

# Financing Behavioral Health Services and Supports *for* Children, Youth and Families *in the* Child Welfare System



## A REPORT OF NATIONAL SURVEY FINDINGS

### **PREPARED BY:**

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Georgetown University Center for Child and Human Development

National Association of Public Child Welfare Administrators  
American Public Human Services Association

Children, Youth, and Families Division  
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The National Association of Public Child Welfare Administrators Web Site  
<http://www.napcwa.org/home/docs/financingstrategiesreport.pdf>

The National Association of State Mental Health Program Directors Web Site  
<http://www.nasmhpd.org/NonNASMHPDPubs.cfm>

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# Acknowledgements

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This report would not have been possible without the vision, support, and leadership of a collaborative workgroup representing two organizations:

- National Association of Public Child Welfare Administrators (NAPCWA), an affiliate of the American Public Human Services Association (APHSA)
- Children, Youth and Families Division (CYFD) of the National Association of State Mental Health Program Directors (NASMHPD).

This workgroup was dedicated to working together to improve behavioral health services and outcomes for children, youth and families involved in the child welfare system. To achieve this, the workgroup undertook a survey to learn how states and communities finance mental health and substance abuse services and supports for children, youth and families involved with the child welfare system. The workgroup helped develop the survey, pilot tested it, encouraged their peers in other states to respond, reviewed initial survey findings, and provided suggestions on the content and format of this report. Workgroup members are listed in *Appendix F*.

The authors would like to express special appreciation to staff from NAPCWA who played key roles in facilitating the workgroup, developing the survey, designing the survey analysis, inputting the data and compiling survey results. Laura LaRue Gertz was very instrumental in the initial stages of survey development, in envisioning the tasks ahead, and in helping the workgroup determine its focus. Kerry Vandergrift played an extensive role in designing the survey and making it available to states on the web and in Word. Kerry also helped design the analysis and set up a format for inputting the data. Gretchen Kolsky assisted in designing the report format, inputting data, and contributed to early drafts of the report. Anita Light, as Director of Children and Family Services at APHSA, provided ideas, guidance and feedback in each phase of survey development and implementation.

We especially acknowledge and thank the state child welfare directors and state children's mental health directors and their staff who, along with state, community and family stakeholders, developed the effective financing strategies that are discussed in this report. This survey was not easily completed. It took a great deal of time and knowledge for respondents to fully explain the financing strategies, as well as a willingness to share their strategies with others. As you will learn in reviewing the report, their efforts are producing positive results.

*Jan McCarthy*

*Lan T. Le*



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# Executive Summary



## Background and Purpose

The National Association of Public Child Welfare Administrators (NAPCWA), an affiliate of the American Public Human Services Association (APHSA), and the Children, Youth, and Families Division (CYFD) of the National Association of State Mental Health Program Directors (NASMHPD) formed a collaborative workgroup to improve behavioral health services<sup>1</sup> and outcomes for children, youth and families involved in the child welfare system. Recognizing the importance of financing strategies in providing appropriate behavioral health services and supports, in 2006 the workgroup undertook a survey *to learn how states and communities finance mental health and substance abuse services and supports for children, youth and families involved with the child welfare system.*

The goals of the survey and this report are to:

- provide comprehensive descriptions of the types of financing strategies that are being implemented *across multiple states and communities*
- describe the types of financing strategies employed *within individual states*
- offer some insight into *how* the financing strategies are being implemented
- provide contact information so readers can obtain more detailed information and assistance related to particular strategies.

The workgroup anticipated that only states with unique financing strategies would respond to the survey and was pleased to receive information about 49 financing strategies from 28 states.

We believe readers, who are in a position to initiate, lead and contribute to the improvement or expansion of behavioral health services for children, youth and families who are involved with the child welfare system, will find that this report provides practical information to assist them in their efforts.

## Chapter 1: Description of the Study

Chapter 1: Description of the Study provides information about:

- the background and purpose of the study
- how the study findings can assist in developing behavioral health services for children, youth and families involved with the child welfare system
- how the report is organized
- the study methodology.

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<sup>1</sup> In this survey, behavioral health services refers to mental health and substance abuse services and supports.



## Chapter 2: Overview of Study Findings

Chapter 2: Overview of Study Findings offers a cross-state summary of trends in the financing strategies that the 28 responding states and communities are developing or have implemented.

### Types of Financing Strategies Being Developed and Implemented

Survey findings indicate that the strategy most frequently *implemented* by the responding states (85%) is financing for community-based behavioral health services and supports for children and families in their own homes that might prevent more restrictive placements. The strategy most frequently *under development* (62%) is funding for evidence-based practices for children in the child welfare system.

### Size and Scope of the Financing Strategies<sup>2</sup>

The financing strategies are serving large numbers of children and families. Half of the strategies (51%) are serving more than 1,000 children, and 49% are serving more than 1,000 families. Less than 10% of the strategies serve fewer than 50 children and families.

Most strategies (65%) are being implemented at the local level on a statewide basis, and a small percentage (13%) are being implemented only in certain localities.

### Populations of Children, Youth and Families Served by Funding Strategies

States are developing or implementing financing strategies primarily for broad populations of children, i.e., the total child welfare population (10 states) and children in custody (10 states). Eleven (11) states described financing strategies for serving children with mental health needs (including children served by child welfare, children outside of the child welfare system and youth with serious emotional disturbances who are at risk for immediate placement). Five states target parents, caregivers, or other family members

### Range of Services Covered or Provided

In describing the range of services covered by their financing strategies, states listed 35 services. The two services covered most often were:

- home and community-based services (14 states)
- involving families in the service planning process through child and family teams (11 states).

### Agencies Involved in Financing Strategies and Partnerships Formed

The agencies most frequently involved in the financing strategies are:

- child welfare (89%)
- mental health (83%)
- Medicaid (65%)
- juvenile justice (61%).

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<sup>2</sup>To determine an approximate number of children and families served by the financing strategy, the survey provided a range of responses to choose from with 0-50 being the lowest and 1,001 + being the highest.



The courts (48%), substance abuse services (46%) and family organizations (43%) were involved in almost half of the financing strategies. The education system was involved in just 26% of the financing strategies.

The vast majority of the responding states (79%) *developed partnerships* among the involved agencies to implement the funding strategies, and most of them (61%) formalized these partnerships.

### Funding Information

We learned that the funding strategies rely heavily on federal and state funding. Ninety-four percent (94%) of the strategies were using some federal funds and 91% were using some state funds. Three strategies used *only* federal funds.

The federal funding source used most frequently, by 84% of the strategies, is the Social Security Act (SSA) in the Department of Health and Human Services. The most frequently used categories within the SSA are:

- Title XIX—Medicaid General (51%) and Medicaid—Rehabilitation Option (51%)
- Title IV-E—Foster Care and Adoption Assistance (49%).

Funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) was listed as a funding source by 34% of the financing strategies. Funding from the federal Administration for Children and Families (ACF) was listed as a funding source by 29% of the financing strategies.

States were asked to describe any specific arrangements they made (i.e., what they had to do differently) in order to use certain funding sources. The most frequently described arrangement (12 states) was to pool, blend or braid funds. In response to a question about *how* states are implementing their financing strategies, the most frequently chosen approach was to identify current spending and utilization patterns (65%). The second most frequently used approach was to maximize federal entitlement funds (56%).

### Data/Information Systems

Almost half of the 28 responding states (46%) updated their data systems in order to implement their financing strategies. A number of them described changes that would enable them to track and monitor process outcomes, services received, and child/family outcomes. Only four states described changes to better track fiscal information.

### Accountability

Many states use existing standard accountability activities such as annual quality assurance reviews, prior authorization of services, utilization reviews, annual reports to funding sources, regular reports to court monitors, state and federal fiscal audits, contract monitoring, CMS audits, accreditation and grants management processes to demonstrate accountability of their financing strategies. Most states reported successful completion of these standard fiscal and program audits.



Ten states described five specific types of outcomes they track to determine whether goals are met:

- child/family outcomes
- service outcomes
- fiscal outcomes
- CFSR outcomes
- process outcomes.

### **Longevity of Financing Strategies and How They Have Been Institutionalized**

The majority (59%) of the financing strategies had been in place more than 24 months when the survey data was collected in the fall of 2006. Only three of the 51 strategies had been in place for less than 6 months. Sixteen funding strategies were described by respondents as being institutionalized, i.e., the strategies will not disappear when the state administration changes. Reliance upon Medicaid was the most frequently mentioned method for institutionalizing a financing strategy.

### **Meeting Child Welfare Timelines**

The child welfare system operates within specific federal (e.g., Adoption and Safe Families Act) and state timelines for providing services and for making decisions about child safety and permanency. These timelines impact front-line practice and require that services be provided in a timely manner. Sixteen of the 28 states affirmed that their financing strategies enable them to meet child welfare timelines.

## **Chapter 3: In-depth Descriptions of Individual Financing Strategies across States**

Chapter 3: In-depth Descriptions of Individual Financing Strategies across States discusses 17 financing strategies. After the study team culled through narrative descriptions of the various financing strategies provided by the responding states, similar strategies from different states were combined and examined together. From this process, we identified the following 17 individual financing strategies which are listed in the order of those most frequently described to those least frequently described by respondents:

1. Community-based and in-home behavioral health services and supports for children and families
2. Individualized, integrated, and coordinated services within systems of care
3. Managed care strategies
4. Behavioral health screenings and comprehensive assessments
5. Behavioral health services and supports for family members of children who are in custody
6. Child and family service planning teams
7. Financing family-run organizations to provide child/family services and supports
8. Training
9. Co-location of child welfare and mental health staff
10. Expansion of the pool of qualified behavioral health providers



11. Development, provision, and monitoring of evidence-based practices
12. Behavioral health services for youth who age out of the foster care system and into the adult system
13. Therapeutic foster care
14. Crisis services and mobile response
15. Reduction of out of state residential placements
16. Services for children with developmental disabilities
17. Strategies to avoid unnecessary custody relinquishment

For most of these strategies the chapter describes:

- what the strategy achieves (e.g., the service, the program, the process)
- how the financing strategies were implemented
- funding sources that support the different strategies.

## Chapter 4: Individual Snapshots of Each State's Financing Strategies

Chapter 4: Individual Snapshots of Each State's Financing Strategies provides a “snapshot” of each state and its financing strategies for providing behavioral health services for children and families in the child welfare system.

The “snapshots” include similar information for each state and most address:

- services or program offered through the funding strategy(ies)
- target population served by the strategy
- how the funding strategy was implemented and future implementation plans
- funding sources
- number and types of agencies or organizations involved in implementing the strategy
- level of implementation (statewide, regional, local)
- how long the strategy has been implemented<sup>3</sup>
- number of children and families served per year by the strategy<sup>4</sup>.

Financing strategies from 24 states are described. The length and detail of the descriptions for each state vary depending upon the amount of detailed information and supporting documents provided by the state in its survey response. *Appendix C* identifies individual survey respondents from each state who may be contacted for further state specific information.

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<sup>3</sup>To determine how long the financing strategy had been in place, the survey provided a range of responses to choose from—less than 6 months (shortest) to more than 24 months (longest). Survey responses were received in the fall of 2006, thus at the time of publication, the financing strategies have been in place longer than indicated in the survey responses.

<sup>4</sup>To determine an approximate number of children and families served by the financing strategy, the survey provided a range of responses to choose from with 0-50 as the lowest, and 1,001 + as the highest.



## Chapter 5: Observations of the Respondents

Chapter 5: Observations of the Respondents describes observations and learnings of the responding states about the financing strategies they have implemented. It addresses:

- major outcomes and accomplishments of the financing strategies
- challenges to implementing the strategies
- lessons learned and key elements for achieving success
- concluding comments.

### Major Outcomes and Accomplishments

It was clear from the survey responses that implementing the various financing strategies has led to significant accomplishments and outcomes. The accomplishments described by respondents included improvement in: assessment, services, clinical functioning, placement outcomes, timeliness and permanency, collaboration, knowledge and expertise about behavioral health, Medicaid and fiscal issues, access to services for older youth, tracking and monitoring systems, and family satisfaction. For example,

- **Assessment**—Four states found that providing behavioral health and/or medical assessments for children entering foster care leads to early identification and intervention and more appropriate service plans.
- **Services**—Seven states described increased community-based services; increased availability and scope of services; strengthened service capacity; the development of innovative, effective service approaches; and increased flexibility in services.
- **Improved Child Functioning and Better Placement Outcomes**—Several states noted stabilized behavior, improved school performance, and improved well-being for children. Others noted that children are placed more appropriately, served closer to home, in their home schools, and in more normalized environments.
- **Timeliness**—Three states described more timely reunification and achievement of permanency.
- **Collaboration**—Four states strengthened collaboration between the child welfare, mental health and/or substance abuse service systems; integrated services approaches; instituted multi-system responsibility for services for children; and increased collaboration among stakeholders, agencies and families.

### Challenges to Implementation of Financing Strategies

The challenges faced by survey respondents often resulted from the concerns and fears of various stakeholders as they faced the fiscal and practice changes brought on by the financing strategies. Challenges clustered around fiscal issues, workforce and provider issues, collaboration, family and youth voice and partnerships, and communication/marketing. For example,

- **Fiscal Challenges**—Financial challenges ranged from simply a lack of adequate funding to complicated tracking, reporting, and evaluation requirements when blending funds from multiple funding streams. States had to deal with the burden on local communities to track expenditures and a reluctance to assign undesignated funds to the system of care. It was a challenge to work with communities to put up matching funds and to convince local systems that pooling funds would lead to more appropriate services for the targeted children and families.



- **Workforce and Provider Issues**—Several states reported challenges related to providers' fears and reluctance to change. Anxiety from the provider community included fears of losing referrals for residential care and of going out of business. Respondents found it a challenge to get residential providers to commit to increasing in-home, community-based, and individualized services.

States also found it a challenge to build a diverse and qualified provider network that was adequate to serve children and families in the child welfare system. Building the capacity to meet specific service needs, to assess young children and infants, and to meet the needs of children of diverse cultures were noted as challenges.

- **Collaboration**—Challenges to collaboration included: turf issues; breaking down silos; merging different agency cultures, expectations and priorities; a lack of committed partners; and the need to develop new partnerships to implement a new practice model (child and family teams) and to change the service culture.
- **Family and Youth Voice and Partnerships**—Challenges ranged from the basics of getting all system partners to understand and value partnering with families to developing the strategies needed to support families as partners.

### Lessons Learned and Key Elements to Achieve Success

Twenty of the 28 states noted at least one key element for success. Many of the key elements were not fiscal in nature, but were related instead to other supports and practices that enabled the funded program, service, or system to be successful. For example,

- **Collaboration**—Several states stressed the importance of consistent communication among all partners and stakeholders, the importance of “joining” between the state and localities, and the value of being inclusive from the very beginning and during all phases of development. They described the need for all stakeholders to feel a part of the initiative and to understand the need for change. They discussed the necessity for creating a structure within which communication can occur, including strategies for troubleshooting and addressing changing service needs.
- **Family and Youth Voice and Partnerships**—Six states cited the voice of families as important in providing the services that families need and achieving positive outcomes. They also described the value of the family voice in all stages of policy development and planning, as well as the importance of family participation at the leadership level.
- **Leadership**—Seven states described the importance of strong leadership and the commitment to persevere.

### Concluding Comments

While a survey such as this is limited in how much specific and detailed information it can offer, we hope that reading what other states and communities have done will stimulate thoughts and provide a range of ideas for those who wish to improve behavioral health services for children and families in the child welfare system. *Appendix C* identifies survey respondents who agreed to be contacted for further information. It is included here so that readers can delve deeper into specific strategies that they wish to consider in their own areas.





## CHAPTER ONE

# Description of the Study



### Readers will learn from this chapter:

- the background and purpose of the study
- how the study findings can assist in developing behavioral health services for children, youth and families involved with the child welfare system
- how the report is organized
- the study methodology.

## Background and Purpose

The National Association of Public Child Welfare Administrators (NAPCWA), an affiliate of the American Public Human Services Association, and the Children, Youth, and Families Division (CYFD) of the National Association of State Mental Health Program Directors (NASMHPD) formed a collaborative workgroup to *improve* behavioral health services<sup>5</sup> and outcomes for children, youth and families involved in the child welfare system. In 2006, recognizing the importance of financing strategies in providing appropriate behavioral health services and supports, the workgroup undertook this survey *to learn how states and communities finance mental health and substance abuse services and supports for children, youth and families involved with the child welfare system*. The survey instrument was developed by the collaborative workgroup and staff from the National Technical Assistance Center for Children's Mental Health at Georgetown University and from NAPCWA. These same staff administered the survey and compiled the results. The workgroup provided feedback at strategic points in the administration and analysis of the survey.

The goals of the survey and this report are to:

- provide comprehensive descriptions of the types of financing strategies that are being implemented *across multiple states and communities*
- describe the types of financing strategies employed *within individual states*
- offer some insight into *how* the financing strategies are being implemented
- provide contact information so readers can obtain more detailed information and assistance related to particular strategies.

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<sup>5</sup> In this survey, behavioral health services refers to mental health and substance abuse services and supports.



The workgroup expected the results of the survey to create the opportunity for peer to peer learning and asked respondents whether they were willing to share their responses, both specifically and as part of a summary of strategies. Twenty-seven of the 28 responding states, agreed to be named in the study and provided contact information to share (see Appendix C). The workgroup anticipated that only states with unique financing strategies would respond to the survey and was pleased to receive information about 49 financing strategies from 28 states.

**Who Will Benefit From the Study Findings**—We believe readers, who are in a position to initiate, lead and support the improvement or expansion of behavioral health services for children, youth and families who are involved with the child welfare system, will find that this report provides practical information to assist them in their efforts

## How This Document Is Organized

This short user's guide is intended to help you navigate through various sections of the report.

**Executive Summary**—provides a quick overview of the study findings.

**Chapter 1: Description of the Study**—discusses background information about the study, its purpose and methodology, and offers a guide for using the report.

**Chapter 2: Overview of the Findings**—provides an overview of the study findings and offers a cross-state summary of the following specific issues:

- Types of strategies being developed or implemented
- Size and scope
- Populations served
- Range of services covered
- Agencies involved and partnerships formed
- Funding sources and arrangements made to use these funding sources
- Impact on data and information systems
- Accountability strategies
- Longevity and institutionalization of the financing strategies
- Impact on meeting required child welfare timelines.

**Chapter 3: In-depth Descriptions of Individual Financing Strategies Across States**—presents information about the 17 different financing strategies that the study team identified after reviewing all survey responses. Each strategy description includes information from all states engaged in the strategy and discusses what the strategy achieves, e.g., the services or programs offered; how the strategy was implemented; and what funding sources were used to support the strategy.



**Chapter 4: Individual Snapshots of Each State’s Financing Strategies**—offers a state by state perspective of the financing strategies being developed or implemented in *each* state to provide behavioral health services for children and families in the child welfare system. It reports on issues similar to those presented in Chapter 2; however, instead of providing a cross-state summary of each issue, each state snapshot summarizes the strategies being employed in that state. The length and detail of the descriptions for each state vary depending upon the amount of detailed information and supporting documents provided in the survey response. Readers who are interested in learning more about a specific state can turn to Appendix C for state contact information.

**Chapter 5: Observations**—presents a cross-state summary of respondents own observations about the financing strategies they have implemented. It discusses:

- major outcomes and accomplishments of the financing strategies
- challenges to implementing the strategies
- lessons learned and key elements to achieve success
- concluding comments.

**Chapter Structure**—It is not necessary to read this document from the front to the back. Each chapter in this report can be reviewed separately. In order to structure the document this way, at times it was necessary to repeat information about a specific strategy in more than one Chapter.

**Appendices**—offer additional resources for the reader. *Appendix A* is a matrix of all the financing strategies by state. *Appendix B* provides more detail about the study methodology. *Appendix C* identifies individual survey respondents from each state who may be contacted for further information. *Appendix D* is a glossary of terms related to financing behavioral health services for children, youth and families (copied from a publication of another financing study)<sup>6</sup>. *Appendix E* is a copy of the survey itself. *Appendix F* lists the members of the workgroup that conceived the study.

### Footnotes/Use of State Names

When the report references a certain number or set of states, e.g., “six states described their Medicaid efforts”, the referenced states are named in a footnote at the bottom of the page whenever there are more than three states. Individual states, however, are not named in the Executive Summary.

### Unidentified State

One state completed the survey, but did not agree to publicly share its information. We have included this state’s responses in the report but have not identified the state by name. For listing purposes, this state is identified as XX.

<sup>6</sup> Armstrong, M.I., Pires, S.A., McCarthy, J., Stroul, B.A., Wood, G.M., & Pizzigati, K., (2006). *A self-assessment and planning guide: Developing a comprehensive financing plan (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. #235-01)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children’s Mental Health, p. 37.



### Use of Other Source Data

In addition to the survey results, we used information from other source documents, where appropriate, to enhance the state descriptions. These documents are noted in the text. The most useful and most frequently used source document was the following study of strategies for financing behavioral health services for children, youth and families in systems of care:

Stroul, B.A., Pires, S.A., Armstrong, M.I., McCarthy, J., Pizzigati, K., & Wood, G.M., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan (RTC study3: Financing structures and strategies to support effective systems of care, FMHI pub. #235-02)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute (FMHI), Research and Training Center for Children's Mental Health.

This document and the *Self-Assessment and Planning Guide* noted in the footnote below are available on line at <http://rtckids.fmhi.usf.edu/study03.cfm>

Print copies are available from the Louis de la Parte Florida Mental Health Institute, University of South Florida, 13301 Bruce B. Downs Boulevard, Tampa, FL 33612-3899, (813) 974-6271.

## Methodology

We followed a series of steps to obtain, organize, analyze, and summarize the information on financing strategies reported by 28 states:

1. The self-report survey was disseminated to the child welfare commissioner and the children's mental health director in each state during the summer of 2006. States had the option of completing the survey online, in hard copy, or using a combination of the two formats. The child welfare commissioner and children's mental health director could submit one joint survey response for the state or two separate responses. In addition to completing the survey, respondents also were allowed to submit supporting documents to more fully describe the financing strategies.
2. A total of 28 states responded to the survey. With several states submitting more than one survey (e.g., separate surveys from the child welfare commissioner and the children's mental health director in a state, or separate surveys for each different financing strategy being utilized in a state), we received 49 individual survey responses. Part of the survey yielded quantifiable information from multiple choice and check-off questions. The survey also provided the opportunity for respondents to write narrative descriptions. To ease the burden of completing the survey and increase the response rate, respondents were encouraged to provide narrative descriptions of *only* the financing strategy(ies) they thought would be most useful to share with others, rather than describing all of the strategies they reported. Thus, there were fewer narrative descriptions than the total number of financing strategies reported by the states in the quantitative section.



3. Following are examples of the types of questions that yielded quantitative and qualitative information:

*Quantitative*—type of financing strategy, how strategy is implemented; length of time strategy has been in place; size and scope of the strategy (statewide, regional or local); size of population served; agencies involved; funding sources used.

*Qualitative*—narrative description of the financing strategy; target population; range of services provided; arrangements made to use certain funding sources; partnerships created; updates to information systems; how strategy demonstrates accountability; institutionalizing the strategy; meeting child welfare timelines; major accomplishments; challenges; lessons learned; key elements for success.

4. Both Microsoft Excel and Access were used to store data, extract material, organize content, and categorize strategies and themes from the surveys. Codes were created to help organize the numerous financing strategies reported into more definitive categories. The generation of codes and the subsequent analysis of strategies involved an iterative process of review and discussion before the final results and summaries were completed. When questions about the data were identified, respondents were contacted for clarification.
5. To more accurately represent the data, quantitative analyses were reported by the actual number of respondents who answered each particular question. Thus, the N for each question may differ. For each of the graphs displayed in Chapter 2, some states chose not to respond to the question, leading to small amounts of missing data throughout.
6. After culling through narrative descriptions of the various financing strategies provided by the responding states, similar strategies from different states were combined and examined together. From this process, we identified and summarized 17 individual financing strategies in Chapter 3.

For additional details about the methodology, see Appendix B.



## CHAPTER TWO

# Overview of Study Findings



**This chapter provides** an overview of the study findings and offers a cross-state summary of the following information about the financing strategies that were being developed or have been implemented by the 28 responding states:

- Types of strategies being developed or implemented
- Size and scope of the financing strategies
- Populations of children, youth and families served by the funding strategies
- Range of services covered or provided
- Agencies involved in financing strategies and partnerships formed
- Funding sources and arrangements made to use these funding sources
- How data and information systems had to be updated
- Accountability of financing strategies
- Longevity of financing strategies and how they have been institutionalized
- Impact of financing strategies on meeting required child welfare timelines.

### Types of Financing Strategies Being Developed or Implemented

The survey provided a list of potential strategies for financing behavioral health services and supports for children and families involved with the child welfare system. Responding states identified whether they were developing or had implemented these strategies and also identified other financing strategies not included in the checklist.

**Chart 1** indicates those financing strategies being developed or implemented. The strategies most frequently *implemented* include:

- financing community-based behavioral health services and supports for children and families in their own homes that might prevent more restrictive placements (85%)
- funding family-run organizations to provide child/family services and supports (76%)
- funding behavioral health screening and comprehensive assessments for children in custody (71%)
- financing child and family team service planning meetings (71%).

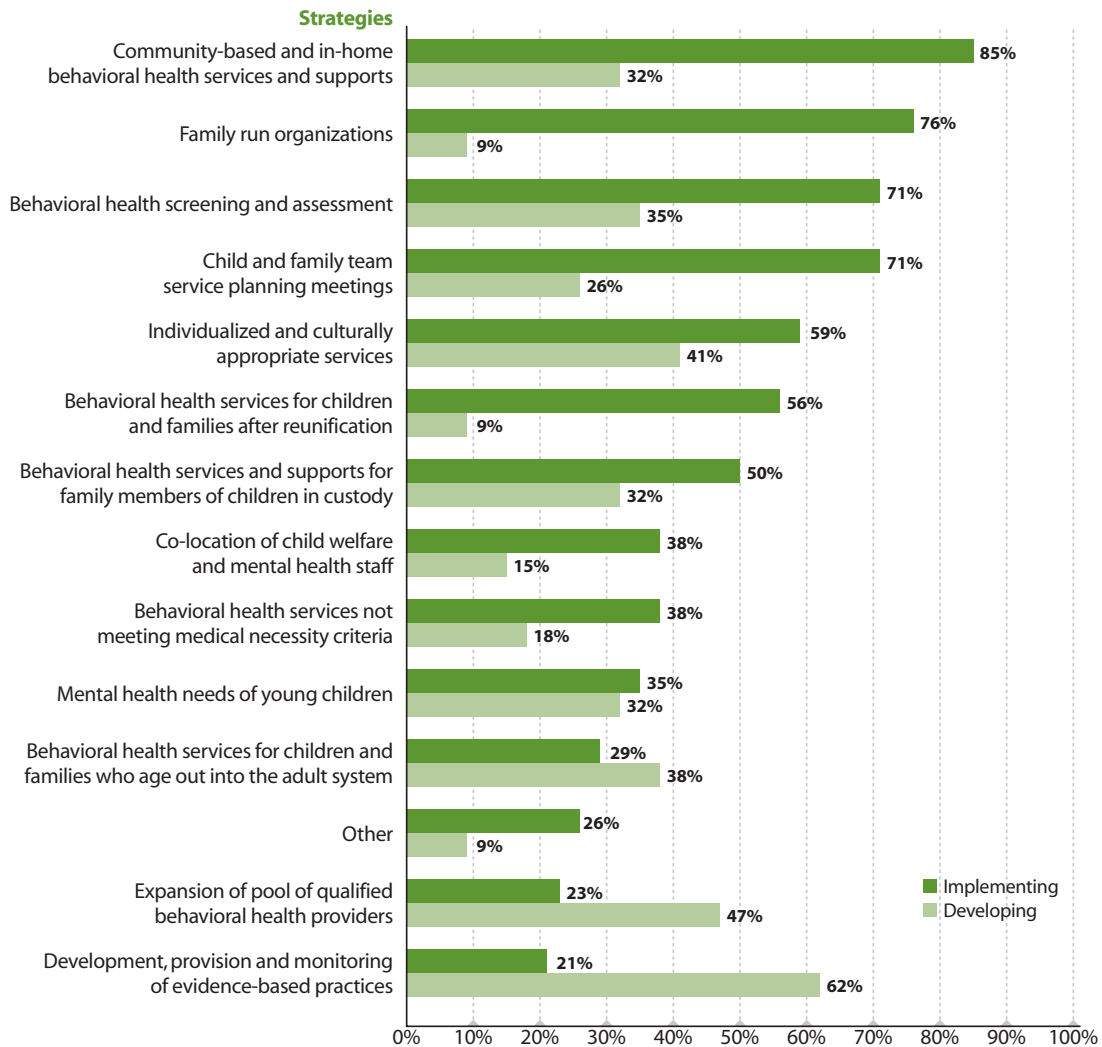
Interestingly, the following two strategies, which were *most* frequently noted as *being developed* by the states, were the two strategies *least* frequently *implemented*.

