

Promising Approaches

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

5: Serving Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems

Beth A. Stroul

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Partial Contents: Introduction to HC RTP – Methodology for Promising Approaches (PA) – Overview of PA 5: Serving Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems – Serving Youth – Issues and Challenges – Responding to Needs – Description of PAs – Levels of Care (DE, MI) – Enhanced Benefits (OK, OR) – Special System of Care Carve Out (IN, WI, MO) – Specialty Provider Network (TX) – Incorporation of System of Care Philosophy and Approach (PA) – Specialized Care Planning and Coordination (RI) – Common Characteristics and Challenges – Conclusion – Appendix – Availability of Reports and Analyses of the HC RTP

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A Series of the

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Introduction

Health Care Reform Tracking Project

Since 1995, the **Health Care Reform Tracking Project (HC RTP)** has been tracking publicly-financed managed care initiatives and their impact on children with mental health and substance abuse (collectively referred to as behavioral health) problems and their families. The HC RTP 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 special analyses related to children involved in the child welfare system. The HC RTP is 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, D.C., and the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development. The mixed method design of the Tracking Project has involved periodic surveys of all states, in-depth impact analyses involving site visits to a selected sample of states, and the identification and dissemination of promising approaches and features of managed care systems.¹

Throughout these activities, the Tracking Project has explored and compared the differential effects of **carve out designs**, defined as arrangements in which behavioral health services are financed and administered separately from physical health services, and **integrated designs**, defined as arrangements in which the financing and administration of physical and behavioral health care are integrated (even if behavioral health services are subcontracted).

¹ All reports of the Healthcare Reform Tracking Project (HC RTP) are available from the Research and Training Center for Children's Mental Health, Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL., (813) 974-6271: See **Appendix**, page 72.

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Methodology for Study of Promising Approaches

The strategies and approaches that are described in the **Promising Approaches Series** were identified by key state and local informants who responded to the HCRTTP's state surveys and who were interviewed during site visits to states for the HCRTTP's impact analyses. Once promising approaches and features of managed care systems were identified through these methods, members of the HCRTTP team, including researchers, family members, and practitioners, engaged in a number of additional methods to gather more detailed information about identified strategies within particular topical areas. 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.

For each general topical area studied, a paper is prepared to explain the challenges and to describe promising approaches or features of managed care systems that are considered by key informants to improve service delivery for youth with behavioral health treatment needs and their families. These papers comprise the *Promising Approaches Series*.

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 HCRTTP has not formally evaluated these approaches. In addition, none of these approaches or strategies is without problems and challenges, and each requires adaptation in new settings to take into account individual state and local circumstances. Additionally, 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.

It is important to note that the series does not describe the universe of promising approaches that are underway in states and localities related to each of the aspects of managed care systems that was studied. Rather, it provides a snapshot of promising approaches that have been identified through the HCRTTP 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. An attempt is made in each paper to identify these commonalities, thus offering guidance to states and communities attempting to refine their managed care systems to better meet the needs of youth with serious behavioral health disorders and their families.

Overview

Promising Approaches 5: Serving Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems

As noted, each paper in the series focuses on a specific aspect of publicly financed managed care systems. This paper focuses on promising approaches for serving youth with serious and complex behavioral health needs in managed care systems. The paper begins with a brief discussion of the issues and challenges related to serving youth with serious and complex behavioral health disorders and their families in the context of managed care. These issues and challenges have surfaced through all of the previous activities of the Tracking Project.

A number of promising approaches for meeting the needs of this population are then described. Identified through the state surveys and impact analyses that have comprised the Tracking Project, these approaches are perceived by key state and local informants to support effective service delivery to this most challenging population.

I. Serving Youth with Serious Behavioral Health Disorders in Managed Care Systems

Issues and Challenges

From the earliest stages of the Tracking Project, a specific emphasis has been placed on exploring the impact of managed care systems on the population of children and adolescents with serious behavioral health disorders and their families and on the systems of care that serve them. These are the youth with the greatest level of need, whose care most challenges their families and communities, who require intensive treatment and supports in multiple arenas of functioning, for whom significant resources are required, and whose problems are most likely to lead to school failure, substance abuse, suicide, and long-term impairments that continue into adulthood. Results from the state surveys and feedback from stakeholders interviewed through the impact analyses has led to the identification of a number of issues that affect the provision of appropriate services to youth with serious behavioral health disorders and their families in the context of managed care systems.

Planning for Youth with Serious Disorders

The need for specific, discrete planning processes for serving youth with serious and complex needs within managed care systems has been consistently found through all of the Tracking Project's activities. The early surveys and impact analyses confirmed a distinct lack of focused attention to the needs of children with serious behavioral health problems; most states did not distinguish this population from the total population of covered children, nor did they include any special benefits or provisions within their managed care systems to serve this group of high utilizers. The 2000 State Survey

revealed increased planning for children with serious behavioral health disorders. It is likely that the increased planning was attributable to states' growing experience with managed care, problems arising in implementation that led states to initiate planning processes and incorporate changes, and increased advocacy on the part of key stakeholders to better address the needs of this challenging population. While reports of discrete planning declined somewhat in 2003, this may be related to the more advanced implementation stages of managed care systems. Overall, attention to children with serious disorders in the managed care planning process has increased over time.

Table 1			
Percent of Managed Care Systems with Discrete Planning for Children and Adolescents with Serious Behavioral Health Disorders			
1997/98 State Survey	2000 State Survey	2003 State Survey	Percent of Change 1997/98 – 2003
57%	83%	74%	+17%

Extent of Coverage of Extended Care Services

Children with serious and complex behavioral health disorders are likely to need multiple services and supports, often at high levels of intensity and over significant durations of time. Thus, short-term, acute care services are not likely to be sufficient to provide for the treatment and support needs of these youngsters and their families; most will need longer-term, extended care. Acute care is defined as brief, short-term treatment with, in some cases, limited intermediate care also provided, and extended care is defined as care extending beyond the brief, acute stabilization phase, i.e., care required by children with more serious disorders and their families. Managed care in the commercial sector historically has focused on providing coverage for acute care, leaving the public sector to assume responsibility for consumers with serious disorders requiring extended care services and supports. The Tracking Project explored the extent to which extended care services are covered in managed care systems in addition to acute care, with obvious implications for children with serious and complex needs.

Early Tracking Project findings revealed that many public sector managed care systems were limiting their coverage to acute care. In leaving extended care out of managed care systems, states were both failing to take advantage of the potential of managed care to spread risk over a total eligible population of children, as well as its potential to manage service delivery and costs for the children who are the highest utilizers of behavioral health services – those with the most serious disorders. By the 1997–98 survey, a trend toward increased inclusion of extended care services in managed care systems was observed, and by 2003, 95% of the managed care systems reported covering extended care services, theoretically enhancing the likelihood of meeting the needs of children with serious and complex disorders and their families.

Table 2 Percent of Managed Care Systems with Coverage for Extended Care Services			
1997/98 State Survey	2000 State Survey	2003 State Survey	Percent of Change 1997/98 – 2003
74%	88%	95%	+21%

Fragmentation of Responsibility for Behavioral Health Extended Care Services

Even though most managed care systems now include coverage for extended care services, other child-serving systems still retain both responsibility and significant amounts of resources for behavioral health services as well. The systems most likely to retain both responsibility and resources, in addition to the managed care system, are the public mental health system, the child welfare system, the juvenile justice system, and the public substance abuse system. All integrated managed care systems reported that these systems retain responsibility and resources, suggesting that although they report covering extended care, the extended care actually provided may be limited, resulting in a reliance on other child-serving systems for longer-term services.

Some stakeholders feel that leaving responsibility and resources in other child-serving systems creates a “safety net” for youngsters with serious disorders should managed care systems not authorize or deliver certain services and supports. However, most stakeholders agree that the multiple funding streams and overlapping responsibility for children’s behavioral health care aggravate the historic fragmentation, duplication, and confusion characterizing children’s services. Managed Care Organizations (MCOs) are forced to grapple with the complexities of multiple systems in the children’s arena, including parallel delivery systems in other children’s systems and resource and boundary disputes with these systems. In addition, this fragmentation may contribute to incentives for managed care systems to underserve children with serious disorders needing extended care services, since they potentially can be shifted to other systems with both responsibility and resources to provide behavioral health care. The potential for such shifting of children and costs to other systems is especially high when capitation or case rates are considered inadequate and/or when there are inadequate risk adjustment mechanisms for high utilizer populations, such as children with serious behavioral health disorders.

Table 3 Percent of Managed Care Systems with Other Systems Also Having Responsibility and Resources for Behavioral Health Extended Care	
	2003 State Survey
Public mental health system	81%
Child welfare system	83%
Juvenile justice system	72%
Education system	58%
Substance abuse system	72%

Access to Extended Care Services

Stakeholders interviewed for the Tracking Project noted a widespread perception that it was more difficult to access services beyond a certain basic level in the managed care system compared with pre-managed care, thereby making it more difficult to obtain extended care for children with serious disorders and their families. Thus, coverage of extended care alone does not guarantee that youngsters with serious disorders will receive needed services and supports if there are substantial barriers to accessing care. A number of explanations for impaired access to extended care were offered, including: cumbersome and strict authorization processes; tighter controls and/or arbitrary limits and resulting reductions in admissions to inpatient, residential treatment, and other services; rigid interpretation of medical necessity and other clinical decision making criteria that limit both the type and duration of care; and lack of sufficient service capacity to meet the need for particular extended care services. Stakeholders also noted particular pressures and emphasis in managed care systems on a short-term, episodic approach to treatment, that is not sufficient for youth with serious disorders who are likely to need ongoing services and supports over time.

In further exploring this area, the 2000 survey found that access to extended care services was indeed compromised in managed care systems with integrated designs — access to extended care was considered to be worse in nearly two-thirds of the integrated managed care systems, as compared with only 4% of the managed care systems with carve out designs. For example, in some managed care systems, it reportedly was significantly more difficult to access hospital or residential treatment services for extended stays, even though, in some cases, children with serious disorders may need this care. The 2003 survey found improvements in this area, with only 6% of the managed care systems reporting worse access to extended care. Where access to extended care is difficult, youngsters with serious disorders reportedly experience more difficulty in obtaining needed services and supports at appropriate levels and durations, and children with higher acuity are served in lower levels of care that may not be equipped to respond to their needs.

Table 4					
Impact of Managed Care Systems on Access to Extended Behavioral Health Services					
	2000 Total	2003			Percent of Change 2000 – 2003
		Carve Out	Integrated	Total	
Access to extended behavioral health services is better	36%	71%	46%	62%	+26%
Access to extended behavioral health services is worse	14%	5%	5%	6%	-8%
No change in access to extended behavioral health services	50%	24%	46%	32%	-18%

Service Capacity for Broad Array of Community-Based Services

Stakeholders noted that underdeveloped service capacity for home and community-based services means that appropriate levels of care often are not available for youngsters with serious disorders. Similar to the issues around access to care, coverage for a broad array of services is necessary, but not sufficient to ensure that youngsters with serious disorders receive the treatment services and supports that they need. Although managed care reforms have expanded coverage, the actual availability of these services is a separate and distinct issue. Lack of sufficient service capacity for children's behavioral health is a systemic issue that predates managed care reforms. However, in many cases, the implementation of managed care systems has not resulted in improvements, and lack of sufficient capacity remains a barrier to serving youth with serious disorders. Stakeholders reported extensive wait lists for some services, pervasive shortages of particular types of services, and large gaps in the service array in rural and frontier areas. They also indicated that providers are reluctant to develop and offer new types of services as they lack start-up resources and particularly if they perceive the payment rates for them to be insufficient or if they perceive overly restrictive authorization practices among MCOs.

The 2000 and 2003 state surveys found that significant expansion of the availability of home and community-based services occurred in very few managed care systems (21% in 2003); 37% of the managed care systems resulted in very little or no expansion in service capacity for the types of services that youngsters with serious disorders are likely to require. Managed care systems with carve out designs have been far more successful in expanding service capacity. Further, ratings of the general level of service capacity in the states were higher for managed care systems with carve out designs, but mean ratings did not approach the level of "highly developed" regardless of managed care system design. Across all managed care systems, only 19% characterized service capacity in their state as highly developed in 2003. This indicates that lack of sufficient service capacity is a continuing problem that affects behavioral health service delivery, particularly for youth with serious disorders.

Despite this lack of service capacity, most managed care systems (68% in 2003) do not require that any savings from the managed care system be reinvested back into the system to expand capacity for children's behavioral health services. Only about half of the states reportedly are investing in service capacity development (53% in 2003), and impact analysis results suggest that stakeholders consider these investments to be inadequate in relation to the need.

Table 5 Service Capacity for Home and Community-Based Services			
	2003 State Survey		
	Carve Out	Integrated	Total
Percent managed care systems with very little or no expansion of availability of home and community-based services	19%	62%	37%
Percent of managed care systems with significant expansion of availability of home and community-based services	36%	0%	21%
Mean rating of service capacity (1 to 5 scale with 1 being highest)	2.80	4.00	3.20
Percent managed care systems with highly developed service capacity (1 or 2 on 5 point scale)	32%	0%	19%
Percent managed care systems with poorly developed service capacity (4 or 5 on 5 point scale)	23%	40%	30%
Percent of managed care systems that require reinvestment of savings in service capacity development	57%	0%	32%
Percent of managed care systems with state investment in service capacity development	59%	53%	53%

Application and Interpretation of Medical Necessity Criteria

The Tracking Project found that nearly all states use medical necessity criteria in clinical decision making processes for authorizing care, including the types, levels, and duration of services and supports. Given their widespread use, the feedback of stakeholders about the barriers that may be created by medical necessity criteria that are too rigid or applied too stringently has been explored, particularly in view of the potential difficulties that could occur in obtaining authorization for services to children with serious and complex needs. Stakeholders noted that narrow definitions of medical necessity, based solely on a medical model, fail to account for the need to link treatment with the social and environmental supports so critical for children and adolescents with serious disorders. In addition, medical necessity criteria in some managed care systems may not “fit” the long-term nature of serious behavioral health disorders, making it difficult to obtain authorization for the more intensive services and supports over time. For example, some medical necessity criteria require the expectation of “continual improvement” in order to maintain eligibility for services. Maintaining stability, rather than improvement, may not be seen as meeting medical necessity criteria, though it may be a legitimate goal for some youth with serious disorders.

In response, many states have created broad definitions of medical necessity, or broadened their definitions to allow for consideration of psychosocial and environmental factors in clinical decision making and to consider the ongoing service and support needs of youth with serious disorders. The 2000 and 2003 surveys found that the majority of managed care systems (89% in 2003) now have criteria that consider psychosocial and

environmental factors. Even with broader criteria, however, stakeholders in some systems noted problems related to the application of medical necessity criteria — inconsistent application by MCOs and overly rigid interpretation and application by some MCOs that create barriers to service delivery, limiting both the types and duration of services. This has particularly strong implications for children with serious disorders and extensive service needs.

Table 6 Medical Necessity Criteria			
	2003 State Survey		
	Carve Out	Integrated	Total
Medical necessity criteria allow consideration of psychosocial and environmental factors	91%	87%	89%
Medical necessity criteria are interpreted narrowly by managed care organizations (MCOs)	20%	27%	23%

Interagency Treatment and Service Planning

Interagency treatment and service planning is a process whereby representatives of all involved child-serving agencies and systems come together, in partnership with the youth and family, to jointly develop and implement a coordinated, individualized service plan for the child and family. This process, which is characteristic of systems of care and most often is convened by a case manager, typically is reserved for youngsters with serious and complex disorders who have multiple needs and are involved with multiple systems. The Tracking Project found a number of barriers to interagency treatment and service planning in the managed care systems in some states:

- Providers may not be able to bill for participating in service planning meetings; there may be no allowable billing code for this activity.
- The process is more complicated with the advent of managed care by the need to include yet another player — the MCO. Since MCOs often do not participate in interagency service planning meetings, providers spend an inordinate amount of time attempting to obtain authorization for services that the service planning team agreed upon but that the MCO is not obligated to provide or pay for.
- Case managers to convene and coordinate the process may not be available, and in some states, their role may be shifted to a more service authorization and gatekeeper role rather than a broker, facilitator, and coordinator of care.

Table 7 Interagency Service Planning			
	2003 State Survey		
	Carve Out	Integrated	Total
Interagency treatment and service planning is incorporated in managed care system	86%	38%	69%

By 2000, requirements for interagency treatment and service planning for youth with serious disorders reportedly were included in managed care systems through RFPs, contracts, service delivery protocols, and other key system documents in most systems, especially those with carve out designs. Over two-thirds of the systems reported incorporating interagency treatment planning in 2003. However, the impact analyses revealed that, even with such requirements, these processes may not be occurring to the degree necessary in some managed care systems, and that, according to stakeholders, MCOs are infrequent participants and are not required to provide or pay for the services and supports that are recommended by the service planning team.

Case Management/Care Coordination for Children with Serious Disorders

For youngsters with serious and complex needs, case management or care coordination services, often at intensive levels, are needed to plan, access, facilitate, and coordinate multiple services and supports, often from multiple agencies and programs. Thus, the availability of enhanced case management services is a critical variable in providing services to this population. By 2000, and again in 2003, the Tracking Project found that case management services for children with serious behavioral health disorders reportedly had increased as a result of the implementation of managed care. However, this was primarily found in managed care systems with carve out designs. Case management services increased in few of the systems with integrated designs, and, in fact, they reportedly decreased in some of the integrated managed care systems.

