Appendix C

DRAFT IMPLEMENTATION PLAN

NEW MEXICO INTERAGENCY BEHAVIORAL HEALTH PURCHASING COLLABORATIVE

For Public Comment

July 23, 2004

This Draft Implementation Plan translates the ideas in the behavioral health concept paper released in April and revised in May 2004, and translates them into requirements and expectations of the statewide entity (SE), to be competitively procured in the Fall of 2004 and Winter of 2005. While there are more specifics in this draft implementation plan than there were in the concept paper, there are also ideas and details not included here either because they are expectations of the Behavioral Health Purchasing Collaborative itself rather than the statewide entity, or because they have not yet been finalized. In some cases, details will not be finalized until the statewide entity has been selected and the actual transition process has begun, sometime in the Winter or Spring of 2005.

The purpose of this draft implementation plan is to seek additional public input at this stage in the evolution of the Behavioral Health Purchasing Collaborative's development. This plan, after input from the public in August of 2004, will form the basis of a request for proposals (RFP) that will be released in September 2004.

Interested parties may comment on this draft implementation plan by e-mailing comments to bhdesign@state.nm.us or by writing to BH Design, Human Services Department, Office of the Secretary, P.O. Box 2348, Santa Fe, NM 87504-2348. Interested parties may also attend a public meeting for this purpose scheduled on August 4, 2004, from 9:00 a.m. to noon, PERA Building, Apodaca Hall, 2nd Floor. A special meeting, designed for potential bidders but open to the public will be held on August 4, 2004, from 1:00 to 4:00 p.m. at the same location. This meeting is designed to discuss, answer questions and receive public input regarding requirements for the statewide entity.

New Mexico Systems of Care—Service Array for Behavioral Health/Substance Abuse

Core Expectations	**Core Components** (Available locally)	**Specialty Components** (Available regionally)	**Unique Components** (State-wide)
Provision by servicing providers to screen for and treat: Co-occurring Disorders Child Abuse Domestic violence Infant mental health issues Strength-based treatment approach	Screening Uniform Care Coordination (macro) Case Management (micro) Medication Management Outpatient Therapies-Co-occurring Basic Psychiatric Evaluation Crisis Services Intensive Home-based services Home-based Services (BMS, Para-professionals) Respite Care School-based BH programs Community Support/AA, Peer Groups (Mentoring, before/after school support) Early Intervention Assessment Foster Care Transition to adulthood Prevention Employment & educational services Psychosocial rehab services towards transition (18-21) Transportation Pharmacy Parenting Skills Training [Core services listed above do not require prior approval processes]	Mobile Crisis Team/ Acute crisis stabilization Forensic Interview Services Forensic Evaluation Services (Domestic Violence shelters) Specialized home-based services * Therapeutic Foster Care (TFC) * Group Home (GH) * Residential Treatment Services (RTS) * Multisystemic Therapy (MST) Day Treatment (DT) * Acute Psychiatric Hospital * Partial Hospital Services Independent/Semi-independent living * Detoxification (3) day inpatient Outpatient detox. Services Reintegration Services Targeted Case Management Services Therapeutic Day Care/Preschool Crisis Shelter/Foster care [* Indicates prior approval required] Specialized Knowledge •DD/MI-High Risk •Sex Offenders •Traumatic Brain Injured •Eating disorder •Severely Aggressive •Neuropsychiatric disorders •Reactive Attachment disorders	Special Populations/Specialized Knowledge •DD/MI-High Risk •Sex Offenders •Traumatic Brain Injured •Eating disorder •Severely Aggressive •Neuropsychiatric disorders •Reactive Attachment disorderl Specialized Milieu for a subset of the above (Criteria) •Separated populations •Special clinical skills •Highest risk/Highest need •Greatest Risk to self/others •Multiple Treatment Failures

Fund Sources	Number of Customers to be Served	Estimate of Dollar Amounts SE to Manage in Phase One
Medicaid *Salud!* (managed care) (HSD)	Enrollment as of 4/04 = 272,640 (approximately 42,000 received at least one behavioral health service during FY 2003)	$137,000,000 (FY 2003), including all BH medication expenditures of approximately $22,000,000
Medicaid Fee-For-Service (FFS) (HSD)	Enrollment as of 4/04 = 146,473 (approximately 28,000 of which received at least one behavioral health service during FY 2003)	$45,000,000 (FY 2003) including all BH medication expenditures of approximately $16,000,000
TANF Substance Abuse Funding (HSD)		$1,000,000
Federal Mental Health and Substance Abuse Block Grants (DOH)		$6,000,000
State General Fund for Non-Medicaid Adults (DOH)		$24,000,000
General Fund Services for non-Medicaid Children and Families (CYFD)		$8,700,000
School-Based Behavioral Health Services (DOH, CYFD, HSD)		$500,000
State Funded Peer Supports for Seniors		$150,000
State General Fund and Federal Funds for Services for High Risk Persons with Behavioral Health Needs Discharged from Prisons with Behavioral Health Needs (NMCD and DOH)		$8,100,000
DWI Prevention Services (DOT)		**TBD**
Housing and Employment Services (DOH and MFA) (Emergency Shelter Grants, Homeless Services, Supported Employment)		$1,000,000
Set Aside for Native American Services (DOH)		$1,400,000

During Phase Two, additional dollars and responsibilities for additional services and populations will be required of the SE. These will be negotiated with the SE before July 1, 2006, and may include the following:

Fund Sources	Number of Customers to be Served	Estimate of Additional Dollar Amounts SE to Manage in Phase Two (based on FY 2005 budgets)
Substance Abuse Prevention (DOH)		$5,500,000
Additional General Fund and Federal Dollars for Juvenile Justice and Domestic Violence (CYFD and HSD)		$19,500,000
Forensic Evaluations, Sexual Assault Services, (DOH)		$1,500,000
Vocational Rehabilitation Funding (DVR)		$4,000,000
Services for Children in Schools & Drug Free Schools Funds (PED)		$1,000,000
Additional Housing Resources (MFA)		TBD

The Collaborative will require that the SE utilize a minimum amount of each fund type on direct services, that is funding for providers or SE operated direct services for customers. In Phase One, a minimum of 85 percent of funding, must be spent on direct services. The actual percentages may differ based upon funding sources/requirements. In Phase Two, the Collaborative will expect the percent of total funding for direct services to increase a minimum of 1 percent. In Phase Three, the Collaborative will expect that even more of the total dollars will be spent on direct services.