- funding the development, provision and monitoring of evidence-based practices for children in the child welfare system (implemented by 21%, being developed by 62%)
- expansion of the pool of qualified behavioral health providers (implemented by 23%, being developed by 47%).



CHART 1

Funding Strategies States Are Developing in Implementing (N=34 responses)







## Size and Scope of the Financing Strategies

The financing strategies are serving large numbers of children and families. Half of the strategies (51%) are serving more than 1,000 children (Chart 2), and 49% are serving more than 1,000 families (Chart 3). Less than 10% of the strategies serve fewer than 50 children and families.

CHART 2

### Approximate Number of Children/Youth Served Per Year By Financing Strategies

(N=39 responses)

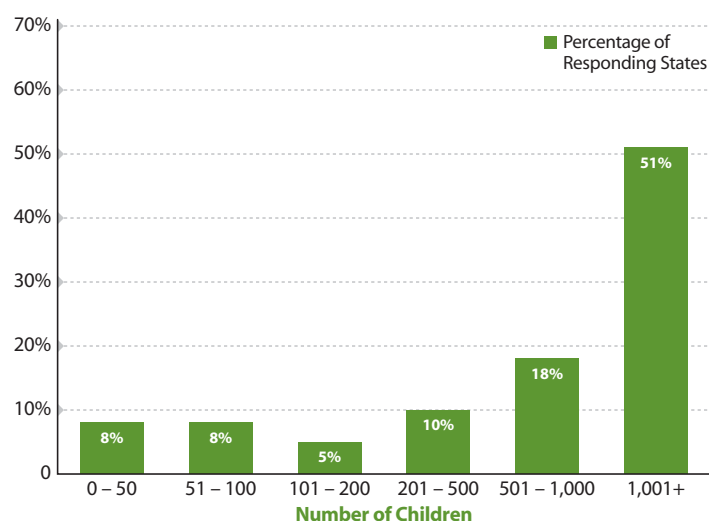
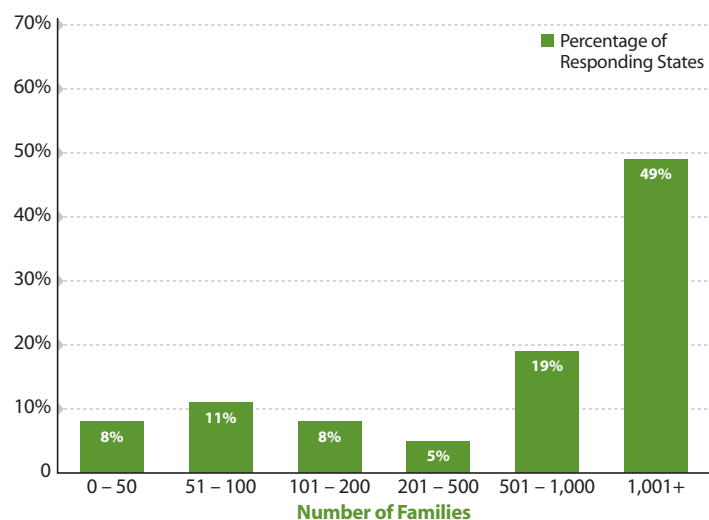


CHART 3

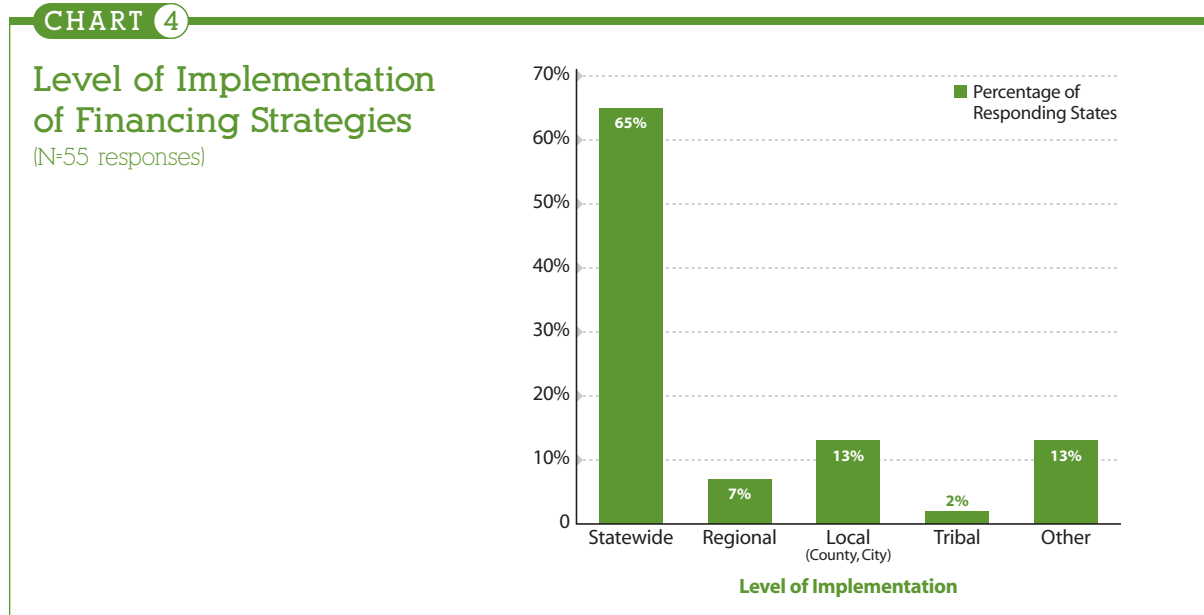
### Approximate Number of Families Served Per Year By Financing Strategies

(N=37 responses)





Most strategies (65%) are being implemented at the local level on a statewide basis, and a small percentage (13%) are being implemented only in certain localities (**Chart 4**).



### Populations of Children, Youth and Families Served by Funding Strategies

**Twenty-four (24)** states noted 23 different populations of children, youth and families being served by their financing strategies for behavioral health services (**Chart 5**). States are developing or implementing financing strategies primarily for broad populations of children, i.e., the total child welfare population (**10 states**) and children in custody (**10 states**).

**Eleven (11)** states<sup>7</sup> described financing strategies for serving children with mental health needs (including children served by child welfare, children outside of the child welfare system and youth with serious emotional disturbances who are at risk for immediate placement). **Five** states<sup>8</sup> target parents, caregivers, or other family members. Very few financing strategies target children based on their age or developmental stage. Older youth (those formerly in foster care or aging out of foster care or juvenile justice) were targeted by **three states**<sup>9</sup>. Young children were the identified target population for a financing strategy in only one state (**NH**).

<sup>7</sup> AR, DE, FL, MO, NH, NJ, PA, VT, WV, WI, XX

<sup>8</sup> ID, NH, NJ, OH, WI

<sup>9</sup> NH, NJ, PA



CHART 5

Populations Served by Funding Strategies (N=24 states)

TARGET POPULATION	NUMBER OF STATES
Children in custody	10 states <sup>A</sup>
Total child welfare population	10 states <sup>B</sup>
All children with certain mental health needs (broader than the child welfare population)	7 states <sup>C</sup>
Children and youth with multiple challenges involved with two or more agencies	6 states <sup>D</sup>
Youth with serious emotional disturbances at risk of immediate placement	6 states <sup>E</sup>
Children with child protective services involvement who live in their own homes	4 states <sup>F</sup>
Families of children in custody	4 states <sup>G</sup>
Children and youth in need of substance abuse services	4 states <sup>H</sup>
Adults in need of substance abuse services	3 states <sup>I</sup>
Children with serious emotional disturbances in out-of-state placement	2 states <sup>J</sup>
Children involved with child welfare and juvenile justice (in home or in placement) who have developmental disabilities	2 states <sup>K</sup>
Youth (18-21) formerly in foster care or juvenile justice	2 states <sup>L</sup>
Youth aging out of foster care	1 state <sup>M</sup>
Alaskan native children	1 state <sup>N</sup>
Children and families with behavioral health needs not eligible for Medicaid who are involved with child welfare, juvenile justice or voluntary services	1 state <sup>O</sup>
Children eligible for Medicaid and/or SCHIP	1 state <sup>P</sup>
Adults in need of mental health services	1 state <sup>Q</sup>
Children in relative placement	1 state <sup>R</sup>
Young children (greater than children in child welfare population)	1 state <sup>S</sup>
Behavioral health providers	1 state <sup>T</sup>
Foster parents and adoptive parents	1 state <sup>U</sup>
Children in residential treatment centers (in state)	1 state <sup>V</sup>
Children involved with child welfare who have serious emotional disturbances	1 state <sup>W</sup>

<sup>A</sup> AZ, AR, DE, FL, ME, MO, NE, NH, NY, WV

<sup>B</sup> AR, DE, FL, GA, IN, NH, ND, PA, SC, WV

<sup>C</sup> AR, DE, NH, NJ, PA, WV, WI

<sup>D</sup> IN, ME, MI, PA, WV, WI

<sup>E</sup> FL, MO, NH, VT, WV, XX

<sup>F</sup> DE, FL, ME, NH

<sup>G</sup> ID, NH, NJ, OH

<sup>H</sup> DE, ID, OH, WI

<sup>I</sup> ID, OH, WI

<sup>J</sup> AK, WV

<sup>K</sup> NH, PA

<sup>L</sup> NH, NJ

<sup>M</sup> PA

<sup>N</sup> AK

<sup>O</sup> CT

<sup>P</sup> CT

<sup>Q</sup> WI

<sup>R</sup> FL

<sup>S</sup> NH

<sup>T</sup> NH

<sup>U</sup> NH

<sup>V</sup> AK

<sup>W</sup> HI



## Range of Services Covered or Provided

In describing the range of services covered by their financing strategies (**Chart 6**), states listed 35 services. The two services covered most often were:

- home and community-based services (**14 states**)
- involving families in the service planning process through child and family teams (**11 states**).

States also fund traditional mental health services, group care, crisis services and supports, family support services, health care services for children in foster care, substance abuse services and supports, services for older youth, and evidence-based practices.

### CHART 6

#### Range of Services Covered by Funding Strategies\*

SERVICE	NUMBER OF STATES
Home and community-based services	14 states <sup>A</sup>
Child and family teams/wraparound	11 states <sup>B</sup>
Traditional mental health services	
Outpatient treatment	10 states <sup>C</sup>
Screening, assessment, diagnosis	9 states <sup>D</sup>
Case management	10 states <sup>E</sup>
Group care	
Inpatient, residential, therapeutic group homes, crisis residential	10 states <sup>F</sup>
Crisis services, mobile crisis response and stabilization	8 states <sup>G</sup>
Family support and education, flex funds for unique family needs	8 states <sup>H</sup>
Primary health care and health care management for foster children	6 states <sup>I</sup>
Substance abuse treatment services and supports	5 states <sup>J</sup>
Services and supports for youth	4 states <sup>K</sup>
Evidence-based practices	4 states <sup>L</sup>

\*States listed 35 services in total. Many services that were identified by only one or two states are not listed here.

<sup>A</sup> AR, CT, DE, GA, HI, ID, IN, MI, MS, MO, NH, NJ, ND, WI

<sup>B</sup> FL, IN, ME, MI, MS, NE, NJ, ND, PA, VT, WI

<sup>C</sup> AK, AR, CT, DE, FL, HI, IN, NH, NJ, SC

<sup>D</sup> AK, AR, CT, FL, HI, NH, NJ, PA, WV

<sup>E</sup> AK, AR, CT, FL, HI, IN, NE, NE, PA, SC

<sup>F</sup> AK, AR, CT, FL, GA, HI, IN, MO, NH, PA

<sup>G</sup> AK, AR, DE, FL, GA, HI, NJ, PA

<sup>H</sup> AK, FL, ID, IN, NH, NJ, ND, WV

<sup>I</sup> AK, CT, IN, NH, NY, SC

<sup>J</sup> CT, ID, NH, OH, WI

<sup>K</sup> MS, MH, NJ, WV

<sup>L</sup> CT, HI, NH, ND

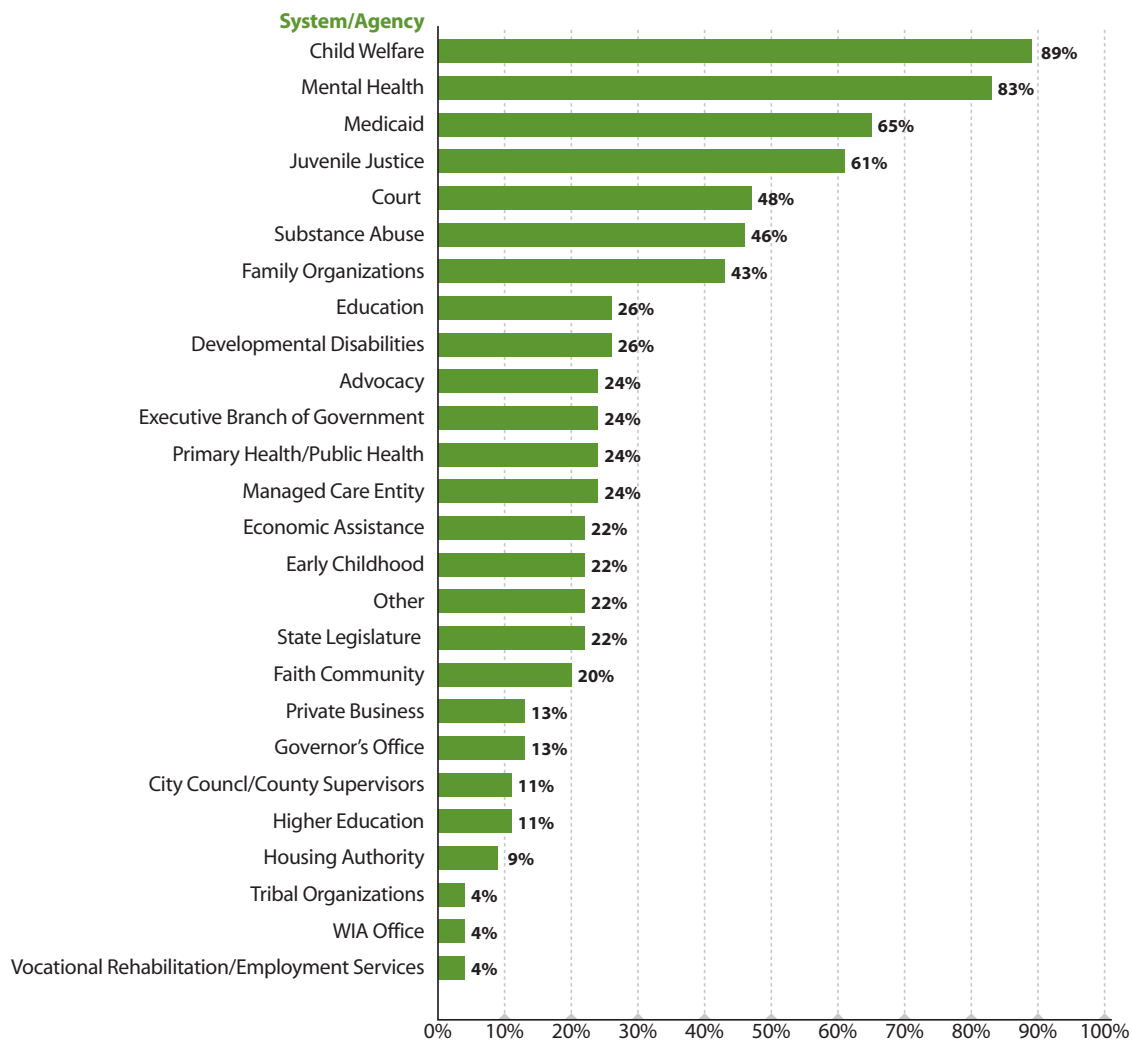


## Agencies Involved in Financing Strategies and Partnerships Formed

Survey respondents identified all agencies involved in their financing strategies (Chart 7). Those most frequently involved were child welfare (89%) and mental health (83%). Medicaid (65%) and juvenile justice (61%) also were significantly involved. The courts (48%), substance abuse services (46%) and family organizations (43%) were involved in almost half of the financing strategies. The education system was involved in just 26% of the financing strategies.

**CHART 7**

### System or Agencies Involved in the Financing Strategies (N=46 responses)





The vast majority of the responding states (79%) *developed partnerships* among the involved agencies to implement the funding strategies, and most of them (61%) *formalized these partnerships* through memoranda of agreement, legislation, contracts, and/or interagency agreements. Partners worked together in regularly scheduled meetings; in workgroups, in cross-system teams; and at forums for training, technical assistance, and education. States “partnered” with families/consumers by involving them in workgroups, on child and family teams, in writing protocols, and through contracts with family organizations. Respondents also noted other partners (not listed above in Chart 7) such as providers and provider associations, child care, and TANF. One state (**Ohio**) involved the state supreme court, and in **Florida** substance abuse service providers and a dependency drug court were partners in one of the financing strategies. Five states<sup>10</sup> indicated that partnerships were actually mandated by legislation or administrative rule, rather than being voluntary.

## Funding Information

### Funding Breakdown

To determine generally how states are funding behavioral health services for children, youth and families in the child welfare system, the survey asked for a breakdown among the following funding categories for each strategy:

- Federal
- State
- Local
- Tribal
- Non-governmental
- Other

We learned that the funding strategies rely heavily on federal and state funding. Ninety-four percent (94%) of the strategies were using some federal funds and 91% were using some state funds. Three strategies (in **Idaho** and **New Hampshire**) used *only* federal funds. **Chart 8** demonstrates that among 26 strategies the use of federal and state funding is fairly balanced.

#### CHART 8

#### Funding Categories: Federal, State, Local, Tribal, Non-Governmental, Other

FUNDING CATEGORY	NUMBER OF FINANCING STRATEGIES
Federal funds (used as 100% of total funding)	3
Federal funds (used for over 50% of total funding)	10
State funds (used for over 50% of total funding)	7
Equal support from federal and state funds (50/50)	6

<sup>10</sup> AR, MO, NJ, OH, WI



We also learned from this question that while almost one-third (31%) of the financing strategies were using some local funds, the amount of local and other funds used in these strategies was small. When all funding categories except federal and state are combined, they make up 25% or less of the total funding in every financing strategy counted in this question.

## Funding Sources

Survey respondents were asked to select from a list of funding sources used in the financing strategies. These included general funding sources and specific federal and state sources.

**Charts 9A, 9B, and 9C** below identify the percentage of financing strategies that use each of the general federal (9A), state (9B), and local/other (9C) funding sources. For additional information about funding sources, see Chapter 3, which provides cross-state summaries of the funding sources for each of the 17 individual financing strategies that are described, and Chapter 4, where the state snapshots list the funding sources used by *each* state.

**CHART 9A**

### Federal Funding Sources Used By States to Finance Strategies (N=44 responses)

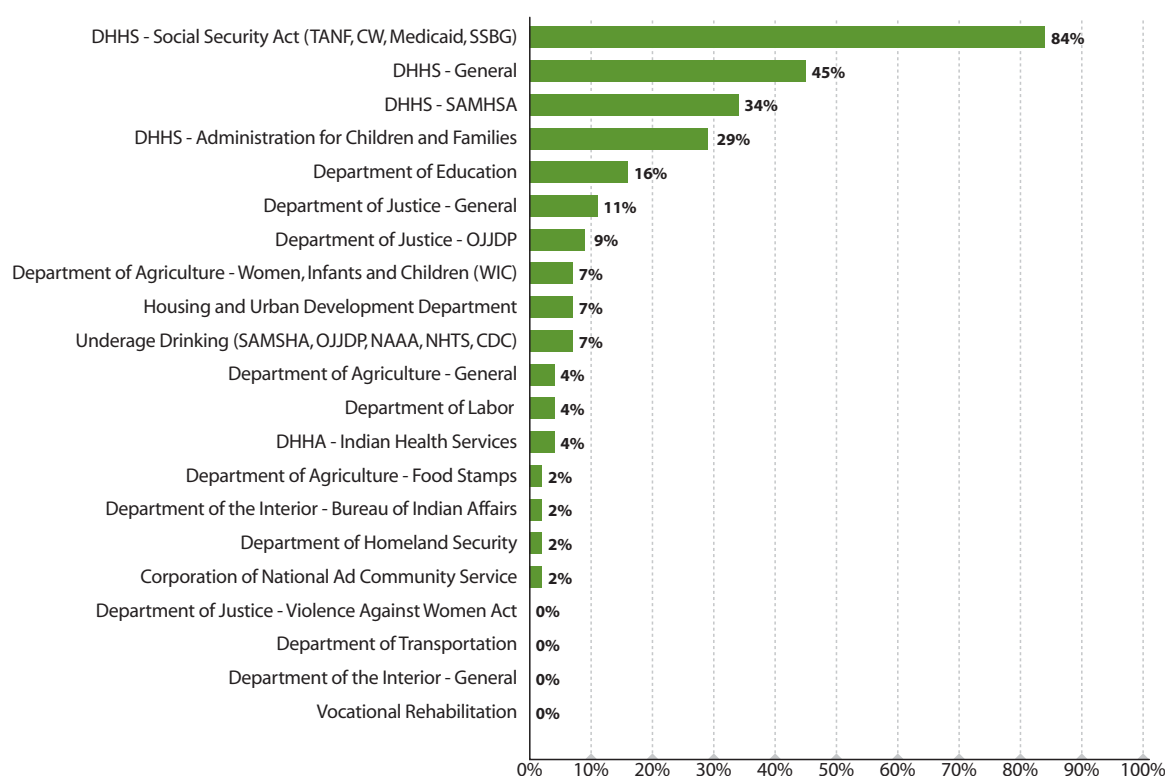




CHART 9B

State Funding Sources Used By States to Finance Strategies (N=44 responses)

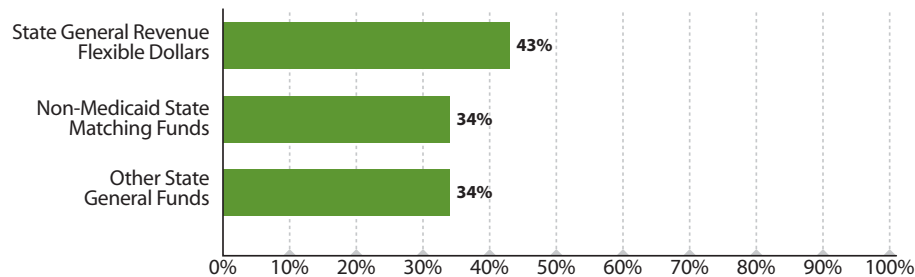
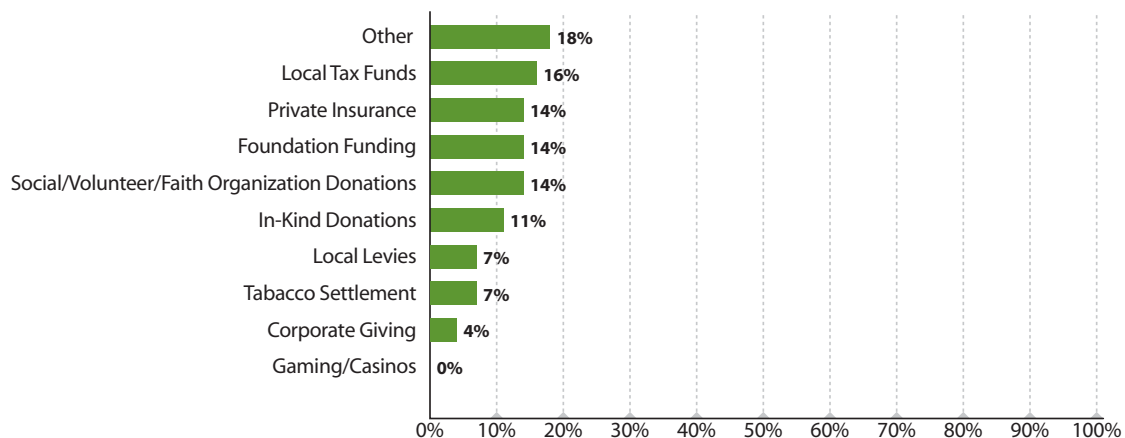


CHART 9C

Local, Tribal, Non-Governmental, Other Sources Used by States to Finance Strategies (N=44 responses)



The funding source used most frequently (in 84% of the strategies) is the Social Security Act (SSA) in the federal Department of Health and Human Services. The SSA includes funding for TANF, child welfare, Maternal and Child Health Block Grant, Medicaid, the Social Services Block Grant, and the State Children’s Health Insurance Program (SCHIP). **Chart 10** below demonstrates which funds *within* the Social Security Act are being used as resources for behavioral health services for children, youth and families involved with the child welfare system. The most frequently used categories within the SSA are:

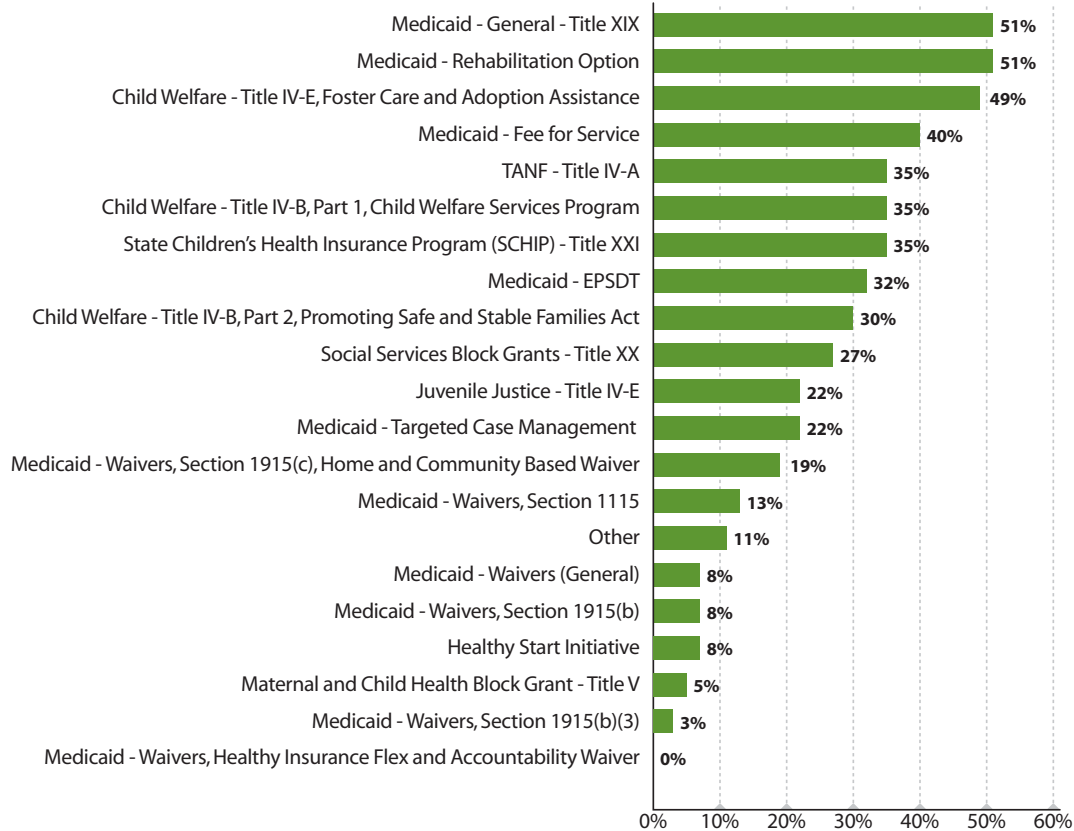
- Title XIX—Medicaid General (51%) and Medicaid—Rehabilitation Option (51%)
- Title IV-E—Foster Care and Adoption Assistance (49%).





CHART 10

### Social Security Administration (SSA) Funding Sources Used By States to Finance Strategies (N=37 responses)

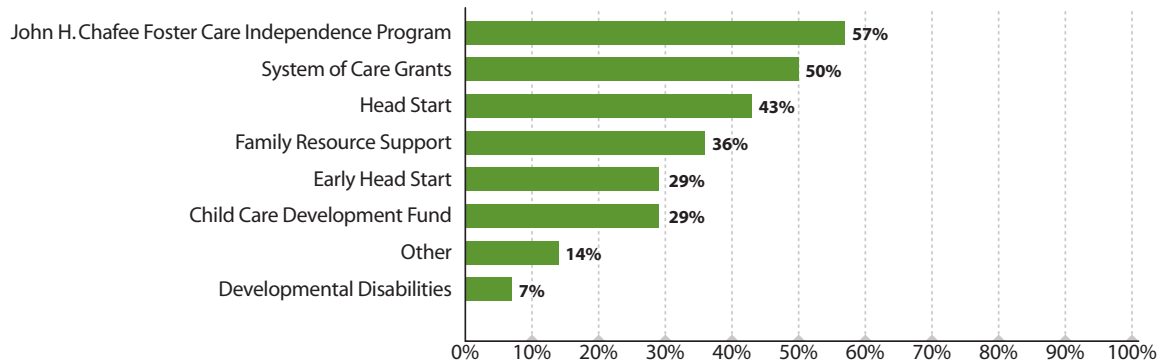


Funding from the federal Administration for Children and Families (ACF) was listed previously in Chart 9A as a funding source used in **29%** of the financing strategies. **Chart 11** below identifies which funds within ACF are being used as resources for behavioral health services for children, youth and families involved with the child welfare system. The most frequently used categories are the Chafee Foster Care Independence Program (**57%**) and the ACF System of Care Grant funds (**50%**).