Table 8			
Impact of Managed Care on Case Management/Care Coordination Services			
	2003 State Survey		
	Carve Out	Integrated	Total
Case management services have increased as compared with pre-managed care	82%	21%	58%
Case management services have decreased as compared with pre-managed care	0%	7%	3%
No effect on case management services	18%	71%	39%

Fiscal Incentives

Unintended financial incentives to underserve consumers with the most serious and potentially most expensive service needs may compromise services to youth with serious disorders in the context of managed care. Some managed care systems attempt to mitigate the financial risk to MCOs and providers of meeting the needs of this group. Higher capitation or case rates for enrolled consumers with serious disorders and/or other risk adjustment mechanisms are used to protect MCOs and providers against financial losses from providing the needed high levels of care to this group. However the use of these approaches to manage the risk posed by high-need populations (in particular children with serious behavioral health disorders) is not extensive. The 2000 and 2003

surveys found that about 30% of managed care systems use risk adjusted rates for any high-need population at all. In 2003, only 13% use risk adjusted rates for youth with serious disorders, and even fewer for youth involved with the child welfare and juvenile justice systems. Further, very few managed care systems use other risk adjustment mechanisms of any type. This raises a question as to the adequacy of safeguards to protect against underservice to children with serious disorders and their families.

Table 9
Percent of Systems with Risk Adjusted Rates for High-Need Populations

	2003 State Survey		
	Carve Out	Integrated	Total
Use of risk adjusted rates for children and adolescents with serious behavioral health disorders	18%	6%	13%
Use of risk adjusted rates for children and adolescents in the child welfare system	5%	18%	10%
Use of risk adjusted rates for children and adolescents in the juvenile justice system	5%	12%	8%
Use of stop loss	5%	24%	13%
Use of risk corridors	18%	6%	13%
Use of reinsurance	5%	18%	10%
Use of risk pools	5%	0%	3%

Understanding of the Special Needs of Children with Serious and Complex Needs

Lack of understanding of the special legal, logistical, coordination, and treatment needs of children with serious and complex behavioral health needs reportedly has compromised the provision of appropriate services and supports to this group, according to stakeholders. This is particularly the case for youngsters involved in other child-serving systems, such as child welfare or juvenile justice, since these systems may have custody of youth needing treatment and complicated legal, logistical, and clinical issues are the norm. To increase understanding of these populations and their needs, states may provide training, education, and technical assistance to MCOs and providers. Such training is most commonly related to children with serious disorders and children in the child welfare system. Still, many managed care systems do not provide training in these areas, raising questions as to the preparedness of MCOs and their provider networks to adequately address the needs and service delivery challenges presented by these high-need, complex youth.

Table 10 Percent of Managed Care Systems Providing Training and Education to MCOs			
	2003 State Survey		
	Carve Out	Integrated	Total
Training on children and adolescents with serious behavioral health disorders	86%	46%	71%
Training on children and adolescents in the child welfare system	73%	31%	57%
Training on children and adolescents in the juvenile justice system	64%	31%	51%

Responding to the Needs

Incorporation of Special Provisions

Over time, many managed care systems recognized the need to incorporate special provisions or arrangements for children with serious and complex needs to address the issues outlined above, perhaps due to the many problems and challenges they experienced in attempting to serve these youngsters. Through the 1997-98 survey, fewer than half of the managed care systems reported including any differential benefits or special provisions for this population, but by 2000 a dramatic increase was noted with 93% of the managed care systems incorporating at least one special provision. The 2000 and 2003 results continued to reflect the previously established pattern of a greater likelihood of special provisions in managed care systems with carve outs, however a substantial proportion of the integrated systems also reported having some special provisions for children with serious disorders. While a decline in reports of special provisions was found in 2003, over time, the inclusion of such provisions has increased dramatically since the first state survey in 1995 (up 37%).

Table 11 Percent of Managed Care Systems with Special Provisions for Youth with Serious Disorders				
1995 State Survey	1997/98 State Survey	2000 State Survey	2003 State Survey	Percent of Change 1995 – 2003
44%	49%	93%	81%	+37%

Based on the results of the 2003 survey, special provisions are most likely to take the form of intensive case management, use of the wraparound process for service planning and delivery, interagency treatment and service planning, and an expanded service array or benefit. However, fewer than one-third of the systems with special provisions reported including a higher capitation or case rate, representing a small decline from 1997–98. This

suggests that although special provisions such as intensive case management, expanded benefits, or the wraparound process are incorporated, the resources to provide these additional services may not be sufficient.

Table 12
Types of Special Provisions Included by Managed Care Systems with Special Provisions

	1997/98 State Survey	2000 State Survey	2003 State Survey
Expanded benefit/service array	90%	79%	85%
Intensive case management	86%	86%	100%
Interagency treatment and service planning	57%	86%	88%
Wraparound process	71%	57%	92%
Family support	67%	79%	77%
Higher capitation or case rate	38%	29%	31%

Incorporation of System of Care Philosophy and Approach

Many of the special provisions included in managed care systems for children with serious disorders are rooted in the system of care philosophy and approach, designed originally to address the multiple needs of youth with serious emotional disturbances and their families. A significant focus of the Tracking Project has been to assess whether states are linking their managed care systems for behavioral health to previous and ongoing efforts to develop systems of care for youth with serious disorders and their families. Early Tracking Project activities found reports that most managed care systems were “building on” previous system development efforts, and the 2000 and 2003 surveys found that in about three-quarters of the cases, managed care systems reportedly are generally supporting and facilitating systems of care. Striking differences between systems with carve out and integrated designs have consistently been found in this regard, with behavioral health carve out systems far more likely to be consistent with and supportive of the system of care philosophy and approach. The basis for these responses typically was that managed care systems have allowed for coverage of and payment for services linked to the system of care philosophy, and have created opportunities and incentives for the development and use of these services. Systems with integrated designs were described as more “traditional,” and stakeholders tended to believe that their design and features were discrepant with the system of care philosophy and approach.

Table 13
Effect of Managed Care Systems on Systems of Care

	2003 State Survey		
	Carve out	Integrated	Total
Managed care systems that generally support and facilitate systems of care	90%	44%	70%

A more specific look at the system of care principles incorporated into managed care systems through RFPs, contracts, service delivery protocols, and other key system documents found that many managed care systems reported including these principles, although systems with carve out designs consistently have had higher rates of inclusion of each principle.

Table 14			
Incorporation of System of Care Principles into Managed Care Systems			
	1997/98 State Survey	2000 State Survey	2003 State Survey
Broad array of services	72%	85%	89%
Family involvement	79%	88%	69%
Individualized care	79%	79%	77%
Interagency treatment planning	77%	85%	69%
Case management	86%	79%	77%
Cultural competence	81%	79%	80%

Despite the general support of systems of care, and reportedly high rates of inclusion of system of care principles, most states have not used managed care reforms as strategic opportunities to advance the goal of system of care development for children and adolescents with serious behavioral health disorders and their families. Only a few states reported that these reforms were used deliberately and planfully to advance the goal of developing systems of care and better meeting the needs of youth with serious disorders.

II. Description of Promising Approaches

As noted, promising approaches for serving youth with serious disorders in the context of managed care systems were identified through the Tracking Project's state surveys and impact analyses. Descriptive information on these approaches was obtained through three approaches: (1) site visits to Delaware and Indiana involving extensive interviews with key stakeholders, (2) telephone interviews with representatives of managed care systems in nine additional states, and (3) review of documents on all of the identified approaches. Analysis of the information gathered led to the grouping of the promising approaches into the following major categories:

- Separate level of care for youth with serious disorders
- Enhanced benefits for youth with serious disorders
- Special "system of care" carve out for youth with serious disorders
- Specialty provider networks
- Incorporating the system of care philosophy and approach in managed care systems
- Specialized care planning and coordination

These categories represent the primary approach used in each system to meet the needs of youth with serious disorders and their families, although all of the approaches described, regardless of the category in which they are included, share many common features — both in their design and operation. For each approach, essential background information is presented and the specific features incorporated for youth with serious disorders are outlined. For the approaches studied through site visits in Delaware and Indiana, more detail is provided about the features incorporated for this population, along with more in-depth descriptions of how the approaches actually work.

Separate Level of Care for Youth with Serious Disorders

- **Delaware — Diamond State Health Plan**

Background

Delaware's statewide managed care system was implemented in 1996 and is described as a "hybrid" design, based on a public-private partnership. Under this system, the private, contracted MCOs that provide physical health services are responsible for providing a limited behavioral health benefit of up to 30 outpatient units, renewable annually. These outpatient services, intended for youngsters with problems of mild acuity, typically are provided through a private practice model, although services can be provided in homes, schools, and other community settings, as well as in office-based settings. Currently, the state has one MCO under contract, which subcontracts with a specialty behavioral health organization (BHO) to manage this behavioral health benefit. Currently, the MCO contracts with United Behavioral Healthcare for mental health and substance abuse services. No authorization is needed for the first behavioral health visit and assessment; however, authorization is required for additional services, which are provided when they are considered medically necessary. Once behavioral health services are authorized, providers can offer the full 30-unit benefit without additional authorization.

A partial carve out, essentially creating a separate level of care, provides services to youngsters needing more than outpatient care — those with moderate to severe problems and more extensive treatment needs. A public agency, the Division of Child Mental Health Services (DCMHS), serves as the managed care entity for these extended care services. Based on its “care assurance model,” managed mental health and substance abuse care is provided to eligible children without benefit limits, as long as care is deemed medically necessary. DCMHS is part of the consolidated department that oversees the full range of children’s services in the state (the Department of Services for Children, Youth, and Their Families) and is accredited by the Joint Commission on Accreditation of Health Care Organizations to manage behavioral health care. Its legal mandate is to provide a “comprehensive continuum of demonstrably effective treatment services for mentally ill, emotionally disturbed, and substance abusing children, youth, and their families in the least restrictive and most community-based service appropriate.” DCMHS provides services to youth with serious disorders, including those who have exhausted their 30-unit outpatient benefit through their MCO, those who require a higher level of care than is available through the outpatient Medicaid benefit, and youth with serious disorders who do not have private insurance or who have exhausted their private insurance benefits.

Features to Address Needs of Youth with Serious Disorders

- **Access to Care** — In order to be eligible for services through the DCMHS carve out, a youngster must be a Delaware resident, be under age 18, meet financial criteria (Medicaid eligible or uninsured), and meet clinical criteria (problems of moderate to severe acuity and require more than outpatient treatment). Youth may access care through several routes:
 - Parents, caretakers, or agencies may contact any DCMHS outpatient behavioral health provider to assess eligibility and to assist children and families to receive care.
 - Parents, caretakers, or agencies may call the DCMHS Intake and Assessment Unit that offers intake, information, and referral (there are local and toll free telephone lines) to request an assessment and services.
 - Contact with the 24-hour crisis intervention service for children or admission to one of the psychiatric hospitals under contract with the state triggers a referral to DCMHS.
 - MCOs may refer children for services through DCMHS if they are receiving outpatient care through the MCO and are expected to require additional services beyond the 30-unit benefit, or at any time when the outpatient level of care is not considered sufficiently intensive to meet the child’s needs. Although it may seem that MCOs have an incentive to shift children (and costs) to the DCMHS level of care, DCMHS respondents reported that there are few inappropriate referrals.

Multiple outreach efforts, including mailings, brochures, training, and other strategies, are used to educate stakeholders (including Medicaid enrollees, MCOs, providers, schools, other child-serving agencies, etc.) about the services available through DCMHS, how to access services, and what constitutes an appropriate referral.

For children who do not meet the eligibility criteria, recommendations are made as to how and where they may access services appropriate to their needs. Children who meet the criteria are referred to one of the system's Clinical Services Management Teams.

- **Clinical Services Management Teams** — Each child receiving care through DCMHS is assigned to a clinical services management team (CSM team) for clinical care management throughout the duration of service delivery. The CSM team's role is to plan, authorize, monitor, and coordinate behavioral health services that are clinically necessary, including facilitating transitions across services and providers. CSM teams typically are comprised of the following:

Composition of Clinical Services Management Teams	
Team Leader	A licensed behavioral health professional who provides authority for clinical decision making and assumes overall responsibility for the team.
Clinical Services Supervisor	Typically a Master's level professional who is responsible for the administration of care management within the team and typically carries a caseload of 15.
Clinical Services Coordinator	Bachelor's and Master's level staff who assume primary responsibility for the completion of care management activities including developing service plans, making referrals, monitoring and coordinating care, advocating for the child, and serving as liaison with other agencies; caseload is typically 1:32.
Family Service Assistants	Staff who support the team and the families by assisting with varied tasks including chart work, obtaining releases, driving, providing family support services, and assisting families to obtain services, enabling team members to spend more time with children and their families managing care.

The system currently is comprised of eight standard teams. Additional teams have specialized functions — two are designated as crisis services management teams (one up-state and one down-state), one for managing outpatient services provided primarily to non-Medicaid youth needing outpatient care and identifying those requiring more extensive services, and one supported by federal grant funds from the Comprehensive Community Mental Health Services for Children and Their Families Program that focuses on a specific population of youth with serious emotional disorders. The target population for this grant-supported team is

comprised of special education students who have a mental health diagnosis; problems functioning in their homes, schools, and communities; and are receiving services from multiple agencies. Each CSM team is responsible for approximately 80 to 120 youngsters, with the exception of the grant-funded team which handles fewer youngsters in order to be able to provide more intensive services. Caseloads for the federal system of care grant-supported team is 1:15 as compared with 1:32 on a standard team. Additional teams are added as dictated by the need for care in concert with the availability of funding.

Children entering care are assigned to a team based upon geographical considerations, as well as room on the team — its current caseload and staff availability. The team leader assigns the case to a clinical services coordinator, and together they review the available clinical information as a prelude to the initiation of the individualized service planning process. Children who are discharged from the system and who later require additional extended care services are assigned to the same team that served them previously to maximize continuity of care.

- **Individualized Service Planning and Service Delivery** — The service planning process begins with the clinical services coordinator (CSC) reaching out to the family to establish contact, review the DCMHS handbook for children and families entering care, clarify expectations regarding the service planning and delivery process, and begin to solicit their input regarding their perceptions, needs, and service preferences. The initial contacts with the family also are used to discuss the appropriate level of care, as well as potential service and provider options. In addition to obtaining information from the family, the CSC obtains information from treatment records, involved clinicians, schools, and other involved agencies and providers. Based upon all of this information, and in collaboration with the family, the CSC develops a service plan that specifies the level of care and the issues to be addressed through service delivery, and also outlines a plan for discharge once treatment is completed. Maintaining the child in the community is a guiding principle in the development of service plans. Families are integrally involved throughout this planning process, and a negotiating process ensues in the event that families are not in concurrence with the level of care or with the specific programs and providers identified.

When a service plan is tentatively agreed upon by the CSC and the family, consultation with the team leader and/or with a consulting psychiatrist is used to establish clinical necessity for the services proposed in the plan. Clinical necessity is judged by applying the DCMHS Level of Care Criteria. The team leader and clinical coordinator must reach consensus in determining the level of care and authorizing the services outlined in the plan. A psychiatrist must approve the service plan whenever residential treatment or inpatient hospitalization is indicated.

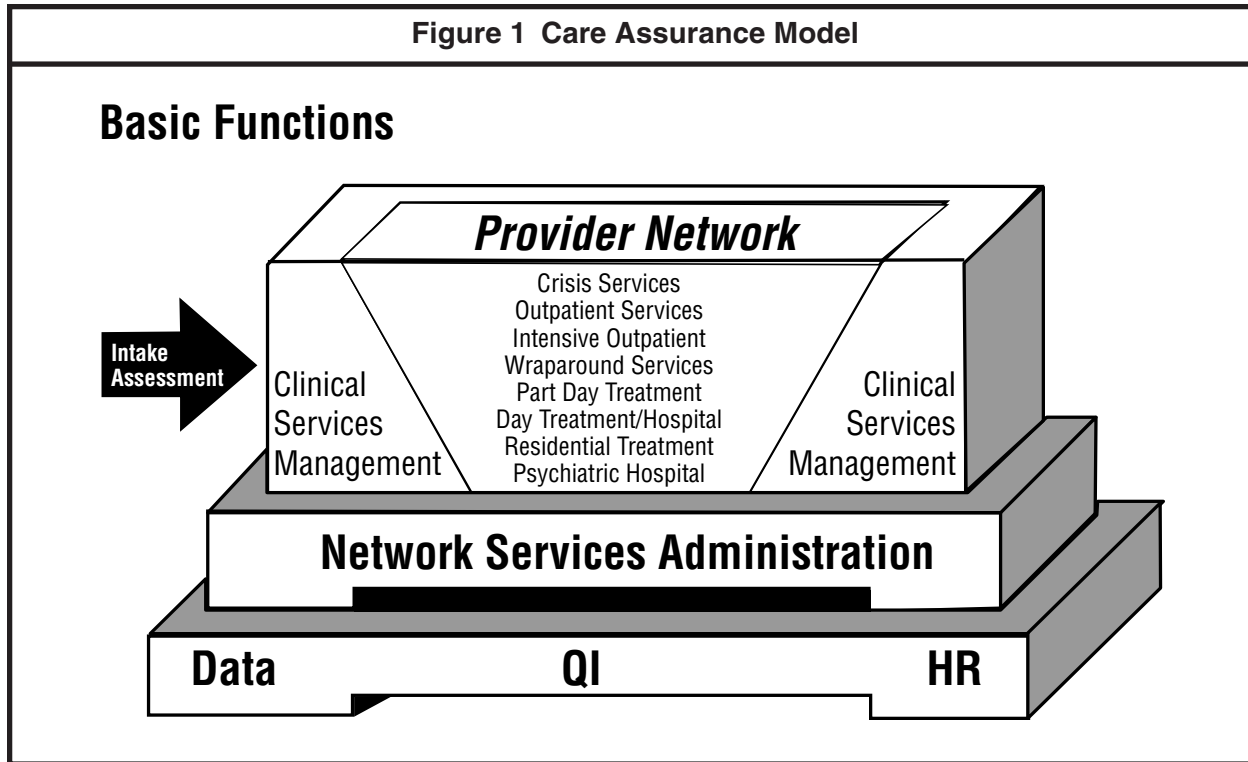
For some youngsters with the most serious and complex needs, multidisciplinary team meetings, bringing together representatives from the various involved agencies, involved providers, the family, and sometimes other community members, comprise an additional aspect of the service planning process. In these cases, the

clinical aspects of the service plan are supplemented by plans for services and supports to be provided by other agencies, such as child welfare or juvenile justice. Even when such multidisciplinary or interdivisional team meetings are not held, the CSC is required to establish contact with other involved agencies to solicit their input and to coordinate care.