In addition, during Phase Two, we expect careful management of all administrative expenditures, including those at the provider levels, to maximize spending on services for customers, families and communities rather than administration, overhead or profit of the SE and subcontract providers. The SE will be responsible for working with providers to accomplish this requirement. In Phase Three, this requirement will again increase.

F. SUMMARY OF SCOPE OF WORK

July 1, 2005 is just the *beginning* of a much longer process. System change of this magnitude is not something accomplished with the "flip of a switch" or on one particular day. Rather, on July 1, 2005, a new system *begins*. It will take a number of years beyond that time for the partnerships, relationships and expectations of this new behavioral health delivery system to fully evolve. The Collaborative reserves the right to expand or reduce the current mandatory benefit or service package at any time during the contract period following negotiations with the successful offeror.

During all Phases of the Project, the Collaborative will require the successful offeror to fully comply with all statements, promises and plans submitted within their proposal that are accepted by the Collaborative. In addition, the offeror and its subcontractors shall comply with any state or federal regulations or statutes, including but not limited to those pertaining to the 1997

services. The third type of resource includes those behavioral health services currently provided directly by state-operated agencies, such as Las Vegas Medical Center and Turquoise Lodge by the Department of health (DOH), and services in state-operated correctional facilities such as Children, Youth and Families Department's (CYFD) juvenile justice facilities and the Department of Corrections' (NMCD) prisons. All these facilities will remain state operated facilities.

NMCD facilities will provide behavioral health services to its inmates through staff or contractors of NMCD. However, behavioral health services for individuals leaving NMCD facilities will be the responsibility of the SE. Therefore, post-release planning and coordination of referrals and services will be critical.

Behavioral health services provided for juveniles under the jurisdiction of CYFD will be included in Phase One. Those juveniles in CYFD facilities may become the responsibility of the SE during Phase Two of the Contract with the SE. This will be determined during Phase One. Regardless, behavioral health services for juveniles under the jurisdiction of CYFD but not in CYFD facilities or juveniles being released from CYFD facilities will be the responsibility of the SE. Therefore, pre-release discharge planning and coordination of referrals and services will be critical.

Finally, behavioral health services for persons admitted to DOH mental health and substance abuse facilities may become the responsibility of the SE even though provided by state employees in state-operated facilities. Initially, in Phase One, the SE will be responsible for providing pre-admission screening and diversion, as well as pre-release planning and follow-up after discharge. In Phase Two, the SE will be responsible for payment for these services within the facilities or for an offset against its funding for services provided within the DOH facilities

NC Department of Health and Human Services

Chapter 4: People wth Severe and Persistent Mental Illness or Severe Emotional Disturbances

Overview

In 1998, approximately 321,820 adults in the State with serious mental illness [29], and between 173,069 and 207,683 children under age 18 with serious emotional disturbances. [30] It is estimated that between 30 and 50 percent of these people also have a co-occurring substance abuse disorder.

The State offers care to adults with severe and persistent mental illness and to children and adolescents with severe emotional disturbances through the state psychiatric hospitals and special care units, area mental health, developmental disability, and substance abuse programs and schools for children with emotional disturbances. Some of the services are residential in nature, others are provided on an outpatient basis; some are for acute episodes, others are for more chronic conditions. In addition, the State helps pay for services provided by private providers through its Medicaid program and NC Health Choice. Other people with severe and persistent mental illness receive SC/SA to support their care in adult care homes.

Use of Mental Health Trust Fund

Through a collaborative process between the State Division of Mental Health, Developmental Disabilities and Substance Abuse Services and four Regional Area Mental Health Planning Teams, a planning process was implemented to address two major goals: 1) identify and develop the array of services that people currently residing in State hospital beds identified for closure need to live in the community; and 2) develop or expand the capacity to serve those who otherwise would be admitted to a state psychiatric hospital. As of June 30, 2002, specific plans for each of the four Regions were completed and provide a blue print that details the kinds of treatment, services, and supports, the quantities required, and the costs associated with providing those services in each region of the state.

Of the 27 individuals in the Wright Transitions Program at Dix Hospital at the time the hospital-based program was closed, nine individuals moved into independent or transitional housing and fourteen moved into supervised group settings such as

group homes. Four individuals were not ready for discharge and were transferred to other units in the hospital to ensure they receive the services that will facilitate eventual discharge. In State Fiscal Year 2002, a total of $671,000 in one time bridge funding from the Mental Health Trust Funds and subsequent reallocation of funding up to $1.8 million annually from the Dix Hospital budget, beginning in State Fiscal Year 2003, will follow these individuals into the community to be used by area programs to establish or expand a variety of services such as Assertive Community Treatment Teams, expanded psychosocial rehabilitation, case management, transportation, and supported housing. allocation of funding from the Dix Hospital budget. This represents the first time that institutional funds have followed clients from state hospitals into the community to provide needed community based services and supports.

Description of Specific Services

The State operates a different system of supports and services for people with severe and persistent mental illness than it does for the frail elderly or people with acquired disabilities. For example, the State offers publicly subsidized inpatient psychiatric services through the four state psychiatric hospitals: Cherry, Umstead, Dix and Broughton. There are also three schools for children with emotional disturbances: Wright School, Whitaker School, and Eastern Adolescsent Treatment Program; and two facilities provide nursing home services to adults with Alzheimers, mental health or behavioral problems: Black Mountain and NC Special Care Center. The State also helps to subsidize outpatient and some residential services through area programs. Area programs provide individual and group therapy, case management, psychosocial rehabilitation, partial hospital/day treatment, and community based services. Residential or 24 hour services include supported housing, group homes, crisis stabilization, inpatient and residential treatment. Appropriate and adequate community based services assist individuals with mental illness to remain in their home and avoid the need for institutional placement.

Certain individuals with mental illness may be able to qualify for Medicaid coverage to help pay for the costs of care. Medicaid is typically limited to low-income individuals who are under the age of 21 or older than 65, pregnant, in families with dependent children, or disabled. To qualify, these individuals must also meet certain income and asset tests. Not all people who are poor qualify for Medicaid, however, because individuals between the ages of 21 and 64 who are without children and who are not considered disabled by the Social Security Administration cannot qualify, regardless of their poverty status. Medicaid provides coverage of inpatient, individual and group outpatient treatment, day treatment, client behavior intervention, admissions to general hospitals psychiatric units, and case management. Services provided by an area program must be ordered by a psychiatrist or PhD psychologist as part of an individualized treatment plan. Services can also be provided by a physician, psychologist, or clinical nurse specialist employed and supervised by a physician.