CHART 11

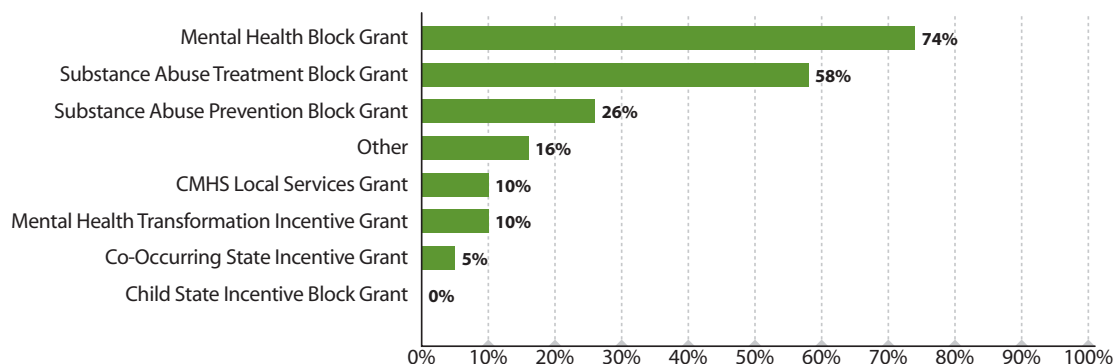
**ACF Funding Used By States to Finance Strategies** (N=14 responses)



Funding from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) was listed as a funding source by 34% of the financing strategies in Chart 9A above. **Chart 12** below demonstrates which SAMHSA funds are being used in the behavioral health financing strategies for children and families served by child welfare. The most frequently used categories are the Mental Health Block Grant (74%) and the Substance Abuse Treatment Block Grant (58%).

CHART 12

**SAMHSA Funding Used By States to Finance Strategies** (N=19 responses)





## Funding Arrangements

States were asked to describe any specific arrangements they made (i.e., what they had to do differently) in order to use certain funding sources. **Chart 13** summarizes these arrangements.

**CHART 13**

### Funding Arrangements (N=22 states<sup>A</sup>)

ARRANGEMENT	NUMBER OF STATES
Funds have been pooled, blended or braided (or are being considered)	12 states <sup>B</sup>
Used legislative mandates to achieve funding strategies	8 states <sup>C</sup>
Modified state Medicaid programs by: amending state plans; obtaining Medicaid waivers; or applying for a Community Alternatives to Psychiatric Residential Treatment Facilities Demonstration (PTRF)	8 states <sup>D</sup>
Case rates were established (or are being considered)	5 states <sup>E</sup>
Language in the state Title IV-E plan was amended	2 states <sup>F</sup>
Memoranda of Agreement were entered into	2 states <sup>G</sup>
Management of funds transferred from child welfare to mental health	1 state <sup>H</sup>
Management of funds transferred from Medicaid to child welfare	1 state <sup>I</sup>

<sup>A</sup> AK, AR, CT, FL, GA, HI, ID, IN, ME, MI, MO, NE, NH, NJ, NY, OH, PA, SC, VT, WV, WI, XX

<sup>B</sup> AR, CT, FL, HI, ID, IN, MI, MO, NH, NJ, PA, WI

<sup>C</sup> AK, CT, MO, ME, NH, OH, PA, WV

<sup>D</sup> AK, FL, MI, NH, NJ, OH, VT, WI

<sup>E</sup> AR, FL, IN, NE, NY

<sup>F</sup> HI, MO

<sup>G</sup> SC, XX

<sup>H</sup> GA

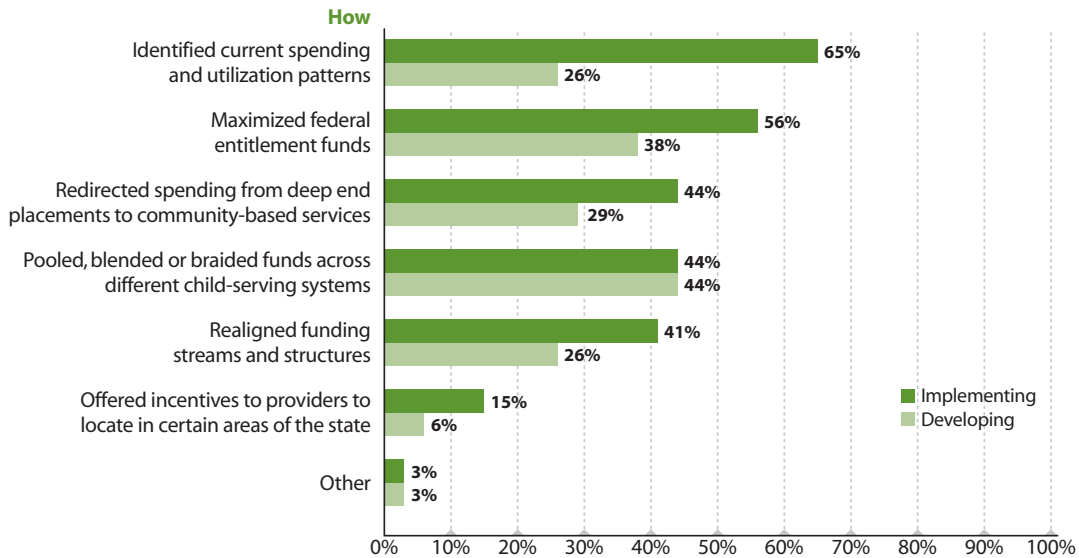
<sup>I</sup> ME

States were asked also to select from a choice of approaches to demonstrate how they implemented their financing strategies. **Chart 14** provides the responses to this question. The most frequently chosen approach was to identify current spending and utilization patterns (65%). The second most frequently used approach was to maximize federal entitlement funds (56%).



CHART 14

### How States Have Implemented or Plan to Implement Financing Strategies (N=34 responses)



## Impact on Data and Information Systems

Almost half of the 28 responding states (46%) updated their data systems in order to implement their financing strategies. A number of them described changes that would enable them to track and monitor process outcomes, services received, and child/family outcomes. (See *Accountability Section below.*) Only four states described changes to better track *fiscal* information:

- **Arizona** reprogrammed its Client Information System and claims/encounters data systems.
- **Florida** updated its Medicaid information system and its substance abuse and mental health information system electronic data warehouse to include new procedure codes that address recipient eligibility, claims reimbursement requirements, and recipient outcomes
- **New Jersey** revised its state budgeting system, the state Medicaid system, and the NJ Family Care information system and provided the regional Family Support Organizations with access to electronic records so they could type progress notes directly into individual electronic records
- **Allegheny County, Pennsylvania** designed and implemented a financial system that tracks expenditures at the individual consumer level.



## Accountability

States were asked to describe how their financing strategies demonstrated accountability. Many use existing standard accountability activities such as annual quality assurance reviews, prior authorization of services, utilization reviews, annual reports to funding sources, regular reports to court monitors, state and federal fiscal audits, contract monitoring, CMS audits, accreditation (e.g., Joint Commission on Accreditation of Healthcare Organizations—JCAHO), and grants management processes. Most states reported successful completion of these standard fiscal and program audits. Several states, however, indicated that one or more of the financing strategies they described are too new or are in the development stage, and thus have not yet proven their accountability<sup>11</sup>.

Ten (10) states<sup>12</sup> described five specific types of outcomes they track to determine whether goals are met:

- child/family outcomes
- service outcomes
- fiscal outcomes
- CFSR outcomes
- process outcomes.

**Child and family outcomes** are being tracked in Alaska, Delaware, Missouri, and Ohio:

- **Alaska** has established performance indicators that address specific child outcomes including reduction in the number of children placed out of state, reduced length of stay in residential care, decreased recidivism in residential care, and improved functioning.
- **Delaware** tracks the percentage of children with successful completion of home-based treatment, without deeper-end admissions.
- **Missouri** provides quarterly reports to legislators, the governor's office, and stakeholders on the number of children diverted from state custody and also tracks placement outcomes.
- **Ohio** has established project-specific reporting requirements such as the number of families receiving substance abuse services and the effectiveness of services.

**Service outcomes** are being tracked in Alaska, Missouri, New Jersey, and Ohio:

- **Alaska** assesses increased capacity to serve children in their communities.
- **Missouri** is tracking specific services and placement outcomes for youth referred through the Custody Diversion Protocol and Voluntary Placement Agreement.
- In **New Jersey**, the Family Support Organizations provide an accounting of services provided at the end of each contract year.
- As mentioned above, **Ohio** tracks the effectiveness of services.

<sup>11</sup> AR, GA, IN, MI, NH

<sup>12</sup> AK, AZ, CT, DE, MO, NH, NJ, ND, OH, WV



**Fiscal outcomes** are being tracked in Alaska, Arizona, Missouri, and New Jersey:

- **Alaska** tracks reduction in match funds being spent on out-of-state services and the increase in match funds spent on in-state services.
- In **Arizona**, regional behavioral health authorities (RBHAs) receive an increased capitation rate for children in foster care. At the end of each year the service encounters/values are compared against the pre-paid capitated funds, and profit/loss corridors are applied. Results drive actuarially-informed new capitation rates for the following year.
- **Missouri** tracks specific fiscal outcomes for youth referred through the Custody Diversion Protocol and Voluntary Placement Agreement.
- In **New Jersey**, the Family Support Organizations provide an annual accounting of funds expended.

### CFSR Outcomes

Two states (**NH and ND**) described how strengthening behavioral health services for children and families through their financing strategies had increased their ability to achieve the requirements of the *Child and Family Services Review (CFSR)* and their *Program Improvement Plan (PIP)*:

- **New Hampshire** mentioned the CFSR in three of its financing strategies.
  - An array of home and community-based services for families served by the child welfare and juvenile justice systems, developed and financed through the state's Medicaid Rehabilitation Option and intended to prevent removal of children from their homes, has allowed the state to perform well in the area of keeping children safe in their own homes.
  - Cost sharing with the counties (75% state DCYF and 25% county) for post-reunification behavioral health services resulted from a weaknesses identified by the CFSR. Implementation of these services has provided access and positive outcomes for children and families.
  - Cost sharing with Bureau of Developmental Services for placement of children with developmental needs was acknowledged as a strength in the CFSR review.
- The wraparound process established in North Dakota is part of its Program Improvement Plan. Performance is assessed via a random sampling of children and families involved in the wraparound process.

**Process outcomes** are being tracked in New Hampshire:

Through two information systems (child welfare and Medicaid) **New Hampshire** determines whether children in first time placements received mental health assessments within 45 days. Where the assessments are late or have not occurred, the state addresses this with the district office supervisors.

**Comprehensive approaches** are being used in Connecticut, Missouri and West Virginia to ensure accountability and evaluate the programs and services provided. These respondents did not, however, discuss evaluation of the financial strategies themselves:

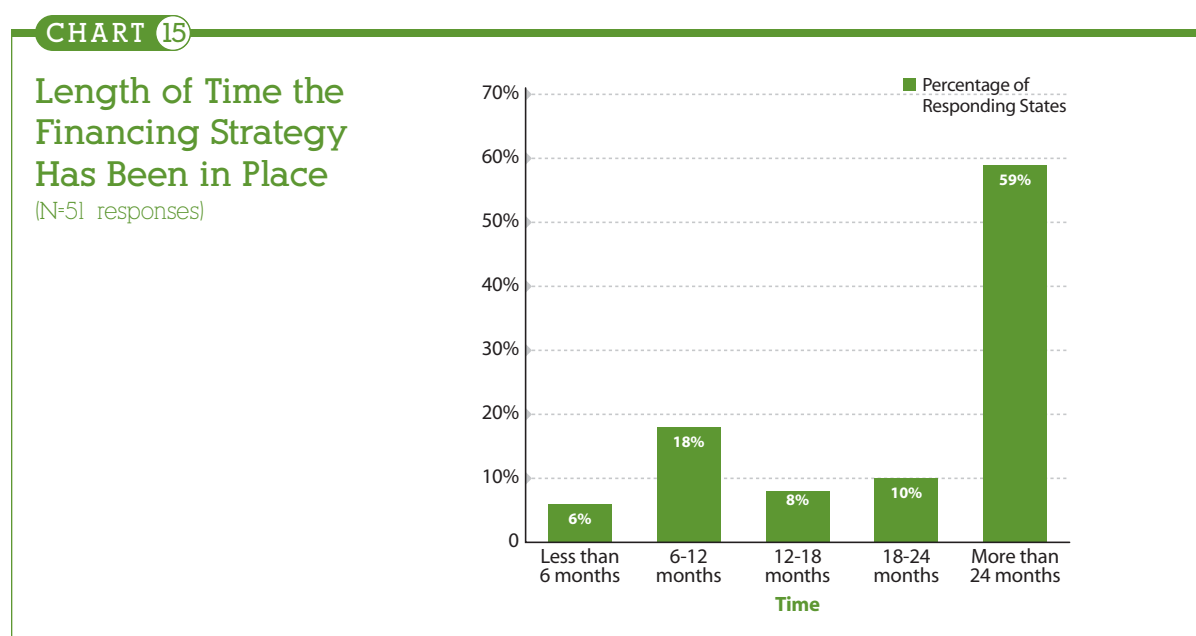
- **Connecticut** conducted an outside audit during its pre-implementation phase to evaluate its readiness to “go live” with its information technology system and clinical services. An independent implementation audit is forthcoming.



- In **Missouri**, legislation mandates that the Children's Services Commission submit an evaluation of the Comprehensive Children's Mental Health Services System by August 2007.
- **West Virginia** is contracting with Marshall University to expand its system of care evaluation from one site to a statewide process.

## Longevity of Financing Strategies and How They Have Been Institutionalized

As **Chart 15** demonstrates, the majority (59%) of the financing strategies had been in place more than 24 months when the survey data was collected in the fall of 2006. Only three of the 51 strategies had been in place for less than 6 months.



**Sixteen** (16) funding strategies were described by respondents as being institutionalized, i.e., the strategies will not disappear when the state administration changes. Half of the institutionalized strategies had been in place more than 24 months. **Six** (6) strategies were described as not yet being institutionalized. Three (3) of these six had been operational less than 12 months.

Reliance upon Medicaid was the most frequently mentioned method for institutionalizing a financing strategy. **Six** (6) states<sup>13</sup> described their Medicaid efforts:

- **Florida and New Jersey** had included the services in their state Medicaid plans.
- Through its state Medicaid managed care plan, **Arizona** made the enhanced capitation rate for foster children an element in the funding formula for managed care plans.

<sup>13</sup> AZ, FL, MI, NJ, NY, VT



- **Florida** required its managed care plans to offer three services (therapeutic foster care, crisis-therapeutic foster care, and comprehensive behavioral health assessments) to children and families in the child welfare system.
- The method **New York** used to establish a Medicaid per diem rate for children placed with private foster care agencies was approved by the federal Center for Medicare and Medicaid Services (CMS).
- **Vermont** used a 1915 C (home and community-based services) Medicaid waiver.
- **Michigan** used a 1915(c) Medicaid waiver to provide intensive community-based and in-home services for children with serious emotional disturbance (SED) whose conditions meet the requirements for placement in a state psychiatric hospital.

Survey respondents described additional approaches to institutionalizing specific financing strategies including the following:

- legislation/statutes
- state policy
- requirement of CFSR Program Improvement Plans
- memoranda of agreement
- court-ordered services
- changes in departmental structures
- institutionalizing cross-system governance structures
- solidifying partnerships with providers and advocacy groups
- multi-year grants that extend beyond the current administration
- incorporating changes into frontline practice
- collecting the data needed to verify need, utilization, and effectiveness
- requiring through standards
- establishing an ongoing funding source.

## Meeting Required Child Welfare Timelines

The child welfare system operates within specific federal (e.g., Adoption and Safe Families Act) and state timelines for providing services and for making decisions about child safety and permanency. These timelines impact front-line practice and require that services be provided in a timely manner. Respondents were asked to describe whether and how the financing strategies enabled states to meet these timelines.

**Sixteen**<sup>14</sup> of the 28 states affirmed that their financing strategies do enable them to meet child welfare timelines. **Eight**<sup>15</sup> indicated that children are seen more quickly by the behavioral health division for assessment and/or services. **Three**<sup>16</sup> states indicated that families can become involved earlier in more effective services, leading to earlier and improved permanency decisions, keeping more families intact, and achieving more timely reunification.

<sup>14</sup> AZ, AR, CT, DE, FL, HI, ID, IN, MO, NH, NY, ND, OH, PA, SC, WI

<sup>15</sup> AZ, AR, DE, FL, HI, NH, NY, SC

<sup>16</sup> ID, NH, WI



## CHAPTER THREE

# In-depth Descriptions of Individual Financing Strategies Across States



### **This chapter discusses 17 financing strategies**

described by responding states. For most strategies the section describes:

- WHAT the strategy achieves (e.g., the service, the program, the process)
- HOW the financing strategies were implemented
- FUNDING SOURCES that support the different strategies.

**A**fter the study team culled through narrative descriptions of the various financing strategies provided by the responding states, similar strategies from different states were combined and examined together. From this process, we identified 17 individual financing strategies. They are listed on the following page in **Chart 16** along with the number of states that provided narrative descriptions of each strategy. The two types of financing strategies most frequently described by the responding states were:

- financing for community-based and in-home behavioral health services and supports
- financing individualized, integrated and coordinated services within systems of care.



## CHART 16

### Individual Financing Strategies Described by States

FINANCING STRATEGY	NUMBER OF STATES <sup>A</sup>
1. Community-based and in-home behavioral health services and supports for children and families	16
2. Individualized, integrated, and coordinated services within systems of care	14
3. Managed care strategies	10
4. Behavioral health screenings and comprehensive assessments	8
5. Behavioral health services and supports for family members of children who are in custody	8
6. Child and family service planning teams	7
7. Financing family-run organizations to provide child/family services and supports	7
8. Training	5
9. Co-location of child welfare and mental health staff	5
10. Expansion of the pool of qualified behavioral health providers	4
11. Development, provision, and monitoring of evidence-based practices	3
12. Behavioral health services for youth who age out of the foster care system and into the adult system	3
13. Therapeutic foster care	3
14. Crisis services and mobile response	3
15. Reduction of out of state residential placements	2
16. Services for children with developmental disabilities	2
17. Strategies to avoid unnecessary custody relinquishment	1

<sup>A</sup>The numbers represent states that provided narrative descriptions of the strategies. Additional states may be developing or implementing some of these strategies; however, the strategies described in this chapter reflect only those states that provided narrative descriptions. See 1-17 for the identity of the states that provided descriptions of each strategy.

1. AK, AZ, AR, DE, ME, MI, NE, NH, NJ, ND, OH, PA, VT, WV, WI, XX
2. AK, AR, CT, FL, IN, ME, NE, NH, NJ, ND, OH, PA, WV, WI
3. AZ, CT, DE, FL, GA, HI, ME, NE, NH, WV
4. AR, DE, FL, HI, MO, NH, NJ, WV
5. AR, FL, ID, MI, NE, NH, OH, XX
6. IN, NE, NH, ND, OH, PA, WI
7. AZ, HI, NE, NH, NJ, ND, VT
8. HI, IN, MO, NH, NJ
9. FL, ID, NE, NH, SC
10. CT, NH, NJ, WV
11. MI, NE, NH
12. MI, NH, PA
13. FL, HI, NE
14. FL, NJ, PA
15. AK, WV
16. NH, PA
17. MO



## STRATEGY 1 Financing Community-Based and In-Home Behavioral Health Services and Supports for Children and Families

### What States Are Doing

Sixteen responding states provided narrative descriptions for financing community-based and in-home behavioral health services and supports. States are engaged in a variety of strategies such as:

1. offering extra supports to prevent placements
  2. providing a comprehensive array of community-based services
  3. prioritizing services for children and families involved with the child welfare system
  4. increasing payments to providers.
1. Seven<sup>17</sup> of the 16 state responses described using community-based services to *support children in their current placements and to prevent removal from their homes, placement in 24-hour care, and/or placement in a treatment facility.*
    - In one state<sup>18</sup>, teams have access to a flexible fund to provide the resources needed to maintain children in their homes and communities.
    - Two states, Delaware and New Jersey, offer 24/7 crisis intervention. For example, New Jersey, which expanded its Medicaid program to include the Rehabilitation Services Option, offers mobile crisis response and stabilization services, available for 72 hours to assist with escalating behaviors. When a child is stabilized, community-based supports are available for an additional eight weeks.
    - Nebraska instituted a case rate methodology to provide intensive care coordination (wraparound model) to children in state custody who are at risk of being placed out-of-state or in intensive behavioral health treatment facilities.
  2. Four<sup>19</sup> states noted that they offered a *comprehensive array/continuum of services*, and five<sup>20</sup> described the specific types of community-based services that they offer, including:
    - 24/7 crisis intervention (as mentioned above) (DE, NJ)
    - intensive home-based outpatient services (4-5 contacts/week) (DE, WV)
    - office-based treatment combined with in-home support provided by behavioral health aides (DE)
    - services in more “normalized” setting, outside of the office, at times convenient for the youth and family (NJ)
    - targeted case management for all children in the child welfare system, funded with a combination of Medicaid, TANF, state general funds, and county funding (ND)

<sup>17</sup> DE, NE, PA, NH, NJ, VT, XX

<sup>18</sup> Unidentifiable state

<sup>19</sup> WV, MI, NH, VT

<sup>20</sup> DE, NJ, ND, OH, WV



- evidence based practices (ND)
- family preservation services (ND)
- parent to parent program (ND)
- substance abuse services including, education, parent training, family skills training, perinatal care, vocational and employment counseling and more (OH).

In **Arizona**, a significantly *higher capitation rate for children in state custody* has quickly and significantly supported behavioral health service capacity development, leading to more timely, sufficient, and effective service provision for these children. Thorough, immediate behavioral health assessment for children in state custody is now almost universal.

3. **Ohio, West Virginia and New Hampshire** have made *children and families connected to the child welfare system a priority population* for services. More specifically, in **Ohio**, HB 484 charged the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) in cooperation with the Department of Job and Family Services to develop a statewide plan to prioritize substance abuse services for families involved with the child welfare system. The Women's Network offers prevention, outpatient and residential programming. ODADAS requires programs in the Women's Network to provide services to the children, as well as the mothers.

Using federal funds from its system of care grant, **West Virginia** established an innovative continuum of community-based interventions, designed to help families and children involved with Child Protective Services and/or Youth Services to achieve safety, permanency and well-being. These services (called socially necessary services) include intensive in-home services and respite, among others.

4. Only **New Jersey** described financing strategies for *increasing payments to providers*. The state has implemented a market-based reimbursement methodology for its new community-based services. The fee schedule established by the state (and approved for Medicaid reimbursement) reflects the clinical credentials and experience providers should have, as well as a clinical model of practice and supervision that incorporates time for supervision and administrative tasks. This reimbursement methodology and fee schedule allow providers, who in the past could not have participated in the system of care due to an inadequate reimbursement rate, to provide services within the system of care.

### How States Are Implementing the Financing Strategies

**West Virginia and one other state**<sup>21</sup> are using flexible funds; **Nebraska** is implementing case rates; **New Jersey** is increasing provider fees to allow time for fuller participation in systems of care and also has appropriated new state funds; **Vermont** is implementing a Medicaid home and community-based waiver; and **Arizona** implemented a risk-adjusted capitation rate for Medicaid-funded behavioral health services for all children in state custody effective July 2004. In all regions of Arizona, the resultant capitation rate has been at least 20 times the rate for all other Medicaid-eligible children. In **West Virginia**, although payment for services may come from multiple individuals or agencies, the process appears seamless to families.

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<sup>21</sup> Unidentifiable state



## Funding Sources

Among the 16 responding states that described funding for community-based behavioral health services, almost all identified the use of state funds. Five<sup>22</sup> of these states described using multiple funding sources (federal, state, local, foundation funds and donations), and five<sup>23</sup> were using a local funding source.

## STRATEGY 2 Financing Individualized, Integrated and Coordinated Services within Systems of Care

### What States Are Doing

Fourteen responding states provided narrative descriptions for financing individualized, integrated and coordinated services within systems of care. States are engaged in a variety of strategies such as:

1. expanding or enhancing systems of care
2. creating or utilizing administrative services organizations
3. using the wraparound process as their service delivery model
4. providing individualized services for children with developmental delays.

#### 1. Systems of Care

Six<sup>24</sup> states described strategies for developing and/or implementing *systems of care* statewide:

- **Alaska** and **Arkansas** are in the development stage.
- **Indiana**, **Pennsylvania**, **West Virginia**, and **New Jersey** are expanding or enhancing current system of care efforts.

Since 1999, **Indiana** has been working to establish system of care communities statewide. They have established and sustained systems of care in 61 of 92 counties. Indiana is trying to achieve integrated services for youth and their families, under *one care plan* that addresses all identified needs through a wraparound process. The target population is all youth with complex needs, involved with two or more organizations. Generally, the majority of children served are known to the child welfare system.

**Pennsylvania** described its efforts in **Alleghany County** to integrate the family group decision making model used by the child welfare division with the system of care model established with grant funds from SAMHSA. This effort at integration focuses on children ages 6-12 who are in the child welfare system and need behavioral health services.

**West Virginia** hopes to develop a comprehensive community-based service system approach to create the best possible access to mental health care for children and families.

<sup>22</sup> AK, ND, OH, PA, WV

<sup>23</sup> MI, ND, OH, PA, WI

<sup>24</sup> AK, AR, IN, NJ, PA, WV



## 2. Administrative Services Organizations

Two<sup>25</sup> states are moving to an *Administrative Services Organization* (ASO) model:

- **Connecticut** has established an ASO to manage the Connecticut Behavioral Health Partnership. The ASO will hire clinical staff to serve as intensive care managers and provide special attention for children and families with complex needs.
- **New Hampshire** is developing a strategy to integrate children's services, across systems, using an ASO model. The goal is to provide services based on child and family need, not on categorical determination. The target population is children with "high needs" and their families.

## 3. Wraparound Process

Five<sup>26</sup> states described the *wraparound process* as their service delivery model:

- **Florida** described how it provides flexible funds to each of the 14 mental health districts in the state to support individualized wrap-around services for children in the child welfare system.
- **Indiana's** individualized care plan is developed through a wraparound process.
- **Nebraska's** Integrated Care Coordination units, which serve children in state custody who are at risk of being placed in higher level of care, are based on the wraparound model.
- **North Dakota** is providing targeted case management for all children in the child welfare system by using multiple funding streams.
- **Wisconsin's** Integrated Service Projects, which are based on the wraparound model and originally served children with serious emotional disabilities, now serve a broader population of children including those with complex needs who are involved in multiple systems, including child welfare. In 2004, Wisconsin established Comprehensive Community Services (CCS) programs, certified by the Bureau of Quality Assurance, to use a wraparound model in providing services for children, adults, and older adults.

## 4. Individualized Services for Children with Developmental Delays

The New Hampshire Division for Children, Youth and Families (DCYF) and the Division of Juvenile Justice Services (DJJS) have a formal agreement with the Bureau of Developmental Services that allows them to provide *individualized services* based on each child's strengths and needs. These agencies cost-share placements of *children diagnosed with developmental delays* who are involved with DCYF or DJJS.

## How States Are Implementing Financing Strategies

More than half of the 14 financing strategies described in this section are using four or more of the following six approaches listed in the survey:

- identifying current spending and utilization patterns
- realigning funding streams and structures
- maximizing federal entitlement funds

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<sup>25</sup> CT, NH

<sup>26</sup> FL, IN, NE, ND, WI



- redirecting spending from “deep-end” placements to community-based services
- pooling, blending, or braiding funds across different child-serving systems
- offering incentives to providers to locate in certain areas of the state.

In addition to these six approaches, states provided details about approaches used to enable them to implement financing strategies for building *systems of care* and implementing the *wraparound process*.

### Systems of Care

- The **Indiana** Division of Mental Health and Addiction awarded \$100,000 as *seed money* for two years to the majority of communities that were implementing *systems of care*. The local Community Mental Health Center (CMHC) in each site serves as the fiscal agency. The CMHC is able to bill Medicaid for some of the wraparound activities. The CMHC provides administrative support and the Medicaid match. The Department of Child Services (child welfare) funded one system of care site, and two sites were funded by a private foundation. Seed funds are not used to provide services. Generally, each involved agency is responsible for providing the services in a child/family care plan through its usual funding mechanisms.
- **Pennsylvania** used *grant funding* from SAMHSA to develop its system and services. This system of care then served as model to extend services. The *graduated* SAMHSA site provided a model for serving 6-14 year old children/youth, and the *current* SAMHSA funded system of care provides a model for youth in transition to adulthood.
- **West Virginia** commissioned studies of children placed out-of-home and out-of-state. Recommendations from these studies supported expansion of the system of care in WV and the development of “social necessity services” (a continuum of interventions for children/families involved with Child Protective Services and/or Youth Services). The system of care in West Virginia is, among other things, “about changing how services are paid for”. While multiple agencies may provide the funds needed for services, the process appears seamless to families and children.