Once the service plan is approved, the CSC generates a “Service Admission Form,” that provides background information and service plans. The CSC forwards this form to prospective service providers and is then responsible for arranging contact between the service provider and family to initiate service delivery, including arranging transportation if necessary, and participating in the admission meeting. In turn, treatment providers are required to conduct a more complete, integrated assessment across life domains and to develop a specific treatment plan that is consistent with the broader DCMHS service plan and that specifies treatment goals, treatment objectives stated in behavioral terms, the specific treatment interventions to be used in achieving the goals and objectives, and the personnel responsible for implementing the interventions. Services typically are authorized for a fixed period of time, ranging from two to three days for psychiatric hospitalization to 30 days for residential treatment. In addition, the CSM team has access to funds for “wraparound” services and supports and can authorize these funds to provide supplemental services and supports when indicated.

Services are provided through a contracted panel of service providers. If a particular specialty service (such as treatment for eating disorders or a clinician able to speak a particular language) is not available through an established provider within the network, DCMHS seeks out providers and negotiates contracts with them. In order to enhance continuity of care, the MCOs are required to include DCMHS providers in their networks. Thus, if a youngster begins treatment through an MCO and then is shifted to the DCMHS level of care, they may continue working with their treatment provider if appropriate. The array of available services is shown on the Care Assurance Model.

Figure 1 Care Assurance Model



CSCs continue to play a critical role throughout the service delivery process. For each child and family, the CSC continuously monitors progress; maintains continuous contact with the family and with other involved agencies, serving as liaison; re-authorizes continued treatment as clinically indicated; intervenes in crisis situations; and facilitates transitions across levels of care and providers of services to ensure continuity of care.

A well-defined case review process is utilized to monitor progress. Referred to as “Continued Clinical Service Reviews,” the process involves contacting the provider prior to the end of the authorization period, most often by telephone, and conducting a semi-structured interview to determine: if the provider’s treatment plan is consistent with the DCMHS approved service plan; what progress has been achieved toward treatment goals; the extent of parental involvement in care; whether the current level of care is still clinically appropriate, or if the child is ready to transition to a less restrictive level of care; discharge plans; and any issues related to services and supports. The outcome of this review can be authorization for continued treatment or denial of continued treatment, in which case the CSC is responsible for working with the provider to develop and coordinate an appropriate discharge plan. In addition to the more formal progress reviews, CSCs maintain more frequent informal contact with providers, particularly if an incident occurs. In addition, the CSM team supervisor and CSCs meet with the team leader monthly to review difficult or complex cases, and a consulting psychiatrist is available to provide assistance as needed.

Youngsters can continue in care as long as services are needed, or until they reach age 18 at which time they may be transitioned to the adult treatment system if they continue to meet clinical necessity criteria. The individualized care process is depicted on the following Clinical Services Management Flow Chart and is described for families on the Individualized Service Planning Team Form.

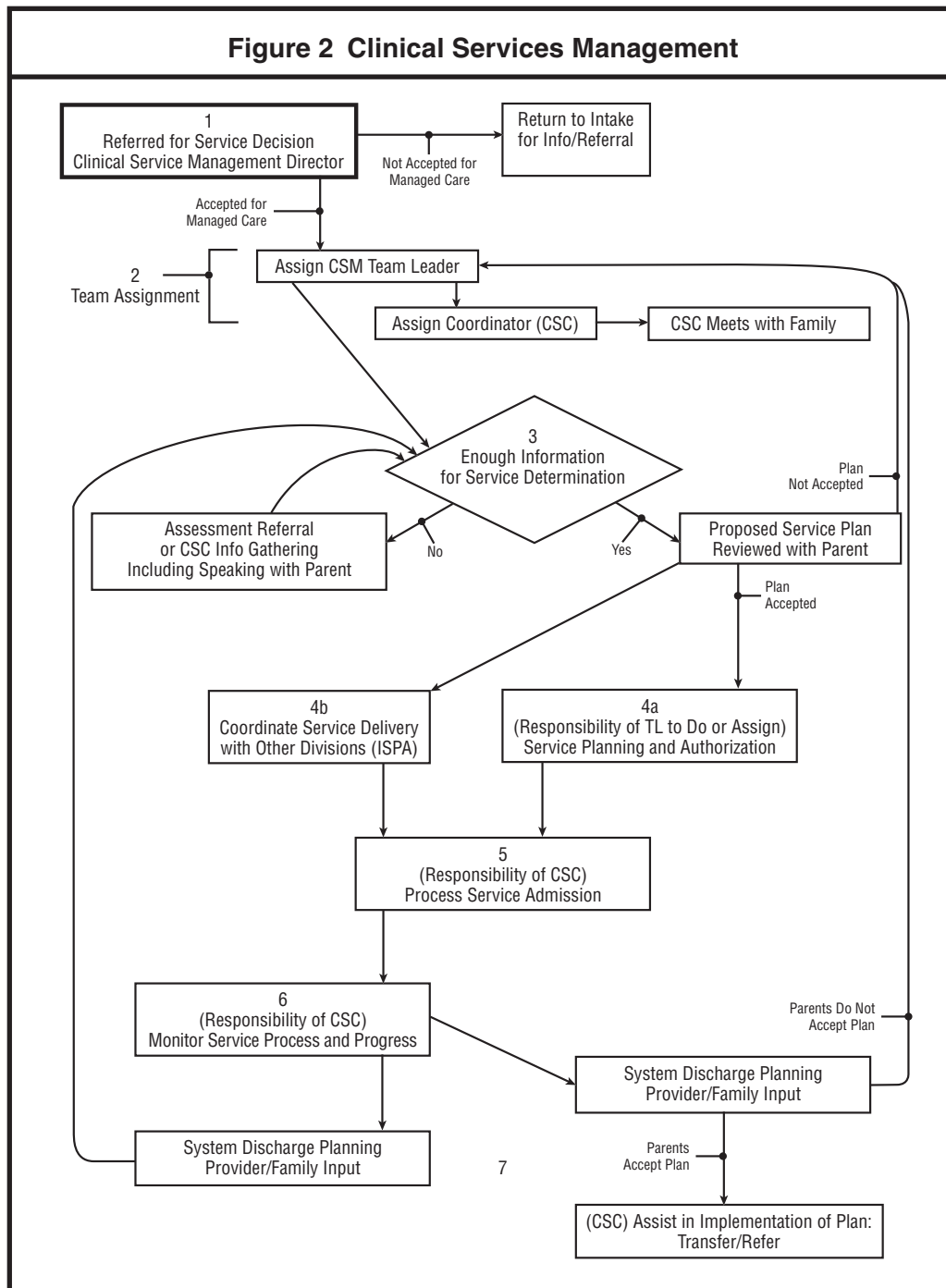
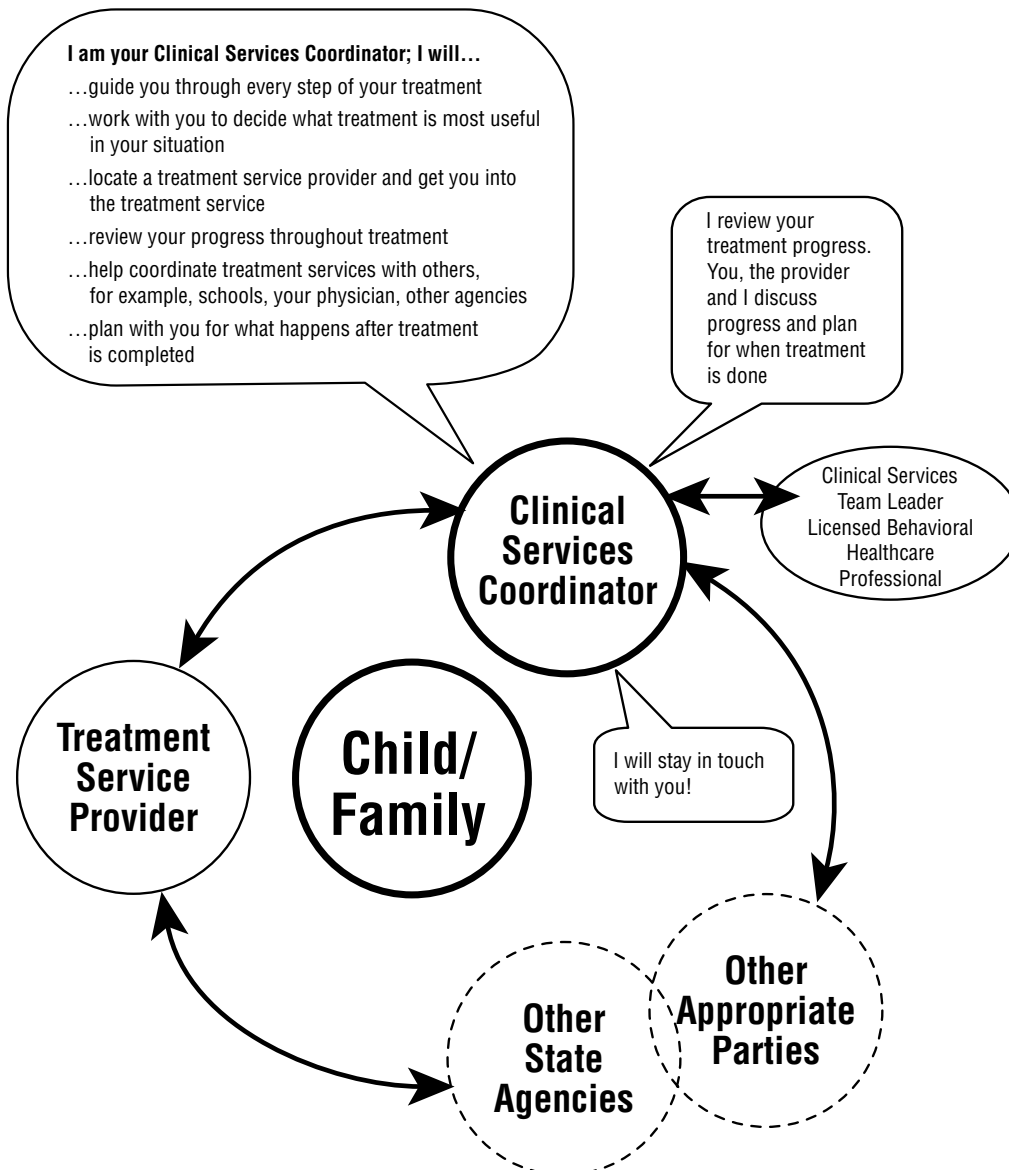


Figure 3 Individualized Child Service Planning Team

Parent/Family & Child _____
 Clinical Services Coordinator
 (Coordinator's Name: _____)
 (Coordinator's Phone Number: _____)
 Clinical Services Management Team Leader _____
 Other State Agencies as indicated: _____
 (Example: DFS, DYRS, School Representative)
 Any other appropriate parties (Specialists, etc.): _____



- **Financing** — As noted, MCOs receive capitation payments for enrollees to cover physical and up to 30 outpatient units of behavioral health care. For services to youth with moderate to severe disorders (the level of care provided through the DCMHS carve out), DCMHS receives a case rate, referred to in Delaware as a “bundled rate,” from Medicaid for each Medicaid-eligible child served; all services provided are Medicaid reimbursable. The current case rate is \$4329 per member per month for each child receiving a direct service. The federal financial participation (FFP) — 50% of these funds — goes into a Children’s Department Fund. The state legislature authorizes expenditure of the dollars in this particular fund. DCMHS receives an allocation from this fund to provide services to children who need and are eligible for public behavioral health services.

The state holds the financial risk in this arrangement. Providers are not at risk; outpatient providers are paid on a fee-for-service basis and residential services are program funded. Some flexible funding is available at the level of the Department for Children, Youth, and Their Families for filling gaps in services and for covering services and supports not covered by any other mechanism; however, the process to obtain flexible funds is cumbersome, impeding its use to the extent intended.

- **System Management and Evaluation** — A statewide automated management information system, the Family and Child Tracking System (FACTS) was developed in Delaware. The DCMHS module in this department-wide system includes data on intake and assessment, clinical services management (service plan, determination of clinical necessity, discharge plan), provider contracts, electronic invoicing, Medicaid claims, and more. FACTS, developed with federal child welfare funds (SACWIS), enables case managers in various divisions to access and share information about the children they are serving, both supporting their work and promoting service integration.

Process measures are tracked (such as timeliness of services and readmissions within 30 days). The children’s department is adopting a screening and outcome measurement instrument, the SENSS (Service Entry, Needs, and Strengths Screen). To date, outcome information from the DCMHS level of care is not available. A consumer survey is conducted every three years exploring satisfaction among caregivers and youth over age 12 with children’s mental health services through DCMHS. The 2000 survey found that over 70% of caregivers reported being satisfied overall and were satisfied with the times they were asked to participate in meetings, with their level of involvement in planning services, with providers’ understanding of the family’s culture, with respect for the family’s beliefs, and with the services received.

- **Michigan — Managed Specialty Services and Supports Program**

Background

Michigan implemented its Medicaid managed care system for behavioral health services in 1998. The Comprehensive Health Plan provides physical health services, although the benefit includes a limited behavioral health benefit of up to 20 outpatient behavioral health visits. Behavioral health services beyond the 20 outpatient visits are provided through a carve out — the Managed Specialty Services and Supports Program, which, in effect, creates a separate level of care within the managed care system for individuals with serious disorders. The program is financed through a capitated approach and is administered by the Department of Community Health, which contracts with county agencies called community mental health services programs (CMHSPs) to manage behavioral health service delivery throughout the state. In turn, CMHSPs subcontract with a wide range of providers, including both agencies and individual practitioners, to provide behavioral health services under the prepaid managed care system. The goals of the managed behavioral health care system include both managing public funding and encouraging individualized service planning through a person-centered planning process.

Features to Address Needs of Youth with Serious Disorders

- Through this carve out, Michigan's managed care system provides an enhanced benefit for individuals with serious and persistent behavioral health conditions, both children and adolescents with serious emotional disorders and adults with serious mental illnesses, as well as children and adults with developmental disabilities. Children are eligible for the enhanced services if they are judged to meet the operational definition of a "serious emotional disturbance" comprised of dimensions including diagnosis (a diagnosable emotional disorder according to DSM IV criteria excluding alcohol and drug disorders, developmental disorders, and social conditions or "V" codes), degree of disability or functional impairment ("substantial" interference with or limitation of the child's proficiency in performing certain age appropriate skills), and duration (evidence of six continuous months of symptomatology or dysfunction, six cumulative months in a twelve month period, or likelihood of disability to continue for more than a year based on diagnosis).

Within the carve out, a protocol was developed to identify youth who are likely to require enhanced services and supports beyond outpatient treatment. Research on the Child and Adolescent Functional Assessment Scale (CAFAS) was used to develop the protocol and its criteria for inclusion in more intensive levels of care within the managed care system, and this instrument is used as a part of the assessment process to measure functional impairment among children. Youth with two or more elevated subscale scores and a total impairment score at 80 or greater may be considered to have marked or severe functional impairment. The service eligibility determination process is the responsibility of the CMHSPs for both Medicaid and non-Medicaid youth; these entities make decisions about which

youngsters referred for services should receive the more extensive and intensive set of services and supports. Only youth with severe conditions are eligible for CMHPs and the enhanced services. Children with mild to moderate conditions are served by the comprehensive health plans or through limited fee-for-service arrangements with medical doctors and psychiatrists.

Once youngsters are determined to have a serious emotional disorder and, thereby, to be eligible for enhanced services, they may receive services and supports from among the “covered services” and “alternative covered services” that are offered through the managed care system. However, eligibility for enhanced services does not constitute an entitlement to an unlimited level and duration of these services and supports; rather, CMHSPs must determine those services and supports that are medically necessary and appropriate and “of sufficient amount, duration, and scope to reasonably achieve their purpose.”

Covered Services	Alternative Covered Services
<ul style="list-style-type: none"> • Assessments, including psychiatric evaluation and psychological testing • Case management • Child therapy • Day programs • Partial hospitalization • Applied behavioral services • Assertive community treatment • Individual/group therapy • Intensive crisis stabilization services • Medication administration • Medication review • Crisis intervention • Crisis residential services • Enhanced health services • Family therapy • Personalized care • Physical therapy • Mental health home-based services • Occupational therapy • Psychosocial rehabilitation and clubhouse programs • Speech, hearing, language therapy • Treatment planning • Transportation • Psychiatric hospitalization 	<ul style="list-style-type: none"> • Community inclusion and integration services • Crisis response — extended observation beds • Family support services — family skill development, respite care • Housing assistance • Peer operated support services • Prevention and consultation services • Specialized behavioral health services (wraparound) for children and adolescents

To determine the specific set of services and supports to be provided to any individual youngster and his or her family, an individualized service planning process referred to as “person-centered planning” is used. It is this process that results in a plan defining the scope, frequency, and intensity of services and supports to be provided. The person-centered planning process is designed to build on the individual’s capacity to “engage in activities that promote community life and to honor the individual’s choices, preferences, and abilities.” Typically, a meeting is held involving the child and family and involved service providers to develop the service plan, through a family-centered, family-driven planning process.