Children also are eligible for treatment provided in residential treatment centers. Some services are excluded from coverage under federal law. Medicaid cannot pay

for the costs of care provided by "institutions for mental disease" [31] (e.g., state or freestanding private psychiatric hospitals) for Medicaid-eligible persons between the ages of 21 and 64. However, Medicaid will cover all costs of a new treatment facilities, with the exception, Medicaid will cover all costs of a new residential treatment called Psychiatric Residential Treatment Facilities for children in which it covers both treatment costs and room and board. Medicaid limits the number of outpatient mental health visits it will cover for adults to 24/year, unless services are provided through area programs. Children's mental health visits are not limited, although prior approval must be obtained for some services.

There is currently no community-alternatives program (CAP) for people with severe and persistent mental illness who are Medicaid-eligible. CAP waivers typically require that states show cost-neutrality in the Medicaid program. Because states do not cover the costs of care provided in public or private psychiatric facilities, states have little ability to show cost-neutrality through a CAP waiver program (i.e., they could not offset new expenditures for community-based services with institutional savings to the Medicaid program). While North Carolina can not implement a CAP-program for people with severe and persistent mental illness under current federal law, the State does have considerable flexibility in its existing program to cover many of the services that would otherwise be offered in a CAP program. However, some services cannot be covered absent a CAP waiver, such as respite care or additional personal care services (beyond the specified limits).

Assessment Process for Currently Institutionalized and At-Risk

Assessment and treatment/habilitation plans are required for all persons admitted to State-operated institutions. The instruments used vary according to disability and age. The progress and status of the treatment/habilitation plans are reviewed periodically and modified as necessary.

Beginning April 2001, the State used a standardized assessment protocol to assess every resident of a state psychiatric institution and school for the emotionally disturbed to determine whether the person desires, and would be an appropriate candidate for reintegration back into the community. The State worked with the person, his or her family or legal representative, and the treatment professionals to determine what community supports and services would be necessary to support the person's transition back to the community. In May 2002,the Division completed assessments with everyone whom was in the facilities when the assessments were implemented. Assessments will be ongoing as individuals are admitted to the facilities. Future plans call for a similar process to be used for adults and children at high-risk for institutional admissions. The goal of this process is to determine whether a services and support plan can be developed in the community to divert people from unnecessary institutionalization.

The State is developing a new assessment protocol for people entering Adult Care Homes. In addition to the regular assessment process needed to determine level of services or for services and support planning purposes, the State will be including

questions to identify people with mental illness or developmental disabilities that may need additional community supports and services.

Operation of Waiting Lists

Each area program maintains a waiting list for persons needing certain types of community based mental health and substance abuse services. These services are either of an urgent, or non-urgent nature. People are moved from these waiting lists as resources become available. These waiting lists are not collected at the state level. As part of the implementation of this Plan, a waiting list has been developed which includes projected community service and support needs for institutional individuals who have bee assessed as potentially able to transition to the community.

Inventory of Community-Based Services to Assist People in Moving Back to the Community

Different inventories exist that collect data about community mental health services and providers through various databases. For example, area programs each maintain their own listing of community resources. The state Division of Facility Services maintains lists of licensed agencies, residential and institutional providers serving people with mental illnesses and emotional disturbances. Similarly, some of the sections within the Division of Mental Health, Developmental Disabilities and Substance Abuse services maintain their own inventory of available community-based services.

What the State lacks is a centralized inventory that includes all relevant public and private providers that offer mental health, developmental disability and substance abuse services. This centralized database should be linked with other community providers, such as medical and dental care, rehabilitation services, and in-home services that also provide services to people with mental illness.

Assess Need for Additional Services

A recent report commissioned by the NC State Auditor concluded that "many of the individuals currently residing in North Carolina's four state [psychiatric] hospitals, in all levels of care, could be treated in community-based services if such services were available." [32] North Carolina has a higher rate of institutionalization than peer states. "At 32.3 beds per 100,000 persons in the general population, the bed capacity is 23 percent higher than the average in the peer group of comparable states. North Carolina's rate of adult admissions, at 243 per 100,000, is second highest among peer group states." The study concluded that over time, North Carolina's hospital bed capacity could conservatively be reduced by 667 beds. However, community resources would have to be created to support individuals in the community.

The Auditor's report identified services that are needed to support people with mental illness in a community-based setting. These include assessment services and acute care services including up to 15 days inpatient treatment. Alternative services should address crisis or acute mental health episodes as well as the ongoing services

and supports needed to care for individuals with severe and persistent mental illness. On the acute care side, each catchment area should provide crisis stabilization beds and observation/holding beds. Respite care, day treatment, intensive in-home services, therapeutic foster care, and outpatient therapy to enable them to live successfully in a home and community-based setting. Some individuals with more severe or complex problems may also need an Assertive Community Treatment Team (ACTT), residential support and other intensive services to enable them to successfully transition and remain in the community.

Identify and Expand the Availability of Local Transportation Resources

Transportation service providers often become frustrated with people with severe and persistent mental illnesses when they are late, slow, or fail to respond in the same manner as the general public, etc. The transportation service provider may not recognize, and sometimes appreciate or understand the barriers that this population faces. In most cases, this can be remedied by appropriate education and sensitivity training to bring about the needed understanding and appreciation.

Addressing consumer transportation needs is an essential element in all stages of program planning and service delivery. State and regional program consultants, as well as division leaders should be knowledgeable of State and local transportation resources. A greater emphasis should be placed on transportation planning. All too often, programs are planned at the State level without consideration of consumer transportation needs and local influences. Failure to address this vital component results in frustration for the consumer, and an inability for them to access needed services.

Regional Non-Emergency Medical Transportation Services:

NC DOT is currently funding two multi-county non-emergency medical transportation demonstration projects, which are located in the mountain and piedmont areas of the state. The programs will expand transportation options for the local transportation systems, riders, human services agencies and medical providers. A regional coordinator position has been established in each of these areas to work with the local community transportation systems, medical facilities and human service agencies.