### Wraparound Process

- The **Florida** legislature appropriates funding for flexible services to the State Mental Health Authority which then allocates the funds to each of the state 14 District Substance Abuse and Mental Health Programs. Each district office identifies a contractor to dispense these funds to meet the individualized needs of the children. These contractors could be the privatized child welfare provider for the region, a mental health targeted case management provider who works with children in child welfare, or others. At the local level, these funds can be braided with other funding sources such as Medicaid. The intent is to provide services not covered by other funding sources but that are necessary to care for each child’s social and emotional well-being.
- Regional Behavioral Health Authorities and the **Nebraska** Department Health and Human Services, Office of Protection and Safety (child welfare and juvenile justice) have partnered to provide intensive care management based on the wraparound process. A *case rate methodology*, created by blending funding sources, serves as a primary funding strategy to support and sustain an intensive care management model. Use of the case rate provides the flexibility to offer individualized care and develop new services. In Central Nebraska where the case rate





methodology originated, cost savings were reinvested in the child-serving system by providing technical assistance to replicate the program in other Regions/Service Areas of the state and by expanding the population of children and families served. This case rate methodology is now used statewide in Nebraska. Medicaid funds are not included in the case rate. The Nebraska DHHS/DBHS funds the public, *non-Medicaid* state mental health system. Regional BH Authorities do not receive or manage Medicaid funds. Behavioral health services reimbursed by Medicaid are authorized by Nebraska's statewide managed care administrative services organization (ASO). Reimbursements to providers are made on a fee for services basis.<sup>27</sup>

- In **Wisconsin**, when the wraparound process was expanded to include children, adults, and older adults, a *certification process* was established for community-based organizations to become Comprehensive Community Services (CCS) programs certified to offer wraparound funded by Medicaid. Counties are reimbursed the federal share of Medicaid for the CCS programs.

## Funding Sources

Among the 14 descriptions of strategies for funding individualized services within systems of care, 12 identified their funding sources. Eleven states use federal funding sources, 10 described using multiple funding sources, 11 are using state funds, and only three are using local funds.

## STRATEGY 3 Financing Managed Care Strategies

### What States Are Doing

Although the survey did not list “managed care” as a funding strategy choice, **ten** states<sup>28</sup> described using managed care structures or managed care technology. Responding states described the following strategies:

1. administrative services organizations
2. case or capitation rates
3. utilization management
4. public children's mental health system as an accredited behavioral health organization (BHO).

### How States Are Using Managed Care Strategies

#### 1. Administrative Services Organizations (ASO)

Four states are currently using or planning to use administrative services organizations (ASO):

- In **Connecticut**, the Department for Children and Families (DCF) and the Department of Social Services (DSS) have procured the services of an ASO to provide clinical oversight, utilization management, quality assurance and network development activities for

<sup>27</sup> From an unpublished May 2006 site visit report about Central Nebraska. This site visit was conducted as part of a national study of *Financing Structures and Strategies to Support Effective Systems of Care*, conducted by the University of South Florida, Georgetown University, Human Service Collaborative, and Family Support Systems, Inc. Study publications are available at <http://rtckids.fmhi.usf.edu/study03.cfm>

<sup>28</sup> AZ, CT, DE, FL, GA, HI, ME, NE, NH, WV





children who rely on publicly funded behavioral health services. All children who are eligible for Medicaid and SCHIP will be served by the ASO, as well as children involved with DCF who are *not* Medicaid eligible and who demonstrate significant behavioral health challenges.

- **Maine** is planning to contract with an ASO in the coming months to conduct utilization review and prior authorization of behavioral health services.
- **New Hampshire** is developing a strategy to integrate children's behavioral health services through an ASO. The goal is to deliver services for children with intensive needs and their families based upon individual need, rather than categorical determination.
- **West Virginia**, which has made a distinction between “socially necessary services” and “medically necessary services”, has engaged an ASO to authorize socially necessary services. These are interventions necessary to improve relationships and social functioning to preserve families, maintain children in their communities, and achieve safety, permanency and well-being.

## 2. Capitation and Case Rates

Three states, **Arizona**, **Florida** and **Nebraska**, are using capitation or case rates:

- **Arizona** uses a statewide managed care system for publicly funded behavioral health services. Under this system, the Arizona Department of Health Services contracts with six Regional Behavioral Health Authorities (RBHA) and two Tribal Behavioral Health Authorities. The RBHAs receive a monthly *capitation rate* for children eligible for Medicaid and State Children's Health Insurance (S-CHIP). In July 2004, Arizona implemented a risk-adjusted capitation rate for all children in state custody that is nearly 20 times higher than the rate for all other eligible children. In Maricopa County, the capitation rate for children in custody is \$600 per member per month (pm/pm); for other children, the capitation rate is \$35 pm/pm. The rate for children in state custody was determined by projecting the number of children in child welfare expected to use therapeutic foster care, the number expected to use counseling services, and the number expected to use residential treatment and group home care.<sup>29</sup>
- At the time of the survey, Florida was developing a capitated/prepaid system for medically necessary mental health treatment services for children involved with the child welfare system. The per member per month capitation rates were based on historical utilization of mental health services in the Medicaid state plan. Only residential treatment level services are not included in the mandatory services package. The non-Medicaid funds in the capitation rate are used as state match to draw down the federal Medicaid dollars. The capitation rates were reviewed by a certified actuary to ensure that they were fiscally sound. Through a competitive procurement process, the state planned to select a single managed care organization (MCO) that will be at “full-risk”

<sup>29</sup> Information provided in the AZ and NE survey responses about this strategy was supplemented with information published in another national financing study report—Stroul, B., Pires, S., Armstrong, M., McCarthy, J., Pizzigati, K., and Wood, G., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan (RTC study3: Financing structures and strategies to support effective systems of care, FMHI pub.#235-02)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health. Available at <http://rtckids.fmhi.usf.edu/study03.cfm>.



for covering all the identified medically necessary services for children involved with the child welfare system. The MCO must include at least one “lead” privatized child welfare agency and is required to spend no less than 80% of its combined capitation payments directly on services. This is monitored through review of encounter data. Mental health services included in the state’s Medicaid Plan are to be covered by the capitated rate. Individual providers are reimbursed on a FFS basis.

- **Nebraska** uses a *case rate* methodology as the financing structure to fund coordinated, individualized care for youth in state custody who have intensive behavioral health needs. This effort, called an Integrated Care Coordination Unit (ICCU), began in Central Nebraska in 2000 as a partnership between Region 3 Behavioral Health Services, the Nebraska Department of Health and Human Services (including the Central Service Area, Office of Protection and Safety and the Division of Behavioral Health Services), and Families CARE (a family support and advocacy organization in Central Nebraska).

To establish the case rate amount in Central Nebraska, in 2000, the cost of care for 201 youth was analyzed. This included all the child *placement* costs for each of the 201 children over a 6-month period. It did not include treatment services that were funded by Medicaid, nor did it include personnel and program operations costs to serve these youth. These treatment services remained available to the youth as needed, outside of the case rate. NE also was concerned about potential long term costs and studied the experience of other systems (e.g., Wraparound Milwaukee) to estimate the potential shift in the use of residential services. They projected living arrangements for the 201 youth and projected per child/per month costs for both residential and community support services. In FY05 the per child/per month case rate in Central Nebraska was \$2,136.53. Nebraska has expanded these efforts, and currently all regions in the state have ICCUs funded by case rates.<sup>30</sup>

### 3. Utilization Management

Hawaii, Georgia and Nebraska have instituted utilization management strategies. For example, **Georgia** is in the process of establishing a utilization management system to review the length of stay (LOS) for youth placed in residential care (75-80% of these youth are in state DFCS custody). The LOS will be matched with timeframes determined as best practice for the level of care each youth is receiving. The state hopes to avoid inappropriate extended lengths of stay in residential placement. Georgia is transferring responsibility for this utilization management from the Division of Family and Children’s Services to the Division of Mental Health, Developmental Disabilities and Addictive Diseases. This includes the transfer of funds between the divisions. The state is currently negotiating with the federal Center for Medicare and Medicaid Services (CMS) for approval of the state’s plan to make these changes.

<sup>30</sup> Information provided in the AZ and NE survey responses about this strategy was supplemented with information published in another national financing study report—Stroul, B., Pires, S., Armstrong, M., McCarthy, J., Pizzigati, K., and Wood, G., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan (RTC study3: Financing structures and strategies to support effective systems of care, FMHI pub.#235-02)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children’s Mental Health. Available at <http://rtckids.fmhi.usf.edu/study03.cfm>.



Hawaii's children's mental health system provides the child welfare system with annual reports on the utilization of mental health services by children in the child welfare system. Utilization monitoring is done every quarter.

4. **Public Children's Mental Health System as Accredited Behavioral Health Organization**  
In Delaware the Division of Child Mental Health Services (DCMHS), within the Department of Services for Children, Youth and Families, provides a broad array of community-based services to children with Medicaid and those without insurance, and their families. DCMHS is an accredited managed behavioral health organization.

## Funding Sources

All eight states using managed care strategies use both federal and state funding. None of them identified local or foundation funding as part of their managed care plans.

## STRATEGY 4 Financing Behavioral Health Screenings and Comprehensive Assessments

### What States Are Doing

Eight responding states provided narrative descriptions for financing behavioral health screening and assessments. Screening and assessing the mental health needs of children in the child welfare system is frequently a two-step process. An initial and immediate mental health screen is used to identify problems that require immediate attention and/or further evaluation. A comprehensive mental health assessment is more extensive and addresses a child's mental/emotional and developmental strengths and needs. It focuses on the child, the family, and the environment in which they live. The descriptions provided by survey respondents primarily did not describe initial screenings, but focused on the more comprehensive assessment process.

Two types of behavioral health assessments were described:

1. Assessment of Children Entering Foster Care<sup>31</sup>
  2. Assessment of Children to Determine Eligibility for and/or the Appropriateness of a Specific Level or Type of Service<sup>32</sup>
1. **Assessment of Children Who Are Entering Foster Care**
    - **Arkansas**—The University of Arkansas for Medical Sciences (UAMS) Department of Pediatrics and the state Division of Children and Family Services (DCFS) have partnered to provide multidisciplinary, comprehensive health evaluations for children entering foster care. These evaluations include a behavioral/emotional assessment, occur within 60 days of placement, and are provided at 16 sites around the state. Health Service Workers housed in county DCFS offices are responsible for obtaining recommended

<sup>31</sup> AR, DE, FL, NH

<sup>32</sup> HI, MO, NJ, WV



follow-up services. Arkansas also ensures that children or parents who are involved in founded maltreatment or foster care receive psychiatric evaluations or assessments, even if they are not Medicaid eligible.

- **Delaware**—In FY 06, Delaware’s Department of Services for Children, Youth and Families, Division of Child Mental Health Services began conducting home-based behavioral health assessments for children entering foster care. These assessments are designed to identify youth with mental health and/or substance abuse issues who may require treatment and to link them and their families to a behavioral health care provider.
- **Florida**—Florida provides a comprehensive behavioral health assessment for every Medicaid eligible child who is removed from home by child protective services and placed in shelter status. The completed assessment allows social workers to integrate each child and family’s behavioral health needs into the case plan.
- **New Hampshire**—The Foster Care Mental Health Program, a collaborative effort of 10 regional community mental health centers and the state Division for Children Youth and Families, ensures that children in first time placement have a behavioral health assessment within 30 days of placement.

## 2. Assessment of Children to Determine Eligibility and/or Appropriateness of a Level or Type of Care

- **Hawaii**—The Child and Adolescent Mental Health Division transfers federal mental health block grant funds to Child Welfare Services to procure psychological assessment services for children in the child welfare system. The children’s mental health system requires an assessment and a CAFAS<sup>33</sup> score to determine a child’s eligibility for services from the comprehensive community-based system of care. Providing funds to Child Welfare Services enables them to more quickly evaluate children for eligibility and to provide this information to the mental health division.
- **Missouri**—A custody diversion protocol was developed in 2003 by staff from the Children’s Division (state child welfare agency), the Department of Mental Health (DMH), the juvenile court, Citizen’s for Missouri’s Children, and parents. The protocol was implemented statewide in 2005. As part of the custody diversion protocol, 696 children have been assessed for mental health needs, and most (93%) have been diverted from inappropriate transfer of custody to the Children’s Division. Of those who have been diverted, 40% have been supported with community-based services, and 60% have required out-of-home services. Typically, placements for out-of-home treatment have been made through a Voluntary Placement Agreement that allows parents to retain legal custody of their children, or by using DMH funds or other funding sources such as adoption subsidies.<sup>34</sup>
- **New Jersey**—New Jersey designed its behavioral health service system to allow for a written assessment of need within two weeks of the referral to a provider, and immediate access to services thereafter. For children who are in crisis, a mobile response agency is available 24/7 to conduct an assessment. If indicated, services are provided 24/7 for

<sup>33</sup> Child and Adolescent Functional Assessment Scale

<sup>34</sup> The Missouri figures represent a March 2008 update by the state.



72 hours to address the escalating behaviors that may jeopardize the youth's current living situation. Community-based behavioral supports are available for an additional eight weeks if needed.

- **West Virginia**—The Bureau for Children and Families is developing a standardized tool and process for conducting comprehensive assessments for all youth at risk of, or returning from, out-of-state placements.

### How States Are Implementing Financing Strategies

Several states have divided the responsibilities for providing behavioral health assessments by using Medicaid funds to cover the clinical costs and state general funds to pay the administrative and management costs of assessment programs:

- **Arkansas**—The comprehensive health evaluations for children in foster care are funded through Medicaid as well as through a contract between DCFS and UAMS utilizing state general funds. The contract covers administrative costs of the approach and is renewed yearly. The contract is sufficiently funded, which enables the program to run well. It has been increased when needed to make improvements in the program. Salaries for clinical staff are not part of the contract between UAMS and DCFS. The UAMS Department of Pediatrics pays the clinical salaries, and relies upon Medicaid reimbursement to cover these costs. An enhanced Medicaid rate was obtained for the assessments in order to make the program cost-effective for UAMS. In addition, DCFS covers the costs for “no shows” and for children not eligible for Medicaid.<sup>35</sup>
- **Florida**—Comprehensive behavioral health assessments are paid for through Medicaid. Providers may bill up to 20 hours per assessment. This enables them to interview the children, their family members, other important players in their lives, as well as to review all available written information about the child's emotional health. State general revenue from the State Mental Health Authority is used as match to draw down Medicaid funding for the assessments. These general revenue funds are appropriated by the State Legislature to the State Mental Health Authority for transfer to the State Medicaid Authority.
- **Missouri**—Missouri hired a consultant to analyze state data and identify service patterns, demographic characteristics and costs for children who entered state custody (and those already in custody) solely to access mental health services. From this analysis the state identified multiple potential funding strategies—creation of the Voluntary Placement Agreement (VPA), application for 1915c Medicaid waiver (home and community-based services), and ultimately an 1115 waiver (research and demonstration projects).<sup>36</sup> When children do enter a placement under a VPA, funding is provided primarily by child welfare, and services are provided by mental health. Missouri has also assessed the children already in custody solely for the purpose of accessing needed mental health services (where there was no parental abuse or neglect). For a number of these children, custody has been restored to the parents. Child welfare continues to fund any treatment the child was receiving.

<sup>35</sup> Information provided in the Arkansas survey response was supplemented with information learned in an earlier study and site visit in Arkansas. Findings from this earlier study, *Meeting the Health Care Needs of Children in the Foster Care System*, were published by the Georgetown University Center for Child and Human Development in 2002 and are available at [http://gucchd.georgetown.edu/programs/meeting\\_health\\_needs/index.html](http://gucchd.georgetown.edu/programs/meeting_health_needs/index.html).

<sup>36</sup> Missouri later decided not to apply for the 1915c Medicaid waiver.



- **New Jersey**—To develop its service system, conduct assessments, and offer its 24/7 mobile response services and supports, New Jersey engaged in multiple funding strategies. It amended its Title XIX (Medicaid) and Title XXI (State Children’s Health Insurance) plans, appropriated new state dollars, and pooled small state funded local grants that were providing similar services. These funds were used to claim federal funding for these services.

## Funding Sources

Among the eight states that described financing strategies for behavioral health screening and assessment, seven listed funding sources. All seven use both federal and state funding. None identified the use of local funds, and Missouri mentioned private insurance. Among the federal funds being used, Florida and Hawaii listed Title IV-E Foster Care and Adoption Assistance funds. New Jersey and West Virginia described multiple Medicaid funding sources, including EPSDT, Medicaid Rehabilitation Option services, and targeted case management.

## STRATEGY 5 Financing Behavioral Health Services and Supports for Family Members of Children Who Are in Custody

### What States Are Doing

Eight states<sup>37</sup> provided written descriptions of how they are funding behavioral health services for family members of children who are in custody. Through another national study, we obtained additional information about one of these eight states (Nebraska), plus two additional states (Arizona and Hawaii).<sup>38</sup> The information below reflects learnings from these ten states.

States described several types of services provided for families who are involved with child protective services and/or whose children are in shelter care or in state custody. These included intensive family services; psychiatric evaluations; family therapy; substance abuse services, supports and education; parent mentors; care coordination; respite care; peer support; transportation; and interpretation services.

- **Arkansas** ensures services for parents who are not eligible for Medicaid by offering intensive family services, counseling, and psychiatric evaluation.
- **Florida’s** state legislature provided funding for 70 Family Intervention Specialists (FIS) who are co-located with child protective services staff across the state. Each FIS screens for parental substance abuse treatment needs, links caregivers to services, provides case management, and coordinates with the child welfare workers and the dependency drug

<sup>37</sup> AR, FL, ID, MI, NE, NH, OH, XX

<sup>38</sup> AZ, HI, NE—survey information on this strategy about these 3 states was supplemented with information published in another national financing study report—Stroul, B., Pires, S., Armstrong, M., McCarthy, J., Pizzigati, K., and Wood, G., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan (RTC study3: Financing structures and strategies to support effective systems of care, FMHI pub.#235-02)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children’s Mental Health. Available at <http://rtckids.fmhi.usf.edu/study03.cfm>.





court. The purpose of these services for caregivers is to preserve a child's placement at home, when possible, and to reduce the length of stay if they do enter the foster care system. The FIS program provides earlier identification of substance abuse treatment needs and improves outcomes for caregivers.

- In **Idaho** and **Ohio**, waiting lists for admission to formal substance abuse treatment services may be 3 weeks to 3 months long. The **Idaho** Department of Health and Welfare, therefore, provides pre-treatment support and education for parents involved with child protection and those whose children have entered shelter care. By doing this, the Department hopes to engage parents/caregivers during this waiting time and increase the number who enroll and successfully complete formal substance abuse treatment programs when space becomes available. In **Ohio**, legislation was passed mandating that alcohol and addiction services boards prioritize the provision of alcohol and other drug services for families involved in the child welfare system.
- **One state**<sup>39</sup> makes flexible funding available through teams to assist families in maintaining their children with serious emotional disturbance at home, rather than being placed inappropriately in 24-hour care.
- **Nebraska's** case rate system also allows care coordinators in the Integrated Care Coordination Units and the Professional Partners Program to have access to flexible funds that can be used to meet individualized needs of children and families and to fund services/supports that are not reimbursable with more traditional funding streams. In addition, there is no charge to families for the care coordination they receive when they are enrolled in Professional Partners Program or the Integrated Care Coordination program.
- In **New Hampshire**, the Division for Children, Youth and Families and the Division for Juvenile Justice Services finance behavioral health services and supports for family members of children who are in custody, especially if the family members are not eligible for Medicaid.
- In **Arizona**, the capitation rate received by Regional Behavioral Health Authorities (RBHAs) allows them to use Medicaid to pay for family education and peer support, respite, behavioral management skills training and other supports to families if these supports are geared toward improving outcomes for the identified child. Medicaid also can be used to pay for transportation and interpretation services for families. Non-Medicaid allowable services can be paid for with the non-Medicaid dollars that are included in the capitation rate. Arizona also defines "family" broadly.

### How States Are Implementing Financing Strategies and Funding Sources

Following are strategies the states use to finance services for family members:

- use of case or capitation rates that allow for more flexibility in service delivery and in who receives services
- creation of flexible funding accounts
- using TANF (emergency assistance) funds, state funds, and local funds to cover the behavioral health service costs for family members who are not eligible for Medicaid
- funding by the state legislature for specific family intervention specialists.

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<sup>39</sup> Unidentifiable state



**Hawaii** and **Nebraska** stressed the importance of the role of social workers and care coordinators in assisting parents/caregivers to access mental health and substance abuse services in the adult public mental health system.

At the state level, **Nebraska** has set aside approximately \$300,000 (mainly from the Division of Protection and Safety, with some contribution from the Division of Behavioral Health Services) to purchase services for family members whose children are served by the Integrated Care Coordination Units across the state.

**Idaho** is engaged in numerous strategies and uses multiple funding sources for the Idaho Pretreatment Education and Support Program described above. The state received a subgrant from the Rocky Mountain Quality Improvement Center (RMQIC), funded by the federal Administration for Children and Families, to fund the pretreatment activities, transportation, child care, training and program evaluation. The state uses state and federal substance abuse funding to contract with substance abuse liaisons (SALs) who are co-located in child welfare offices. The SALs conduct substance abuse assessments necessary for the authorization of treatment services and facilitate referrals for substance abuse service/supports that are paid for with state and federal substance abuse funds. Costs for the contract services of the SALs were based on hourly rates and charged to various funding sources based upon activity and enrollment. For example, assessments were charged to the substance abuse program, but once a family enrolled in the pretreatment program, the costs would be charged to the RMQIC.

To access the RMQIC funds for services, families had to consent/enroll in pretreatment. Idaho used child welfare funding from Title IV-B, Subpart 2 (Promoting Safe and Stable Families-PSSF) and from TANF to cover the costs associated with consultation, case planning, court activity, and pretreatment services to families not formally enrolled in the pretreatment program. Although the RMQIC grant has ended, the state has continued to fund the SAL positions through PSSF, TANF, and state and federal substance abuse funds.

## STRATEGY 6 Financing Child and Family Team Service Planning Meetings

### What States Are Doing

Seven states provided written descriptions of their efforts to establish child and family teams. These states generally shared similar ideas about how child and family teams work and described teams as: based on trust relationships; having families as active team members; supportive of individualized services for each child's needs; relying on community-based care with linkages to community resources; and achieving better outcomes for children and families.

Six of the states<sup>40</sup> appear to be *implementing child and family teams statewide*. **Indiana** sees this “teaming” as a statewide practice reform initiative and has engaged a consulting group to train family case managers on how to facilitate family team meetings.

<sup>40</sup> IN, NE, NH, ND, OH, WI





While states described child and family teams similarly, they differed in the target population served by the teams, e.g.,

- **Ohio** described family team meetings with families with confirmed chemical dependency problems who are referred to the child welfare system.
- **Nebraska** serves children in state custody who are at risk of being placed out of state or in high-end behavioral health placements.

### How States Are Implementing Financing Strategies and Funding Sources

Five states described how they funded child and family teams:

- With funding from the state legislature, **Indiana** hired 175 new family case managers in 2005-2006 and planned to hire an additional 200 in the next year. With assistance from the Annie E. Casey Foundation, initial training on child and family teams was provided. Additional funds are being sought from an Indiana Foundation.
- **North Dakota** allocated state general funds, TANF, Title IV-B funds, and Busch Grant funds for the Family Group Decision-making Program.
- **Nebraska** uses a case rate methodology paid to the Regional Behavioral Health Authorities as the financing structure to fund Integrated Care Coordination Units that support child and family teams for the involved children.
- **Allegheny County, Pennsylvania** described shared funding from multiple systems (CYF/child welfare, behavioral health, and mental retardation/developmental disabilities) that is blended and braided.
- **Wisconsin** described using federal mental health block grant funds and a category within state general purpose revenue called Hospital Diversion Funding.

Several of the states described *partnerships* that enabled them to develop the programs that support child and family teams:

- In **Ohio**, H.B. 484 charged the Ohio Department of Alcohol and Drug Addiction Services, in cooperation with the Ohio Department of Human Services, to develop a statewide plan to prioritize substance abuse services for families involved with the child welfare system. Family team meetings are part of these services.
- In **Nebraska**, the Integrated Care Coordination Unit, described above, is a partnership between child welfare, behavioral health, and family organizations.



## STRATEGY 7 Financing Family-Run Organizations to Provide Child, Youth and Family Services and Supports

### What States Are Doing

Four states<sup>41</sup> provided narrative descriptions of how they fund family organizations and what they are funding them to do. Through another study, we obtained additional descriptive information about two of these four states<sup>42</sup>, plus three other responding states<sup>43</sup> that indicated they are developing or have implemented strategies to fund family-run organizations. Thus, the information below reflects findings from seven states.<sup>44</sup>

States described how they were using family-run organizations to provide child, youth and family services and peer to peer support services<sup>45</sup>:

- The **Arizona** Department of Health Services, Division of Behavioral Health Services (ADHS/BHS) uses both discretionary (e.g., federal State Infrastructure Grant) and formula grant dollars to contract with two family organizations—MIKID, a statewide family organization, and the Family Involvement Center (FIC) in Maricopa County. These family organizations provide direct services, participate on mental health advisory committees, recruit and train families to be family support partners, provide information and referral, and provide technical assistance to providers and others on partnering with families. In Maricopa County, the FIC also hires family support partners to provide family-to-family-services as part of the provider network. FIC has become licensed as an outpatient behavioral health provider, which allows it to bill for telephone contact and provide case management.
- **Hawaii** Families as Allies employs parent partners to serve as peer advocates and provide assistance and support to other family members.
- In **Central Nebraska**, Region 3 Behavioral Health Services (BHS) contracts with Families CARE, a family support and advocacy organization, to hire family partners who support each family through the service planning/wraparound process. Family partners are based in the

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<sup>41</sup> NE, NH, NJ, ND

<sup>42</sup> NJ, NE

<sup>43</sup> AZ, HI, VT—survey information on this strategy about these 3 states was supplemented with information published in another national financing study report—Stroul, B., Pires, S., Armstrong, M., McCarthy, J., Pizzigati, K., and Wood, G., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan (RTC study3: Financing structures and strategies to support effective systems of care, FMHI pub.#235-02)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health. Available at <http://rtckids.fmhi.usf.edu/study03.cfm>.

<sup>44</sup> AZ, HI, NE, NH, NJ, ND, VT

<sup>45</sup> States differ in the titles they use for those who provide peer to peer services, e.g., family advocates, parent partners, family support partners, family partners, family mentors, family support coordinators, peer navigators, and family peer specialists. However, the roles they play in each state are similar. Families who have experienced the child-serving systems first hand provide one to one support for other families through the service planning and service delivery process. This section describes how family-run organizations offer peer to peer support. Connecticut described another strategy for offering peer to peer support services. Its Administrative Services Organization (ASO) hires family peer specialists who are consumers in recovery or parents of children with behavioral health challenges. As ASO staff members, these peer specialists provide support and guidance to families as they navigate through the behavioral health system.



communities where they live. Region 3 BHS also contracts with Families CARE for certain evaluation components that measure wraparound fidelity and family and youth satisfaction.

- **New Hampshire** has a statewide family support and education program called Family Mentors which is available to support families who are served by community mental health centers. Family Mentors is supported by the Bureau of Behavioral Health funds. New Hampshire also provides funding for the Foster and Adoptive Parent Association (FAPA), a non-profit agency that promotes constructive social action needed to bring about change and improvement in child welfare and in legislation for all children and families. FAPA also acts as an information center, does research on child welfare, and is the vehicle for communication among the state FAPA, local FAPAs and child welfare agencies.
- In **New Jersey**, Family Support Organizations (FSOs) are funded in each region of the state to employ parents who currently have, or recently had, youth in the behavioral health system. Drawing on the skills and knowledge that families have developed through their own experiences, the FSOs provide direct one on one peer support to families who request them. These families, who receive the highest intensity of care coordination services, receive assistance in navigating the system, finding their own voice in the service planning process, and in implementation of an integrated service plan. For families who do not receive the one on one peer support, the FSOs provide a broad range of community activities, information, lectures and informal community supports.

Understanding the importance of the youth voice, **New Jersey** also has funded, under the auspices of the FSOs, a youth partnership organization. The youth organization provides support, technical assistance and training to youth who are currently receiving behavioral health services.

- **North Dakota** offers a parent to parent program through the Federation of Families for Children's Mental Health.
- In **Vermont**, the Federation of Families for Children's Mental Health provides an array of services and supports, e.g., peer navigation, parent and provider training, information and referral. The peer navigator program offers the support of someone who has experienced the system first-hand. It assists individuals and families with accessing and navigating the health, education and human service systems.