For children, the child and family are integral to the planning and help to shape both its content and process. Prior to the planning meeting, the child and family contribute their goals and desires; topics they would like to address and those they would prefer not to discuss at a meeting; whom to invite; when and where the meeting will take place; and who will facilitate the process. The planning process entails discussing potential treatment and support options to meet expressed needs, considering the preferences and choices of the child and family throughout the deliberations. The group focuses not only on mental health treatment needs, but on health, safety, and all other life domains as appropriate. Strategies are designed to respond to urgent needs, as well as those needs that require services and supports over an extended duration of time, and resources to provide services and supports are identified. The result is an individual plan of service, with opportunities for review, feedback, and modification. Medical necessity criteria guide decision making.

Services and supports included in the plan may include any of the covered services or alternative covered services, including wraparound services which are a highly individualized set of services (treatment and supports) targeted to the specific needs of a particular child and family. Wraparound service arrangements typically are the result of the collaborative service planning process involving the child and family in partnership with involved community agencies. Alternative services are defined as “other substitute activities that meet the essential treatment/support function, service objectives, and intended outcomes of a covered service.”

Enhanced Benefits for Youth with Serious Disorders

• Oklahoma — SoonerCare Plus and SoonerCare Choice

Background

The Oklahoma legislature mandated a transition from the fee-for-service Medicaid program to a comprehensive managed care system, with the goals of increasing the focus on primary care and prevention, expanding access, and containing costs. Two distinct delivery systems became operational in 1995. SoonerCare Plus is a fully capitated prepaid managed care system, operated in the state's more urban areas, in which the state contracts with health plans (HMOs) to provide both physical and behavioral health care services. SoonerCare Choice is a primary care case management system that is operated primarily in rural areas that could not sustain a capitated approach; in these areas, the state contracts directly with providers. Both systems are overseen by the Oklahoma Health Care Authority (OHCA).

Features to Address Needs of Youth with Serious Disorders

- SoonerCare Plus includes a mandatory minimum behavioral health benefit package that is available to all health plan members. Recognizing that these services would not be sufficient to meet the needs of individuals with serious disorders, an enhanced benefit was incorporated into the managed care system for these members — both youth and adults. The enhanced behavioral health benefit includes the range of services that must be available to members with serious disorders in conjunction with the basic benefit.

Basic Behavioral Health Benefit	Enhanced Behavioral Health Benefit for Individuals with Serious Disorders
<ul style="list-style-type: none">• Evaluation and testing• Outpatient treatment (individual, group, family, and marital)• Day treatment• Outpatient crisis intervention• Residential treatment• Inpatient treatment• Medical detoxification	<ul style="list-style-type: none">• Intensive outpatient treatment (mental health and substance abuse)• Psychosocial rehabilitation• Home-based services• Rehabilitative case management• Therapeutic foster care (residential behavioral management)

In order to be eligible for the enhanced benefit, youth must be designated as having special behavioral health needs (SBHN) by the Oklahoma Health Care Authority. Health plans are required to have protocols for assessing youth believed to have special behavioral health needs. The assessments must be performed by a licensed mental health professional, such as a psychologist, psychiatrist, licensed marital and family therapist, licensed professional counselor, or licensed clinical social worker. The health plan then submits the completed assessment to the Authority for review. Once SBHN status is approved by the state authority, the youth may receive the enhanced services in addition to those services included in the

basic benefit. These additional benefits are supported by an enhanced capitation rate provided to the health plan for members determined to have SBHN status. The current SBHN rate for individuals ages 0 to 20 is \$691.46 per member per month, as compared with rates ranging from \$70.62 to \$373.35 for TANF children ages 0–20 (average monthly capitation rate is \$221 per member per month across regions and type of Medicaid recipient).

Health plans participating in SoonerCare Plus are responsible for providing, on request from the Authority, documentation to support the maintenance of SBHN status for each member. In addition, annual reassessments of all members with SBHN status are required, as well as monthly reports regarding their work with SBHN members. These monthly reports are used as a mechanism to monitor the care provided to individuals with serious behavioral health disorders by detailing: the plans' success or failure to contact SBHN members, the provision of mandatory supportive services, and SBHN members who have not received at least weekly services for a period of 90 days or more.

Other requirements have been incorporated by the state to ensure that members with special behavioral health needs receive needed services and are aware of the services they are entitled to receive.

Thus, SoonerCare Plus incorporates the following features for youth with serious behavioral health disorders:

- Broader array of services through an enhanced benefit package
- Eligibility through the designation of Special Behavioral Health Needs status
- Enhanced capitation rate for SBHN youth to support expanded benefit
- Treatment planning
- Case management services
- Monitoring and reporting procedures to ensure appropriate service provision and continuity of care for SBHN youth

**Health Plan Requirements
for All Members with
Special Behavioral Health Needs (SBHN)**

- Contact each SBHN member with 10 days of enrollment or designation as SBHN
- Develop a treatment plan for each SBHN member
- Educate SBHN members regarding the plan and its benefits
- Ensure that SBHN members know how to contact their health plan case manager and primary care practitioner
- Identify behavioral health services needed by members and determine appropriate providers
- Educate members regarding emergent and urgent care and how to access these if necessary
- Arrange for transportation and other supportive services
- Assist with obtaining self-referral services as needed
- Gather medication information and ensure access to prescription medications
- Provide case management services at a level sufficient to meet the needs of each SBHN member, with at least one contact per month

- SoonerCare Choice, the primary care physician case manager program, also incorporates the potential for expanded benefits for youth with serious disorders. Under this system, prior authorization is used to manage service utilization, and the state contracts with the Oklahoma Foundation for Medical Quality (OFMQ) to conduct prior authorization for behavioral health services.

Behavioral health services under SoonerCare Choice are measured by “relative value units” (RVUs). Some behavioral health services require no prior authorization, for example, community-based emergency care, crisis intervention, individual and family counseling, treatment plan development, and medical review. Rather, a specified number of relative value units of the service are allowable per year without formal authorization. To illustrate, 12 RVUs of medical review are allowable per year, once per month, without authorization, as are 6 units of individual counseling, and 40 of crisis intervention.

Additional RVUs of services, however, are allowable for children who are assessed to have more serious disorders. The level of severity of children’s disorders is assessed using level of functioning scales with child-specific anchors. Contracted behavioral health providers conduct these assessments. Results are then faxed to OFMQ for clinical review and authorization of enhanced services, based on the severity of the disorder. The criteria used for decision making regarding level of severity were jointly developed by OHCA and OFMQ, in collaboration with behavioral health providers and the state mental health department.

Levels of severity range from Level I, which is defined as slight to moderate functional impairment, to Level IV, which is defined as severe functional impairment. Children at Level I may receive a maximum of 18 RVUs of services per month, whereas those at Level IV may receive up to 62 units per month. Thus, an increasing range and level of behavioral health services are available to youth with more serious and complex problems based upon the assessed level of severity of their disorders.

Services including inpatient care, residential treatment, and therapeutic foster care do require prior authorization and continuing care authorization at intervals. Medical necessity criteria are used to make these clinical decisions; OFMQ is responsible for authorizing these services.

Thus, SoonerCare Choice incorporates an increased range and higher levels of services for youth at higher levels of severity, with eligibility determined by the level of severity of the child’s disorder.

• Oregon — Intensive Services Project

Background

The Oregon Health Plan is the state's managed health care system, financed through a capitated approach. First implemented in 1995, the system incorporated behavioral health services on a statewide basis two years later in 1997. Currently, substance abuse services are integrated with physical health services, and depending upon the area of the state, mental health services are either integrated or are provided through a specialty mental health carve out. Mental health service delivery is managed by Mental Health Organizations (MHOs) that take a variety of forms in different regions, including local mental health authorities; private, nonprofit entities; regional mental health consortiums; or fully capitated health plans that provide and manage mental health care along with physical health care.

Features to Address Needs of Youth with Serious Disorders

- Until 1999, a number of the intensive services needed by youth with serious emotional disorders were not included in the managed care system. The services excluded from the mental health benefit package were the most intensive and restrictive levels of care provided in Oregon's publicly funded system, such as day treatment, residential treatment, and inpatient services, those services designed to stabilize the symptoms of serious emotional disorders. These services operated with funding streams separate from the continuum of mental health services included in the Oregon Health Plan, and the accompanying regulations required that youth be in facility-based programs.

In 1999, however, the state implemented the Intensive Treatment Services (ITS) Pilot Project to integrate the entire range of services needed by youth with serious disorders into the capitated managed care system, thus expanding the mental health benefit package. The goal of this effort is to facilitate the provision of the full range of services needed by children and their families and to increase flexibility in service delivery in order to maintain youngsters in their families and communities and in the least restrictive treatment settings appropriate to their needs. By including the intensive service components in the capitated system, MHOs and ITS providers were given the flexibility to better integrate these services with other home and community-based services and supports, as well as to develop and substitute alternatives to the more "traditional" service delivery patterns. MHOs and providers now are able to offer a wide variety of types and levels of care based on the needs of the child and family, rather than being limited to rigidly defined services based upon filling a "bed" or a "slot." The state anticipated that with greater flexibility in the use of funds and in service delivery, positive outcomes would be achieved including serving a greater number of youth with serious disorders, improving the quality of care, and developing alternative service delivery methods.

ITS was initiated as a pilot program in five areas to determine the viability of incorporating these intensive services into the capitated managed care system. It created the opportunity for some programs to participate in the managed care system under capitation, without placing the entire system of intensive service providers under managed care with uncertain consequences; participation of intensive service programs in the system is voluntary.

The range of service added to the system of care through ITS now includes components such as treatment foster care, therapeutic group homes, psychiatric day treatment, partial hospitalization, residential psychiatric treatment, inpatient care, sub-acute care, home services, behavioral specialists, case management, and other services that provide active psychiatric treatment for children with serious emotional disorders and their families. The ITS pilot projects are based on the system of care philosophy, specifically calling for child and family centered care; full inclusion of the child and family; flexible, integrated, community-based service plans; funding mechanisms that match the evolving needs of the child and family; and flexible service approaches to extend intensive treatment from facilities to community-based treatment settings. In order to participate, intensive services providers must meet the requirements shown.

Requirements for Intensive Services Providers
<ul style="list-style-type: none">• Interdisciplinary treatment capability• 24 hour, 7 day treatment responsibility• Delivery of treatment in the least restrictive, least intensive setting appropriate to each child• Demonstrated family involvement and participation in all phases of service delivery• Demonstrated cultural competency in the delivery of services• Individualized plans of care developed by interdisciplinary teams

MHOs are responsible for identifying enrollees who are appropriate for participation in the ITS pilots; clinical decision making authority also rests with the MHOs. Decisions regarding initial authorization for services, as well as for continuing care and discharge, are made by the MHOs in collaboration with other involved partner agencies, providers, and the family. The vehicle used for planning and providing care is called a community treatment team, or an “Essential Provider Team” in one of the areas. Such a team is convened for each child and meets, at minimum, on a monthly basis. The team’s composition is individualized for each child and family, and includes any person who is significant for meeting the service and support needs of the child and family. Working in partnership with the family, the team develops and implements an individualized plan of care and fulfills the ongoing functions of care coordination and oversight.

Special “System of Care” Carve Out for Youth with Serious Disorders

• Indiana — The Dawn Project

Background

Indiana’s statewide behavioral health managed care system is called the Hoosier Assurance Plan. Implemented in 1995, this system manages non-Medicaid behavioral health care services and resources and is designed to serve children with serious emotional disorders and adults with serious and persistent mental illnesses who have financial need. Under the Hoosier Assurance Plan, the Division of Mental Health (DMH) contracts with 32 community mental health centers as “managed care providers” serving the various regions of the state. DMH funds are used to provide a case rate (currently in the amount of \$1,670 per year) for each individual with a serious disorder served. This case rate is not considered to cover all care, but rather as a supplement to care financed through other sources. The community mental health agencies all use fee-for-service Medicaid financing for Medicaid-eligible clients (and other sources of direct and third-party billing) to cover outpatient, day treatment, and inpatient services, as well as a broad range of services under the rehabilitation option, including case management.

In addition to the Hoosier Assurance Plan, a managed care system for behavioral health care operates in one county in Indiana, serving children and adolescents with serious emotional disorders and their families — the Dawn Project. Marion County, which includes Indianapolis, found that its out-of-home placement costs for youth with serious disorders were spiraling. An interagency effort in the community considered approaches to addressing this problem, forming a consortium of state and Marion County child and family agencies, along with family members and other community stakeholders. In 1996 the state DMH received a \$75,000 planning grant from the Robert Wood Johnson Foundation to create a replication of its Mental Health Services Program for Youth in Indiana. The funds were used in Marion County to hire a coordinator and obtain technical assistance, and the consortium agreed to collaborate in a new effort to serve youth with serious disorders who were in or at risk for out-of-home care. The consortium members worked to develop the initial design for the Dawn Project, which was begun as a pilot and served its first 10 youth in 1997.

The goal of Dawn was and remains to improve services for Marion County youth with serious emotional disorders and to enable them to remain in their homes and community by providing a system of care comprised of a network of individualized, coordinated, community-based services and supports, using managed care technologies. The managed care system is designed to serve youngsters with the most serious and complex disorders and needs across child-serving systems, those who typically are the most costly to serve and who are in residential care or at risk for residential placement. The design creates a separate “system of care carve out” for this population. Dawn is administered by a nonprofit care management organization and funded by a case rate provided by the participating child-serving systems. The interagency consortium continues to meet monthly to oversee the system, to review progress and outcomes, and to support system reform consistent with this philosophy of care within each of the consortium agencies.

In 1999, a five-year federal grant from the Comprehensive Community Mental Health Services for Children and Their Families Program was awarded to the Dawn Project, enabling an increase in the number of children and families served, including an expansion in the target population to serve children at risk for out-of-home care, as well as support for the development of a family support and advocacy organization (Families Reaching for Rainbows) and evaluation activities. Lake County in northern Indiana also received one of these grants at the same time. In addition, the Indiana Division of Mental Health and Family and Children provided start-up resources in 2000 for the development of systems of care based on Dawn’s experience in four other areas of the state; ten additional sites were funded in 2002, and ten more in 2003 for a total of 24 sites incorporating 39 counties. Dawn has been a key technical assistance resource for these sites, and, in 2002 was officially funded by the state as a technical assistance center (Technical Assistance Center for Systems of Care and Evidence-Based Practice) to provide assistance in developing similar managed systems of care throughout the state.

Features to Address Needs of Youth with Serious Disorders

- **Care Management Organization** — The Dawn Project is administered by Indiana Behavioral Health Choices, a private nonprofit corporation that was created by four Marion County community mental health centers as a separate and independent entity to manage the Dawn system of care. Fulfilling the role of a “care management organization,” Choices provides the necessary administrative, financial, clinical, and technical support structure to support service delivery and manages the contracts with the provider network that serves youth and their families. The responsibilities of Choices include providing financial and clinical structure; providing training; organizing and maintaining a comprehensive provider network (including private providers); providing system accountability to the interagency consortium; managing community resources; creating community collaboration and partnerships; and collecting data on service utilization, outcomes, and costs.

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

- **Access to Care** — The Dawn system of care was designed to serve youth with the most serious and complex emotional and behavioral disorders across child-serving systems, those who typically are the most costly. Specifically, youngsters are eligible for Dawn if they are residents of Marion County, ages 5 to 17, have a DSM IV diagnosis or a special education designation, have functional impairment in two or more areas (personal, family, community, school and/or work), have a history of impairment for more than six months with indications that functional impairment will continue into the future, are involved in two or more child-serving systems, and are at imminent risk of or already in out-of-home placement.

Referrals to Dawn must come from one of the county’s child-serving systems – juvenile court probation department, child welfare, Indianapolis Public Schools, state hospital, special education, or juvenile correction. Choices staff determine if a youngster meets the eligibility criteria; to date all but one or two youngsters referred for care have been deemed eligible. Many youngsters are referred to Dawn as an alternative at the point that a referral for residential care is being considered, and, in fact, the program has offered to evaluate all youth referred for residential care to determine if they could be served through Dawn’s system of care. The average population served by Dawn averages 190 youth at a given time.

- **Service Coordination Teams and Participatory Care Management** — Each child and family served by Dawn is assigned to one of four service coordination teams, and in turn, is assigned to a service coordinator on that team. The teams typically are comprised of a supervisor, five service coordinators, and one to three case managers. The teams are physically located at Dawn, and most of their training and supervision occurs at Dawn, but they are actually employed by the four community mental health centers in order to enable them to bill Medicaid through the rehabilitation option for the care management services provided to eligible children (approximately 90% of the Dawn service populations is Medicaid eligible). Each service coordinator carries a case load of about eight to ten children; case managers are considered “service coordinators-in-training” and play a supportive role.