The purpose of these programs is to strengthen and improve regional transportation coordination efforts in an efficient, cost-effective and customer oriented manner while increasing the efficiency of the local transportation systems. A centralized telephone number will be established for transportation providers to use for scheduling out-of-county trips in the piedmont area. In the mountain area, a web site has been established to enable local transportation providers from each county to find out when and where trips are being scheduled. Based on this information, the county transportation systems contact each other to plan coordinated trips.

Medical providers (hospitals, doctors, clinics, etc.) are contacted and informed about appointments accordingly(when possible). These coordination efforts have benefited the medical providers by reducing the number of missed appointments. It is believed that better coordination will also reduce operating costs and duplication of services. It will increase communication and the development of standardized routes and schedules.

Rural General Public Discretionary Projects

In SFY 2001-02, NCDOT received an increase of $3million for the Rural General Public Program (RGP), making it a $4.1 million program. In order to encourage the local transportation systems to expand and create services to serve the rural general public, NCDOT has provided $1.6 million in discretionary RGP funds to support 38 projects statewide. Rural General Public funds may not be used to target isolated populations. It must be used to serve any member of the community that needs transportation. Additional RGP funding will support increased transportation services such as trips to shopping malls, recreational activities, grocery stores, banks, etc. for all populations, including persons who are elderly and have disabilities.

Identify Housing Alternatives to Institutional Placement

Individuals who need residential services and supported living situations sometimes receive services in Adult Care Homes. In 2000, approximately 23,000 people received State-County Special Assistance to help pay for the costs of Adult Care Homes. Extrapolating from an earlier study of Adult Care Home residents, nearly one-quarter of these individuals are likely to have a diagnosis of mental illness or to have used mental health services, including a past stay in a psychiatric hospital. Another 12 percent will have a mental retardation or developmental disability diagnosis and will have received mental health services. Almost three-quarters of all residents are likely to have behavioral problems, including wandering, being verbally or physically abusive, or resisting ADL assistance.

Often people with severe and persistent mental illness end up in Adult Care Homes because there are no other appropriate residential services in the community. About 10 percent of people with severe and persistent mental illness, or 9,900 adults, are in need of stable and affordable housing. The type of housing needed includes transitional housing to help move people out of institutions, subsidized housing in the private market and supervised group homes and residences (for individuals with the most serious disabilities or specialized treatment needs). Because many individuals with mental illness rely on Supplemental Security Income (SSI) or Social Security Disability Insurance (SSDI) as their income, they are in need of rental assistance subsidies to make housing affordable. [33] Yet, there are only 992 adults with severe and persistent mental illness who receive subsidized housing through HUD mental health funded units. The existing housing resources are woefully inadequate to address the housing needs of people with severe and persistent mental illness.

Adequacy of the Workforce to Provide Services

People with mental illness face the same problems finding well trained, motivated and adequately compensated staff to provide services as do other groups of people with disabilities. Access to trained mental health professionals is a particular problem in some communities. According to the NC Health Professional Database, the ratio of licensed mental health professionals varies from a low of no practicing providers per 1,000 people in Jones and Camden counties to a high of 3.63 mental health professionals per 1,000 people in Orange County. [34]

Assure and Monitor Quality of Care

Oversight of the institutions, facilities and providers serving adults with severe and persistent mental illness or children/adolescents with serious emotional disturbances is split between the Division of Facility Services and Division of Mental Health, Developmental Disabilities and Substance Abuse Services. The Division of Facility Services has the responsibility for licensing ICF-MR, adult care homes and group homes for the mentally ill licensed that is assigned under 122C of the North Carolina General Statutes. The Division of Mental Health, Developmental Disabilities and Substance Abuse, through its area authorities, has the responsibility for accrediting and overseeing other community based services.

The North Carolina General Assembly recently enacted legislation to strengthen the oversight of facilities serving people with mental illness and developmental disabilities. In the 2000 session, the General Assembly passed legislation to impose administrative penalties on licensed facilities serving people with mental illness, developmental disabilities or substance abuse services for violations that harm the person's health or safety. [35] A new system was also created to oversee the use of restraints in facilities serving people with mental illness, developmental disabilities or substance abuse services.

Additional safeguards are provided in each of the state run psychiatric facilities by the facility Human Rights committee and client advocates. The Human Right committees are comprised of interested citizens who meet on a monthly basis and review, among other things, incidents of seclusion or restraint, complaints of individuals receiving services, allegations of abuse and other aspects of care. Additionally, the facilities employ client advocates whose job it is to protect the rights of individuals by investigating complaints and advising and training facility staff on human rights protections. Area programs must maintain a client rights committees to safeguard the interests of individuals.

To chapter 5

Notes to Chapter 4

[29] Ibid.

[30] Comprehensive Child Health Plan: 2000-2005. Report to the North Carolina of Medicine, May 23, 2000 at p. 86.

[31] 42 USC 1396d(a)(1).

[32] Office of the State Auditor. Study of State Psychiatric Hospitals and Area Mental Health Programs. Final Report. April 1, 2000.

[33] Division of Community Assistance, Department of Commerce. 2001-2005 N.C. Consolidated Plan. Sept. 19, 2000 at p. 89.

[34] The aggregated numbers of mental health professionals include active non-federal, non-resident and resident physicians who have a primary specialty in psychiatry, and psychiatry/child; psychologists and psychological associates with the primary specialty of clinical, community, counseling, developmental, educational, personality, physiological, rehabilitation, school or social; active RNs who have a major clinical practice or training in psychiatric/mental health; and active nurse practitioners with physician extender type of psychiatric mental health. The data are current as of October 1999, and have been supplied to the Cecil G. Sheps Center for Health Services Research, University of North Carolina, Chapel Hill from the respective licensing boards of these professions.

[35] Session Law 2000-55.

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III. Description of Promising Design and Financing Approaches

Statewide Approaches

A. New Jersey Children's System of Care Initiative

Overview

The New Jersey Children's System of Care Initiative is a behavioral health carve out, serving a statewide, total population of children and adolescents with emotional and behavioral disturbances who depend on public systems of care, and their families. The population includes both Medicaid and non Medicaid-eligible children and includes both children with acute and extended service needs. The State describes the Initiative as, "not a child welfare, mental health, Medicaid, or juvenile justice initiative, but one that crosses systems." The Initiative creates a single statewide integrated system of behavioral health care to replace the previously fragmented system in which each child-serving system (i.e., child welfare, juvenile justice, mental health, and Medicaid) provided its own set of behavioral health services. The New Jersey (NJ) Department of Human Services is the state purchaser, and the Initiative is being rolled out by county or groups of counties over a five-year period. The goals of the Initiative are to: increase funding for children's behavioral health care; provide a broader array of services; organize and manage services; and provide care that is based on core values of individualized service planning, family/professional partnership, culturally competent services, and a strengths-based approach to care.