### How States Are Implementing Financing Strategies

Family organizations are funded to provide services primarily in two ways:

- the family organizations bill the funding source (most likely Medicaid) for services and supports provided, i.e., the family organization has become a provider agency
- states contract with family organizations to conduct specific activities and/or provide specific services.

In **Arizona**, family organizations can provide direct services, such as respite services, behavioral coaching, skills training, peer support, personal care services, and case management. The family organization can bill Medicaid for these services and supports. **New Hampshire**, **New Jersey**, **Vermont**, and **Central Nebraska**, on the other hand, contract with family organizations for specific activities. **Arizona** also contracts with two family organizations, including the one that serves as a provider.



## Funding Sources

The states in which family organizations provide behavioral health services use federal and state funds for these activities. Two states described the use of local tax funds or local levies. Specific examples of funding sources for services provided by family organizations included the following:

- The **Arizona** Department of Health Services/Division of Behavioral Health Services uses discretionary (federal SIG) and formula grant dollars to contract with the two family organizations. The family organization serving as a provider bills the Regional Behavioral Health Authority that operates with a capitation rate funded by Medicaid.
- In **Hawaii**, Medicaid, block grant, and general funds finance parent partners, parent skills training, peer mentoring services for youth, and parent-to-parent supports.
- **New Hampshire** uses Bureau of Behavioral Health Services funds for Family Mentors and DCYF funds for the contract with the Foster and Adoptive Parent Association.
- In **Central Nebraska**, Region 3 Behavioral Health Services receives a case rate to provide integrated care coordination for children in custody who have complex behavioral health needs and multi-agency involvement. Eight percent of this case rate is allocated for its contract with Families CARE, the family advocacy and support organization. State and federal funds are included in the case rate: state child welfare funds, state general funds, Federal Title IV-E, and some state juvenile justice funding.
- **New Jersey** funds Family Support Organizations with a combination of state general revenue, Medicaid administrative case management dollars, and federal discretionary grants.
- **North Dakota** uses state general funds for the Parent to Parent program provided by the Federation of Families for Children's Mental Health.
- **Vermont** originally used a federal grant from the Administration on Developmental Disabilities and the Administration for Children and Families to offer peer navigator services through family organizations. Peer navigation now is supported by agency grant and contract funds.



## STRATEGY 8 Financing Training

### What States Are Doing

Although the survey did not list “training” as a funding strategy choice, **five states**<sup>46</sup> described how they were funding training efforts. Their strategies include:

1. Achieving practice reform
2. Training across systems

#### 1. Achieving Practice Reform

- **Indiana** focused on engaging families by developing trust-based relationships. They are training child welfare staff in these skills and to facilitate family team meetings.
- **Missouri** is working across systems to provide community-based care for children with mental health needs and to divert them from child welfare custody. They provided statewide interagency training on a custody diversion protocol.
- **New Jersey** offered training in systems of care for providers, and is credentialing those who meet all of the requirements.

#### 2. Training Across Systems

States used training as a strategy to increase collaboration among systems and with providers by *training across systems* and including mental health providers and child welfare workers in the same training.

- **Hawaii** trains child welfare workers and mental health providers together on accessing and coordinating mental health services.
- **New Hampshire** uses private mental health providers to train state agency staff and community mental health centers on topics such as trauma and attachment theory. New Hampshire also places second year child psychiatry residents from Dartmouth in its busiest child protective services office.

### How States are Implementing Financing Strategies

The training efforts described by states primarily resulted from interagency efforts to improve and reform their systems. They also focused on strengthening provider skills and increasing the pool of qualified behavioral health providers.

### Funding Sources

Very few states described the funding sources used specifically for training. **Hawaii** is using Title IV-E to train child welfare and mental health workers together. **Indiana** received foundation funding to train family case managers to facilitate family team meetings.

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<sup>46</sup> HI, IN, MO, NH, NJ



## STRATEGY 9 Financing the Co-location of Child Welfare and Mental Health Staff

### What States Are Doing and How They Are Doing It

Five responding states provided narrative descriptions of their co-location efforts<sup>47</sup>.

- **Florida** has co-located in child protective services offices across the state 70 family intervention specialists who provide screening, referral, case management, and motivation for caregivers who need substance abuse treatment services.
- **Idaho** has established a Pretreatment Education and Support Program that offers educational and support services for parents and caregivers involved with the child welfare system who are waiting admission to a more formal substance abuse treatment program. Substance abuse liaisons are co-located in child welfare offices to facilitate quick referrals and contact with parents.
- In **Nebraska**, Regional Behavioral Health Authorities and the DHHS Office of Protection and Safety partner to offer intensive case management/wraparound services to children in custody who are at risk of being placed out-of-state or in intensive behavioral health treatment settings. These services are offered by Integrated Care Coordination Units (ICCU). In Central Nebraska (a 22-county area), care coordinators from child welfare and mental health are co-located at ICCU sites to facilitate the integration of services and to share resources.
- **New Hampshire** described two co-location initiatives:
  - To ensure that all children in first time placement have a behavioral health assessment within 30 days of placement, clinicians from the regional community mental health centers are placed in each district child welfare office for two hours of consultation per month.
  - Second-year child psychiatry residents from Dartmouth Medical School are placed in Concord, one of the state's busiest child protection offices, for a four-month rotation (one day per week). This arrangement enables the residents to learn the intricacies of the child welfare system and the mental health needs of the children served by child welfare. It also provides the child welfare office with needed psychiatric expertise.
- **South Carolina** places child mental health professionals in child welfare and adoption offices to intervene as early as possible with families, provide support to child welfare workers, ensure that children and youth are seen in a timely manner and have access to a full array of mental health services, decrease the number of adoption disruptions, and assist youth with the transition back to their homes.

### Funding Sources

Four states described their various funding sources for co-location in more detail:

- **Florida** uses multiple federal and state funding sources, including TANF-IVA, Substance Abuse Treatment Block Grant, and state general funds, using approximately 50% federal sources and 50% state sources. The Florida legislature specifically earmarks funds in its budget allocations for the 70 Family Intervention Specialist positions. Contracts with district substance abuse and mental health offices require compliance with the Guidelines for Family Intervention Specialists and specifically identify funds for these services.

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<sup>47</sup> FL, ID, NE, NH, SC





- **Idaho** uses multiple funding sources for its Pretreatment Program and the services provided by the co-located substance abuse liaisons (SALs). For example, state and federal substance abuse funding is used to conduct substance abuse assessments. Funding from the Title IV-B, Subpart 2, Preserving Safe and Stable Families (PSSF) and Temporary Assistance for Needy Families (TANF) covers the costs associated with consultation, case planning, and court activity. The SAL contracted services are based upon hourly rates for the specific services they offer. The SALs complete daily activity sheets for billing purposes.
- In **Central Nebraska**, the Region 3 Behavioral Health Services (BHS) and the Central Area Office of Protection and Safety (child welfare) share the cost for personnel, space, supplies, and furniture for the Integrated Care Coordination Unit (ICCU). Each agency employs half of the care coordinators in ICCU and divides the cost of supervision.<sup>48</sup>
- The **South Carolina** Child Mental Health/Child Welfare Initiative is a collaborative initiative between the Department of Mental Health and the Department of Social Services. DSS uses federal block grant dollars to place the clinicians in the child welfare offices.

## STRATEGY 10 Financing the Expansion of the Pool of Qualified Behavioral Health Providers

### What States Are Doing and How They Are Doing It

Four states<sup>49</sup> provided written descriptions of how they are expanding the pool of qualified providers. Through another national study, we obtained additional descriptive information about the efforts of three responding states<sup>50</sup> that indicated they are developing or have implemented strategies to strengthen or expand the provider pool. The information below reflects findings from these seven states.<sup>51</sup> States are engaged in a number of activities to expand their provider pools, including:

1. Developing new types of providers
2. Restructuring rates and how providers are reimbursed
3. Strengthening relationships with providers
4. Revamping certification processes and providing training.

<sup>48</sup> Nebraska's survey information for this strategy was supplemented with information from another national financing study report—Stroul, B., Pires, S., Armstrong, M., McCarthy, J., Pizzigati, K., and Wood, G., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan (RTC study3: Financing structures and strategies to support effective systems of care, FMHI pub.#235-02)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health. Available at <http://rtckids.fmhi.usf.edu/study03.cfm>.

<sup>49</sup> CT, NH, NJ, WV

<sup>50</sup> AZ, HI, VT—survey information for this strategy was supplemented with information about these 3 states published in another national financing study report—Stroul, B., Pires, S., Armstrong, M., McCarthy, J., Pizzigati, K., and Wood, G., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan (RTC study3: Financing structures and strategies to support effective systems of care, FMHI pub.#235-02)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health. Available at <http://rtckids.fmhi.usf.edu/study03.cfm>.

<sup>51</sup> AZ, CT, HI, NH, NJ, VT, WV



### 1. New Types of Providers

- **Arizona** developed a new type of provider designation, the “community service agency”, within its managed behavioral healthcare system. This opened up the provider network to family organizations and community agencies that do *not* have to be licensed as an outpatient mental health clinic to provide certain Medicaid services. These services include: respite, peer support, habilitation, skills training, and crisis services.
- **West Virginia** established a new services category, socially necessary services, and found providers to offer these services.

### 2. Restructuring Rates and Reimbursement Methods

- **Arizona** established higher rates for out-of-office than for in-office services to encourage therapists to provide services in homes and schools and not just in offices. Also, it pays a tiered system of rates for out-of-home care, with rates decreasing with longer stays. The longer the length of stay in a level one placement (i.e., hospital or residential treatment center), the rate drops (with the exception of level one programs serving youth with sex offenses). In Maricopa County, the Regional Behavioral Health Authority (RBHA) supports the involvement of community and family-run organizations in the behavioral health system by paying them on a prospective basis. For example, 12% of the annual contract is paid each month. Eventually, the RBHA hopes to move these agencies to a fee for service arrangement.
- **New Jersey** implemented a market-based reimbursement methodology for its new community-based services. The fee schedule established by the state and approved for Medicaid reimbursement reflects the market indices for the clinical credentials and experience they are looking for in providers. It also reflects a clinical model of practice and supervision that incorporates the supervisory and administrative time needed to provide the services within a system of care.

### 3. Strengthening Relationships with Providers

- In **Connecticut**, an Administrative Services Organization (ASO) is charged with network development activities for children who rely on publicly funded behavioral health services. The ASO has hired clinical staff to serve as Intensive Care Managers who provide specialized oversight and consultation to providers and consumers who need specialized care. Eight system managers have been hired to work with the state child welfare area offices and their complements of community providers, schools, local service providers, systems of care, to develop Local Area Resource Development Plans. Providers are members of the Legislative Oversight Council, a body to oversee the Connecticut Behavioral Health Partnership. One of the four Council workgroups focuses on provider issues.
- In **Hawaii**, the Child and Adolescent Mental Health Division (CAMHD) finances a Provider Relations Liaison position whose goal is to strengthen the relationship between CAMHD and its network of contracted providers. General Fund and Title IV-E resources are used to finance workforce development activities.
- **New Hampshire** has used the Commissioner’s Committee on Adoption, Sub-Committee on Mental Health to bring together private and state child-serving agencies to discuss the need to increase the number of qualified mental health providers.





#### 4. Revamping Certification Processes and Providing Training

- Some of the private providers in **New Hampshire** have committed to train state agencies, state contracted community mental health centers, and CPS workers. New Hampshire is also revamping its process for certifying behavioral health providers so that they must demonstrate a certain number of hours of training/year in trauma and attachment theory.
- **West Virginia** requires providers of its new category of “socially necessary services” to register and be approved in order to be paid.
- **New Jersey** provides free training sessions in the system of care practice model for practitioners and providers. CEUs are granted to credentialed practitioners if they meet all requirements.

### Funding Sources

Three of the states are using the following funding sources:

- **Arizona’s** efforts to build its provider pool were based primarily on Medicaid funds that make up the capitation rates for the RBHAs.
- **Connecticut’s** Behavioral Health Partnership integrates Medicaid funding for behavioral health services and SCHIP funding with Department of Children and Families (DCF) grant funded (state dollars) services.
- **Hawaii** uses general fund and Title IV-E resources to finance workforce development activities.

## STRATEGY 11 Financing the Development, Provision and Monitoring of Evidence-Based Practices (EBP)

### What States Are Doing

The information below reflects the narrative descriptions of financing strategies for implementing evidence-based practices (EBPs) provided by **three** states, Nebraska, Michigan and New Hampshire.

**Nebraska** and **Michigan** have created strategies to fund Multisystemic Therapy (MST):

- Central **Nebraska** (which includes 22 counties) offers MST through a contract between the regional behavioral health authority and a community mental health center. The target population for MST includes youth with diagnosable clinical, social and educational problems; living in their own homes or long term foster homes; between the ages of 6 and 20; involved or at risk of involvement with juvenile justice; and whose parents or caregivers are willing to participate.<sup>52</sup>

<sup>52</sup> AZ, HI, VT—survey information for this strategy was supplemented with information about these 3 states published in another national financing study report—Stroul, B., Pires, S., Armstrong, M., McCarthy, J., Pizzigati, K., and Wood, G., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan (RTC study3: Financing structures and strategies to support effective systems of care, FMHI pub.#235-02)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children’s Mental Health. Available at <http://rtckids.fmhi.usf.edu/study03.cfm>.



- In **Michigan**, MST is being implemented in 5 counties across the state for youth involved in county Community Mental Health Centers (CMHC). These Centers are partnering with local family courts to implement MST.

**New Hampshire** has established a stakeholder committee representing the children's directors from the community mental health centers, child welfare, family organizations and providers to identify EBP's for mental health delivery to the priority children's population. They are working with a federal SAMHSA grant to develop Trauma-focused Cognitive Behavioral Therapy as their first EBP.

### How States Are Implementing the Financing Strategies

Two states provided information on how they implemented their strategies:

- **Nebraska** built MST into its application for a federal system of care grant and used those funds for the development phase, including clinical consultation and training potential providers. Nebraska "grew its own" MST rather than inviting a MST provider to come into the state. Although no one system is able to pay for all the costs of MST, by sharing the financing responsibilities, the provider is guaranteed to receive the full case rate amount.
- In **Michigan**, the MST initiative grew at a local level out of the need for mental health services for children in the juvenile justice system. In all of the counties where this service is being implemented they have experienced a decrease in the need to place children in out of home care settings. In some instances they have saved the local courts millions of dollars.

To implement overall financing reform, all three states are identifying current spending and utilization patterns, realigning funding streams and structures, maximizing federal entitlement funds, and redirecting spending from deep end placements to community-based services. **New Hampshire** is offering incentives to providers to locate in certain areas of the state. **Nebraska**, **New Hampshire** and **Michigan** are pooling, blending or braiding funds across different child serving systems.

### Funding Sources

**Nebraska** uses a variety of funding sources to cover the actual service costs for MST. Providers are paid a case rate based on outcomes achieved with each youth/family. Funding sources include the federal system of care grant (development), Medicaid (intensive outpatient services), federal mental health block grant (coordination of services), child welfare funds, families, and the regional behavioral health authority. **Michigan** funds MST with community mental health, local court and state support. Federal Mental Health Block Grant funds have been used to support training and technical assistance.

**New Hampshire** is using a federal SAMHSA grant to develop Trauma-focused Cognitive Behavior Therapy.



## STRATEGY 12 Financing Behavioral Health Services for Youth Who Age Out of the Foster Care System and into the Adult System

### What the States Are Doing

The information below reflects the narrative descriptions of **two** states' efforts to fund behavioral health services and supports for youth aging out of the foster care system:

- **New Hampshire** offers the DCYF Teen Independent Living Aftercare Program, a voluntary program that provides continued planning, support, and financial assistance to assist former foster care youth pursuing educational, employment, and other personal goals. DCYF aftercare workers assist young adults who need behavioral health services in finding appropriate services in the community. Approximately 60-80 young adults access DCYF aftercare services on a yearly basis.
- In **Alleghany County, PA**, a Multi-System Rapid Response Team (MSRRT) was created for youths (birth to 21) with complex needs who exhibit severe behavioral disorders in the presence of a mental health diagnosis, mental retardation, and/or developmental disabilities. Youths from this population between the ages of 16-21 receive additional attention as they transition from child-centered to adult services. The MSRRT has achieved positive outcomes for this population of youth in transition by investigating formal and informal community services, identifying and creating new resources, negotiating with providers, tailoring formal services, and putting together individualized packages of services.

### How States Are Implementing the Financing Strategies and Funding Sources

In **New Hampshire**, behavioral health services can be paid by Medicaid for youth up to age 19. After that Chafee Independent Living funds are used for youth age 19-20. Since NH Medicaid coverage for former foster youth ends at age 19, the state is working to develop collaborations with mental health providers so that they are both accessible and affordable for the young adults who need them.



## STRATEGY 13 Financing Therapeutic Foster Care

### What States Are Doing

Although the survey did not list Therapeutic Foster Care (TFC) as a funding strategy choice, **two** states (Florida and Hawaii) described how they were funding TFC programs. Both are working across systems to provide Therapeutic Foster Care.

- In **Florida**, Specialized Therapeutic Foster Care (STFC) is a focused service for children in the child welfare system with serious emotional disturbances who have been removed from various placements and appear to be at high risk of placement in a residential treatment facility. Placement in STFC must be authorized by a multidisciplinary team that includes representatives from state Medicaid, mental health and child welfare. To avoid unnecessary inpatient treatment placements, STFC is also available on a crisis basis.
- **Hawaii** offers therapeutic foster homes that are jointly funded by child welfare and mental health. Foster parents in the therapeutic homes are more highly trained than most foster parents in the child welfare system.

### How States Are Implementing Financing Strategies

The state Medicaid, child welfare, and mental health authorities in **Florida** have partnered to develop a funding strategy for therapeutic foster care. They use state general revenue from the State Mental Health Authority as matching funds for Medicaid. These general funds are appropriated by the state legislature to the State Mental Health Authority for transfer to the State Medicaid Authority. A bundled per diem rate for STFC covers most community-based behavioral health services, excluding psychiatric treatment and assessment (which are available in a traditional unbundled method). **Hawaii** also blends funds to offer TFC. The child welfare system provides room and board, and the mental health system reimburses for treatment services.

### Funding Sources

To provide TFC, Florida is using general revenue funds appropriated to the State Mental Health Authority, Medicaid, and child welfare funds (for room and board). In Hawaii, the child welfare agency covers room and board with state general funds and Title IV-E, while mental health covers treatment costs with general fund and Medicaid dollars.



## STRATEGY 14 Financing Crisis Services and Mobile Response Systems

### What States Are Doing

Although the survey did not list crisis services as a funding strategy choice, **three** states, **Florida, New Jersey and Alleghany County, Pennsylvania**, described how they were financing crisis response services.

- **Florida** offers therapeutic foster care on a crisis basis. Specialized Therapeutic Foster Care—Crisis (STFC-Crisis) is similar to the Specialized Therapeutic Foster Care program in Florida; however, it is available on an emergency basis. STFC-Crisis is intended for children who require immediate behavioral health intervention in a structured environment, who do not yet meet the clinical criteria for emergency inpatient psychiatric care. STFC helps avoid inpatient setting while meeting each child’s immediate need for emergency mental health services.
- In **New Jersey**, mobile response services are available 24/7 for a period of 72 hours to address the escalating behaviors that may jeopardize the youth’s current living situation. Community-based behavioral supports are available for an additional eight weeks, as needed, based on the assessment of the mobile response agency. Available outcome data indicates that these services, when utilized as part of a mobile response stabilization plan, have allowed 95% of all youth who receive mobile response services to remain in their current living arrangement.
- **Alleghany County, PA** offers a Multi-System Rapid Response Team (MSRRT) for youth (birth to 21) with complex needs who exhibit severe behavioral disorders in the presence of a mental health diagnosis and/or developmental disabilities. The Multi-System Rapid Response Team (MSRRT) also is part of, and the gatekeeper for, RESPOND, a partnership between the Department of Human Services (DHS) and three residential providers. It has a residential component and a mobile treatment team. Residential Enhanced Service Planning Opportunities for New Directions (RESPOND) has a “no reject no eject” agreement with the county. DHS is seeing positive outcomes for individuals referred to the program.

### How States Are Implementing Financing Strategies and Funding Sources

- Florida uses the same funding arrangement for STFC-Crisis and STFC. The state Medicaid, child welfare, and mental health authorities in **Florida** partnered to develop the funding strategy. State general revenue from the State Mental Health Authority is used as matching funds for Medicaid. These general funds are appropriated by the state legislature to the State Mental Health Authority for transfer to the State Medicaid Authority. STFC-Crisis is included in the state Medicaid plan and is paid on a bundled rate.
- New Jersey amended its state Medicaid and SCHIP plans to include crisis services. New state dollars were appropriated and small state funded local grants were pooled to use as match to claim federal funding for these services.
- In 2003, the **Alleghany County** DHS issued a RFP to address the unique and complex needs of children and youth who are hard to place, who have co-occurring disorders, who experience frequent hospitalizations, and whose needs are not fully met by existing levels of treatment. RESPOND resulted from the RFP.



## STRATEGY 15 Financing the Reduction of Out of State Residential Placements

### What States Are Doing

Although the survey did not list the reduction of placements in out-of-state residential treatment centers (RTCs) as a financing strategy choice, **two** states (**Alaska** and **West Virginia**) described their efforts to reduce such placements.

- In **Alaska**, the Department of Health and Social Services initiated the “Bring the Kids Home” (BTKH) Project. It is intended to significantly reduce the numbers of children and youth in out-of-state care and to keep future use of out of state facilities to a minimum. The BTKH Project will build upon the existing infrastructure to treat youth in their own communities, regions, and state.
- **West Virginia** is developing and expanding a community-based approach to reduce out-of-state residential placements. The state conducted a comprehensive clinical review of youth in out-of-state placements at a point in time (12/30/05) to understand which children are in out of state placements and why. The review resulted in numerous recommendations, including (among others) the state’s commitment to sustain the system of care that was implemented with federal funding in Region II and a focus on expanding systems of care statewide.

### How States Are Implementing Financing Strategies

- The BTKH Project in **Alaska** intends to reinvest funding, now going to out-of-state care, to in-state services to develop the capacity to serve children closer to home. Alaska also described other funding arrangements such as: amendments to their state Medicaid plan, legislative mandate, Mental Health Trust Authority funding, and provider grants.
- Similar to Alaska, **West Virginia** described intentions to place more children in-state, thus spending fewer dollars out-of-state. Other financing strategies being discussed in West Virginia to reduce out-of-state placements included: investing in the total system to ensure quality and performance outcomes are at the levels needed; finding ways to acquire funding from new sources from garnering grant funding to rethinking current resource allocation for programs and services; reviewing existing federal and state funding streams to determine availability and flexibility of funds to support the plan; and asking the Legislature and others for resources.

### Funding Sources

In general, **Alaska** and **West Virginia** are both utilizing federal and state funds to finance their strategies. Alaska is also taking advantage of tobacco settlement, private insurance, foundation funding and donations to fund their strategies.



## STRATEGY 16 Financing Services for Children with Developmental Disabilities

### What States Are Doing

Although the survey did not list services for children with developmental disabilities as a funding strategy choice, **two** states (**New Hampshire** and **Alleghany County, Pennsylvania**) described their efforts to serve these children.

- **New Hampshire** provides placement and in-home services that are flexible and allow for individualized services to be provided to each child based on his or her own needs. The Division for Children, Youth and Families (DCYF) and the Division for Juvenile Justice (DJJS) have a formal agreement in place with the Bureau of Developmental Services that allows the collaboration of the two Divisions regarding children/youth with a primary diagnosis of developmental delays who are involved with both abuse/neglect and delinquency issues.
- In **Alleghany County, PA**, the County Multi-System Team includes administrators from the MR/DD system, in addition to child welfare, juvenile justice, behavioral health and other administrators. Children with mental retardation or developmental disabilities are included in the population of children served by the Multi-System Rapid Response Team (MSRRT) described previously in the section on crisis response services. An additional MSRRT activity includes early identification of developmental delays in an at-risk population through the Ages & Stages developmental screening tool for children 0-5. The goal of the project is to identify earlier those children in the care of Children, Youth, and Families (CYF) who are at risk for developmental delays, thus providing an opportunity to identify, plan for and provide appropriate services and funding as early as possible.

### How the States Are Implementing Financing Strategies and Funding Sources

- The collaboration in **New Hampshire** allows DCYF and DJJS to cost share placements through Developmental Services by providing the state matching funds.
- In **Alleghany County**, shared funding from CYF, the Office of Behavioral Health (OBH), and the MR/DD program office occurs frequently based on eligibility for programs. Past statistics have shown funding through MR/DD at 59%, OBH at 52% and CYF with 43%. The distribution of funding for the most part is reflective of the number of children involved in the respective systems.





## STRATEGY 17 Financing Strategies to Avoid Unnecessary Custody Relinquishment

### What the State Is Doing

Although the survey did not list avoiding unnecessary custody relinquishment as a financing strategy choice, **one** state (**Missouri**) described its efforts to divert children from inappropriate placements, to offer community-based services when possible, and to engage in voluntary placement agreements with families of children who do require out of home care.<sup>53</sup>

In 2004, **Missouri** passed legislation (Senate Bill 1003) that provided direction for reform of the children's mental health system. The call for reform began with parents and families who faced challenges in access to treatment for their children. Sometimes parents relinquished custody of their children to the child welfare system (Children's Division of Department of Social Services) for the sole purpose of accessing needed mental health care. Contributing factors to this dilemma included: families who had exhausted their private health insurance; Medicaid not covering residential care; and families who were not familiar with the intensive (non-traditional) services available through the Department of Mental Health.

While the state began working on a long term strategy for comprehensive reform of children's mental health, it also focused on issues needing immediate response, including:

- returning children, solely in state custody to access mental health services, to the custody of their parents
- implementing custody diversion protocols statewide
- establishing Voluntary Placement Agreements.

### Returning children to the custody of their parents

In 2004, upon review of the children in custody statewide, the Children's Division identified 112 children who possibly met the criteria of being placed solely to access mental health care. Legislation required the appropriate agencies to convene meetings (Family Support Teams) with families of children who met the criteria to develop an individualized service plan for each child. These plans, which identified which agencies would provide and pay for services, were to be submitted to the juvenile court. In 2005, 20 children were returned to the custody of their parents. In 2006, four children were returned. The state attributes the 2006 decrease to the success of the custody diversion protocol (see below). The total number of children returned to their families to date (March 2008) is 49.

### Implementing custody diversion protocols

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<sup>53</sup> In addition to the survey response, information for Missouri strategies was provided through communication with the children's clinical director and from documents on the state of Missouri website. These included *Reforming Children's Mental Health Services in Missouri, A Comprehensive Children's Plan in Response to Senate Bill 1003*, December 2004, [www.dmh.missouri.gov/diroffice/depdir/childsvcs/Final%20CCMHP.pdf](http://www.dmh.missouri.gov/diroffice/depdir/childsvcs/Final%20CCMHP.pdf); and *Status of Children's Mental Health in Missouri Comprehensive Children's Mental Health System*, December 2006, [www.dmh.mo.gov/diroffice/StatusofChildrenAnnualReport2006.doc](http://www.dmh.mo.gov/diroffice/StatusofChildrenAnnualReport2006.doc)





State agencies (mental health and social services), the courts and families, developed a protocol that specified the steps child serving agencies must follow in those cases involving parents who are considering voluntarily relinquishing custody for the sole purpose of accessing mental health care for their children. The protocol's purpose is to divert children from being placed in state custody unnecessarily and to provide the needed community-based services. The custody diversion protocol was implemented statewide in 2005. By March 2008, 696 children had been referred, 648 of these children (93%) were diverted from state custody. Of these 648 children, 40% were supported in their own homes with community-based services, and 60% received out-of-home services, either through a Voluntary Placement Agreement (see below) with their parents, or by using DMH funds or other funding sources such as adoption subsidies.

#### **Voluntary Placement Agreements (VPAs)**

Legislation passed in 2004 (HB 1453) made major reforms in the state foster care system, including authorization for the Department of Social Services to enter into VPAs for a maximum of 180 days with parents or guardians whose children needed out of home placement solely for mental health services. Through a VPA, parents retain legal custody of their children.

### **How the State Is Implementing the Financing Strategy**

Through targeted legislation, collaboration across child-serving agencies, and new funding arrangements, Missouri has begun statewide reform of its children's mental health system. Overall funding strategies include:

- restructuring of Title XIX (Medicaid)
- redirection of funds from high cost institutional settings to c/b services
- leveraging state resources, through the expanded access to federal Title IV-E reimbursement
- flexible use of existing state and federal block grant resources.

#### **Implementation of the three specific strategies described above:**

Missouri notes that effective local interagency teams are critical to successful implementation of these strategies.

- *Returning children, who are solely in state custody to access mental health services, to the custody of their parents*

SB 1003 created a new funding arrangement between the Department of Mental Health (DMH) and the Children's Division (CD) of the DSS. After children return to the custody of their family and are being served by DMH, DMH can bill the CD for the cost of care pursuant to the individualized service plan and the comprehensive financing agreement made between the two agencies, thus funding for services follows the child.