The responsibilities of the service coordinator are extensive and involve:

- Organizing and convening a child and family team
- Facilitating a strength-based discovery/assessment process
- Developing an individualized service coordination plan with the team
- Assisting teams in finding the services and supports necessary to address service plan goals
- Authorizing services monthly for the upcoming month
- Monitoring and evaluating service provision and outcome attainment
- Coordinating service delivery among all involved providers and the family

- Writing all required reports
- Providing information to referring workers and other team members
- Serving as an educator and facilitator for the family and the various systems

The approach used by the service coordinators is referred to as “participatory care management.” Developed by Dawn, the approach uniquely blends the concepts of both managed care and systems of care by integrating the system of care philosophy and its core values (e.g., family involvement, individualized/wraparound approach, coordinated care) with managed care technologies for clinical and fiscal management (e.g., case rates, focus on outcomes).

- **Child and Family Teams and Strengths Discovery Process** — One of the first tasks of the service coordinator is to create and convene a child and family team. The first team meeting is held as soon as possible, always within 30 days of the referral, and continues to meet at least monthly thereafter. Child and family teams are comprised of all the individuals who can contribute to the child and family’s services and support, as shown. Special efforts are made to include school personnel on all child and family teams to help to ensure that children can stay in and be successful at school. Dawn also attempts to remove all potential barriers to the participation of family members at team meetings, such as transportation, child care, and conflicts with work, to facilitate and maximize their involvement.

Composition of Child and Family Teams
<ul style="list-style-type: none">• Interdisciplinary treatment capability• Parents or other caregivers• Child (if appropriate)• Service coordinator• Referring worker• Currently involved service providers• Therapist• School representative• Other natural or community supports identified by the family (e.g., minister, relative, respite provider)

Each team member receives a Dawn Project Team Handbook that discusses the guiding philosophy and principles underlying care, the composition and role of the child and family team, expectations and role of team members, procedures to follow to build strong and effective teams, ground rules for team meetings, principles for resolving conflicts, and more. The approach to services described in the handbook is reflected in the excerpt “Service Principles for Child and Family Teams.”

Service Principles for Child and Family Teams	
1. Decisions are reached by general agreement, or consensus, whenever possible. Consensus is not always completely possible in cases involving legal restrictions.	<ul style="list-style-type: none"> • All members have input into the plan • All members have ownership of the plan
2. Teams meet regularly, at least monthly. NOT just around crises.	
3. Teams develop plans that are based on youth/family strengths.	
4. Teams pay attention to and address a full range of life needs that may impact a youth/family.	<ul style="list-style-type: none"> • Mental Health • Family • Living Arrangement • Medical • Legal • Vocational • Educational • Social/Recreation • Crisis/Safety • Cultural/Spiritual • Substance Use
5. Teams reach out for and utilize assistance from the family’s natural support system, community-based programs, and professional providers.	
6. Teams stay focused on realistic, attainable goals instead of on excuses why goals can’t be reached.	
7. Care is unconditional—change the plan, not the commitment, when success is not seen.	

All team members participate in a service planning process referred to as the “strengths discovery process,” used as a framework to jointly develop and reach consensus on goals and a course of action. The strengths discovery process involves analyzing the child and family’s strengths and needs across significant life domains, focusing not only on deficits and concerns but also on existing competencies.

The resources and strengths of the child and family are used as tools to create solutions and to build a “service coordination plan,” which essentially is the individualized service and support plan. The service coordination plan focuses on three to five of the identified needs determined to be the top priorities to be addressed during the next 30 days. For each need, the plan specifies desired outcomes (measurable), specific interventions (services, supports, or resources) planned to achieve the outcomes, and who is responsible for providing each of the

Life Domains
<ul style="list-style-type: none"> • Health/medical • Safety/crisis • Family/relationships • Educational/vocational • Psychological/emotional • Substance abuse • Social/recreational • Daily living • Cultural/spiritual • Financial • Legal

specified interventions. A safety and crisis plan also is developed by the team and includes clear cut instructions for what to do whenever a crisis may occur. The child and family team is responsible for reviewing and monitoring progress toward goals at least every 30 days and altering service plans and/or providers as needed.

- **Service Delivery** — Based on the service coordination plan, services are authorized for a 30-day period and, based upon the team’s review and adjustments, are pre-authorized for the next 30 days. The array of services provided through the Dawn project is extensive, with many additions to the traditional mix of services. Services fall under the broad categories of behavioral health, psychiatric, mentor, placement, respite, service coordination, discretionary, and other services.

Supportive services are widely used in conjunction with behavioral health treatment to support the functioning of children and their families. Mentoring services, for example, are used in a variety of settings, such as homes, schools, neighborhoods, and work settings. Mentors focus on helping youth in many spheres of their lives –developing appropriate social skills, developing good study habits, maintaining friendships, building positive relationships with parents and school personnel, learning daily living skills, and more. Overall, the key to service delivery in the Dawn project is its flexibility in terms of the types of services offered, the individualized package for each youngster and family, the availability of many providers to deliver services and supports, and the adjustments made to services as dictated by changing circumstances.

The flexibility in service delivery through Dawn is supported by an extensive provider network comprised of both agencies and individual practitioners under contract with Choices. Some providers may offer a single service, while large agencies may offer multiple services. The network as a whole offers a unique blend of traditional and formal services coupled with nontraditional and alternative services and supports. Providers are not at risk, but rather are paid on a fee-for-service basis. For each individual youth and family, providers are identified to provide the services specified in the service coordination plan. Private psychiatrists or psychiatrists from the affiliated community mental health centers are used for psychiatric assessment and for medication trials and follow-up. (Dawn resources cover the cost of medications for children who do not have coverage through Medicaid or through private insurance, or for those whose insurance coverage is exhausted.) In addition, Choices may contract for specialized services to meet a particular need. In this way, the provider network can be expanded and enhanced in a flexible and timely manner in response to the service needs presented by children and their families.

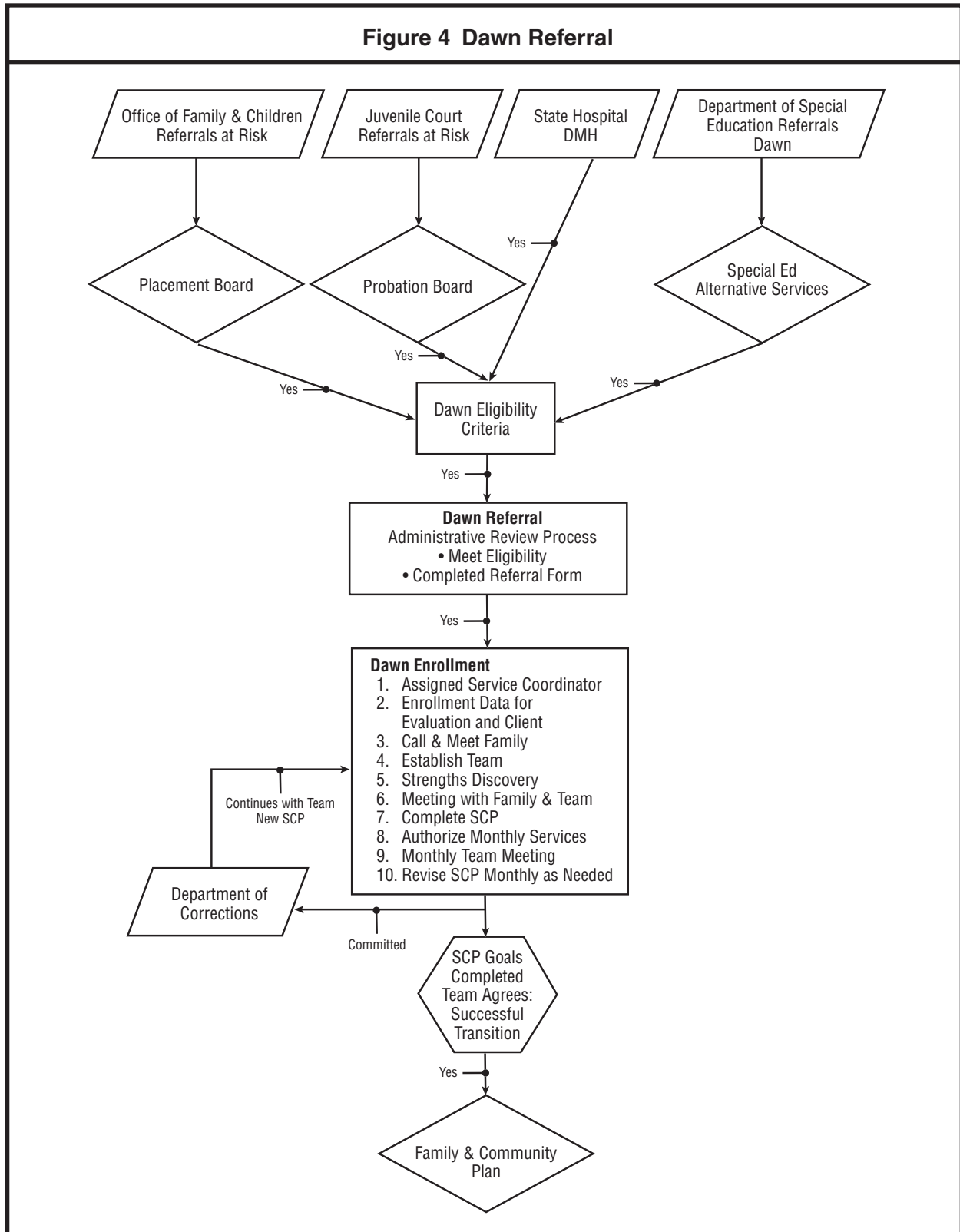
Service Array			
Behavioral Health <ul style="list-style-type: none"> • Behavior management • Crisis intervention • Day treatment • Evaluation • Family assessment • Family preservation • Family therapy • Group therapy • Individual therapy • Parenting/family skills training • Substance abuse therapy, individual and group • Special therapy 	Psychiatric <ul style="list-style-type: none"> • Assessment • Medication follow-up/psychiatric review • Nursing services 	Mentor <ul style="list-style-type: none"> • Community case management/case aide • Clinical mentor • Educational mentor • Life coach/independent living skills mentor • Parent and family mentor • Recreational/social mentor • Supported work environment • Tutor • Community supervision • Intensive supervision 	Placement <ul style="list-style-type: none"> • Acute psychiatric hospitalization • Foster care, non-therapeutic • Therapeutic foster care • Group home care • Relative placement • Residential treatment • Shelter care • Crisis residential • Supported independent living
Respite <ul style="list-style-type: none"> • Crisis respite (daily or hourly) • Planned respite (daily or hourly) • Residential respite 	Service Coordination <ul style="list-style-type: none"> • Case management • Service coordination • Intensive case management 	Discretionary <ul style="list-style-type: none"> • Activities • Automobile repair • Childcare/supervision • Clothing • Educational expenses • Furnishings/appliances • Housing (rent, security deposits) • Medical • Monitoring equipment • Paid roommate • Supplies/groceries • Utilities • Incentive money 	Other <ul style="list-style-type: none"> • Camp • Team meeting • Consultation with other professionals • Guardian ad litem • Transportation • Interpretive services

Prior to contracting with providers to become part of the network, efforts are made to assess their competencies, as well as their values and beliefs regarding the care of children, family involvement, strengths-based practice, cultural issues, and the like to ensure consistency with Dawn’s philosophy and approach. Further, quarterly forums are held with providers in the network to discuss themes, trends, the philosophy of care, the wraparound approach, and other topics to enhance their ability to work with Dawn children and families. Additional support to providers is provided through Dawn’s service coordinators who are considered “ambassadors” to the providers and who consistently communicate Dawn’s philosophy and approach to care.

A unique addition to the continuum of care provided through Dawn is the Family and Community Unit at the Lutherwood Residential Treatment Center. This program offers a residential treatment approach in which children can go home at night and beds are used only when absolutely necessary. Operated in partnership with Dawn, the program offers a nontraditional, strength-based residential program in which youngsters are integrated in the community as much as possible, family reunification is the goal, and parents are highly involved in treatment and decision making as members of the treatment team.

The average length of stay in the Dawn program is 14 to 15 months. From the time of the child’s enrollment in Dawn, a goal is to define how the child and family will become empowered to be more self-sufficient when they are no longer involved with the program. Continual reassessment of progress and outcomes occurs at monthly team meetings, and decisions regarding “disenrollment” are made based on the completion of planned tasks and the accomplishment of desired outcomes. Treatment services and community-based supports are continued following disenrollment from Dawn, based on the child and family’s continuing needs. A policy of automatic disenrollment from Dawn after 15 months and a requirement for approval from the payer agencies to override this policy and continue care beyond this point was instituted, to some degree limiting the program’s flexibility in serving youth with the most serious and complex disorders who may need longer-term care. However, few, if any, children have been automatically disenrolled due to this policy, as referring agencies typically agree if longer-term care is needed. A step-down or transition period of three to nine months was proposed with a reduced payment rate, giving children and families time to sustain their successes at Dawn and complete the transition from the intensive intervention of Dawn to more self-sufficiency in the community. The following flow chart depicts Dawn’s referral and service delivery process.

Figure 4 Dawn Referral



- **Financing** — Services through Dawn are funded through a standard monthly case rate that comes with each referral from the referring system (child welfare, juvenile probation, or special education). The original case rate established in 1997 was \$3,963 per child per month; the case rate was increased in 2001 to \$3,985 and in 2002 to \$4,089 and has remained at that level. A new case rate may be negotiated for a new contract to begin in 2004. This case rate is supplemented by a \$2,000 per year case rate from the Hoosier Assurance Plan (HAP), a larger amount than the standard HAP case rate of \$1,670 provided for each child determined to have a serious emotional disorder; all children served by Dawn receive these funds. Thus, the total current monthly case rate, including the supplemental HAP funds, is \$4,256. The Dawn case rate does not necessarily finance all of the services included in the service coordination plan. For Dawn children who are Medicaid eligible (about 90% qualify for Medicaid), Medicaid is billed for allowable behavioral health services, such as individual and group therapy, day treatment, and inpatient hospitalization, as well as for case management and other services through the rehabilitation option, leaving the case rate funds to finance many of the supportive services that might not be covered.

The case rates establish a fixed and predictable cost for payers and allow greater flexibility in using funds for individualized services. The case rate is given to a fiscal intermediary (Choices) to cover the costs of treating all children in care, regardless of actual utilization. Thus, the fiscal intermediary holds the risk and is incentivized to manage care in a way that keeps the average cost of treating the population in services at or below the aggregate of the case rates. For Dawn, the child and family team approach is seen as the key ingredient to achieving cost containment balanced with effective results. Monthly feedback on the service package allows an opportunity for immediate adjustment to services, discarding ineffective directions and implementing new, more effective approaches.

A tiered case rate structure has been proposed that would include lower rates for two populations of children: those in a step-down phase as they solidify gains and transition out of the Dawn program and into less intensive services and supports, and those comprising an at-risk population with a lower level of impairment and not as yet at the level of severity at which residential treatment would be indicated. The first step in this direction was taken by the Indianapolis Public Schools which recently agreed to fund 20 new slots in Dawn at \$1,809 per child per month, a rate that covers all the services to the child and family Dawn provides with the exception of out-of-home placement.

- **System Management and Evaluation** — An integrated management information system, called The Clinical Manager (TCM), was developed as a tool for system management in both the clinical and fiscal arenas. Encompassing all aspects of the Dawn project’s data requirements, TCM includes clinical information and plan of care, claims adjudication, service authorization, service utilization, tracking progress, tracking outcomes, tracking costs, medication management, historical information, and contact management. Clinical and fiscal records for a child and family can be viewed together, affording team members prompt access to both types of data and resulting in more efficient care management. In addition, service coordination teams can review and respond to trends in service provision and cost data among the population assigned to their team, enabling them to assess their approach more globally and plan their service strategies. TCM helps to link process, outcome, service utilization, and cost data in a way that assists the Dawn Project to assess what services work, in what ways, for which children, and at what cost.

Choices contracts with the Indiana Consortium for Mental Health Services Research to conduct evaluation activities relative to the Dawn project in areas including profiles of Dawn project participants, patterns of service use, the dynamics of the service coordination teams, client outcomes and service effectiveness, system-level functioning (the implementation of system of care principles within the managed care system), and the functioning of the family support and advocacy organization. Early findings include the following:

- Services provided by Dawn are less costly than the standard treatment typically received.
- Dawn has been successful in improving the overall clinical functioning of youth from enrollment to 6 months and to 12 months post-enrollment.
- Successful completion of Dawn is associated with a significant reduction in the likelihood of returning to the system either through the department of corrections or through a CHINS report (child in need of services).
- Dawn has been successful in transitioning youth from restrictive residential placements to community-based settings.

- **Wisconsin –Wraparound Milwaukee**

Background

Wisconsin’s statewide managed care system, implemented in 1996, is an integrated system providing physical and behavioral health care to Medicaid recipients. In addition to this system, Wisconsin has implemented two special “system of care” carve outs for youth with serious disorders – Children Come First in Dane County (Madison) and Wraparound Milwaukee.

Wraparound Milwaukee defines itself as a system of care for children with serious behavioral health needs and their families. Based on the wraparound philosophy and approach, the system offers a comprehensive and flexible array of services to youth and families and uses managed care technologies and approaches to oversee and manage service delivery. Wraparound Milwaukee was initiated in 1995 with the support of a grant from the federal Comprehensive Community Mental Health Services for Children and Their Families Program. The intent of the effort was, and still is, to foster comprehensive home and community-based care for children and adolescents with serious behavioral health disorders and their families and to reduce the use of institutionally-based care.

