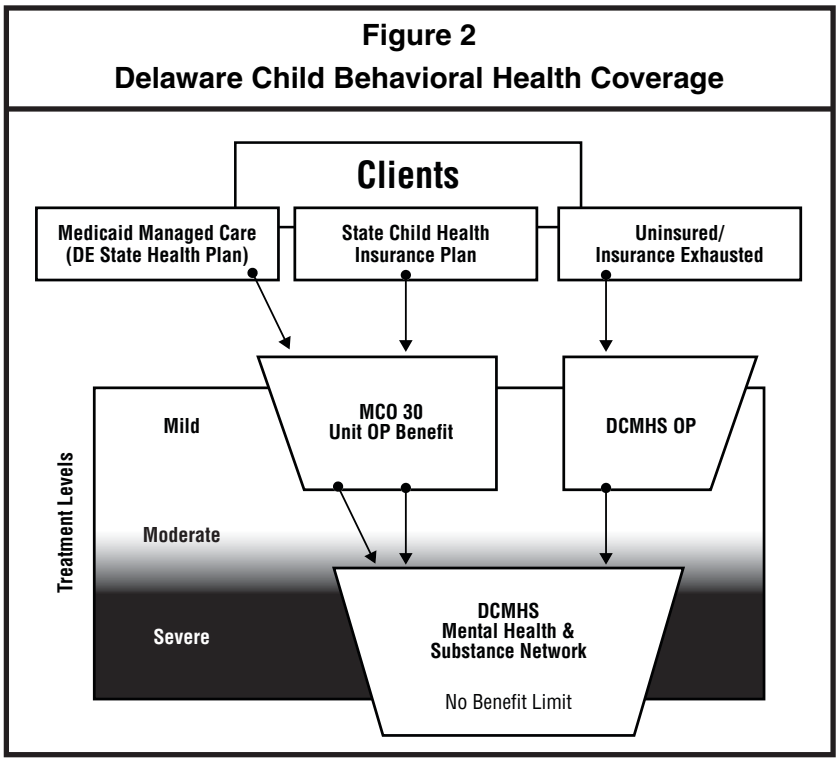
The essential design feature of Delaware's statewide Medicaid managed care initiative, the Diamond State Health Plan, is a partnership between commercial managed care plans and the State Division of Child Mental Health Services (DCMHS) for the delivery of children's behavioral health services. Delaware's 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**

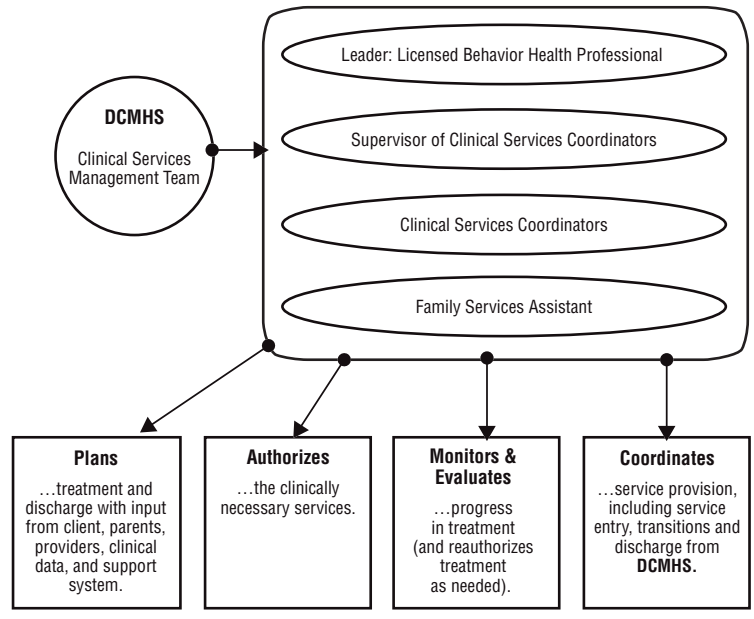



- **Broad Benefit Design**. The Partnership covers a broad array of services, including: 24-hour, statewide mobile crisis services and crisis residential; intake and assessment; clinical service team functions, including treatment planning and monitoring and case management; outpatient services; behavioral 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

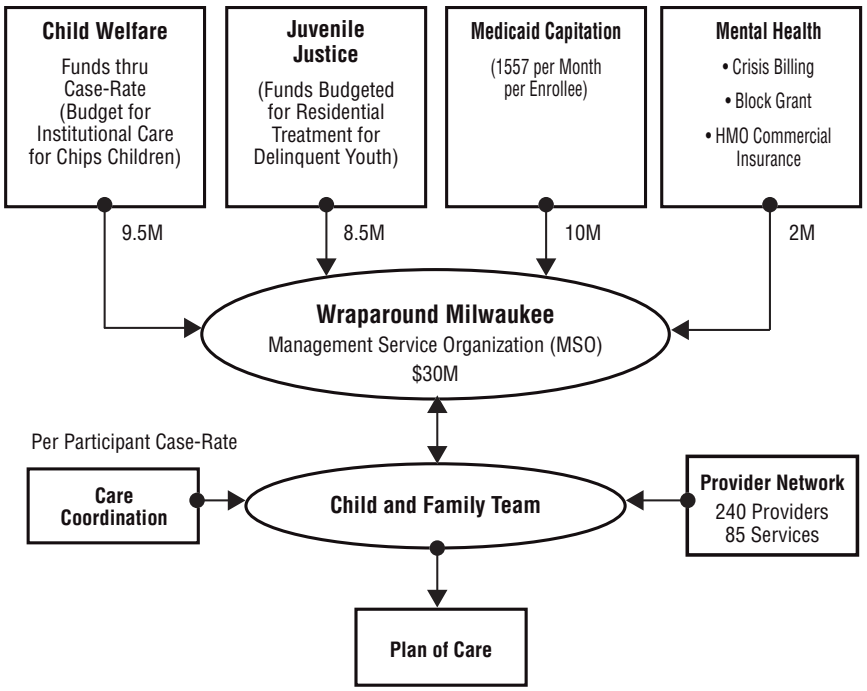
**wraparound plan of care** for each child referred to the system. The Child and Family Team is comprised of the child and his or her family, other key people in the child's life, including providers, teachers, family advocate, etc., and the care coordinator. Care coordinators meet the child and family, 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.