Key Design and Financing Features

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

relevant. They also must address safety and permanency issues for those children referred to CMOs who are involved in the child welfare system. The CMOs employ *Care Managers*, who carry small caseloads (1:10) and who receive close supervision and support from *Clinical Supervisors*. Care Managers and Child and Family Teams also are supported by *Family Support Coordinators* (see **Provider Network**, page 17) and *Community Resource Development Specialists*, whose job it is to identify and develop informal community supports and natural helpers to augment treatment services.

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

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

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

- **Interagency Governance Structure.** The design involves an interagency governance structure that includes: an Interagency Policy Body comprised of key Executive Branch heads and a statewide advisory council with broad stakeholder representation; a State-level Implementation Team comprised of interagency management staff, family representatives, and designated representatives from local implementing teams; and local Children's Initiative (i.e., local implementation) Teams comprised of interagency regional and local managers and family representatives.

- **"Pooled" Resources and Maximization of Medicaid Revenue.** The Initiative is financed by existing dollars supporting child behavioral health care from child welfare, juvenile justice, mental health, and Medicaid systems; new dollars approved by the legislature; and expansion in Medicaid covered services facilitated by conversion from the Medicaid Clinic to the Rehabilitation Services Option. The Initiative pooled $85 million in mental health and child welfare dollars alone to leverage federal Medicaid dollars. Initiative funds support services and system infrastructure and availability of **flexible funds** allocated to Care Management Organizations to facilitate a wraparound service approach. The Initiative also uses the Early Periodic Screening, Diagnosis and Treatment Program (EPSDT) to screen children for the Initiative. The use of EPSDT and the Medicaid Rehabilitation Option provides federal participation in services previously funded by State dollars alone.[6] The New Jersey Initiative creates a **single payer system** by lodging all Initiative dollars (Medicaid and non Medicaid) with the State Medicaid agency and having the Medicaid agency handle all reimbursements through its existing financial management system. By integrating financing and payment mechanisms, the Initiative can mitigate the effects of categorical funding streams on children with serious disorders, eliminate a child's need to go on the DYFS caseload to obtain residential services, and allow for service continuity across eligibility status. The Initiative in effect creates a single enrollment and payer system for families and providers, with eligible children receiving a "Children's System of Care Initiative (CSOCI)" card (see **Figure 1**, page 17).

- **Presumptive Eligibility Enrollment.** The design allows for presumptive enrollment for children needing behavioral health care if they are Medicaid eligible, eligible for NJ Family Care (State Children's Health Insurance Program), or eligible as a Children's System of Care Initiative child (i.e., a child who has a serious emotional disorder and is involved or at risk for involvement in multiple systems). Regardless of whether the child is eligible for the system of care through a Medicaid or non Medicaid-eligible route, and regardless of the other systems in which the child may be involved (e.g., child welfare,

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

juvenile justice, etc.), he/she is assigned a "system of care" identifier number that is tracked through the State Medicaid agency's management information system. In addition, the state allows for designation of a child with a serious disorder as a "family of one" to qualify for Medicaid-reimbursed residential treatment services.

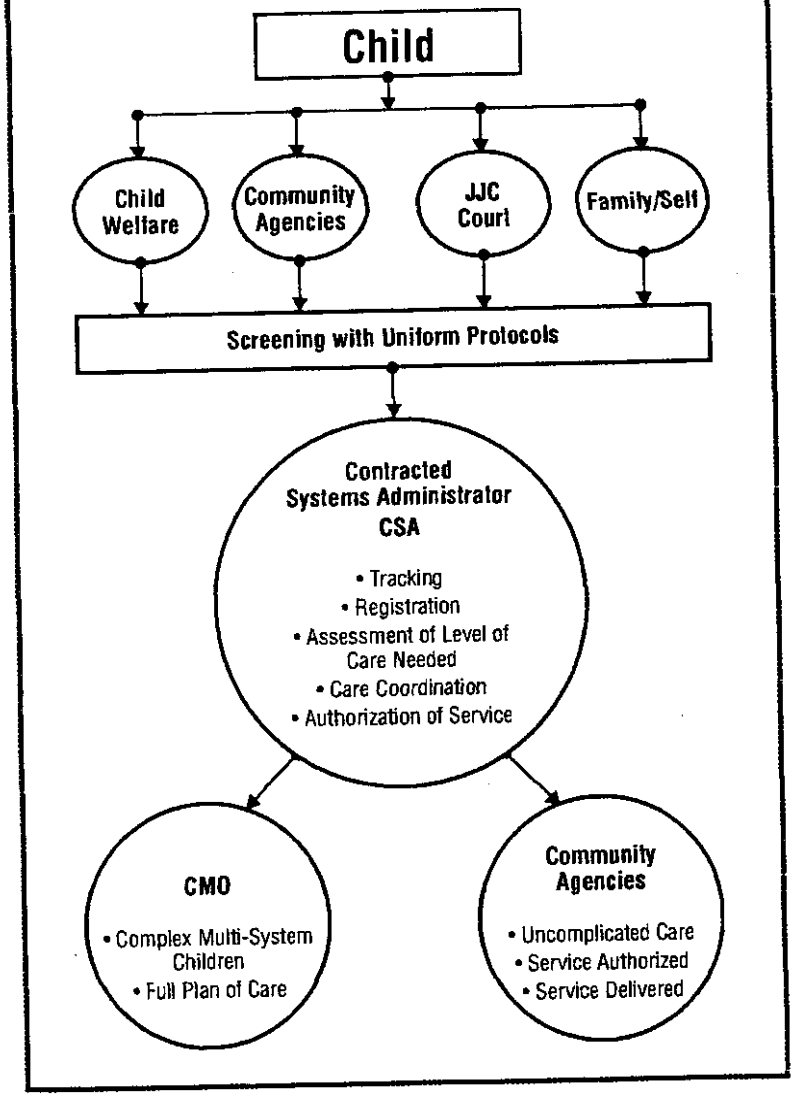
- **Provider Network**. All providers under contract with the NJ Department of Human Services are eligible to participate in the Initiative. Providers must meet Division of Youth and Family Services (DYFS) licensing requirements. Contracts are on a fee-for-service basis through a combination of cost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