The system started as a pilot project, referred to as the “25 Kid Project.” Twenty-five youths residing in residential treatment centers for six months or longer, and who had no immediate discharge plans, were selected for the pilot effort by the child welfare and juvenile justice systems. Wraparound Milwaukee began its intervention process with this group of youth to determine if they could be returned to their homes and communities, if their safety and the community’s safety could be maintained when they returned, and how the cost of intensive community-based care compared to the cost of residential treatment. The pilot project achieved impressive results; 17 of the 25 youths were placed back in the community within 90 days, and within one year, 24 were reintegrated into their communities. Recidivism rates were low, and the average cost of community-based services was significantly less than the cost of residential treatment. As a result of this successful experience, all youth remaining in residential treatment centers were incrementally enrolled in Wraparound Milwaukee starting in 1996, as were all newly identified youth at risk of residential placement.

Currently, youth who would have been court ordered or placed in residential treatment centers in Milwaukee County are enrolled in Wraparound Milwaukee, and the system then determines their placement and service needs. The major child-serving systems in the county contract with Wraparound Milwaukee to serve this target group, including the child welfare agency, delinquency and court system, and the health care agency that administers Medicaid services. Wraparound Milwaukee is operated and administered by the Mental Health Division of the Milwaukee County Health and Human Services Department.

Features to Address Needs of Youth with Serious Disorders

- Wraparound Milwaukee functions as a publicly operated care management organization that is responsible for providing a range of mental health, substance abuse, social, and other supportive services to its enrollees. The enrolled population is comprised exclusively of youth with serious and complex disorders who have high levels of service needs and who typically are the most expensive to serve. The target population is defined as children and adolescents up to age 18 who have serious emotional, behavioral, or mental health needs and who are identified by the child welfare or juvenile justice system as being at immediate risk of placement in a residential treatment center or a psychiatric hospital. Approximately 550 youths and their families are served at a given time. The program is guided by a well-defined value base that underlies service delivery.

Milwaukee Wraparound Value Base	
Build on Strengths to Meet Needs	Most existing programs have been designed around the child and family's deficits and problems. Wraparound Milwaukee's philosophy is centered around identifying a child and family's strengths because those personal, family, and community strengths become resources around which to develop an effective care plan.
One Family—One Plan	There should be a single care plan developed among all agencies serving that family. There should not be separate education plans, child welfare plans, mental health agency plans, etc. Care should be delivered in a seamless fashion.
Best Fit with Culture and Preferences	We must truly understand the culture and heritage of the families we work with to be competent to understand their needs.
Community-Based Responsiveness	Children are best served when cared for in the community rather than in institutions. Institutional placements are not natural settings and not where children want to be cared for.
Increase Parent Choice and Family Independence	The care plan and services delivered to families should be developed by the family and designed to help strengthen the family to make their own choices and ultimately to function independently. Families do not usually want to be dependent on formal system services any longer than necessary.
Care for Children in the Context of Families	Families usually are the best judges of what their children and families need. Family involvement is seen as integral to and not detrimental to the care planning process.
Never Give Up	Care should be provided in an unconditional manner. If a case plan is not working, change the plan—don't blame the family.

Care coordination is described as the “cornerstone” of the system. A care coordinator is assigned to each enrolled youth and family; caseloads are kept small (one worker to eight or nine families) to allow for intensive involvement and intervention. The care coordinators’ responsibilities are critical to the service delivery process, and include:

- Performing strength-based assessments
- Assembling child and family teams
- Conducting plan of care meetings
- Helping to determine needs and resources with the child and family
- Assisting the child and family team in identifying services to meet defined needs
- Arranging for service provision
- Monitoring the implementation of the plan of care

Currently, Wraparound Milwaukee contracts with nine community agencies, each of which provides eight care coordinators, a lead care coordinator, and a supervisor.

As a care coordinator begins meeting with a family, one of the initial tasks is to identify the people who should comprise a child and family team. This team includes all individuals who support the child and family, typically the care coordinator, family members, natural supports to the family (such as relatives, church members, and friends), and systems staff (such as teachers, counselors, therapists, mentors, probation or child welfare workers). These individuals are convened to conduct an individualized treatment and service planning process referred to as the “plan of care” meeting, resulting in a plan for the provision of services and supports. This plan essentially serves as the vehicle for authorizing services. A crisis safety plan also is developed for each child and family, with clear guidance as to what should be done in crisis situations.

Wraparound Milwaukee has developed a broad array of services and supports to respond to the needs identified through the individualized service planning process. Vendors apply to the system to become a part of the provider network and to provide one or more of the services displayed. The provider network currently includes over 250 individual providers and agencies. Providers are not at risk; they are paid on a fee-for-service basis for services provided to Wraparound Milwaukee enrollees.

In addition to these more “formal” services, care coordinators and child and family teams also enlist informal services and natural supports to assist the family. Often, these types of informal services and supports add highly effective interventions at relatively low cost, with the advantage that they will remain in place for the child and family even after their involvement in the system has been phased out. These may include a friend or relative who may become a mentor for the child or provide respite care, a neighbor who may provide transportation, a local church that may have a peer support group, or a community center that may offer recreational opportunities, after school, or summer programs. Family support also is provided through Families United of Milwaukee, a family organization that operates support groups, sponsors family activities, and provides peer support to other parents in crisis situations, in addition to its advocacy activities and participation in system management and oversight.

Milwaukee Wraparound Services

- Care Coordination
- In-Home Therapy
- Medication Management
- Outpatient Individual and Family Therapy
- Alcohol and Substance Abuse Counseling
- Psychiatric Assessment
- Psychological Evaluation
- Housing Assistance
- Mental Health Assessment/Evaluation
- Mentoring
- Parent Aide
- Group Home Care
- Respite Care
- Child Care for Parent
- Tutor
- Specialized Camps
- Emergency Food Pantry
- Crisis Home Care
- Treatment Foster Care
- Residential Treatment
- Foster Care
- Day Treatment/Alternative School
- Nursing Assessment/Management
- Job Development/Placement
- Kinship Care
- Transportation Services
- Supervision/Observation In Home
- After School Programming
- Recreation/Child-Oriented Activities
- Discretionary/Flexible Funds
- Housekeeping/Chore Services
- Independent Living Support
- Psychiatric Inpatient Hospital

An additional service provided through Wraparound Milwaukee is the Mobile Urgent Treatment Team, comprised of psychologists and social workers who are trained to intervene in crisis situations and are available on a 24-hour-a-day basis. The team intervenes in crises that could easily result in removing children from their homes, schools, or communities and frequently is able to avert these placements. In addition to on-site crisis intervention, the crisis team operates an eight-bed group home and several foster homes that are prepared to provide short-term crisis stabilization services. The crisis team can also provide short-term emergency case management services and family preservation. The mobile crisis service is available not only to Wraparound Milwaukee enrollees, but to any child in the county, and the

team is responsible for reviewing all requests for inpatient psychiatric admissions for children and adolescents in the county. With the services and resources provided through the mobile crisis service, the system has nearly eliminated the use of inpatient psychiatric care.

Resource teams also are available to support the work of the care coordinators with children and families. The system has identified clinical experts in highly specialized areas who are available to provide consultation to care coordinators as they develop plans of care for youth with the most serious (and dangerous) problems – sex offenders, fire setters, and youth who have committed very serious offenses, for example.

Residential treatment is now used as a short-term service, purchased by Wraparound Milwaukee to stabilize a child and to initiate treatment, which is then completed in the community rather than in the residential center, a component of the continuum of care provided by Wraparound Milwaukee. The child and family team (or coordinated treatment team) continues to be the treatment planning vehicle, even if the child enters a residential treatment facility. The average length of stay in residential treatment settings has been reduced from 14 months to 3.5 months by using this approach.

Wraparound Milwaukee is financed through a pooled funding approach that blends the resources provided through the child welfare, juvenile justice, mental health, and Medicaid systems. Pooling these funds at the level of the care management organization (Wraparound Milwaukee) creates maximum flexibility to meet the needs of youth with serious and complex disorders and their families. The funds are available to families to support service delivery through the child and family team process.

The fund pool includes a monthly case rate of \$3600 from the child welfare system for each child enrolled in the system, an annual funding allocation of \$8.5 million from the juvenile justice system intended to support service delivery for 300 active cases, a monthly capitation payment of \$1557 per child for each child eligible for Medicaid, and block grant funding from the mental health system. In addition, the system bills Medicaid directly for crisis intervention services provided by the mobile team, crisis stabilization workers, and other staff. The crisis benefit is billed on a fee-for-service basis, because the benefit is newly created and the costs of these services were not included in the construction of the capitation rate.

Wraparound Milwaukee uses a sophisticated internet-based management information system to manage the disbursement of funds. Referred to as “Synthesis,” the system includes modules for enrollment, service authorization, claims adjudication and processing, automated care plan, on-line invoicing, general ledger, utilization review, and report writing.

The system also utilizes a comprehensive quality assurance team that evaluates the quality of the services provided from program and consumer perspectives and measures the outcomes achieved for children and families. The results reported by

Wraparound Milwaukee reflect clinical and functional improvements among the youth served by the system, as well as system-level outcomes that have benefited the community at large:

- By 2000, the system reduced residential treatment center placement from an average of 375 placements per day to just 65 placements, and, as a result, expenditures for residential treatment declined sharply, allowing additional youngsters to be served in the community.
- The use of psychiatric inpatient treatment declined by 80%, from 5000 Medicaid reimbursed inpatient days in 1995 to 250 in 2000.
- Scores on instruments including the Child and Adolescent Functional Assessment Scale (CAFAS), Child Behavioral Checklist (CBCL), and Youth Self Report (YSL) indicate significant improvements in the clinical and functional status of youth participating in the system.
- Substantial reductions in delinquency among the population served have been documented, including dramatic declines in arrests and offenses committed.
- School attendance increased significantly for youth in the system.

• Missouri – Interdepartmental Initiative

Background

The Missouri Interdepartmental Initiative was, in essence, a separate behavioral health carve out for children with serious and complex behavioral health disorders that operated with managed care approaches, including case rate financing and management of service delivery by a care management organization. The initiative was implemented in 1999 and was operated and overseen by a consortium comprised of the departments of social services, mental health, health, and education. A goal of the initiative was to demonstrate a multi-agency system of care for youth with serious disorders and their families in order to provide integrated, coordinated, community-based, family centered care; to assure the provision of necessary and appropriate services and supports; and to assure that youth at risk for out-of-home placements were supported to the extent possible in community-based living environments. Initially operating in two regions, St. Louis and surrounding areas and a region comprised of 18 counties in central Missouri, the initiative currently is serving approximately 300 children across the two regions.

During early 2002, a looming budget crisis in Missouri influenced decisions by the state’s Department of Mental Health and Division of Youth Services to withdraw, or transfer to the state’s child welfare agency, all of their enrolled children. Since July 2002, all youth served through the initiative have come from the state’s child welfare agency. Services through the initiative’s care management organization will continue through the end of the current contract period (June, 2004), at which time the child welfare agency plans to subsume youth currently served through the initiative under a new contract that will incorporate the best practices and lessons learned from the initiative.

Concurrent with the initiative, the departments involved, along with juvenile justice, were implementing coordinated systems of care for children with mental health needs in specific areas of the state. In 2001, the departments committed to statewide expansion of systems of care and to the establishment of a state-level system of care team to provide oversight and direction. Today, the system of care initiative has evolved into a comprehensive child mental health service system initiative which includes all previously involved departments plus family members. The comprehensive system will incorporate the initiative and lessons learned from this experience in the implementation of the children’s mental health service delivery system.

Features to Address Needs of Youth with Serious Disorders

- Initially, to determine their eligibility for services through the Interdepartmental Initiative, children were referred to the interagency team in their area. The team includes representation from all the participating agencies, and following presentation of the youth, determined whether or not eligibility criteria were met. Youngsters eligible for the initiative were ages 4 to 21 (though had to enter the program by age 18), resided in the regions served, were required to have severe behavioral health problems, and had been in, or were at serious risk of out-of-home placement. The presence of “severe behavioral health problems” was measured, in

part, by the Childhood Scale of Psychiatric Illness (CSPI). Currently, eligibility criteria remain the same; decisions about participation in the initiative are made by the child welfare agency (referred to as the Children’s Division).

Under the existing structure, once a youngster is determined to be eligible, services are then provided through a care management organization (CMO) under contract to the state. The first CMO contract was awarded to a nonprofit organization comprised of a group of provider agencies, the Missouri Alliance for Children and Families. The CMO is responsible for recruiting, developing, and contracting for a comprehensive array of community-based services and supports for children and families served by the initiative. The initiative was built on the assumption that CMOs will offer a sufficient array of home and community-based services to enable them to move youngsters relatively quickly from high-end, restrictive service settings to less restrictive community settings, while still providing the intensive levels of services and supports needed by these youth with serious and complex problems and their families.

The CMO assigns a care manager, who is responsible for creating and convening an individualized Family Support Team (FST) for each youngster to develop the plan of care. Family Support Teams include those individuals involved in the child and family’s life who are most likely to assure a successful outcome, such as family members, relatives, providers, school personnel, and other invested individuals. An individualized plan of care is developed utilizing a “wraparound” process. It is then the responsibility of the CMO and the care manager to implement the plan of care, either through services provided directly by the CMO or through subcontracts with service providers. Care managers carry caseloads of no more than ten children; the CMO also employs family aides to work with children and their families.

Youngsters are “disenrolled” from the initiative when they show evidence of stability and meet a number of pre-established criteria, with the decision regarding disenrollment made by the Family Support Team. Average length of involvement is approximately 12 to 18 months. For a period of 120 days following disenrollment, the CMO continues to work with the child and family to support their continued stability and to ensure that the disenrollment follow-up plan is implemented and linkages with ongoing community supports are established and maintained. Financial incentives for the CMO were incorporated if the child remains stable post-disenrollment, as well as financial disincentives to be imposed if, for example, the child requires a more restrictive placement post-disenrollment.

The services to youngsters with serious disorders and their families are financed by a monthly case rate provided to the CMO, accompanied by the flexibility to creatively provide services and supports to children and families. Initially, each of the participating departments contributed a specified percentage of the case rate, regardless of which agency presented the child to the initiative. The intent was to create an incentive for the CMO to manage the costs of care and to move children from expensive, high-end treatment settings.

The initiative originally included a Technical Support Organization (similar to an “administrative services organization”) to provide administrative support, manage the data system, and monitor the CMO’s compliance with contract requirements. Ultimately, however, this aspect of the system was abandoned, and state staff assumed these various administrative functions.

Specialty Provider Networks

- **Texas – NorthSTAR**

Background

NorthSTAR is a behavioral health carve out serving the Dallas area that became operational in 1999. The system is a joint initiative of the Texas Department of Mental Health and Mental Retardation (TDMHMR) and the Texas Commission on Alcohol and Drug Abuse (TCADA) designed to blend state, local, and federal funding for behavioral health services (Medicaid, mental health, and substance abuse funds) and to create a single, “seamless” system of public mental health and substance abuse services to residents of seven counties (Collin, Dallas, Ellis, Hunt, Kaufman, Navarro, and Rockwall). The state contracts with a behavioral health managed care organization (BHO), currently ValueOptions, on a capitated basis to develop and manage provider networks and to manage service delivery. A local behavioral health authority, the Dallas Area NorthSTAR Authority (DANSA), was created to ensure that the local communities within the seven-county area have a voice in the delivery of behavioral health services; its functions span areas including policy development, problem resolution, liaison to contractors and local communities, intersystem coordination, monitoring and oversight, and quality improvement. DANSA also provides ombudsman services to NorthSTAR enrollees and meets regularly with community-based organizations, consumer and advocacy groups, managed care coordination groups, and NorthSTAR service providers and relays information about community concerns, as well as consumer complaints, directly to the state. By integrating publicly funded systems of mental health and substance abuse services to create a single, managed system, NorthSTAR seeks to achieve goals including: increasing access to behavioral health services, increasing consumer and provider satisfaction, improving the cost effectiveness of behavioral health expenditures, improving behavioral health outcomes, and developing a more comprehensive array of services and supports.

Features to Address Needs of Youth with Serious Disorders

- Texas incorporated specialty provider networks (SPNs) into its NorthSTAR managed care system to respond to the needs of adults with serious mental illnesses and children with serious emotional disorders — the state’s priority populations. The BHO is required to have SPNs, which are defined as designated networks of provider agencies that provide intensive treatment and care management to these priority populations. ValueOptions developed a set of criteria for the selection of providers to be included in an SPN, focusing on their experience and demonstrated ability in working with individuals with serious disorders and their capacity to provide, coordinate, and manage the specialty services.

ValueOption's Criteria for SPN Providers
<ul style="list-style-type: none"> • Previous experience and demonstrated ability to provide necessary services to priority populations
<ul style="list-style-type: none"> • Ability to coordinate care and maintain accountability for service provision
<ul style="list-style-type: none"> • Referral relationships and written coordination agreements with local human service agencies to ensure the availability and accessibility of necessary support services
<ul style="list-style-type: none"> • Policies and procedures to ensure coordination between behavioral and physical health providers
<ul style="list-style-type: none"> • Ability to provide all core SPN services and to provide or arrange for all coordinated SPN services
<ul style="list-style-type: none"> • Policies, procedures, and sufficient staff to provide plan of care oversight, coordination of care, and case management services
<ul style="list-style-type: none"> • Ability to accept referrals and ensure access to care within required timeframes for routine, urgent, and emergent care
<ul style="list-style-type: none"> • Policies, procedures, and staff necessary to assist in managing the mental health commitment process
<ul style="list-style-type: none"> • Sufficient numbers of qualified staff to provide clinical assessments within required timeframes for all eligible enrollees
<ul style="list-style-type: none"> • Functional quality management program, including policies and procedures for utilization review and utilization management
<ul style="list-style-type: none"> • Ability to maintain and report data, including enrollee and encounter data, within required timeframes in an acceptable format

All children and adolescents who are Medicaid eligible are eligible for NorthSTAR. An initial screening or assessment is used to determine service needs. The initial screening considers treatment history, current signs or symptoms that appear consistent with a designation of “serious emotional disturbance,” or other indications that the child’s functioning or service needs are similar to youngsters with serious disorders. If the assessment suggests that services beyond “traditional” care may be needed, a referral is made to a specialty case manager within the BHO who makes a determination of eligibility for SPN services and authorizes such care when appropriate. In some cases, based upon the initial screening, a youngster may be referred directly to an SPN for a more thorough clinical assessment. Non-Medicaid-eligible children and adolescents also may receive services through SPNs if they meet the definition of serious emotional disturbance established by TDMHMR to identify mental health priority populations and meet financial eligibility criteria.