- *Implementing custody diversion protocols*

The state expanded the availability of home and community-based mental health services through changes to the state's Medicaid Community Psychiatric Services Rehab Option for children. The new services include Family Support, Family Assistance, Day Treatment and Psychosocial Rehabilitation.



- *Voluntary Placement Agreements*

The children placed through a VPA become eligible for mental health services reimbursed by Medicaid and for residential services (room and board) funded with Title IV-E funds. The state amended its federal Title IV-E plan so that the CD could enter into a contract (the VPA) with parents to fund a child's out of home placement for a maximum of 180 days, without the CD taking custody of the child. This placement must be deemed appropriate through a level of care assessment by DMH.

### Funding Sources

To implement the three strategies described above, Missouri is using Medicaid funds, Title IV-E funds, and existing state and federal block grant funds.

## CHAPTER FOUR

# Individual Snapshots of Each State's Financing Strategies



**This chapter provides** a “snapshot” of each state and its financing strategies for providing behavioral health services for children and families in the child welfare system. The “snapshots” include similar information for each state (**in bold**), and most address:

- services or program offered through the funding strategy(ies)
- target population served by the strategy
- how the funding strategy was implemented and future implementation plans
- funding sources
- number and types of agencies or organizations involved in implementing the strategy<sup>54</sup>
- level of implementation (statewide, regional, local)
- how long the strategy has been implemented<sup>55</sup>
- number of children and families served per year by the strategy<sup>56</sup>.

The length and detail of the descriptions for each state vary depending upon the amount of detailed information and supporting documents provided by the state in its survey response.<sup>57</sup> See *Appendix A* for a list of all the financing strategies each state is developing or has implemented and *Appendix C* for a list of individual survey respondents who can be contacted for further state specific information.

## Alaska

Alaska is reinvesting funds from out-of-state placements into community-based services and local residential treatment centers for **children with serious emotional disturbances and Alaska native children**. The state is implementing this strategy by: identifying spending and utilization patterns, realigning funding streams and structures, maximizing federal entitlement funds, and redirecting spending from deep-end to community-based services. **Future implementation plans include:** developing the ability to pool, blend or braid funds across different child-serving systems.

Multiple **funding sources** (*federal, state, tobacco settlement, private insurance, foundation funding and donations*) are used in this financing strategy. **Nineteen agencies are involved** in the reinvestment including cross-system child-serving agencies, TANF, Medicaid, higher education, the faith community, advocacy, family organizations, tribal organizations, a managed care entity, the Governor’s Office, the executive branch of the government, and the housing authority. Alaska is implementing the funding strategy **statewide** at the regional, local and tribal levels. The state has been engaged in this effort for **more than 24 months** and serves **more than 1,000 children/youth** and families per year.

<sup>54</sup> In this chapter, when the term “cross-system child-serving agencies” is used to describe involved agencies, it usually encompasses the child welfare, mental health, juvenile justice, and education systems.

<sup>55</sup> To determine how long the financing strategy had been in place, the survey provided a range of responses to choose from—less than 6 months (shortest) to more than 24 months (longest). Survey responses were received in the fall of 2006, thus at the time of publication, the financing strategies have been in place longer than indicated in the survey responses.

<sup>56</sup> To determine an approximate number of children and families served by the financing strategy, the survey provided a range of responses to choose from—0-50 (lowest) to 1,001 + (highest).

<sup>57</sup> Four states that submitted surveys are not described in this section. They either requested that their state not be identified, or they did not provide adequate descriptive information.



## Arizona

Arizona is implementing a risk-adjusted enhanced capitation rate for **all children in state custody** in its managed behavioral health system. The resultant capitation rate for each Regional Behavioral Health Authority (RBHA) is at least 20 times the rate for other Medicaid-eligible children. Arizona is **implementing this strategy by:** identifying current spending and utilization patterns and also maximizing federal entitlement funds. **Future implementation plans include:** realigning funding streams and structures; redirecting spending from deep end placements to community-based services; and developing the ability to pool, blend or braid funds across different child serving agencies.

**Funding sources include:** *federal* Medicaid funds (DHHS SSA funds), under a Section 1115 waiver, and state matching funds (non-Medicaid). **Seven agencies are involved** including cross-system child serving agencies, Medicaid and a managed care entity. The state is implementing the funding strategy **statewide**. Arizona has been engaged in this strategy for **more than 24 months**. **More than 1,000** children/youth and families are served per year.

## Arkansas

The Arkansas financing strategies include:

- providing psychiatric evaluations for children who are not eligible for Medicaid and their parents to ensure assessment and treatment for families in the child protective system and those with children in foster care
- providing comprehensive health assessments, including mental health, for all children entering foster care within 60 days
- transforming the children's behavioral health system by developing a system of care for children with certain mental health needs. This includes children in the child welfare system as well as other children.

Arkansas is **implementing these strategies by:** identifying current spending and utilization patterns and also realigning funding streams and structures. **Future implementation plans include:** maximizing federal entitlement funds and developing the ability to pool, blend or braid funds across different child serving systems.

**Funding sources include:** *federal* ACF, Medicaid, and Social Services Block Grant dollars along with *state* general revenue. **Sixteen agencies are involved** including cross-system child serving agencies, Medicaid, advocacy, family organizations, a managed care entity, the state legislature, and the Governor's Office. The strategies are being implemented **statewide**. Arkansas has been engaged in some efforts for **6-12 months**. It has been providing the comprehensive health assessments for **more than 24 months**.



## Connecticut

Connecticut is financing an Administrative Services Organization to provide clinical oversight, utilization management, quality assurance, and network development activities for **children who rely on publicly funded behavioral health services**. This initiative, called the Connecticut Behavioral Health Partnership, integrates Medicaid funding with Department for Children and Families grant funded services (state dollars) for behavioral health services for HUSKY A children and adults, HUSKY B children, and children involved with DCF who are not Medicaid eligible and who demonstrate significant behavioral health challenges.<sup>58</sup>

Connecticut is **implementing this strategy by**: identifying current spending and utilization patterns and also realigning funding streams and structures. **Future implementation plans include**: maximizing federal entitlement funds; redirecting spending from deep end placements to community-based services; and developing the ability to pool, blend or braid funds across different child serving systems.

**Funding sources include**: *federal* (TANF, Medicaid (Section 1915(b) waiver), SCHIP—Title XIX) and state funds. **Twelve agencies are involved** including cross-system child serving agencies, TANF, Medicaid, advocacy, family organizations, a managed care entity, the state legislature, and the executive branch of the government. Connecticut is implementing the funding strategy **statewide**. The state has been engaged in this strategy for **6-12 months**. They plan to serve **more than 1,000** children/youth served per year.

## Delaware

Delaware has developed statewide financing strategies to provide:

- community-based behavioral health services and supports for children and families in their own homes that might prevent more restrictive placements
- behavioral health services and supports for family members of children who are in custody, including family members who are not eligible for Medicaid
- home-based behavioral health screening and comprehensive assessments for children (ages 4 to 17) entering foster care
- child and family team service planning meetings.

Through its public children's behavioral healthcare system, Delaware offers a broad array of community-based services including:

- intensive Outpatient Treatment (home-based, frequent contact—4 to 5 times per week)
- office-based outpatient treatment with community interventionist/behavioral health aides for in-home/in-community support
- crisis intervention services (24/7).

<sup>58</sup> The Connecticut Healthcare for Uninsured Kids and Youth program (HUSKY) is a health insurance program for children and eligible caregivers. HUSKY Part A is the state's existing full Medicaid program. HUSKY Part B provides health insurance for children who are not eligible for Part A (Medicaid). The state's intent is to support the enrollment of children of all income levels into a health insurance program.



These three services, in particular, provide help to children and families in their own homes and may prevent them from entering more restrictive placements (such as residential treatment or psychiatric hospitals). Because Delaware's system serves all children who meet the clinical criteria need, including those without insurance or Medicaid coverage, family members (particularly parents) of children in custody are included, where clinically appropriate, in the services provided.

Generally, Delaware is **implementing these strategies by:** identifying current spending and utilization patterns; realigning funding streams and structures; maximizing federal entitlement funds; redirecting spending from deep end placements to community-based services; and pooling, blending or braiding funds across different child serving systems.

**More specifically,** Delaware has an 1115 Medicaid Waiver under which the Division of Child Mental Health Services (DCMHS), located in the Department of Services for Children, Youth and Families (DSCYF), operates as a public managed care organization (MCO). DCMHS manages behavioral health care for children with intermediate to severe behavioral health needs. As the public MCO, DCMHS "recovers" a "bundled" or case rate of \$4,239 per member/per month for each enrolled child who receives direct services. Medicaid pays DSCYF the bundled rate that is based on actual service and expenditure data. These two agencies entered into a formal partnership—Cost Recovery Plan of DSCYF Budget Initiative. Federal financial participation in this rate is 50%. The DSCYF/DCMHS provides all match dollars.

The child mental health division and the child welfare division partnered to establish the *initial behavioral health screen* for children entering foster care. This was achieved through a successful budget initiative in CY 06 for DSCYF. As a result the children's mental health division contracted with a provider to conduct the initial screens.

For the *child and family teams*, the cost to staff the DCMHS clinical services management teams is included in the calculation of the Medicaid bundled rate described above. Initially, the concept of clinical care management was seen as exclusively administrative costs. However, documentation of staff roles in working directly with children/families in service planning and care management showed clearly the direct service side of clinical services management. This, plus the positive impact of the care coordination (less restrictive and less intensive placements, appropriate clinical services provided) helped get the cost of clinical services management rolled into the Medicaid negotiated bundled (case) rate. Other children and families (not Medicaid enrolled) also have access to clinical services management.

**Funding sources include:** *federal* (DHHS SSA, including TANF IV A; Child Welfare Title IV-B, Parts 1 and 2; Title IV-E Foster Care and Adoption Assistance; Medicaid Title XIX—EPSDT, Rehabilitation Option, and Fee for Service; Social Service Block Grant—Title XX; SCHIP—Title XXI; Department of Justice, Office of Juvenile Justice and Delinquency Prevention; SAMHSA Substance Abuse and Mental Health Block Grants) and *state* (Non-Medicaid State Matching Funds; Other State General Funds; and State General Revenue Flexible Dollars) funds.



As part of Delaware's combined children's department, the children's mental health division works closely with the child welfare division to ensure that children identified as needing behavioral healthcare receive services in a timely fashion. **Thirteen agencies or governing bodies have been involved** in one or more of the financing strategies, including: all cross-system child-serving agencies, Medicaid, advocacy groups, managed care entity, family organizations, courts, providers, state legislature and the governor's office.

Delaware is implementing these strategies **statewide** and has been engaged in all strategies, except the initial behavioral health assessment for children entering foster care, for **more than 24 months**. The initial behavioral health assessments were begun in 2006. Most of the financing strategies serve **more than 1,000** children per year. The initial behavioral health screening serves between 200 and 500 children each year.

## Florida

The Florida financing strategies include funding for:

- Specialized Therapeutic Foster Care (STFC)
- Specialized Therapeutic Foster Care—Crisis (STFC-Crisis)
- comprehensive behavioral health assessments for children entering foster care
- contracts with 14 children's mental health districts to provide individualized services and supports for children in child welfare (with flexible funding)
- a capitated, pre-paid system of mental health care for children in child welfare
- co-location in child welfare offices of Family Intervention Specialists offering substance abuse support services.

STFC serves **children in the child welfare system with serious emotional disturbances (SED)** who are at risk for placement in a residential treatment facility. Placement is authorized by a multidisciplinary team that includes Medicaid, mental health and child welfare representatives. To avoid unnecessary inpatient treatment placements, STFC is also available on a crisis basis. The Comprehensive Behavioral Health Assessments are provided for all **children eligible for Medicaid who are removed from their homes by child protective services and placed in shelter status**. Flexible funding for individualized services is available for **children with or at risk of SED who are in custody, or at risk of custody**. The capitated pre-payment system was being designed at the time of the survey for **all children with an active child welfare case**. **Parents and caregivers involved in a CPS investigation where substance abuse is suspected** as a contributing factor are served by the Family Intervention Specialists.

Florida is **implementing these strategies by:** identifying current spending and utilization patterns; maximizing federal entitlement funds; redirecting spending from deep end placements to community-based services; and pooling, blending or braiding funds across different child serving systems. A bundled per diem rate for STFC covers most community-based behavioral health services, excluding psychiatric assessment and treatment, which are available in a traditional unbundled method. **Future implementation plans include:** realigning funding streams and structures.





**Funding sources include:** *federal* (DHHS SSA, including Title IV-E Foster Care and Adoption Assistance, TANF, SSBG, SAMHSA and Medicaid Title XIX, Fee for Service) and *state* (State General Revenue Flexible Dollars) funds. For STFC, the state Medicaid, child welfare, and mental health authorities use state general revenue from the State Mental Health Authority as matching funds for Medicaid. Child welfare funds are used for room and board. The comprehensive behavioral health assessments are funded by Medicaid. Providers may bill up to 20 hours per assessment which enables them to conduct multiple interviews with the child and significant others, as well as review available written materials about the child's emotional health. **Multiple agencies are involved** including child welfare, mental health, Medicaid, substance abuse, court, managed care entity, and the state legislature. Florida is implementing the strategies statewide and has been engaged in most of them for **more than 24 months**. They serve more than 1,000 children/youth and their families per year.

### Georgia

Georgia is in the process of transitioning management of its Level of Care (LOC) program, which approves and funds placement of **youth in long-term residential treatment**, from the Division of Family and Children's Services (DFCS) to the Division of Mental Health, Developmental Disabilities, and Addictive Diseases (DMHDDAD). DMHDDAD will manage the funding and the operation of this program and institute a utilization management process to review length of stay based on a best-practice time frame for the level of care each youth is receiving. The intent is to avoid extended lengths of stay in residential placement and provide behavioral health services in the most appropriate and the least restrictive level of services for each child. The majority of the youth in residential treatment (75-80%) are in state DFCS custody.

Georgia is **implementing this strategy by:** identifying current spending and utilization patterns; realigning funding streams and structures; maximizing federal entitlement funds; redirecting spending from deep end placements to community-based services; and developing the ability to pool, blend or braid funds across different child serving systems. Transition of the Level of Care program is dependent upon the federal Center for Medicare and Medicaid Services' (CMS) approval of the state's plan.

**Funding sources include:** *federal* (DHHS SAMHSA, including Substance Abuse Treatment Block Grant and Mental Health Block Grant) and *state* (non-Medicaid State Matching Funds, State General Revenue Flexible Dollars, and Other State General Funds) funds. **Ten agencies** are involved including cross-system child-serving agencies, Medicaid, family organizations, and a managed care entity. Georgia is implementing the strategy **statewide**. The state has been engaged in the strategy for **less than 6 months**. Although the strategy has been in place for a brief time, the state plans to serve **more than 1,000 children/youth** and their families per year.





## Hawaii

Hawaii is maximizing its ability to serve **children involved in the child welfare system with serious emotional disturbance** by:

- sharing electronic mental health data quarterly with the child welfare system to identify the children in the child welfare system who are served and the services they are receiving. The data is community specific to demonstrate geographic differences.
- procuring psychological assessment services to support access to the children's mental health system by more quickly evaluating the eligibility of children for comprehensive mental health services
- providing therapeutic (mental health) foster homes
- training child welfare case managers to access and coordinate services with mental health providers.

Hawaii is **implementing these strategies by:** identifying current spending and utilization patterns, and also pooling, blending or braiding funds across different child serving systems.

**Funding sources include:** *federal* (DHHS SSA including Title IV-E Foster Care and Adoption Assistance; DHHS SAMHSA, including Mental Health Block Grant funds) and *state* (non-Medicaid State Matching Funds and Other State General Funds) funds. **Three agencies** are involved including child welfare, mental health and Medicaid. Hawaii is implementing the strategies **statewide**. The state has been engaged in the strategies for **6-12 months**. They plan to serve **201-500** children/youth per year.

## Idaho

Idaho is supporting pre-treatment substance abuse education and support services for **parents or caregivers of children referred to child protection**. The pre-treatment services are offered while the parents or caregivers wait for admission to a formal treatment program. The approach utilizes contracted substance abuse liaisons who are co-located in child welfare offices.

Idaho is **implementing this strategy by:** identifying current spending and utilization patterns; maximizing federal entitlement funds; and redirecting spending from deep end placements to community-based services. **Future implementation plans include:** developing the ability to pool, blend or braid funds across different child serving systems.

**Funding sources include:** *federal* funds (DHHS SSA including TANF Title IV-A, Title IV-B Part 2 Promoting Safe and Stable Families Act; DHHS SAMHSA Substance Abuse Treatment Block Grant). **Five agencies** are involved including child welfare, mental health, substance abuse, the court, and TANF. Idaho is implementing the strategy **statewide**. The state has been engaged in the strategy for **more than 24 months**. They serve **51-100** children/youth and their families per year.



## Indiana

The Indiana financing strategies include funding for:

- a practice reform initiative in which child and family team service planning meetings are led by trained Family Case Managers to engage all families in the child welfare system and provide better outcomes for children
- developing systems of care in communities to integrate services for youth and their families under one care plan that addresses all identified needs through a wraparound process. The target population is all youth with multiple challenges involved with two or more child serving agencies. Generally, children known to the child welfare system comprise the majority of children served. Systems of care exist in 61 of Indiana's 92 counties.

Indiana **implemented the practice reform initiative** by identifying current spending and utilization patterns. **Future implementation plans for this initiative include:** realigning funding streams and structures; maximizing federal entitlement funds; and redirecting spending from “deep-end” placements to community-based services. **The system of care initiative was implemented by:** identifying current spending and utilization patterns; realigning funding streams and structures; and maximizing federal entitlement funds. **Future implementation plans for the system of care initiative include:** redirecting spending from “deep-end” placements to community-based services; and pooling, blending, or braiding funds across different child-serving systems.

**For the practice reform initiative, funding sources include:** *federal* (DHHS SSA), *state* (State General Revenue Flexible Dollars), and foundation funding. Also, the state legislature funded the hiring of more than 300 new Family Case Managers and foundation funds provided for initial training. **For the system of care development, funding sources include:** *federal* (DHHS General, DHHS SSA, including TANF IV A; Child Welfare Title IV-B, Parts 1 and 2; Title IV-E Foster Care and Adoption Assistance; Juvenile Justice Title IV-E; Medicaid Title XIX—EPSDT, Rehabilitation Option, Fee for Service, and Medicaid Waivers Section 1915 (c); Social Service Block Grant—Title XX; SCHIP—Title XXI; SAMHSA, Mental Health Block Grants; ACF System of Care Grants, Head Start and Chafee FC Independence Program; DOE, IDEA general and Part C Infants and Toddlers; DOA, WIC and Food Stamps; Housing and Urban Development) *state* (Other State General Funds; State General Revenue Flexible Dollars); *local* (local tax funds); and donations from organizations and in-kind.

**Two agencies**, the child welfare system and the courts, **are involved** in the child and family team practice reform initiative. **Four major partners** for the system of care initiative are child welfare, courts, education, and the mental health centers. Indiana has been engaged in the first strategy for **less than 6 months** and in the second strategy for **more than 24 months** (*since 1999*). Given the brief implementation time for the first child and family team initiative, the approximate number of children/youth and families served per year has yet to be determined.



## Maine

The Maine financing strategies include:

- a reduction in the use of residential treatment that has allowed the state to redirect these Medicaid funds to the child welfare system to offer community-based services through a wraparound model (Wraparound Maine)
- creation of a trauma-informed system of care in three counties, funded through a federal Center for Mental Health Services grant which also supports a parent advocate in child welfare offices
- agency restructuring that merged the child welfare and children's behavioral health offices into one
- contracting with an administrative services organization (ASO) to do utilization review.

Maine is **implementing these strategies by:** redirecting spending from deep end placements to community-based services and pooling, blending, or braiding funds across different child-serving systems. The state legislature approved the transfer of \$4 million dollars from the state's Medicaid budget line to the child welfare budget line. Maine was able to do this because it had significantly reduced the number of children in the child welfare system placed in residential care. Maine has also integrated child welfare and children's behavioral health into one office. As a result of that merger, various other integration efforts are in process, including a common prior authorization and quality assurance process for placement of children in treatment foster care or residential care. An administrative services organization will be in place in the coming months to do utilization review and prior authorization of behavioral health services. Contract providers are reimbursed for facilitating wraparound team meetings.

**Funding sources include:** *federal* (DHHS SSA—Medicaid, Title XIX; SAMHSA system of care grant funds) and *state* (State General Revenue Flexible dollars and other State General Funds) funds.

The target population for the Wraparound Maine initiative are **children in state custody, children with extensive behavioral health needs and multi-system involvement, and children involved with the child protective services system.** Although the Medicaid dollars have been transferred to the child welfare system, *any* youth with complex, multi-system needs who is placed, or at-risk for placement, in residential care is eligible. **Four agencies are involved**, including child welfare, mental health, juvenile justice and higher education. Maine has established local collaborative boards to oversee the process, including, among other roles, quality assurance.

Wraparound Maine is a **statewide** initiative that began in January 2007. It is projected to serve **200** youth per year. The trauma informed system of care is located in **three counties.**



## Michigan

Michigan is engaged in several funding strategies:

- 1915 (c) Medicaid waiver to provide intensive community-based and in-home services for children with serious emotional disturbance (SED) whose conditions meet the requirements for placement in a state psychiatric hospital
- intensive community-based services to reduce out-of-home care placements and provide intensive community-based services through blended funding arrangements in numerous counties

The target populations include **children with SED in the child welfare, juvenile justice and mental health systems.**

**The state is implementing these strategies by:** identifying current spending and utilization patterns; realigning funding streams and structures, maximizing federal entitlement funds through a 1915 (c) waiver; redirecting spending from deep-end placements to community-based services; and primarily by pooling and blending funds across child-serving systems at the local level.

Multiple **funding sources** are used to implement these strategies, including: *federal* DHHS funds, system of care grant funding; *state* (non-Medicaid State Matching Funds, Other State General Funds); and *local* (local tax funds, local community mental health and substance abuse funds, United Way) funds. In addition, the Michigan legislature allocated \$13.2 million to improve mental health services for children in foster care and those who have experienced abuse or neglect.

**Numerous agencies are involved** including: mental health, juvenile justice, child welfare, substance abuse, Medicaid, local governing bodies, and state government. The financing strategies are being **implemented in numerous counties.** Michigan counties have been blending funds for quite a few years; however, the 1915 (c) waiver and the allocation of the \$13.2 million are new. Approximately **43 children** are being served through the waiver.

## Missouri

Missouri has developed financing strategies to:

- divert children from unnecessarily entering state custody (child welfare) solely to access mental health services
- enter into Voluntary Placement Agreements (VPA) with parents that allow for funding of clinically indicated out of home placements while parents retain legal custody of their children
- reunify families with their children who were already in state custody solely to access mental health services (with services and supports)
- create a children's data warehouse shared by mental health and social services that identifies the number of children served, available services, fiscal tracking, and outcomes.



Missouri is **implementing these strategies by:** identifying current spending and utilization patterns; realigning funding streams and structures; redirecting spending from deep end placements to community-based services; and pooling, blending or braiding funds across different child serving systems. More specifically, Missouri amended its Title IV-E plan to allow child welfare to enter into a VPA with parents and fund a child's out-of-home placement for up to 180 days (mental health services are reimbursed through Medicaid and room and board is funded with Title IV-E). Missouri also created a new funding arrangement between child welfare and mental health that allows mental health to bill the child welfare system for the cost of services for children who have been reunified with their families. **Future implementation plans include:** maximizing federal entitlement funds. The state is considering an application for a 1915 (c) Medicaid waiver.

**Funding sources include:** *federal* (DHHS SSA, including Child Welfare Title IV-B Part 1; Title IV-E Foster Care and Adoption Assistance; Medicaid Title XIX, Rehabilitation Option, Targeted Case Management, Fee for Service, and Medicaid Waivers Section 1915(c); Social Services Block Grant—Title XX; and SCHIP—Title XXI; DHHS ACF—System of Care Grants, Chafee Foster Care Independence Program; DHHS SAMHSA—Mental Health Block Grant), *state* (Non-Medicaid State Matching Funds, Other State General Funds); and *private insurance*. **Eleven agencies are involved** including cross-system child-serving agencies, Medicaid, advocacy, family organizations, state legislature, and the executive branch of the government. Missouri is implementing these strategies **statewide** and has been engaged in the strategies for **18-24 months**. They serve **201-500** children/youth and families per year.

## Nebraska

Through a collaborative partnership between six Regional Behavioral Health Authorities and the state Department of Health and Human Services (HHS) Office of Protection and Safety, Nebraska offers intensive case management. This initiative is based on the principles of the wraparound process, family-centered practice and using a child and family team model. It serves **children in state custody who have complex behavioral health needs, multiple agency involvement and are at risk of being placed out of state or in high end behavioral health placements**. To implement this model, care coordinators from child welfare and mental health are co-located to facilitate the integration of services and to share resources.

**Generally, Nebraska is implementing this strategy by:** identifying current spending and utilization patterns; realigning funding streams and structures; maximizing federal entitlement funds; redirecting spending from deep-end placements to community-based services; and blending, braiding or pooling funds across different child serving systems. **More specifically,** the state uses a case rate methodology that blends funding sources, to support and sustain this intensive care management model. Use of the case rate provides the flexibility to offer individualized care and develop new services.

**Funding sources include:** *federal* (Child Welfare Title IV-E, Medicaid Title XIX Targeted Case Management and Fee for Service) and *state* (State General Revenue Flexible Dollars). Medicaid funds are used to provide direct treatment services, but they are not



included in the case rate for care coordination. In Nebraska, the state DHHS/Division of Behavioral Health Services funds the public, *non-Medicaid* state mental health system. The Regional BH Authorities do not receive or manage Medicaid funds. Behavioral health services reimbursed by Medicaid are authorized by a statewide managed behavioral healthcare organization which operates as an administrative services organization (ASO). The ASO reimburses providers of treatment services on a fee for services basis. Although the Medicaid funds are not controlled by the Regional Behavioral Health Authorities, the care coordinators and clinicians on the child and family team work closely with the ASO to fund the plan of care for each child.

**Six agencies are involved** including child welfare, mental health, substance abuse, Medicaid, family organizations, and the managed care entity. Nebraska is implementing the funding strategy in **every region** and has been engaged in this effort for **more than 24 months**. The strategy serves **over 1,000** children and youth per year.

### New Hampshire

New Hampshire is implementing or actively planning 13 financing strategies:

- community-based behavioral health (BH) services for children in custody and their families
- BH services and supports for family members of children who are in custody and are not eligible for Medicaid
- comprehensive BH assessments for children in custody within 30 days of placement
- through its relationships with mental health (MH) vendors, New Hampshire can provide BH services for children in custody who do not meet medical necessity criteria
- programs for very young children based on functional need, diagnosis and family need
- child and family service planning teams as part of the state's strategy to integrate children's services through an Administrative Service Organization
- placement and in-home services that are flexible and individualized for children with developmental delays
- expanding the pool of qualified behavioral health providers via training opportunities and revamping their certification process to better serve all children in care with serious emotional disturbances
- an implementation plan for the Individualized Resiliency and Recovery Options and Support program to identify evidence-based practices for mental health delivery for children in the child welfare system
- behavioral health services for children and families after reunification
- continued planning, support and financial assistance to youth ages 18-21, formerly in foster care or juvenile justice, as they transition from youth to adult services
- co-location of mental health professionals in child welfare district offices
- family-run organizations to provide child and family services and supports through the Family Mentors program for families of children in custody, as well as foster parents and adoptive parents.





New Hampshire is **implementing these strategies by:** identifying current spending and utilization patterns; realigning funding streams and structures; maximizing federal entitlement funds; redirecting spending from deep end placements to community-based services; pooling, blending or braiding funds across different child serving systems; and offering incentives to providers to locate in certain areas of the state.

**Funding sources for the multiple strategies being implemented include** a variety of *federal*, *state*, local, and private insurance funds. **Seven or more agencies are involved** including child welfare, juvenile justice, mental health, developmental disabilities, TANF, higher education, and family organizations. New Hampshire is implementing the strategies **statewide**. Given the variety and reach of the initiatives described, the state is serving a **large number** of children, youth and families each year.

## New Jersey

New Jersey is engaged in a multi-pronged financing strategy to:

- implement a statewide system of care through a market-based reimbursement methodology that allows practitioners who could not have previously participated to provide services for youth with mental health needs
- provide community-based, individualized behavioral health services and supports, including mobile response services, to improve or stabilize home and community functioning for youth up to age 18, and for youth 18 to 21 who are still in school or formerly in foster care or juvenile justice
- to support and fund family support organizations (FSO) statewide. The FSOs employ parents of children in the behavioral health system, offer peer support to families, sponsor youth organizations, and provide a broad range of community information and support activities for parents.