[9] www.njkidsoc.org

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

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

Figure 1
New Jersey System of Care Flow Chart



B. Pennsylvania HealthChoices

Overview

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

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

Key Design and Financing Features

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

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

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

- **Local Management Control.** The design feature of giving counties the first option to act as their own MCOs builds on the historical structure and experience in the State, which since the 1960s has given the counties the authority for behavioral health care delivery. The design gives counties a population-based responsibility that has the potential to improve accountability for care and acknowledges that many counties in the State have invested considerable resources over the years in building behavioral health services, which could have been undermined by a centralized design. The design also allows for localities to adjust system parameters to reflect local differences.

- **Broad Benefit Design.** HealthChoices covers a broad array of mental health and substance abuse services and covers both acute and extended care. Services include: *hospital-based services* (inpatient mental health treatment, inpatient detoxification, inpatient rehabilitation services, partial hospitalization); *behavioral rehabilitation services for children and adolescents* (designed to keep families together and children in school and community, including therapeutic staff support services, such as behavioral aides, behavioral specialist consultation, family support services, neuropsychological evaluations, summer therapeutic activities, mobile therapy, therapeutic group and foster care, and residential treatment); *emergency services* (telephone, walk-in, mobile crisis, in-home crisis support, and crisis residential services); *community-based outpatient* (individual, family, group therapy, psychiatric evaluation, medication monitoring, case management and intensive case management, methadone therapy, outpatient drug and alcohol clinic, halfway house services, nonhospital detoxification and rehabilitation treatment; and, *wraparound services through EPSDT.*

- **Interagency Service Coordination.** RFPs and contracts require that, for children with serious disorders who are involved in multiple systems, BH-MCOs must serve on interagency (i.e., CASSP) service planning teams. In addition, BH-MCOs are required to have letters of agreement in place with county child welfare, juvenile probation, and substance abuse agencies and with local school districts that address coordination of service planning and delivery.

- **Guidelines for Mental Health Medical Necessity Criteria for Children and Adolescents.** With the input of stakeholders, including families, the State developed clinical decision-making criteria specifically for children, "Guidelines for Mental Health Medical Necessity Criteria for Children and Adolescents". These guidelines act as broad admissions and level of care criteria for certain services in the benefit package, including: inpatient, residential treatment, partial hospitalization, outpatient, behavioral health rehabilitation services under EPSDT, including home and community-based services, and family-based mental health services. In addition, the State requires use of the American Society of Addiction Medicine (ASAM) Patient Placement Criteria for determining medical necessity for substance abuse services for children and adolescents.

- **Family Involvement.** As noted, RFPs and contracts incorporate CASSP values and principles, which stress the importance of family involvement in service planning. RFPs and the State's Readiness Assessment Instrument, which gauges the readiness of counties for managed care prior to the implementation of the HealthChoices program, have standards related to family involvement in a wide array of systems-level activities, including: grievance and appeals process, quality assurance, program oversight,

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

- **Provider Network**. The HealthChoices design allows for inclusion of providers who had contracts with the county and Medicaid fee-for-service providers. The design also encourages the use of nontraditional providers through designation under Medicaid of a so-called "Type 80" provider. These nontraditional providers provide services not covered historically by Medicaid in Pennsylvania, such as nonhospital detoxification and rehabilitation services. The State requires that BH-MCO contracts with providers include requirements for participation on interagency teams and coordination of behavioral health services with other child-serving systems, such as child welfare, juvenile justice, and the schools. Also, the state design includes requirements that BH-MCOs must orient and train providers in CASSP principles.

- **Blended Financing.** HealthChoices is funded with a blend of Medicaid, mental health, and substance abuse dollars. HealthChoices also provides for reinvestment of savings generated by the system back to the county of origin. Counties must develop reinvestment plans, with input from key stakeholders, including families, and plans must be approved by the State. Counties receive capitated contracts from the State purchaser; the average, statewide capitation rate for both adults and children and adolescents in 2000 was $56 per member per month (pmpm).

- **Performance/Outcome Management System (POMS)**. The state Office of Mental Health and Substance Abuse Services has created a performance monitoring system, tied to a **Continuous Quality Improvement (CQI)** process. The county/BH-MCOs must submit for approval their quality management plans, their QI structure, plans for including consumers/families in the QI process, specific areas their QI will track and monitor, QI policies and procedures, and areas of special study. Each year the State selects key areas for review and sends monitoring teams on site to meet with counties and BH-MCOs around priority issues. The state's POMS system draws on multiple data sources, including encounter data, enrollee eligibility and demographic data, consumer/family satisfaction reports, a consumer registry file that BH-MCOs are required to maintain that is a minimum data set on behavioral health service utilizers, a quarterly file that BH-MCOs must maintain concerning the status of priority populations (which includes children with serious emotional disorders), and performance indicator reports. POMs tracks the following "outcome dimensions": (1) increase community tenure and less restrictive services; (2) increase vocational and educational status; (3) reduce criminal/delinquent activity; (4) improve health care; (5) increase penetration rates; (6) increase consumer/family satisfaction; (7) implement CQI activities; and (8) increase the range of services and improve utilization patterns. Under each of these larger headings are indicators pertaining specifically to children and adolescents. In addition, the State instituted an **Early Warning System** to provide data across a select number of clinical and administrative indicators to identify quickly potential areas of concern and issues needing immediate attention.