Once care is authorized, the SPN proceeds to complete the assessment and to develop a treatment plan. The SPN requests authorization for services by submitting a “Treatment Plan Request Form” to the BHO. If the request for services is consistent with assessment data, then services are authorized for a period of six months. A specialized case manager from the BHO typically is assigned to work with each SPN in the BHO’s network, and the case manager may participate in developing and reviewing plans of care for children (and adults) with serious and complex disorders.

A broad range of services are provided through SPNs, including traditional behavioral health treatment services along with nontraditional modalities and an array of rehabilitative and supportive services to assist youngsters with serious disorders, to enhance their level of functioning, and to support their families in the role of caregiver.

Thus, the features incorporated in NorthSTAR for children with serious disorders include:

- Designated networks of provider agencies with experience and expertise to serve children with serious disorders
- Expanded array of treatment and rehabilitative services and supports for children with serious disorders and their families
- Care management and service coordination

Services Provided by Specialty Provider Networks to Children and Adults

- Clinical Assessment
- Individual, Family, and Group Therapy
- Mental Health Intensive Outpatient
- Day Treatment
- Community Support Services (Symptom Management, Community Living Skills Training, Employment-Related Services)
- Assertive Community Treatment
- Service Coordination
- Plan of Care Oversight
- Medication Management
- Acute Inpatient Stabilization
- Sub-Acute Inpatient Stabilization
- 24-Hour Observation Bed
- Partial Hospitalization
- Supported Housing
- Supported Employment
- Respite Care
- Residential Treatment
- Early Childhood Pre-School Day Treatment
- Early Intervention
- Mental Health Services—Birth to Age Six
- Children and Youth Wraparound
- In-Home and Family Support
- Therapeutic Foster Care
- Treatment Foster Care
- Transportation
- Mobile Crisis Services
- Crisis Stabilization
- Intensive Crisis Residential Services
- Substance Abuse/Chemical Dependency Services

Incorporating the System of Care Philosophy and Approach in Managed Care Systems

• Pennsylvania — HealthChoices Behavioral Health Services

Background

Pennsylvania's managed care system was implemented in 1997 to provide managed medical, psychiatric, and substance abuse services to Medicaid recipients in a five-county area. Expanding to ten counties in 1999 and phasing in an additional ten counties in 2000, the goal of the managed care system is to “improve the accessibility, continuity, and quality of services” for the state's Medicaid population, while controlling costs. Behavioral health services were designed as a carve out.

By the time that managed care was implemented, Pennsylvania had a long history and substantial base of accomplishments in building community-based systems of care for children with serious behavioral health disorders and their families. The state received a grant from the federal Child and Adolescent Service System Program (CASSP) in 1985. The state established a CASSP Training Institute, and eventually incorporated CASSP into its community-based mental health services for children and adolescents, initiated a number of pilot programs, developed a CASSP coordinator in each of its counties, hired child mental health specialists in its regional offices, expanded the children's mental health focus at the state level, and provided significant levels of training and technical assistance to agencies and providers on the system of care philosophy and approach, as well as on clinical best practices for children and adolescents. The introduction of managed care was seen as a strategic opportunity to strengthen the state's commitment to systems of care by incorporating the values, principles, and approaches into managed care system policy. Through a partnership with the state's Medicaid agency, the Bureau of Children's Services (the agency within the Department of Public Welfare responsible for children's mental health) worked to infuse the system of care philosophy in the HealthChoices behavioral health carve out and continued to develop system of care standards and requirements through HealthChoices' RFPs, contracts, readiness reviews, and performance and compliance monitoring processes.

Under the HealthChoices Behavioral Health system, either the county or a behavioral health managed care organization (BH-MCO) manages the purchase and provision of services in each county. County governments are given the first opportunity to enter into a capitation contract with the Department of Public Welfare (DPW) for management and oversight of behavioral health service delivery. In Pennsylvania, county governments have statutory authority for administering publicly funded human service programs. Given their role and responsibilities and strong history of community-based service provision, it was determined that counties were in a particularly advantageous position to coordinate the behavioral health managed care system with other public health and human services. In addition, county governments had the experience and expertise in providing behavioral health care to high-need populations with serious and complex disorders. County governments could choose to become the BH-MCO and administer the managed behavioral health system directly, or they could subcontract with a licensed, private sector BH-MCO. Such subcontracts could capitalize on the public sector's experience in serving

children and adults with serious behavioral health disorders and the private sector's experience and expertise in managing financial risk. Currently, most counties contract with private sector BH-MCOs to manage behavioral health services with county oversight. All eligible Medicaid recipients are automatically enrolled in their county's BH-MCO.

Features to Address Needs of Youth with Serious Disorders:

- Readiness reviews are a unique feature of HealthChoices. Prior to contracting with a primary contractor and a contracted BH-MCO, the state evaluates their readiness to administer the purchase and provision of behavioral health services under the managed care system. A formal review process is undertaken during which the ability of the contractors to meet the requirements outlined in the RFP is assessed. One of these requirements is that BH-MCOs deliver service in accordance with the principles established through CASSP (i.e., the system of care philosophy). Thus, readiness reviews are one of the first vehicles used with contractors to ensure that their approach is consistent with the system of care philosophy. The state developed a list of specific indicators that can be used to assess the application of CASSP principles on both a county-wide and an individual agency level.

CASSP Principles	
Child-Centered	Services are planned to meet the individual needs of the child, rather than fit the child into an existing services. Services consider the child's family and community contexts, are developmentally appropriate and child-specific, and also build on the strengths of the child and family to meet the mental health, social and physical needs of the child.
Family-Focused	Services recognize that the family is the primary support system for the child. The family participates as a full partner in all stages of the decision-making and treatment planning process, including implementation, monitoring, and evaluation. A family may include biological, adoptive, and foster parents, siblings, grandparents and other relatives, and other adults who are committed to the child. The development of mental health policy at state and local levels includes family representation.
Community-Based	Whenever possible, services are delivered in the child's home community, drawing on formal and informal resources to promote the child's successful participation in the community. Community resources include not only mental health professionals and provider agencies, but also social, religious, and cultural organizations and other natural community support networks.
Multi-System	Services are planned in collaboration with all the child-serving systems involved in the child's life. Representatives from all these systems and the family collaborate to define the goals for the child, develop a service plan, develop the necessary resources to implement the plan, provide appropriate support to the child and family, and evaluate progress.
Culturally Competent	Culture determines our world view and provides a general design for living and patterns for interpreting reality that are reflected in our behavior. Therefore, services that are culturally competent are provided by individuals who have the skills to recognize and respect the behavior, ideas, attitudes, values, beliefs, customs, language, rituals, ceremonies, and practices characteristic of a particular group of people.
Least Restrictive/Least Intrusive	Services take place in settings that are the most appropriate and natural for the child and family and are the least restrictive and intrusive available to meet the needs of the child and family.

Although all children in need can access behavioral health care, the state established as priority populations adults with serious mental illnesses or addictive disorders and children and adolescents with or at risk of serious emotional disorders and who, without services and supports, are at risk for separation from their families through placement in treatment facilities, homelessness, or incarceration, and/or who present a risk of harm to themselves or others. A family may self-refer their child for behavioral health care, or a child may be referred by another party either to a BH-MCO or directly to a provider. All Medicaid eligible children have access to medically necessary behavioral health care. A preliminary assessment is completed and a determination made as to whether the child meets medical necessity criteria, a requirement in order to receive services.

BH-MCOs are required to coordinate services with other child-serving agencies for youngsters with multiple needs and who are involved with multiple agencies. For these youth with serious disorders, BH-MCOs must enter into written agreements with other agencies specifying procedures for referral, care authorization, coordination of care, and responsibility; liaison relationships for working together and problem solving on the system and individual client levels; and arrangements for assuring continuity of behavioral health care when youth are in substitute care placements, a frequent occurrence in this high-risk population.

In addition to requiring coordination, the managed care system includes requirements for interagency service planning for children involved with multiple systems. The BH-MCO must be available to attend or convene these interagency service planning teams, which are convened for youth with serious and complex problems. Such teams generally include the evaluator, primary clinician, family and child, and representatives of all other involved agencies. The result of the interagency service planning meeting is an individualized service plan that identifies the treatment to be provided, the agency responsible for delivering each service, and the source of funding for each service. The plan developed by the team is then submitted to the BH-MCO for approval and authorization. In the majority of cases, plans submitted by interagency teams are approved; in the few cases in which services are not deemed medically necessary, alternative services are considered.

Similar to other individualized service planning processes, the structure for planning used within HealthChoices involves delineation of the child and family's current problems and current strengths by domain and by setting. The following format is included in Pennsylvania's "Guidelines for Best Practice in Child and Adolescent Mental Health Services".

Matrices of Current Problems and Current Strengths by Domain and Setting			
Domains	Setting		
	Home	School	Community
Medical			
Behavioral			
Emotional			
Cognitive/Learning			
Interpersonal			
Leisure			
Unique/Other			

Decisions about services and supports also are guided by medical necessity criteria that provide a common set of criteria for children's behavioral health services. The CASSP/system of care philosophy is evident in the medical necessity criteria. The medical necessity criteria are seen as a vehicle for improving consistency between a child's treatment needs and the system's fundamental philosophy of providing care in the least restrictive setting, in a manner that is family focused, community-based, coordinated, and culturally competent. Unlike medical necessity criteria that rely on diagnostic criteria, HealthChoices medical necessity criteria for children's behavioral health care incorporate an "ecological" approach that considers the child's functioning in all relevant environments and that focuses on "screening children into the program rather than out of the program." Criteria provide guidance for admission, continued stay, and discharge for psychiatric inpatient care, residential treatment, partial hospitalization, and psychiatric outpatient treatment; for behavioral health rehabilitation services that include a wide range of home and community service options; and for family-based mental health services.

The services provided through HealthChoices also are grounded in the system of care philosophy. The broad service array blends traditional behavioral health care (such as outpatient, inpatient, partial hospitalization, and residential treatment) with a range of home/community services. These are not intended to replace clinic and hospital-based care, but rather to address the complex needs of children with serious disorders. The CASSP philosophy within the managed care system reflects a change in emphasis from serving children exclusively in established sites, to

Incorporating the System of Care Philosophy and Approach in Managed Care Systems • Pennsylvania continued

“serving children individually where they live, learn, and play in the community.” In-plan services are those included in the HealthChoices behavioral health capitation rate and are the payment responsibility of the primary contractor. Supplemental services are not part of the capitated, in-plan benefit package. However, the BH-MCO may choose to purchase supplemental services for its enrollees in lieu of or in addition to in-plan services. At minimum, BH-MCOs are required to facilitate access to the supplemental benefits, as well as to coordinate these services with in-plan services, for priority populations (including children with serious disorders and their families).

Behavioral Health Services Provided Through HealthChoices	
In-Plan Services	Supplemental Services
<ul style="list-style-type: none"> • Inpatient psychiatric hospital services • Inpatient drug and alcohol detoxification • Psychiatric partial hospitalization services • Inpatient drug and alcohol rehabilitation • Non-hospital residential detoxification, rehabilitation and halfway house services • Psychiatric outpatient clinic services • Behavioral health rehabilitation services (home/community services) • Mental health residential treatment services • Outpatient drug and alcohol services • Crisis intervention services • Family-based mental health services • Targeted mental health case management • Methadone and LAAM 	<ul style="list-style-type: none"> • Partial hospitalization for drug and alcohol abuse • Targeted drug and alcohol case management • Family education and support services, e.g., respite care • Assistance in obtaining and retaining housing, employment, and income support • Continuous community-based treatment teams • Community residential rehabilitation services • Child/adolescent support groups • Psychiatric rehabilitation services for adults

The services included in the managed care system are conceptualized in three major categories — clinic/hospital services, home/community services, and personal supports. When determined to be medically necessary, various types of home/community services can be provided and coordinated with other needed behavioral health services and supports. Home/community services are geared for children with serious and complex disorders, including those who require highly intensive community treatment and supports to prevent out-of-home placement and to assist them to return from a more restrictive setting back to their homes, schools, and communities. Home/community services are divided into four levels of intensity (least, moderate, intensive, and highly intensive), defined by the amount of time the service is provided. They are intended to meet individualized needs and strengths identified through the interagency service planning process and to address multiple life domains. Home/community treatment involves integrated efforts by all service providers, facilitated by a lead case manager.

BH-MCOs are required to develop a network of qualified providers and facilities to ensure access to all of the in-plan services. HealthChoices documents clearly require that networks include providers trained and experienced to work with priority populations, including children and adolescents with serious disorders. Further, BH-MCOs are required to provide orientation and training to network providers, with specific requirements to focus on the CASSP principles, priority and special needs populations (such as children in the child welfare or juvenile justice systems), coordination with other child-serving agencies, and current best clinical practices. BH-MCOs are required to provide ongoing training and professional development for their own staff in similar topical areas. The state established and supports a program at the Pennsylvania State University, the CASSP Training Institute, that trains MCOs and providers in areas relevant to systems of care and to providing effective services and supports to children and adolescents with serious disorders and their families.

The managed care system is financed through prepaid capitated contracts to the primary contractors, which provide an established rate per eligible Medicaid recipient in the county. The primary contractor is then responsible for all medically necessary in-plan services. To ensure that valid claims submitted by providers will be paid, contractors are required to have risk protection arrangements to protect against extraordinarily high costs for individual recipients. Stop loss reinsurance policies are required to cover, at minimum, 80% of the inpatient costs of a member incurred during one year in excess of \$75,000 or an alternative risk protection arrangement. Documentation of risk protection is needed to successfully pass the readiness review.

In recognition that service capacity is not optimal, HealthChoices encourages reinvestment of available funds to enhance service capacity. Reinvestment resources, which come from any savings that may be realized from the managed care program, can be used to purchase cost-effective services, as seed money to increase program capacity, to cover start-up costs for in-plan services, or to develop and/or purchase supplemental services. Every six months, BH-MCOs are required to submit reinvestment plans, proposing how they will spend reinvestment dollars to target unmet needs in their county, including the services to be funded, the priority and special needs populations to be targeted, and the amount of funds to be expended in priority order. Consumers and families are required to participate in the development of the reinvestment plans.

A Performance Outcomes Measurement System (POMS) supports the HealthChoices Behavioral Health system. POMS is a database concerning enrollees in the BH-MCOs that is maintained by the Department of Public Welfare. It serves as a vehicle for producing information on a set of performance measures that are used to continuously evaluate the BH-MCO contractors in achieving a variety of outcomes. The system includes encounter data, enrollee eligibility and demographic data, consumer/family satisfaction reports, BH-MCO consumer registry files, BH-MCO quarterly status reports on outcome measures related to priority populations, and performance indicator reports. The outcome dimensions assessed for children and adolescents with serious behavioral health disorders include: increasing community

tenure and less restrictive services, increasing vocational and educational status, reducing criminal/delinquent activity, improving health care, increasing penetration rates, increasing consumer/family satisfaction, implementing continuous quality improvement, and increasing the range of services and improving utilization patterns.

A unique mechanism used for the evaluation of satisfaction with services is referred to as a consumer/family satisfaction team. Required for each BH-MCO, these teams must include family members of children and adolescents with serious emotional and/or substance abuse disorders who are receiving or have received services in the publicly funded system, and may also include older adolescents or young adults who are current or previous service recipients. The teams are responsible for determining whether individuals in the priority populations and their families are satisfied with services and for helping to ensure that problems related to service access and delivery are identified and resolved. The teams gather information primarily through face-to-face interviews with children, adolescents, and family members, with follow-up reports, discussions, and problem resolution with the primary contractor in the county. Quarterly reports summarizing findings and improvement activities are required.

Specialized Care Planning and Coordination

- **Rhode Island — CEDARR (Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Re-evaluation) Services and Supports**

Background

The CEDARR initiative in Rhode Island resulted from the recognition that children with special health care needs enrolled in the state's Medicaid program (RIteCare) and their families often confronted significant challenges in accessing needed services and supports. In 1998, the state convened a Leadership Roundtable on Children with Special Health Care Needs and Their Families. The group (comprised of parents, advocates, providers, state agency representatives, and policy makers) emphasized the need for fundamental improvements in the Medicaid system for these children and families, citing particular needs for information, objective professional assessments, care planning, care coordination, referral assistance, and support. Recognizing that families play a central role in their children's lives and that they should be partners in service delivery, the Leadership Roundtable further recommended that all care and services be family centered. In response to these findings and recommendations, the state implemented CEDARR services – comprehensive evaluation, diagnosis, assessment, referral, and re-evaluation – that are available to children in the managed care system. These services are overseen by the state's Center for Child and Family Health within the Department of Human Services, which also oversees the state's Medicaid program. Other state agencies (including child welfare, mental health, and education) are collaborating with the Department of Human Services in the ongoing development and implementation of CEDARR services.