The system of care in New Jersey is statewide and serves **children, youth and families who depend upon the public system for behavioral health services**. This includes children who are eligible for Medicaid and those who are not. New Jersey is **implementing these strategies by:** identifying spending and utilization patterns; maximizing federal entitlement funds; and pooling, blending or braiding funds across different child-serving agencies. **Future implementation plans include** realigning funding streams and structures. New Jersey elected to use the Medicaid Rehabilitation Option to secure funding for services for youth who qualified for Medicaid services, and it amended its S-CHIP state plan to provide federal funding for services for youth who qualified S-CHIP. A new provider fee schedule, established by the state and approved for Medicaid reimbursement purposes, allowed providers who had not participated in the system of care, due to an inadequate fee schedule, to provide services consistent with their own business model.

**Multiple funding sources are used for these financing strategies:** *federal* (DHHS SSA, including Medicaid—Title XIX, EPSDT, Rehabilitation Option, Targeted Case Management, and Fee for Service; SCHIP—Title XXI) and *state* (Non-Medicaid State Matching Funds, State General Revenue Flexible Dollars) funds. In addition, mental



health block grant funds are used for Family Support Organizations, and the FSOs can seek support and funding from community-organizations. **Nine agencies are involved** including cross-system child-serving agencies, Medicaid, private business, and family organizations. New Jersey is implementing the strategies statewide and has been engaged in the strategies for **more than 24 months**. They serve **more than 1,000** children/youth and their families per year.

## New York

New York financing strategies include:

- establishing a Medicaid per diem rate that is paid to voluntary foster care agencies to provide outpatient health and mental health services for each child placed with them
- an enhanced rate of state reimbursement to counties for preventive services, beyond federal funds that may be available (65% state/35% local).

New York is **implementing these strategies by:** realigning funding streams and structures; maximizing federal entitlement funds; and redirecting spending from deep-end placements to community-based services. **Future implementation plans include:** blending, braiding or pooling funds and offering incentives to providers to locate in certain areas of the state. Their target population for the Medicaid per diem rate is **children in custody placed in voluntary agencies**. The target population for enhanced state reimbursement for preventive services is **all children served by child welfare and juvenile justice agencies**.

**Funding sources include:** *federal* (DHHS SSA, Medicaid—Title XIX general, EPSDT, Fee for Service, Waivers), *local* tax funds and *local* levies for the per diem rate. *State* general funds, local tax funds, local levies, foundation funding, and donations make up the funding sources for the enhanced reimbursement for preventive services. **Many agencies are involved** in these two strategies, including: cross-system child serving agencies, Medicaid, faith community, private business, early childhood, primary health/public health, the governor's office, and the executive branch of state and local government. The prevention strategy also involves family organizations, tribal organizations, advocacy groups, higher education, vocational rehab, state legislature, city/county supervisors and the housing authority. New York is implementing the strategies **statewide**. They have been engaged in these efforts for **more than 24 months** and serve **more than 1,000** children/youth and families per year.

## North Dakota

North Dakota is implementing targeted case management (a wraparound process) for **all children in the child welfare system**. In its survey response, North Dakota identified a number of other services and programs and their related funding sources. **The state is implementing these strategies by:** identifying current spending and utilization patterns; realigning funding streams and structures; maximizing federal entitlement funds; redirecting spending from deep-end placements to community-based services; and offering incentives to providers to locate to certain areas of the state. All of the strategies mentioned by North Dakota are available to the **total child welfare population**.





**Funding sources for the strategies include:** *federal* (DHHS—SSA, including TANF, Child Welfare, Medicaid, and Social Services Block Grant; ACF; SAMHSA; and DOJ funds); *state* (non-Medicaid state matching funds, state general revenue flexible dollars, other state general funds); *local* (local tax funds, local levies); private insurance; foundation funding; in-kind donations and others). The North Dakota survey response matched services and programs to funding sources as follows:

- Targeted case management (a wraparound model) is funded with Medicaid, General Funds, TANF, and county funds.
- The Partnerships Program uses federal Mental Health Block Grant funds and general funding.
- State general funds and grant funds are used to implement evidence-based practices.
- Family preservation services use safety permanency funds.
- Respite care is provided with state general funds, federal Title IV-B, TANF and county funds.
- The TANF Kinship Care Program uses TANF and state general funds.
- Family Group Decision Making relies on state general funds, TANF, Title IV-B and Busch Grant funds.
- The Parent to Parent Program and the state's family organization are funded with state general funds.
- The Voluntary Treatment Program also uses state general funds.

**Twenty-one agencies are involved** in these endeavors. North Dakota is implementing the funding strategies **statewide** and has been engaged in these strategies for **more than 24 months** and is serving **between 500 and 1,000** children/youth and families per year.

## Ohio

Ohio reported on three of its funding strategies:

- Access to Better Care (ABC)
- Family and Systems Team Dollars SFY 2005 (FAST)
- House Bill 484—substance abuse services prioritized for families involved with child welfare.

**Access to Better Care (ABC)**—The ABC Initiative represents Ohio's collaborative efforts to determine service needs and funding issues across multiple systems and to develop cross-system strategies for addressing service gaps. Its goal is to increase the capacity of the behavioral healthcare system to address the needs of children, youth and their families and to build a cross-system capacity to partner effectively with families. ABC provides a strategic framework for community-based prevention, early intervention, and treatment services. Ohio has completed multi-systemic needs assessments, analyzed out of home placement trends and expenditures, identified areas for program development, and worked together to establish joint programming through pooled dollars. In total, the Ohio Family and Children's First agencies are investing \$18.2 million in ABC for behavioral health programs and services in FY 2007.



**Family and Systems Team Dollars SFY 2005 (FAST)**—FAST is a first step toward the broader vision of ABC. The state pooled funds from the mental health, child welfare, juvenile justice, and substance abuse services systems and made them available to local systems through the county and regional alcohol and drug and mental health boards. Counties use the funds for behavioral health services for youth with multiple needs; to expand family voice and responsibility in policy development and in planning for services for their own children; and to establish a statewide parent advocacy network. The budget for FAST in SFY 2005 was \$4,830,000. Ninety percent (90%) was distributed to counties for services, and 10% was set aside for wraparound training, parent advocacy activities and evaluation. Funding sources were approximately 60% federal (Title IV B, Part 2 Family Support dollars) and 40% of state pooled funds.

**House Bill 484** mandates that alcohol and addiction services boards in Ohio prioritize the provision of alcohol and other drug services to **families involved in the child welfare system**. The state biennial budget bills require ODADAS to distribute \$4 million annually for this purpose. Local contributions are also committed to these programs (\$2 M in 05, \$1.6 M in 07). Counties can elect to use part of their HB 484 allocation to meet local match requirements for alcohol and other drug treatment of Medicaid-eligible clients who are involved with the child welfare system.

Ohio is **implementing these strategies by:** identifying current spending and utilization patterns; realigning funding streams and structures; maximizing federal entitlement funds; pooling, blending or braiding funds across different child-serving agencies; and offering incentives to providers to locate in certain areas of the state. Child welfare and the substance abuse service system jointly developed a service matrix to identify appropriate uses of multiple funding streams. **Future implementation plans include:** redirecting spending from deep end placements to community-based services.

**Ohio identified multiple funding sources which include:**

- *federal* (DHHS SSA including: TANF—Title IV-A; Child Welfare Title IV-B, Part 1 and Part 2; Child Welfare Title IV-E; Juvenile Justice Title IV-E; Maternal and Child Health Block Grant Title V; Healthy Start Initiative; Medicaid—Title XIX, EPSDT, Rehabilitation Option, Fee for Service, Medicaid Waivers Section 1915(c), and SCHIP Title XXI; DHHS ACF including: System of Care Grants, Head Start, Early Head Start, Child Care Development Fund, and Family Resource Support; DHHS SAMHSA including: SA Prevention Block Grant, SA Treatment Block Grant, MH Block Grant, and MH Transformation Incentive Grant; DOE including: Title I; IDEA General, Part B and Part C; DOJ including: General and OJJDP; DOA general and WIC; Housing and Urban Development Department; Department of Homeland Security. Underage Drinking; DOL)
- *state* (non-Medicaid state matching funds and state general revenue flexible dollars)
- *local* (local tax funds and levies)
- tobacco settlement
- private insurance
- foundation funding
- corporate giving, social/volunteer/faith organization donations
- in-kind donations are used in this financing strategy.



Twenty-three agencies are involved including: cross-system child serving agencies, TANF, Medicaid, higher education, private business, the faith community, advocacy, family organizations, a managed care entity, Workforce Investment Act office, state legislature, Governor's Office, executive branch of government, and the housing authority. Ohio is implementing these strategies **statewide at the regional and county level** and has been engaged in these strategies for various lengths of time (12 to more than 24 months). FAST has enrolled **2,160 youth**; and in 2006, **7,078 families** were served under House Bill 484.

## Pennsylvania

In Pennsylvania, the survey response was from Allegheny County. This snapshot reflects the work and funding strategies of **one county**, rather than the state. Allegheny County has instituted a team approach to improve cooperation between families, providers and system partners; provide an array of individualized services; and promote a cross-system integrated planning process. The integrated planning process, which has led to jointly funding some projects and services by braiding funds, occurs at several levels:

- ***County Interagency Review Process*** (first level)—a collaborative, strength-based approach in which consumers, families, system partners, and providers convene to establish reasonable solutions for children for whom traditional behavioral health intervention has failed. It serves **children/youth (birth to 21) who exhibit severe behavioral disorders in the presence of a mental health diagnosis, mental retardation (MR), and/or developmental disabilities (DD)**.
- ***Multi-System Rapid Response Team Integrated Planning Process*** (next level)—comprised of cross-system county administrators and targeted for those **children and youth whose needs could not be fully addressed by the County Interagency Team**. This team plans globally (via monthly meetings) to develop resources for the target population. It also convenes to address individual child-specific emergency situations. Of the children seen, 71% are involved with the child welfare system.
- ***Residential Enhancement Service Planning Opportunities for New Directions (RESPOND)***—a partnership between the University of Pittsburgh Medical Center, three residential programs, and the Department of Human Services (DHS) which began in 2003 through a RFP process initiated by DHS. RESPOND includes a residential component and a mobile treatment team. It serves **children and youth who have not had their needs met through the other planning processes**, who have co-occurring disorders, and who have had frequent hospitalizations. RESPOND has a “no reject—no eject” agreement with the county and has significantly reduced hospitalizations.

From this team approach, Allegheny County has initiated several other strategies relevant to children in the child welfare system, including:

- Improved transition to the adult system of youth with developmental disabilities who are in custody
- Early identification of developmental disabilities in children age 0 to 5 who are in foster care



Allegheny County is **implementing these strategies by:** identifying current spending and utilization patterns; realigning funding streams and structures; maximizing federal entitlement funds; redirecting spending from deep end placements to community-based services; and pooling, blending or braiding funds across different child-serving agencies.

**Funding sources include:** *federal* (DHHS General; DHHS SSA including TANF Title IV-A, Child Welfare Title IV-B Part 1 and Part 2, Child Welfare and Juvenile Justice Title IV-E; Healthy Start Initiative; Medicaid Title XIX, General, EPSDT, Targeted Case Management, Fee for Service, Medicaid Waivers Section 1915(b), 1915(b)3, 1915(c) and 1115; Social Services Block Grant Title XX; SCHIP Title XXI; DHHS ACF including System of Care Grants, Head Start, Early Head Start, and John F. Chafee Foster Care Independence Program; DHHS SAMHSA including CMHS System of Care grants, SA Prevention Block Grant and SA Treatment Block Grant; DOE; DOA WIC; Housing and Urban Development Dept; Underage Drinking), *state* (Non-Medicaid State Matching Funds, State General Revenue Flexible Dollars); *local* tax funds; foundation funding; and social/volunteer/faith organization donations.

**Twenty-one agencies are involved**, including child-serving agencies, TANF, Medicaid, private business, the faith community, advocacy, family organizations, a managed care entity, WIA Office, state legislature, City Council/County supervisors, Governor's Office, executive branch of government, and the housing authority. The county has been engaged in these strategies for **more than 24 months**. They serve **more than 1,000** children/youth and families per year.

## South Carolina

South Carolina is engaged in a collaborative initiative between the state Department of Mental Health and the Department of Social Services to place child mental health professionals in the child welfare and adoption offices (co-location) in **several counties**. The purpose of this is to intervene as early as possible in the lives of families interfacing with the child welfare agency, decrease the number of adoptions that are not successful and which might disrupt, transition children back into their homes, and provide support to child welfare workers. Co-location enables children to be seen within 24 hours by the mental health professional and provides access to the full array of mental health services.

South Carolina is **implementing this strategy by:** realigning funding streams and structures and redirecting spending from deep end placements to community-based services. **Future implementation plans include:** identifying current spending and utilization patterns; maximizing federal entitlement funds; developing the ability to pool, blend or braid funds across different child serving systems; and offering incentives to providers to locate in certain areas of the state.

**Funding sources:** The child welfare agency used federal child welfare block grant funds to implement the initiative. South Carolina is working to establish a formula for billable and non-billable services to sustain the positions after the seed funding from child welfare ends. The state has been engaged in the strategy for **more than 24 months**. They serve **501-1000** children/youth and **more than 1,000** families per year.



## Vermont

In 1982, Vermont was the first state to secure a Medicaid home and community-based services waiver for children with serious emotional disorders.<sup>59</sup> Vermont's waiver provides services for **children who would otherwise be considered for psychiatric hospital levels of care**. Eligibility is determined by the child's intensity of need and the child's income and resources. The parents' income and resources are waived (or not counted). Referrals for services are made by community mental health centers and services are provided through community mental health centers.

Vermont is **implementing this strategy** by maximizing federal entitlement funds through its Medicaid Waiver. **Funding sources include:** *federal* (DHHS—SSA, Medicaid Waivers Section 1915 (c)). **Four agencies**, child welfare, mental health, Medicaid, and education, **are involved** and have formed partnerships through interagency agreements. The state is implementing the strategy **statewide**. It has been engaged in this strategy for **more than 24 months** (since 1982). They serve **less than 50** children/youth and families per year through the Waiver.

## West Virginia

West Virginia is financing an innovative continuum of community-based interventions through a system of care approach to create the best possible access to mental health care for **families and children involved with Child Protective and/or Youth Services**. The state plans to go statewide with a system of care approach implemented previously in one region. More specifically, funds are being used to:

- return youth from out of state placement
- provide intensive in-home services for children at risk of out of home/state placement
- develop skilled professionals to address the treatment needs of special populations.

**West Virginia plans to implement these strategies** by identifying current spending and utilization patterns and developing the ability to pool, blend or braid funds across different child serving systems.

**Funding sources include:** *federal* (DHHS General; Medicaid—Title XIX—General, EPSDT, Rehabilitation Option, and Targeted Case Management; Social Services Block Grants—Title XX; DHHS SAMHSA, including Substance Abuse Treatment Block Grant and Mental Health Block Grant; Department of Education IDEA General) and *state* (Other State General Funds) funds. A concentrated effort was made to obtain support from top level state administrators and the legislature to use these funds. The system of care expansion was mandated by a legislative commission. **Nine agencies are involved** including cross-system child-serving agencies, education, Medicaid, family organizations and treatment providers. They serve **over 1,000** children/youth and families each year.

<sup>59</sup> Stroul, B.A., Pires, S.A., Armstrong, M.I., McCarthy, J., Pizzigati, K. & Wood, G.M., (2008). *Effective financing strategies for systems of care: Examples from the field—A resource compendium for developing a comprehensive financing plan*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health, 2008, p. 8.





## Wisconsin

Wisconsin is engaged in the following three strategies to provide individualized, community-based mental health and substance abuse services, based on the wraparound model, for children, families and adults:

- ***Integrated Services Projects (ISP)***—Wisconsin’s original initiative supports **families of children with severe emotional disabilities** in their homes and communities (in the least restrictive setting possible). It uses a wraparound service planning process developed by child and family centered teams.
- ***Coordinated Services Teams (CST)***—This is an expanded ISP process, begun in 2002, that includes a larger group of children and families, those **with complex needs who are involved in multiple systems** (including child welfare, juvenile justice, substance abuse, and/or mental health).
- ***Comprehensive Community Services (CCS)***—CCS represents Wisconsin’s transformation of its mental health and substance abuse services system. In 2004, the state began to use a wrap around service planning process with **children, families, adults and elders (consumers across the life span with mental health and/or substance use issues)** in order to increase access to services and allowing counties to receive funding they could not bill for in the past. CCS is not specific to child welfare; however, children in the child welfare system can be served. CCS is designed to promote the child’s rehabilitation, and thus supports safety, permanency and well-being.

Wisconsin is **implementing these strategies by:** identifying current spending and utilization patterns; realigning funding streams and structures; maximizing federal entitlement funds; redirecting spending from deep end placements to community-based services; and pooling, blending or braiding funds across child serving systems. Multiple funding sources were blended to support the first two initiatives (ISP and CST) and a Memorandum of Understanding was signed by the mental health and child and family services divisions. In the CCS program, services must fall within the federal definition of “rehabilitative services” in order to be reimbursed by Medicaid. Counties are certified by the state to offer CCS and then are reimbursed the federal share of Medicaid. In the early stages, the state used Mental Health Block Grant funds to contract with an individual to assist state staff to develop CCS and provide technical assistance to counties.

**Funding sources for the first two initiatives (ISP and CST) include:** *federal* (DHHS SSA—Child Welfare Title IV-E; Medicaid General—Title XIX, Targeted Case Management; DHHS SAMHSA—MH and SA Block Grants), *state* (State General Revenue Flexible Dollars), *local* (tax dollars and levies), corporate giving, donations from organizations and in-kind donations). **Funding sources for the CCS program** are the same, except that there is no Title IV-E funding involved.

**Multiple agencies are involved** in the ISP and CST initiatives, including cross-system child serving agencies, Medicaid, education, private business, the faith community, advocacy, primary health and public health, family organizations, and the City Council/County supervisors. **The primary agencies involved in the Comprehensive Community Services program (CCS) are mental health, substance abuse, and Medicaid.** The state has been engaged in the strategies for **more than 24 months**. They serve **more than 1,000** children/youth and families each year.

## CHAPTER FIVE

# Observations of the Respondents



### This chapter describes

observations and learnings of the responding states about the financing strategies they have implemented. It addresses:

- major outcomes and accomplishments of the financing strategies
- challenges to implementing the strategies
- lessons learned and key elements for achieving success
- concluding comments.

## Major Outcomes and Accomplishments

It was clear from the survey responses that implementing the various financing strategies has led to significant accomplishments and outcomes. The accomplishments described by respondents included improvement in: assessment, services, clinical functioning, placement outcomes, timeliness and permanency, collaboration, knowledge and expertise about behavioral health, Medicaid and fiscal issues, access to services for older youth, tracking and monitoring systems, and family satisfaction.

### Assessment

Four states found that providing behavioral health and/or medical assessments for children entering foster care leads to early identification and intervention and more appropriate service plans<sup>60</sup>. **Florida** also noted that earlier identification of substance abuse treatment needs for families has improved outcomes for those families.

### Services

Seven states<sup>61</sup> described increased community-based services; increased availability and scope of services; strengthened service capacity; the development of innovative, effective service approaches; and increased flexibility in services. **North Dakota** noted increased regional CFSR scores and more timely services for children and families.

### Improved Child Functioning and Better Placement Outcomes

Several states noted stabilized behavior, improved school performance, and improved well-being for children<sup>62</sup>. Others noted that children are placed more appropriately, served closer to home, in their home schools, and in more normalized environments.<sup>63</sup> Six states<sup>64</sup> noted decreases in restrictive placements, fewer children

<sup>60</sup> AZ, AR, FL, NH

<sup>61</sup> AZ, FL, NJ, NY, ND, HI, WI

<sup>62</sup> NH, SC, WV

<sup>63</sup> GA, NE, NH, NJ, PA, WV

<sup>64</sup> FL, IN, MO, NH, WV, WI



removed from their homes or sent out of state, reduced length of stay in out-of-home care; and others<sup>65</sup> had decreased the number of residential placements and inpatient psychiatric hospitalizations. Services in **Florida** have promoted the adoption of children with serious emotional disorders.

### **Timeliness**

Three states<sup>66</sup> described more timely reunification and achievement of permanency.

### **Collaboration**

Four states<sup>67</sup> strengthened collaboration between the child welfare, mental health and/or substance abuse service systems; integrated services approaches; instituted multi-system responsibility for services for children; and increased collaboration among stakeholders, agencies and families.

### **Increased Knowledge and Expertise**

Three states<sup>68</sup> have increased knowledge about behavioral health issues and the unique needs of children/families in the child welfare system, improved training for staff in the art of psychotropic medication, and/or increased the number of qualified providers.

### **Medicaid/Fiscal Issues**

More families have access to Medicaid and/or S-CHIP in **New Jersey**. **New Hampshire** has increased Medicaid funding for services, and **Nebraska** has reduced service costs. **Arizona** noted that an understanding of the significant behavioral health needs of children in state custody led to establishing an enhanced capitation rate and to developing services that were commensurate with the needs of children in state custody.

### **Youth**

**New Hampshire** noted that young adults have greater access to behavioral health services and a better opportunity for success as they transition to adulthood. **New Hampshire** also has formed a Youth Advisory Board.

### **Tracking and Monitoring Systems**

**West Virginia** and **Arkansas** noted as a major accomplishment their ability to accumulate data to track specific indicators and to track child and family outcomes.

### **Family Satisfaction**

**Delaware** cited increased family satisfaction with services as a major accomplishment.

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<sup>65</sup> DE, FL, NH, NJ, WV

<sup>66</sup> FL, IN, NH

<sup>67</sup> FL, HI, OH, WI

<sup>68</sup> AZ, NH, OH





## Challenges to Implementation of Financing Strategies

The challenges faced by survey respondents often resulted from the concerns and fears of various stakeholders as they faced the fiscal and practice changes brought on by the financing strategies. Challenges clustered around fiscal issues, workforce and provider issues, collaboration, family and youth voice and partnerships, and communication/marketing.

### Fiscal Challenges

Financial challenges ranged from simply a lack of adequate funding to complicated tracking, reporting, and evaluation requirements when blending funds from multiple funding streams. States had to deal with the burden on local communities to track expenditures and a reluctance to assign undesignated funds to the system of care. It was a challenge to work with communities to put up matching funds and to convince local systems that pooling funds would lead to more appropriate services for the targeted children and families. A state that capitated all behavioral health services for children in the child welfare system noted that it took several years to develop this strategy and that careful planning was needed to ensure that a comprehensive package of services and supports was available under the new MCO.

A few states cited lack of commitment or mandate to: support best practices, train new staff in systems of care, and use state general funds to pay for behavioral health services when no other funding source was available. One state described the difficulties in obtaining federal approval for its Medicaid waiver, and another was challenged to sustain mental health positions that were co-located in child welfare offices after the seed funding from the child welfare system ended.

### Workforce and Provider Issues

Several states reported challenges related to providers' fears and reluctance to change. Anxiety from the provider community included fears of losing referrals for residential care and of going out of business. Respondents found it a challenge to get residential providers to commit to increasing in-home, community-based, and individualized services. In one state, children with significant emotional and behavioral needs were carved out of the existing MCOs and served by a behavioral health partnership. Working with the MCOs to achieve this change was a challenge.

States found it a challenge to build a diverse and qualified provider network that was adequate to serve children and families in the child welfare system. Building the capacity to meet specific service needs, to assess young children and infants, and to meet the needs of children of diverse cultures were noted as challenges. Also, as Medicaid service definitions and reimbursement procedures changed, providers had to be retrained on how to meet Medicaid qualifications and how to bill for Medicaid services.

Additional workforce challenges included resource limitations for training and technical assistance, high staff and foster parent turnover in a therapeutic foster care program, and working with private contractors.



### Collaboration

Challenges to collaboration included: turf issues; breaking down silos; merging different agency cultures, expectations and priorities; a lack of committed partners; and the need to develop new partnerships to implement a new practice model (child and family teams) and to change the service culture.

### Family and Youth Voice and Partnerships

Challenges ranged from the basics of getting all system partners to understand and value partnering with families to developing the strategies needed to support families as partners. One state had difficulty obtaining family leadership at the system level, due to the families' extensive commitment to their own children. Another described the challenge of moving *away* from advocating for families and *toward* assisting families to advocate on their own behalf. Another state described the challenge of treating family support organizations as equal system partners.

### Communication and Marketing

A few states described the challenges inherent in changing attitudes and practice and making communities aware of new services. In one state, mental health treatment was seen as a “bed” or a placement. It was a challenge to change this expectation of mental health treatment from simply a “bed” to individualized care in the least restrictive setting. Another state found it a challenge to inform legislators and other state leaders of the value of a system of care. For one state that co-located substance abuse intervention specialists in child welfare agencies, it was difficult, at first, to get referrals from child welfare staff. This was later resolved and now the demand is great.

### Additional Challenges

Individual states described several other challenges including ensuring strong performance measurement and continuous quality improvement; developing community-based services to reduce reliance on residential care; decreasing reliance on “bed-based” care; developing gate-keeping strategies to divert children from psychiatric residential care; ensuring that flexible funds were used properly; and articulating a formal theory of change.

## Lessons Learned and Key Elements to Achieve Success

A number of states described the lessons learned during implementation of the financing strategies and their key elements for success. Twenty (20) of the 28 states noted at least one key element for success. Many of the key elements were not fiscal in nature, but were related instead to other supports and practices that enabled the funded program, service, or system to be successful.

### Fiscal

One state felt that it waited too long to put a financing strategy in place. Another identified the importance of using both state and local funds. A third state noted that fiscal functions should be integrated with regulatory and quality improvement functions to ensure effective use of newly created services, and a fourth state stressed being flexible with the funding model so that it fits each local community.



Key elements for success included:

- Continued federal and state funding (AK)
- Analysis of data to establish the risk-adjusted case rate (AZ)
- Medicaid cost recovery for the services for Medicaid enrollees (DE)
- Savings in general fund dollars by state and county (NH)
- Cost effectiveness and improved outcomes (NH)
- Adequate reimbursement for services (NJ)
- Jointly written grant proposals (OH)
- The importance of pooled funding and the establishment of fiscal guidelines for utilization of blended funding streams. (OH, NJ)
- Ensuring the appropriate use of funds through quality assurance measures (FL).

## Workforce

Lessons learned by states focused on the importance of training, including:

- coaching and training to sustain each community-based system of care
- technical assistance that is varied to fit local needs
- partnerships with universities to strengthen pre-service training, enhance curriculum to include an understanding of system of care values, and teach clinical skills needed to work with children and families.

Key elements for success included:

- training and technical assistance for communities, providers, and system partners, including the need for *continuous* retraining
- using the most seasoned professionals and the importance of a good fit, when co-locating mental health or substance abuse staff in child welfare offices<sup>69</sup>.

## Collaboration

Several states stressed the importance of consistent communication among all partners, the importance of “joining” between the state and localities, and the value of being inclusive from the very beginning and during all phases of development. One state described collaboration among all parties as “the best treatment for children and their families”. Another felt that by blending funds, the partners involved strengthened the perception of “our” children, resulting in a more consistent service approach. One state stressed the importance of a functioning interagency team to guide the financing strategy.

Key elements for success included<sup>70</sup>:

- maintenance of solid working relationships
- engagement of all child-serving systems in both the development and governance of the initiative.

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<sup>69</sup> ID, SC

<sup>70</sup> AK, CT, FL, GA, IN, MI, MO, NH, NY, ND, PA, WI



### Family and Youth Voice and Partnerships

Six states<sup>71</sup> cited the voice of families as important in providing the services that families need and achieving positive outcomes. They also described the value of the family voice in all stages of policy development and planning, as well as the importance of family participation at the leadership level. **New Jersey** stressed the importance of viewing the Family Support Organizations as equal partners.

### Communication and Marketing

States stressed the importance of conveying a consistent message and educating the community about the values, principles and outcomes of systems of care, in order to obtain community “buy-in”. One state advised, “Shout your achievements to the world”. Five states<sup>72</sup> stressed the value of *ongoing* communication with *all* stakeholders and the necessity to create a structure within which communication can occur, including strategies for troubleshooting and addressing changing service needs. They described the need for all stakeholders to feel a part of the initiative and to understand the need for change.

### Strategic Planning

One state mentioned the importance of having a good overall plan that addresses governance, regional readiness, service development and delivery, evaluation and quality assurance, and financing. One state described the importance of phasing in a strategic plan, starting small and nurturing often and carefully. Another noted that implementation takes longer than anticipated and should be planned for.

### Quality Assurance

One state indicated that evaluation and quality assurance are essential to demonstrate how funds are spent and cost effectiveness. Two states determined that success depends upon utilization management and improved outcomes for children and families. **Arkansas** indicated that collaborative *monitoring* by both child welfare and mental health was a key to success. In **New Jersey**, having a data information system that can measure effectiveness of services and utilization management was essential.

### Leadership

Seven states<sup>73</sup> described the importance of strong leadership and the commitment to persevere.