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

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

Overview

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

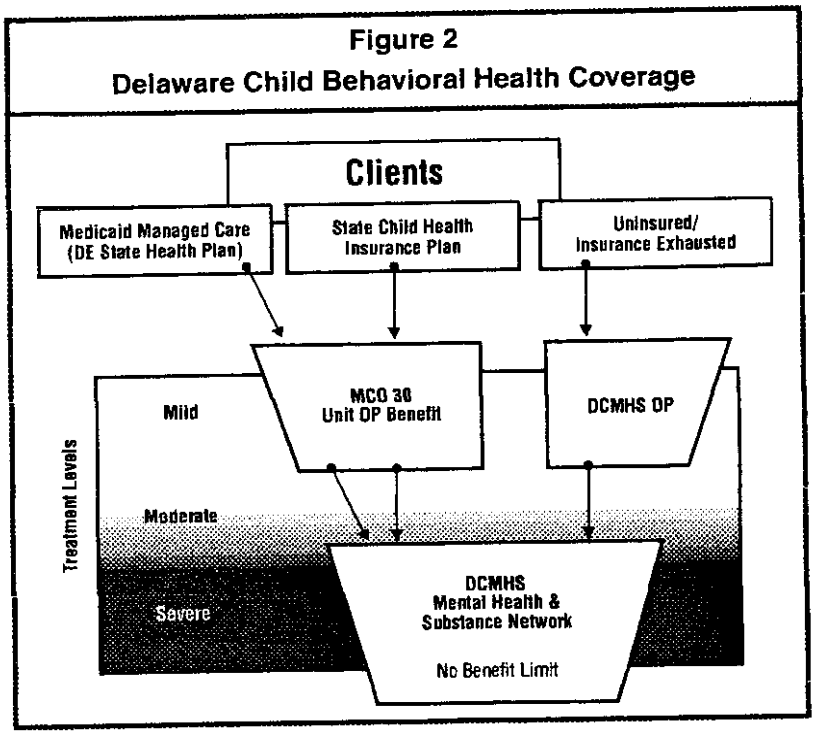
Key Design and Financing Features

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

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

Figure 2

Delaware Child Behavioral Health Coverage



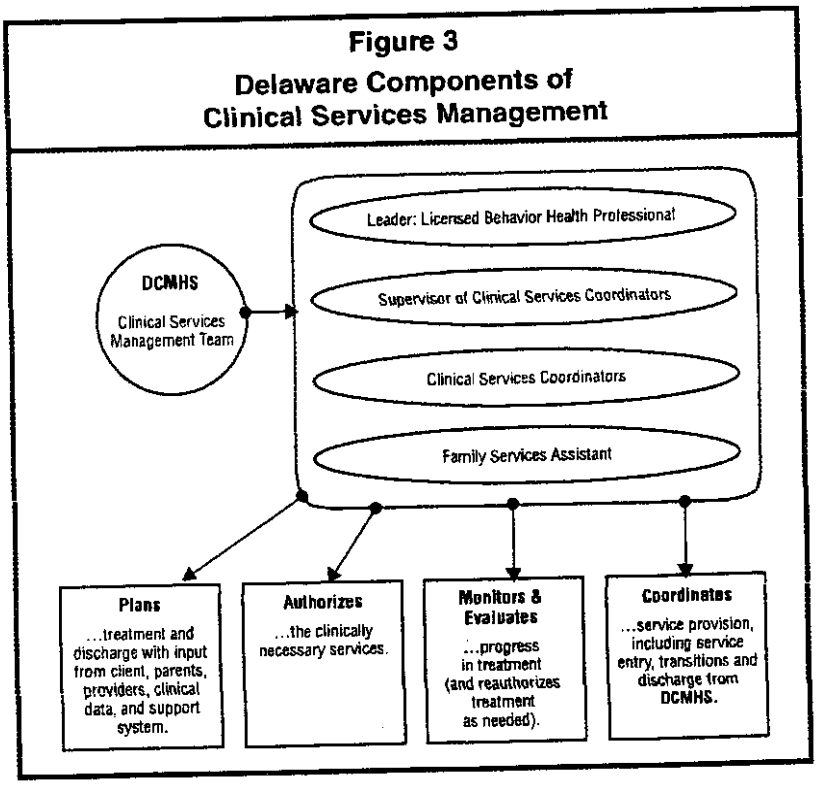
- **Broad Benefit Design**. The Partnership covers a broad array of services, including: 24-hour, statewide mobile crisis services and crisis residential; intake and assessment; clinical service team functions, including treatment planning and monitoring and case management; outpatient services; behavioral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

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

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

Figure 3

Delaware Components of Clinical Services Management



- **Level of Care Criteria**. DCMHS developed level-of-care criteria specific to children's behavioral health, which guide clinical decision-making between the commercial MCOs and DCMHS and guide the CST treatment planning process. In addition, DCMHS has developed other clinical guidelines related to such areas as the definition of urgent care and requirements for physicals for children involved in the child welfare system. Also, the State Medicaid agency funded DCMHS to develop a behavioral health screening instrument for children, which is used by providers as a screen to trigger assessments for mental health and substance abuse treatment services.

- **Provider Networks**. To further promote continuity of care between the commercial MCOs and DCMHS, Medicaid requires the MCOs to enroll DCMHS providers in MCO networks. This requirement created an issue initially in that the MCOs had to revise their credentialing and privileging processes to include community agencies, as opposed to their standard practice of credentialing only individual practitioners. In addition, Medicaid requires that providers in MCO networks cannot discriminate between serving commercial and Medicaid-insured consumers. DCMHS provides an ongoing series of training/workshops for MCOs and providers, among others. Trainings have been held on such topics as cultural competency in behavioral health care, mental health and substance abuse integration, and performance improvement in behavioral health care.

- **Service Continuity and Coordination**. In the Delaware system, once a child becomes eligible for Medicaid, he/she automatically remains eligible for six months, unless incarcerated or moves out of state. This helps to prevent disruptions in behavioral health care, particularly for children involved in the child welfare system who experience multiple placements. Children may access behavioral health services directly without having to go through their primary care physician (PCP). When children are admitted to services provided through DCMHS, their primary care providers are sent a letter (with consent of parents or guardians) and given the name of the clinical services management team leader and care coordinator. PCPs also are notified when children leave DCMHS care. The State Medicaid agency holds quarterly meetings with DCMHS, the child welfare and juvenile justice agencies to address service continuity and coordination issues.

- **Bundled Rate Financing**. The commercial MCOs receive a capitation from Medicaid for both physical and behavioral health services (the statewide average rate is about $100 per member per month). Medicaid and DCMHS worked out an agreement for a bundled rate for the DCMHS service population, (i.e., those with intermediate to severe behavioral health needs). Medicaid pays the Department of Services for Children, Youth and Their Families a bundled rate of $4,239 per Medicaid-eligible client served per month, a rate that was based on actual DCMHS client service and expenditure data. Mental health general and block grant revenue and some child welfare dollars also help to finance the system. DCMHS and Medicaid share the risk. EPSDT is built into the system as the screening process for behavioral health services.