Features to Address Needs of Youth with Serious Disorders

- The cornerstone of this approach is the CEDARR Family Center. The first such center opened in 2001; four centers currently are operational across the state. The CEDARR Family Center is designed to be a “one stop” comprehensive source of information, clinical expertise, connection to community supports, and assistance to help families meet the needs of children with special health care challenges. The goal is to create a unified, coordinated system of services and supports for children with serious disorders and their families.

Children with a range of conditions are eligible for CEDARR services, including youth with serious behavioral health disorders, autism and related disorders, severe medical or physical disabilities, developmental disabilities, and those who are technology dependent. Eligibility is determined based on the family's and the CEDARR Center's determination of the need and desire for services and supports.

Families may contact a CEDARR Family Center seeking assistance or may be referred. In either case, the CEDARR Family Center provides the following services, with visits often taking place in the family's home or a community setting, as well as at the center.

- **Initial Family Assessment** — An initial family assessment is conducted with the goal of creating a working profile of the child and family that includes information about the child's developmental and diagnostic history, current involvement with care providers, and the child and family's strengths and needs. Financial issues also are a focus of the initial assessment, with a determination of the child and family's current insurance status and potential eligibility for various public programs and community supports. To ensure a holistic approach, the assessment process includes exploration of a series of domains, covering all aspects of the family's life: family systems and environmental; behavioral; social and peer relationships; medical/physical; life skills; educational/vocational; cognitive/developmental; recreational and leisure; legal; system coordination; and future planning.
- **Specialty Clinical Evaluation** — The initial assessment may identify the need for an in-depth, specialty clinical evaluation. In these cases, clinical specialists affiliated with the CEDARR Family Center are enlisted to conduct such evaluations.
- **Development of the Family Care Plan and Treatment Consultation** — The results of the initial family assessment and any specialty clinical evaluations are used to guide the development of a comprehensive service plan, referred to as the Family Care Plan. The plan is developed by the family in partnership with a team of professionals from the CEDARR Family Center, in coordination with other involved providers and community resources (e.g., the local coordinating council responsible for behavioral health care to children with serious disorders). The plan is intended to be comprehensive and to address the child and family's needs for services and supports across life domains, including provisions for handling crises.
- **Family Care Coordination Assistance** — The center provides care coordination services, including a range of activities to support the implementation of the Family Care Plan. Care coordination assistance also is designed to empower families and to help them to develop self-advocacy skills. Although limited to six months, care coordination assistance may reoccur during periods of transition.
- **Family Care Plan Review and Revision** — CEDARR Family Centers require that the Family Care Plan be reviewed every six months at minimum, in order to assess progress in achieving goals and to identify needed changes. The review leads to a revised plan as appropriate.
- **Basic Services and Supports** — Centers provide a range of basic services and supports directly to families. These may include providing resource information about specific disorders, treatments, and providers; providing information about the entire system of services, supports, and legal rights available to children with special health care needs and their families; helping families to identify formal and informal resources, beyond the scope of Medicaid, to support home and community-based care; and helping families to determine their eligibility and to make application for various programs, such as Medicaid, early intervention, special education, and the local coordinating council for mental health.

- **Crisis Intervention Services** — CEDARR Family Centers are accessible 24 hours a day to respond to crises. Crisis intervention services include clinical triage and crisis follow-up care coordination. Staff work with families to determine the next steps and to arrange for needed community-based services and supports in response to the crisis.

Although CEDARR Family Centers were not designed to provide direct treatment services per se, they are becoming involved filling gaps in the available continuum of care. For example, therapeutic services in child care settings and intensive home-based services for children with serious behavioral health disorders are being developed by the CEDARR Family Centers.

CEDARR services are considered “out of plan” benefits in the RItCare managed care system, so that the centers bill Medicaid directly for services. In some cases, employer provided health plans cover CEDARR services, and families without Medicaid or private coverage may also access CEDARR services by paying directly.

III. Concluding Observations

Common Characteristics and Challenges

- **Common Characteristics**

The features and approaches incorporated by managed care systems to respond to the needs of youth with serious and complex behavioral health disorders and their families share a number of common characteristics:

- **Broad Array of Services** — The promising approaches involve a much broader array of services and supports than typically is available in managed care systems. In addition to the more familiar behavioral health treatment modalities (such as outpatient therapy, day treatment, inpatient hospitalization, and residential treatment), these systems have incorporated numerous additional service and support options that have proven invaluable for providing treatment and supporting community functioning, ranging from crisis services to mentoring, home-based services, respite care, and family support.
- **Individualized Service Planning Process** — A common feature across these managed care systems is the use of some type of individualized service planning process. This process involves the creation of a service planning team, comprised of the family and youngster (when appropriate), relevant providers, and other individuals of significance to the family. The use of a well-defined, individualized service planning process allows the strengths and needs of each youth and family to be assessed and considered and for a service plan to be designed to specifically target their needs and goals.
- **Flexible Service Delivery** — Many of the promising features described enable much greater flexibility and creativity in service delivery than is possible in most managed care systems. Mechanisms have been incorporated to support flexible “service packages,” innovative service delivery and the “whatever it takes” approach to serving and supporting youth with serious and complex disorders and their families.
- **“Ecological” Clinical Decision-Making Criteria** — The medical necessity, level of care, and other clinical decision-making criteria used by most of these systems are ecological in nature in that they allow for the consideration of psychosocial and environmental factors in clinical decision-making and recognize that, particularly for youth with serious disorders, their ability to function in their homes, schools, and communities are critical factors to address in service delivery.
- **Family Involvement** — The approaches share respect for families and a commitment to family involvement in a variety of ways. Families and surrogate families are integral members of the service planning teams and an ongoing, trusting relationship with families is a goal throughout service delivery. Often, families also are involved at the system level in policy and system management decisions. In some cases, family organizations play a role in advising and supporting the system, and may provide peer support to other families involved in services.

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- **Service Coordinators** — The role of a service coordinator is important in most of these systems, with one person taking primary responsibility for planning, facilitating, and coordinating care. The use of a service coordinator, particularly for youngsters with serious and complex problems, enhances continuity of services; allows one person to develop a genuine understanding of the issues; develops an ongoing, supportive relationship with the family; facilitates communication and coordination among involved service providers; and maintains a “big picture” perspective for assessment of progress over time and adjusting services and supports as needed. Whether they are called service coordinators, care coordinators, care managers, or case managers, their role in these approaches is a major departure from the more narrow care authorization/gatekeeper role seen in some managed care systems.
 - **Cross-System Focus** — Most of the approaches used to serve children with serious disorders within managed care systems recognize that these youngsters have multiple needs and typically are involved with multiple agencies and child-serving systems. The approaches involve input, collaboration, problem solving, and, often, resources from multiple child-serving systems in an attempt to create more coherent and coordinated service delivery.
 - **Culture of Providing Care that Works** — Though all of these systems struggle with issues of resource scarcity and the need for cost consciousness, the primary focus is based on a culture of providing care that works for youth with serious and complex problems. Care authorization processes incorporate flexibility, and denials of services are infrequent.

- **Common Challenges**

All of the managed care systems face significant challenges in their efforts to serve youth with serious disorders and their families. Many of these challenges stem from fiscal pressures; others reflect the complexities inherent in serving this population whether in the context of managed care or not.

- **Financial Constraints** — Financial pressures, particularly in the current environment of fiscal crises and budget deficits, have made it challenging for these systems to continue providing the levels of care that are deemed necessary for youth with serious disorders. In some cases, partner agencies reportedly are unable to maintain their level of financial participation in the system. A number of measures are being taken by systems to maintain their viability given impending or actual funding cut-backs, including reducing eligibility for care, tightening authorization procedures for higher-cost services, reducing length of stay, lowering provider reimbursement rates, and reducing services to uninsured youth, and others. Increased judiciousness in decisions about providing multiple services and increased cost consciousness have resulted from the current economic pressures.
- **Pressure to Control Length of Stay or Limit Services** — Some of the systems have experienced pressure from referral sources to move children out of services after a particular length of time or to decrease length of stay in general. Internal pressures to control length of stay may also exist. These pressures are felt for individual service components, such as inpatient care, and for overall involvement in care. Most of these systems do not have arbitrary limits on care; however, there appears to be an implicit understanding that the goal is to move children out of

intensive services as quickly as possible both for financial reasons and in order to be able to serve additional children. While such incentives for shorter-term care are associated with managed care, such pressures may create complications when serving youngsters with serious disorders and their families who may require long-term services and supports in order to maintain their progress and stability. Negotiating issues around length of service delivery and the frequent need for long-term care for youth with serious disorders constitutes a formidable challenge.

- **Conflicts of Control, Philosophy, and Mission Across Systems** — Partnerships across child-serving systems are inherently complex and challenging. In these systems, the close partnerships may surface disagreements among agencies as to which agency is the final decision maker, differences in mission and philosophy and lack of understanding of these differences, discrepancies in opinion about what constitutes appropriate care for a child and family, and concerns about the cost of specialized services for these high-need youth. A common example is the frequent difference of opinion between child welfare and mental health staff as to what constitutes active treatment and what constitutes a home/family substitute. The roots of many of these conflicts are in the different ideologies and missions of the systems. “Culture clash” among systems, while not unique to these managed care systems, is the source of continual challenges.
- **Insufficient Service Capacity** — Despite the broad array of services offered through these approaches, most systems reported insufficient service capacity to meet the need. Some systems reported wait lists for services including day treatment, intensive outpatient services, and behavioral aides. In addition, insufficient resources for service capacity development, including start-up capital for new services, is a challenge shared among them. In some cases, even if the managed care system generates savings in children’s mental health services, there is no requirement that these resources be reinvested back into the children’s mental health system. Some systems have looked to grant funding (as from the Comprehensive Community Mental Health for Children and Their Families Program) as a way to further develop services. Thus, systems reported that chronic underfunding and a lack of new resources prevent the development of services to increase capacity. Even with the creation of individualized service plans, some services may simply not be available to children and their families.
- **Ongoing Education, Information, and Training for Stakeholders** — Educating stakeholders in a number of critical areas is a continual challenge for these systems. Stakeholders need to have a basic understanding of managed care concepts, as well as an understanding of how the system operates, how to access care for youth with serious disorders, and what to expect. In addition, education and training is needed about the approach to care used in many of these systems for youth with serious disorders (i.e., an individualized/wraparound approach, family focus, community-based services and supports, etc.). This challenge is complicated by the staff turnover that plagues many child-serving systems, especially among front-line workers. For families, information is needed on what services are available, what they are entitled to, and how to access care.

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- **Family Involvement Across Systems** — Although these promising approaches share a commitment to family involvement, this value is not always shared among front line staff or among partner agencies and systems. Respecting families as experts on their children, enlisting them as partners in their child's care, supporting them in their caregiver role, and involving them as partners in decision making at the system level are goals that have not been fully achieved in any of the systems. Handling resistance to family involvement and encouraging staff and partner agencies to understand and adopt this value requires attention and persistence.
 - **Convincing Stakeholders that the Approach is Cost-Effective** — A challenge for these systems has been to use data and accountability approaches to substantiate the cost-effectiveness of the service approaches used for youth with serious disorders and their families. Some systems have sought to document cost avoidance in other systems by providing services and supports in the managed care system.
 - **Complaints About Service Authorization Process** — Many managed care systems have experienced complaints about requirements to obtain prior authorization for services and re-authorization for continued care. The authorization requirements and process sets up a dynamic in which providers may feel that their clinical judgment is being questioned, that they have lost their autonomy in providing care, and that they are being micromanaged. Disagreements about what care is appropriate may arise between those providing services and those reviewing and authorizing care. Additionally, some have charged that the authorization processes themselves can be time consuming, cumbersome, and inconsistent and that they significantly increase administrative burden and expense. These systems are challenged by the need to balance the use of managed care technologies to ensure that service utilization is appropriate (and within the system's established medical necessity and level of care guidelines), with the administrative burden and complaints these processes may generate in the provider community.
 - **Streamlining the Functioning of Service Planning Teams** — Some systems have found that individualized service planning teams may become too large, that meetings may take too long, and that it may be difficult to reach consensus among stakeholders as to the priority issues to be addressed and the appropriate service plan. More explicit and defined guidelines for these teams, streamlining team membership, and mediation training for service coordinators are among the strategies that systems have taken to address this challenge.
 - **Caseload Size** — Service coordinators in some systems are burdened with caseloads that preclude them from devoting as much time or attention to an individual youth or family as may be warranted. Large caseloads impede proactive work with families and the development of the desired level of intensity in the relationship with the child and family. Some of the systems have suggested that a caseload of 8 to 10 is the optimal size for a service coordinator/care manager when serving youth with serious and complex disorders. If caseloads are too large, the work of care coordinators is limited to crisis intervention and individualized care is compromised.

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- **Lack of Expertise to Meet Specialized Service Needs** — Some of the systems reported that their provider networks do not include clinicians skilled to meet specialized needs. Special expertise is needed to work with young children and their families, sex offenders, youth with co-occurring mental health and substance abuse disorders, youth with co-occurring emotional disorders and developmental disabilities, youth with attachment disorders, eating disorders, and more.

Conclusion

In considering the characteristics shared by the various promising approaches to serving youth with serious disorders, it is clear that they all represent elements inherent in the system of care philosophy. A broad array of services, individualized care, flexible services, family involvement, service coordination, and interagency collaboration are among the key tenets of the system of care philosophy, first espoused in 1986 as a value base to guide service delivery for youngsters with serious emotional disorders and their families.² Although not necessarily described in these terms, these managed care systems have incorporated these elements in response to the needs and characteristics of this difficult-to-serve population.

Despite incorporating specific features and approaches to serve youth with serious disorders, all of the managed care systems experience problems, constraints, and challenges, including resource constraints, service gaps, insufficient service capacity, and interagency disagreements. The perennial struggle in managed care systems of achieving an appropriate balance between “managing care” and “managing costs” is particularly acute with respect to serving this high-need, high-utilizer population that often constitutes the most significant expenditures for behavioral health care.

In response to queries about what changes would be made in the approach or feature if it were possible, it is apparent that system managers, while proud of what they have accomplished, recognize much room for improvement. Some of the desired changes include the following:

- Make specialized services/approaches available to a wider population of children, those at risk in addition to those already meeting the criteria for a serious disorder
- Invest in increasing service capacity, including filling service gaps and increasing “slots” in existing services
- Incorporate greater flexibility with regard to the duration of services
- Provide “booster” sessions or follow-up care for a period of time following intensive service delivery
- Upgrade service coordinator staff and work to reduce turnover and increase retention
- Reduce caseload size of service coordinators
- Increase initial and ongoing training for service coordinators
- Increase information and education about the system to other child-serving agencies
- Increase efforts to collaborate with other child-serving agencies at the system level
- Increase the input of clinicians in clinical decision making and authorization processes

² Stroul, B. and Friedman, R. (1986). *A system of care for children and youth with severe emotional disturbances*. (rev ed). Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children’s Mental Health.

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- Increase communication with providers, implement better methods to obtain provider input and to involve providers in a partnership for problem solving
 - Offer more training to providers on values, philosophy, service approaches
 - Incorporate more specialized services in provider networks
 - Increase family involvement at the system level
 - Increase family involvement in decision making in all phases of service delivery

Appendix

All reports of the Health Care Reform Tracking Project (HC RTP) are available from the Research and Training Center for Children's Mental Health, at the *Louis de la Parte* Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL., (813) 974-6271:

HC RTP Promising Approaches Series

Stroul, B. A., (2003). *Health care reform tracking project (HC RTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems – 5: Serving youth with serious and complex behavioral health needs in managed care systems*. 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 #211-5)

Armstrong, M. I., (2003). *Health care reform tracking project (HC RTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems – 4: Accountability and quality assurance in managed care systems*. 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 #211-4)

Hepburn, K. & McCarthy, J. (2003). *Health care reform tracking project (HC RTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems – 3: Making interagency initiatives work for the children and families in the child welfare system*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. (Georgetown University Publication #211-3)

McCarthy, J. & McCullough, C. (2003). *Health care reform tracking project (HC RTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems – 2: A view from the child welfare system*. Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development. (Georgetown University Publication #211-2)

Pires, S.A (2002). *Health care reform tracking project (HC RTP): Promising approaches for behavioral health services to children and adolescents and their families in managed care systems – 1: Managed care design & financing*. 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 #211-1)

HC RTP State Surveys and Impact Analyses

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)

HC RTP Issue Briefs

The following Issue Briefs are available from the National Technical Assistance Center for Children's Mental Health, Georgetown University Center for Child and Human Development, 3307 M Street, NW, Washington, DC 20007, (202) 687-5000:

Pires, S. A. (2002). *Issue Brief 4. Accountability for Children with Behavioral Health Disorders in Publicly Financed Managed Care Systems*. Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Pires, S. A. (2002). *Issue Brief 3. Financing and Risk*. Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Stroul, B. A. (2002). *Issue Brief 2. Special Provisions for Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems*. Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

Stroul, B. A. (2002). *Issue Brief 1. Service Coverage and Capacity in Managed Care Systems*. Washington, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.

HCRTTP Special Analyses: Child Welfare

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 Center for Child and Human Development, 3307 M Street, NW, Washington, DC 20007, (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, D.C.: National Technical Assistance Center for Children's Mental Health, Georgetown University Child Development Center.



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

5: Serving Youth with Serious and Complex Behavioral Health Needs in Managed Care Systems

Beth A. Stroul, M.Ed.

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