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

Local Managed Care Systems[12]

A. Wraparound Milwaukee, WI

Overview

Wraparound Milwaukee is a behavioral health carve out, serving several subsets of children and families in Milwaukee County, Wisconsin. Its primary focus is on children who have serious emotional disorders and who are identified by the child welfare or juvenile justice system as being at risk for residential or correctional placement. Wraparound Milwaukee serves about 600 children a year. A combination of several state and county agencies, including child welfare, Medicaid, juvenile probation services, and the county mental health agency, finance the system. Their dollars create, in effect, a pooled fund that is managed by Wraparound Milwaukee, housed within the Milwaukee County Mental Health Division, Child and Adolescent Services Branch, which acts as a public care management entity. Wraparound Milwaukee organizes an extensive provider network and employs, directly or by contract, care coordinators, who work within a wraparound, strengths-based approach. Wraparound Milwaukee involves families at all levels of the system and aggressively monitors quality and outcomes. It has an articulated values base that emphasizes: building on strengths to meet needs; one family-one plan of care; cost-effective community alternatives to residential placements and psychiatric hospitalization; increased parent choice and family independence; care for children in the context of their families; and unconditional care.

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

Key Design and Financing Features

- **Publicly-Operated Care Management Organization.** Wraparound Milwaukee is a publicly-operated managed care system, with the Child and Adolescent Services Branch of the County Mental Health Division acting as the managed care entity. The Branch prefers to designate itself a "care management", rather than managed care, entity, emphasizing a values base which it feels is more consistent with its public sector responsibilities than the term, "managed care", may connote. The Branch, however, utilizes managed care technologies, including a management information system designed specifically for Wraparound Milwaukee, capitation and case-rate financing, service authorization mechanisms, provider network development and management, accountability mechanisms, and utilization management, in addition to care management.

- **Broad Benefit Design.** Wraparound Milwaukee covers a very broad array of services and supports, including: case management; referral assessment; medication management; outpatient individual/family; outpatient group; outpatient/drug and alcohol; psychiatric assessment; psychological evaluation; mental health assessment/ evaluation; inpatient psychiatric; nursing assessment/management; consultation with other professionals; daily living skills-individual; daily living skills-group; parent aide; child care; housekeeping; mentoring; tutor; life coach; recreation; after school programming; specialized camps; discretionary (i.e., flexible) funds; supported work environment; group home care; respite; respite foster care; respite-residential; crisis bed-residential; crisis home; foster care; treatment foster care; in-home treatment; day treatment; residential treatment; and transportation. The system provides over 80 core services (see **Provider Network and Consumer Choice**, page 28). The ability to cover an extensive array of services and supports is made possible by the diverse funding streams that support the system.

- **Mobile Urgent Treatment Team (MUTT).** Wraparound Milwaukee has a 24-hour mobile crisis team attached to it; it is one of the few service components directly staffed by the Child and Adolescent Services Branch itself, rather than contracted. It also is the one component of Wraparound Milwaukee that serves not only the 600 enrolled youth but the community at large, handling about 4,000 calls a year and 1,500 face-to-face contacts. Its primary purpose is to respond when a child's behavior threatens his or her removal from home, school, etc. The team goes to where the crisis is occurring, assesses the situation, identifies alternatives to hospitalization whenever possible, and makes referrals as needed. In addition to crisis intervention, the team can provide access to short-term case management, intensive (30-day) case management, 60-day family preservation services, and crisis group home care. The team acts as a first-line response to prevent unnecessary hospitalization and improve families' access to care in crisis situations. The team operates from 9 a.m. to 10 p.m. on Monday through Friday and from 1:30 p.m. to 10 p.m. on Saturday and Sunday. After hours, MUTT can be reached by telephone through an on-call system. The team is staffed by child psychologists, psychiatric social workers, and case managers and serves all children in the County, including those enrolled in Wraparound Milwaukee.

- **Care Coordinators Working in a Wraparound Approach.** As a care management organization, Wraparound Milwaukee utilizes care coordinators, largely on a contracted basis, who are responsible for convening a **Child and Family Team** to develop a

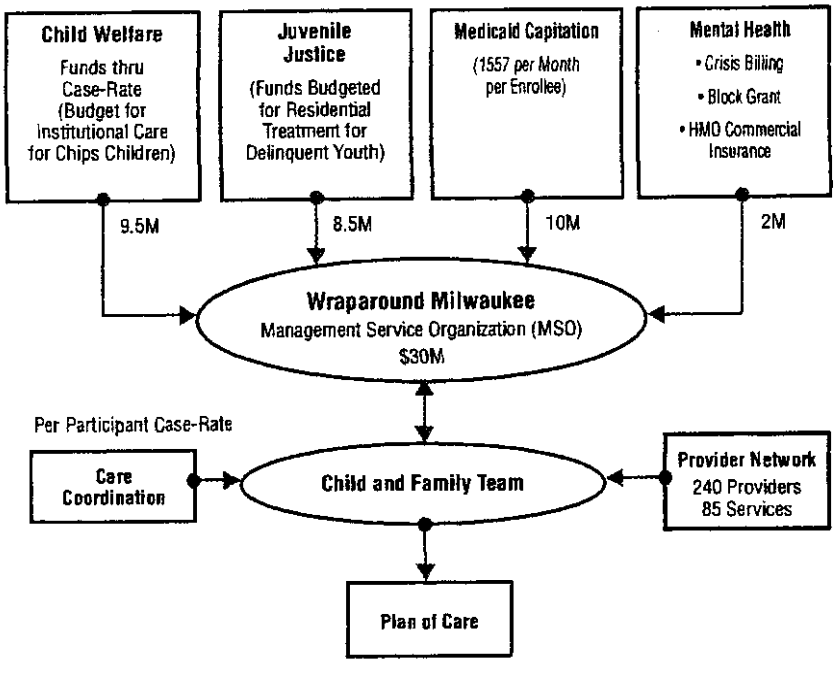
wraparound plan of care for each child referred to the system. The Child and Family Team is comprised of the child and his or her family, other key people in the child's life, including providers, teachers, family advocate, etc., and the care coordinator. Care coordinators meet the child and family,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

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

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

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

Figure 4
Wraparound Milwaukee Pooled Funds



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

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

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

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

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

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