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<sup>71</sup> CT, IN, OH, NJ, NH, WV

<sup>72</sup> CT, GA, NH, NJ, AZ

<sup>73</sup> AK, AZ, NH, IN, OH, PA, WI



## Concluding Comments

The states and communities that responded to the survey have shown the value of working together across systems on financing strategies to provide effective behavioral health services for children and families involved with the child welfare system. Through their descriptions of challenges and accomplishments, they affirmed that while these are not easy tasks, the rewards (outcomes) are great.

While a survey such as this is limited in how much specific and detailed information it can offer, we hope that reading what other states and communities have done will stimulate thoughts and provide a range of ideas for those who wish to improve behavioral health services for children and families in the child welfare system. **Appendix C** identifies survey respondents who agreed to be contacted for further information. It is included here so that readers can delve deeper into specific strategies that they wish to consider in their own areas.



## APPENDIX A

# Matrix of Financing Strategies by State<sup>74</sup>

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<sup>74</sup>This matrix includes all of the financing strategies that respondents checked off as being developed or implemented in their states to fund behavioral health services and supports for children and families in the child welfare system. For a number of strategies respondents chose to share more information. Chapter 2 provides in-depth descriptions for the 17 strategies that had narrative descriptions attached to them.



## APPENDIX A: Matrix of Financing Strategies by State

FUNDING STRATEGY	AK	AZ	AR	CT	DE	FL	GA	HI	ID	IN	ME	MI	MO	NE	NH	NJ	NY	ND	OH	PA	SC	VT	WV	WI	XX
1. Community-based, in-home behavioral health services and supports for children and families	•	•	•	•	•						•	•		•	•	•		•	•	•		•	•	•	•
2. Individualized, integrated and coordinated services within systems of care	•		•	•		•				•	•			•	•	•		•	•	•			•		
3. Managed care strategies		•		•	•	•	•	•			•			•	•								•		
4. Behavioral health screenings and comprehensive assessments for children in custody			•		•	•		•					•		•	•							•		
5. Behavioral health services and supports for family members of children in custody			•			•			•			•		•	•	•			•					•	
6. Child and family service planning teams										•				•				•	•	•				•	
7. Family run organizations to provide child and family services and supports		•						•						•	•	•		•				•			
8. Training								•		•			•			•									
9. Co-location of child welfare and mental health staff					•				•					•	•						•				
10. Expansion of pool of qualified behavioral health providers				•											•	•							•		
11. Family peer specialists				•												•							•		
12. Development, provision and monitoring of evidence-based practices for children in the child welfare system												•		•	•										





FUNDING STRATEGY	AK	AZ	AR	CT	DE	FL	GA	HI	ID	IN	ME	MI	MO	NE	NH	NJ	NY	ND	OH	PA	SC	VT	WV	WI	XX
13. Behavioral health services for youth who age out of the foster care system into the adult system												•			•					•					
14. Therapeutic foster care						•		•						•											
15. Crisis services and mobile response					•											•				•					
16. Behavioral health services for children in custody not meeting medical necessity criteria					•							•			•										
17. Reduction of out of state residential placements	•																						•		
18. Services for children with developmental disabilities															•					•					
19. Mental health needs of very young children												•			•										
20. Behavioral health services for children and families after reunification												•			•										
21. Substance abuse treatment services and supports for parents										•									•						
22. Transportation										•						•									
23. Strategies to avoid unnecessary custody relinquishment													•												
24. Family drug courts																			•						
25. Enhanced residential services																				•					
26. Culturally appropriate services that are targeted to meet the needs of each child												•													
27. Youth partnership organizations																	•								
28. Cross-system management information systems													•												



## APPENDIX B

# Methodology

### Development

This survey was developed in 2006 by workgroup members from the Children, Youth and Families Division (CYFD) of the National Association of State Mental Health Program Directors (NASMHPD); the National Association of Public Child Welfare Administrators (NAPCWA) of the American Public Human Services Association (APHSA); NAPCWA staff; and the National Technical Assistance Center for Children's Mental Health at the Georgetown University Center for Child and Human Development (TA Center). The survey purpose was to learn how states and communities finance behavioral health services and supports for children, youth and families involved with the child welfare system.

### Sample

Beginning in the summer of 2006 the financing strategies survey was disseminated to both the child welfare commissioner and the children's mental health director in each state. Although we preferred to receive one combined response from each state, the directors had the option of submitting one response or two separate responses. We encouraged them to forward the survey to other jurisdictions, including tribes, that had effective financing strategies and either include their responses in one combined state response or have them respond separately and directly. The survey was presented to states in an online format via SurveyMonkey as well as a hard copy format using Microsoft Word. They had the option of completing the survey online, in hard copy, or using a combination of the two formats. SurveyMonkey allowed the directors to complete portions of the survey at a time and change any of their answers until the survey was submitted.

A total of 28 states responded to the survey. Of the 28 states, 3 states partially completed their surveys while the remaining submitted full surveys. About a half of the responding states chose to submit the survey online, a quarter by paper and a quarter using a combination of formats. Approximately half of the directors chose to complete and submit a joint survey while the remaining half were about evenly split between mental health and child welfare respondents. With several states submitting more than one survey (due to separate surveys from both the child welfare commissioner and the children's mental health director in a state or separate surveys for each of the different financing strategies being utilized in a state), there were 49 individual survey responses in all. In addition to the survey responses, a few states enclosed extensive attachments to give a fuller description of their efforts. From the wealth of additional descriptive information received, it seems that the majority of responding states were eager to share more detailed information on their various funding efforts.



## Measures

The survey asked states whether they agreed to be identified by state name in the report of survey findings. All but one state agreed to publicly share the information in their survey responses.

A number of the questions in the survey yielded data that was straightforward and quantifiable. A second part of the survey asked respondents to provide more descriptive detail about individual financing strategies employed within their states. To reduce the burden of completing the survey and increase the response rate, the survey instructions allowed respondents to select one or more financing strategies they felt would be most useful to share with others. They were asked to provide descriptive information for these selected strategies, rather than for all of the strategies they were developing or had implemented. Although respondents were given the opportunity to answer questions for up to five separate strategies; one state chose to share descriptive information about 13 of their strategies. States also shared attachments to more fully describe their activities. Respondents were contacted when questions about the data were identified.

## Data Cleaning and Analysis

The final state survey response was received in the fall of 2006. The survey team then met to review the data and discuss the multi-stage analysis process. The online survey data was imported from SurveyMonkey into Microsoft Excel and Access. Excel housed the quantitative or survey check off data and Access housed the qualitative or descriptive data. Surveys completed via Word were manually entered into the databases. Once imported and inputted, the data were cleaned, checked and data forms created to organize the information for analysis. Data reports created in Access were ultimately arranged by code to assist with the summary process. Graphs were created using Excel capabilities.

For the states who chose to write narratives on one or more of their financing strategies, we engaged in thorough content analysis of the qualitative data by:

- Reducing the data into meaningful and manageable amounts
- Developing and assigning codes to relevant content
- Using the codes to create categories of financing strategies that linked together
- Reorganizing, analyzing and summarizing the material within the identified categories of strategies
- Checking and verifying the accuracy of the data
- Coming to a consensus around how to highlight and report out the summarized information.

Content analysis of the descriptive information revealed 17 individual financing strategies being utilized by states to fund behavioral services and supports for children and their families in the child welfare system. These 17 strategies are listed and described in Chapter 3.



States reporting the development or implementation of similar strategies were grouped together by strategy. Once like strategies were combined, themes, commonalities and differences between states emerged for each of the financing strategies. From these groupings of states, summaries were created for each of the 17 financing strategies describing: 1) what the strategy achieves (e.g., the service, the program, the process); 2) how the financing strategies were implemented; and 3) the funding sources that support the different strategies.

The in-depth descriptions of individual financing strategies across states that are summarized in Chapter 3 represent only the financing strategies for which states provided narrative descriptions. It does not represent the full range of strategies being employed across the country to serve children and families in the child welfare system. For example, although 27 states checked that they are developing or implementing community-based behavioral health services, only 16 states went on to provide a more detailed narrative description of this particular strategy. Given the non-exhaustive nature of the survey findings, states interested in developing and implementing a certain financing strategy can use the key contact list in the appendix to contact a state to learn more about a strategy of particular interest.

Staff from the National TA Center and from NAPCWA facilitated several conference calls with the joint workgroup members during the analysis phase to share the survey findings, determine what areas were most important to focus on, and to gather ideas for the report format and dissemination. The report underwent an extensive editing process before being formatted for distribution.



## APPENDIX C

# Survey Respondents and Key State Contacts (Current as of 2006)

STATE	NAME & TITLE	DEPARTMENT	CONTACT INFORMATION
Alaska	<b>Richard Nault</b> Social Services Program Officer	Office of Children's Services	<b>ADDRESS:</b> PO. Box 110630 Juneau, AK 99811 <b>E-MAIL:</b> Richard.Nault@health.state.ak.us <b>PHONE:</b> 907-465-4894 <b>FAX:</b> 907-465-3656
Arkansas	<b>Anne Wells</b> Assistant Director, Children's Services	Department of Health and Human Services, Division of Behavioral Health Services	<b>ADDRESS:</b> 4313 West Markham Little Rock, AR 72205 <b>E-MAIL:</b> Anne.wells@arkansas.gov <b>PHONE:</b> 501-686-9489 <b>FAX:</b> 501-686-9182
Arkansas	<b>Mona Davis</b> Program Manager	Department of Health and Human Services, Division of Children and Family Services	<b>ADDRESS:</b> PO Box 1437 Little Rock, AR 72203 <b>E-MAIL:</b> Mona.davis@arkansas.gov <b>PHONE:</b> 501-683-2044 <b>FAX:</b> 501-682-6968
Arizona	<b>Frank Rider</b> Bureau Chief, Children's Services	Arizona Department of Health Services, Division of Behavioral Health Services	<b>ADDRESS:</b> 150 No. 18th Avenue Phoenix, AZ 85051 <b>E-MAIL:</b> riderf@azdhs.gov <b>PHONE:</b> 602-448-8060 <b>FAX:</b> 602-364-4760
Connecticut	<b>Karen Andersson, Ph.D.</b> Director, Behavioral Health Programs and Planning	Connecticut Department of Children and Families, Bureau of Behavioral Health	<b>ADDRESS:</b> 505 Hudson Street Hartford CT 06106 <b>E-MAIL:</b> Karen.andersson@po.state.ct.us <b>PHONE:</b> 860-550-6683 <b>FAX:</b> 860-566-8022
Delaware	<b>Susan Cycyk</b> Director, Division of Child Mental Health and Division of Family Services	Division of Child Mental Health and Division of Family Services	<b>ADDRESS:</b> 1825 Faulkland Road Department of Services for Children, Youth & Families Wilmington, DE 19805 <b>E-MAIL:</b> susan.cycyk@state.de.us <b>PHONE:</b> 302-633-2600 <b>FAX:</b> 302-633-5118
Delaware	<b>Nancy Widdoes</b> Managed Care System Administrator	Department of Services for Children, Youth and Their Families	<b>ADDRESS:</b> 1825 Faulkland Road Division of Child Mental Health Services Wilmington, DE 19805 <b>E-MAIL:</b> nancy.widdoes@state.de.us <b>PHONE:</b> 302-633-2603 <b>FAX:</b> 302-533-5118





## APPENDIX C: Survey Respondents and Key State Contacts

STATE	NAME & TITLE	DEPARTMENT	CONTACT INFORMATION
Florida	<b>Frank Platt</b> Senior Management Analyst, Supervisor	Department of Children and Families, Office of Family Safety	<b>ADDRESS:</b> 1317 Winewood Boulevard Building 6, Room 153 Tallahassee, FL 32399 <b>E-MAIL:</b> frank_platt@dcf.state.fl.us <b>PHONE:</b> 850-922-2860 <b>FAX:</b> 850-414-6472
Florida	<b>Sue Ross</b> Bureau Chief	Department of Children and Families, Children's Mental Health	<b>ADDRESS:</b> 1317 Winewood Boulevard Building 6, Room 290 Tallahassee, FL 32399 <b>E-MAIL:</b> Sue_ross@dcf.state.fl.us <b>PHONE:</b> 850-410-1177 <b>FAX:</b> 850-413-6886
Florida	<b>Artica Warr</b> Team Leader, Substance Abuse Prevention and Treatment	Department of Children and Families, Substance Abuse Program Office	<b>ADDRESS:</b> 1317 Winewood Boulevard Building 6, Room 290 Tallahassee, FL 32399 <b>E-MAIL:</b> Atrica_warr@dcf.state.fl.us <b>PHONE:</b> 850-413-6773 <b>FAX:</b> 850-413-6623
Georgia	<b>Susanne L. Lindsey</b> Program Director	Georgia Department of Human Resources, Division of Mental Health, Developmental Disabilities and Addictive Diseases	<b>ADDRESS:</b> 2 Peachtree Street Atlanta, GA 30303 <b>E-MAIL:</b> slindsey@dhr.state.ga.us <b>PHONE:</b> 404-657-2136 <b>FAX:</b> 404-463-7149
Hawaii	<b>Christina M. Donkervoet</b> Chief	Department of Health, Child and Adolescent Mental Health Division	<b>ADDRESS:</b> 3627 Kilauea Avenue, Rm. 101 Honolulu, Hawaii 96816 <b>E-MAIL:</b> cmdonker@camhmis.health.state.hi.us <b>PHONE:</b> 808-733-9339 <b>FAX:</b> 808-733-9357
Idaho	<b>Michelle Britton</b> Division Administrator	Health and Welfare, Family and Community Services	<b>ADDRESS:</b> 450 W State Street Boise, ID 83720-0036 <b>E-MAIL:</b> brittonm@idhw.state.id.us <b>PHONE:</b> 208-334-5680 <b>FAX:</b> 208-334-6664
Idaho	<b>Bethany Gadzinski</b> Substance Abuse Program Manager	Health and Welfare, Behavioral Health	<b>ADDRESS:</b> 450 W State Street Boise, ID 83720-0036 <b>E-MAIL:</b> gadzinsb@idhw.state.id.us <b>PHONE:</b> 208-334-5756 <b>FAX:</b> 208-332-7351
Idaho	<b>Chuck Halligan</b> Children's Mental Health Program Manager	Health and Welfare, Behavioral Health	<b>ADDRESS:</b> 450 W State Street Boise, ID 83720-0036 <b>E-MAIL:</b> halligan@idhw.state.id.us <b>PHONE:</b> 208-334-6559 <b>FAX:</b> 208-332-7351



STATE	NAME & TITLE	DEPARTMENT	CONTACT INFORMATION
Indiana	<b>M. B. Lippold</b> Deputy Director, Programs and Services	Indiana Department of Child Services	<b>ADDRESS:</b> 402 W. Washington Street MS47, W392 Indianapolis, IN 46204 <b>E-MAIL:</b> mb.lippold@dcs.in.gov <b>PHONE:</b> 317-234-3925 <b>FAX:</b> 317-234-4497
Indiana	<b>Gina Eckart</b> Assistant Director	Division of Mental Health and Addictions	<b>ADDRESS:</b> 402 W. Washington Street W353 Indianapolis, IN 46204 <b>E-MAIL:</b> Gina.eckart@fssa.in.gov <b>PHONE:</b> 317-233-4319
Maine	<b>Jim Beougher</b> Director	Office of Child and Family Services, Maine Department of Health and Human Services	<b>ADDRESS:</b> 221 State Street Augusta, ME 04333 <b>E-MAIL:</b> James.Beougher@Maine.gov <b>PHONE:</b> 207-287-5034
Massachusetts	<b>Joan Mikula</b> Assistant Commissioner	Department of Mental Health, Child and Adolescent Services	<b>ADDRESS:</b> 25 Staniford Street Boston, MA 02114 <b>E-MAIL:</b> joan.mikula@dmh.state.ma.us <b>PHONE:</b> 617-626-8086
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## APPENDIX C: Survey Respondents and Key State Contacts

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STATE	NAME & TITLE	DEPARTMENT	CONTACT INFORMATION
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## APPENDIX C: Survey Respondents and Key State Contacts

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STATE	NAME & TITLE	DEPARTMENT	CONTACT INFORMATION
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## APPENDIX D

# Glossary

**NOTE:** We were granted permission from the authors of another national study of financing strategies to support systems of care to include this glossary of terms as a resource for this report. See the footnote below for the citation for this glossary.<sup>75</sup>

**Administrative Services Organization (ASO):** A contractual arrangement whereby a Managed Care Organization provides only the administrative services required by a health plan or payer.

**Assessment:** Assessment services, sometimes referred to as diagnostic and evaluation services, involve a professional determination of the nature of an individual's problem, the factors contributing to the problem and the strengths and resources of the individual and family. Recommendations for treatment and services are based on this information. It is important for the provider and family together to decide what kind of treatment and supports, if any, are needed. Comprehensive assessments focus on the child, family and the environment in which they live. They address each child's individual culture and physical, mental/emotional and developmental condition. Assessment plays a particularly important role for children and youth with serious emotional disturbances because their problems are complex and do not fit established diagnostic categories.

**Behavioral Health Services and Supports:** Coordinated and integrated healthcare with the goal of restoring optimal behavioral health through the treatment of mental health and substance abuse disorders. Includes a broad array of mental health, chemical dependency, forensic, mental retardation, developmental disability, and cognitive rehabilitation services that are not limited to any setting or facility. Incorporates a full continuum of treatment intensities (from emergency and acute care to rehabilitation to stabilization) as well as prevention interventions at individual, family and community levels.

**Blended Funding:** The process of combining categorical funds from different sources and agencies into a single funding stream or "pool" to gain more flexibility in how these funds can be spent on individualized services. Once blended these funding sources are indistinguishable from each other. Blended funding can allow systems to fund activities that are not reimbursable through specific categorical programs. Systems must track, document and account for the funds they spend, whether using a blended or braided approach.

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<sup>75</sup> Armstrong, M.I., Pires, S.A., McCarthy, J., Stroul, B.A., Wood, G.M., & Pizzigati, K., (2006). *A self-assessment and planning guide: Developing a comprehensive financing plan (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub. #235-01)*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, Research and Training Center for Children's Mental Health, p. 37.



**Braided Funding:** Funds from various sources are used to pay for a coordinated package of services for individual children, but tracking and accountability for each pot of money is maintained at the administrative level. The funds remain in separate strands but are joined or “braided” for the individual child and family. Systems must track, document and account for the funds they spend, whether using a blended or braided approach.

**Capitation Rate:** A fixed amount of money paid for every person enrolled in a health plan whether or not they present for services during a specific time. Usually expressed in units of per member per month.

**Care Management:** A process to facilitate individual child and family care at critical treatment junctures to assure their care is coordinated, received when they need it, likely to produce good outcomes, and is neither too little nor too much service to achieve the desired results. This process establishes an identifiable point of accountability between the child and family and all helping systems.

**Case Rate:** A fixed amount of money paid for each person who presents for covered services. May be expressed differently in different programs, e.g., per child per month or per child per episode of care.

**Case Manager:** An individual who organizes and coordinates services and supports for children with mental health problems and their families, also, referred to as a care manager.

**Child and Family Outcome Data:** Data used for determining the impact of programs on the children and families served.

**Child and Family Teams:** Teams of children, families, providers and others who come together to develop individualized service plans. The team is usually made up of the providers and other agency representatives who work with the family, extended family members, and other support persons, such as neighbors or ministers. The family approves all team members. The team reviews each family’s strengths and needs, identifies and plans for needed services and supports.

**Child Find:** A component of the Individuals with Disabilities Education Act (IDEA) that requires states to identify, locate, and evaluate all children with disabilities, aged birth to 21, who are in need of early intervention or special education services.

**Clinic Option:** A Medicaid optional benefit that allows for outpatient services to be provided through a wide variety of health care clinics including community mental health agencies. Services must be based at the clinic (except for services to homeless people) and supervised by a physician.

**Co-Occurring Disorder:** A term referring to co-occurring substance-related, mental health or developmental disorders. At the individual level, a co-occurring disorder exists when at least one disorder of two types can be established independent of the other and is not simply a cluster of symptoms resulting from a single disorder.



**Cost Benefit Data:** Data on child/family outcomes and on system performance to use in weighing the cost of a service, policy, or procedure against the benefits achieved for children and families.

**Cost Neutrality:** Refers to the requirement that States applying for Medicaid waivers under sections 1115, 1915(b) and/or 1915(c) must demonstrate that the program does not exceed what the federal government would have spent without approving the waiver. States can do this by showing that the average per capita expenditure estimated by the State in any fiscal year for medical assistance provided with respect to the group affected by the waiver does not exceed 100 percent of the average per capita expenditure that the State reasonably estimates would have been made in that fiscal year for expenditures under the state plan for such individuals if the waiver had not been granted. The concept of cost neutrality applies to other federal waivers also, e.g., Title IV-E.

**Cost Shifting:** The practice of one agency or system obtaining care for a child at the expense of another agency or system, i.e. shifting the cost of care from one agency to another.

**Cross-System:** Implies that more than one child-serving agency or system participates in a service, a program, a training event, etc.

**Cultural Competence:** Cultural competence is a developmental process that evolves over an extended period. It requires that organizations:

- Have a defined set of values and principles, and demonstrate behaviors, attitudes, policies and structures that enable them to work effectively cross-culturally
- Have the capacity to value diversity, conduct self-assessment, manage the dynamics of difference, acquire and institutionalize cultural knowledge, adapt to diversity and the cultural contexts of the communities they serve
- Incorporate the above in all aspects of policymaking, administration, practice, service delivery and involve systematically consumers, key stakeholders and communities.

**Disparities:** Differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups in the United States. Research on health disparities related to socioeconomic status is also encompassed in the definition.

**Disproportionality:** A situation in which a particular racial/ethnic group of children is represented at a higher percentage than other racial/ethnic groups.

**Early Childhood Mental Health:** The social, emotional, and behavioral well-being of children birth through five and their families, including the developing capacity to: experience, regulate, and express emotion; form close, secure relationships; and explore the environment and learn.



**EPSDT (Early and Periodic Screening, Diagnostic, and Treatment):** A Medicaid program that is designed to improve primary health benefits for children with an emphasis on preventive care. States must cover regular and periodic exams for all eligible children under the age of 21; and must provide any medically necessary services prescribed by the exams, even those not covered in a state's Medicaid plan.

**Evidence-Based Practice:** The provision of services in a manner that is: consistent with current professional knowledge; supported by careful, systematic, and rigorous research and evaluation; based on best clinical experience; and consistent with child/family values.

**Family-Driven:** A term meaning families have a primary decision making role in the care of their own children as well as the policies and procedures governing care for all children in their community, state, tribe, territory and nation. This includes: choosing supports, services, and providers; setting goals; designing and implementing programs; monitoring outcomes; partnering in funding decisions; and determining the effectiveness of all efforts to promote the mental health and well being of children and youth.

**Family of One:** The “family of one” option is a basic Medicaid rule (optional for states) that allows children who have been in an out-of-home placement for 30 days or longer (e.g., residential treatment or therapeutic foster care) to become eligible for Medicaid, regardless of their family's income, while they need and remain in the placement. It does not allow eligibility during the first 30 days in placement and does not allow the use of Medicaid to cover costs during that time. When the child returns home, he/she is no longer eligible as a “family of one.”

**Family Organization:** An organization with the explicit purpose to serve families who have a child, youth, or adolescent with special physical, mental, emotional, behavioral, developmental or educational needs. It is governed by a board of directors comprised of a majority of individuals who are family members; gives preference to family members in hiring practices; and is incorporated in a State as a private non-profit entity.

**Individualized Service Plans (ISP):** The written procedures and activities that are appropriately scheduled and used to deliver services, treatments, and supports to a child and the child's family. Families help create these plans which guide the work of the care manager. The ISP is created uniquely for each child and family and changed as often as necessary to reflect changes in the child, the family, and/or their circumstances. Such plans treat the family as a unit and seek to coordinate service efforts across all family members.

**Level of Care Criteria:** Guidelines employed to assist in the determination of the appropriate setting and intensity of behavioral health treatment.

**Linguistic Competence:** The capacity of an organization and its personnel to communicate effectively, and convey information in a manner that is easily understood by diverse audiences including persons of limited English proficiency, those who have low literacy skills or are not literate, and individuals with disabilities. Linguistic competency requires



organizational and provider capacity to respond effectively to the health literacy needs of populations served. The organization must have policy, structures, practices, procedures and dedicated resources to support this capacity.

**Managed Care Organization:** An organization that either directly provides or arranges managed health care by applying various strategies designed to optimize the value of provided services by controlling their cost and utilization, promoting their quality and measuring performance to ensure cost-effective outcomes.

**Management Information System (MIS):** A system (almost universally automated or computer based), which collects the necessary information in proper form and at appropriate intervals for managing a program or other activities. The system shall afford indicators, which measure program progress toward objectives, identify discrete costs, and facilitate identifying problems that need attention.

**Medicaid Options:** Options granted by the federal government to states through which they can provide an expanded range of services to a target group of children.

**Medical Necessity Criteria:** Criteria used by the managed care entity to determine if requested interventions or services are medically appropriate and necessary to meet the needs for a particular individual.

**Part C:** The Early Intervention Program of the Individuals with Disability in Education Act (IDEA) that focuses on infants and toddlers and requires a range of early intervention services needed as a result of developmental delays affecting cognitive development, physical development, language and speech, or psychological development.

**Performance-Based or Outcomes-Based Contracts:** Emphasizes that all aspects of an acquisition be structured around the purpose of the work to be performed as opposed to the manner in which the work is to be performed or broad, imprecise statements of work which preclude an objective assessment of contractor performance. It is designed to ensure that contractors are given freedom to determine how to meet performance objectives, that appropriate performance quality levels are achieved, and that payment is made only for services that meet these levels.

**Pooled Funding:** See definition for Blended Funding.

**Practice Based Evidence:** A range of treatment approaches and supports that are derived from, and supportive of, the positive cultural attributes of the local society and traditions. Practice based evidence services are known to be effective by the local community, through community consensus. They address the therapeutic and healing needs of individuals and families from a culturally specific framework. Practitioners of practice based evidence models draw upon cultural knowledge and traditions for the treatment and are respectfully responsive to the local definition of wellness and dysfunction.



**Practice Based Evidence/Promising Practices:** Practice knowledge supported by evidence of effectiveness through the experiences of key stakeholders, such as families and direct-care providers and usually outcome data.

**Provider Network:** Group of agencies and/or individual providers that agree to provide and are reimbursed for services to members of a managed care plan or an organized system of care.

**Psychiatric Rehabilitation Options (Rehabilitation Option):** An option in Medicaid services that incorporates rehabilitative, community-based services to persons with psychiatric and co-occurring psychiatric-substance abuse diagnosis. This category is known as the Medicaid Rehabilitation Option or MRO. Medicaid also pays for behavioral health services through the Clinic Option and through Targeted Case Management (TCM).

**Psych Under 21:** An optional benefit under section 1905(a)(16) of the Social Security Act that covers inpatient hospitalization of children under age 21. The benefit must provide any services listed in section 1905(a) that is needed to correct or ameliorate defects and physical and mental conditions discovered by EPSDT screening, whether or not the service is covered under the State plan.

**Purchasing Collaborative:** A collaborative behavioral health services model that brings all agencies tasked with the delivery, funding or oversight of behavioral healthcare services together to create a single behavioral health service delivery system in a state.

**Quality Assurance:** An approach to improving the quality and appropriateness of medical care and other services. Includes a formal set of activities to review, assess, and monitor care to ensure that identified problems are addressed.

**Quality Improvement/Continuous Quality Improvement:** A process that continually monitors program performance. When a quality problem is identified, CQI develops a revised approach to that problem and monitors implementation and success of the revised approach. The process includes involvement at all stages by all organizations, and stake holders that are affected by the problem and/or involved in implementing the revised approach.

**Risk Adjustment Mechanisms:** Various methods that can be used to level the playing field prospectively or retrospectively for at-risk provider systems under situations where voluntary or mandatory enrollees may choose among competing providers. Adjust rates paid to managed care organizations or providers for the cost of caring for populations with known high service costs.

**Risk Pool:** A grouping of enrollees or contracts by some common factor, (e.g., contract, size, geographic location, services utilization pattern) that allows all revenue and expenses for that group to be aggregated and to distribute risk among participants and thus insure that the losses faced by any one participant are minimized. Used to spread risk for low incident, high cost conditions or to buffer a risk bearing managed care organization or provider from catastrophic cost that are outside provider's control.





**Screening:** A guideline that recommends periodic interventions be performed for the early detection of behavioral health problems so that appropriate care can be provided early on.

**Section 1115 Research & Demonstration Projects:** This section provides the Secretary of Health and Human Services broad authority to approve projects that test policy innovations likely to further the objectives of the Medicaid program.

**Section 1915 (b) Managed Care/Freedom of Choice Waivers:** This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

**Section 1915 (c) Home and Community-Based Services Waivers:** This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings.

**Service Utilization:** A description, usually statistical, of the level, frequency, and necessity of services actually used by consumers. Generally aggregated into population measures, rather than individual consumer measures.

**Single Plan of Care:** A single care plan developed among all agencies serving the family. There should be no separate education plans, child welfare plans, mental health agency plans, etc.

**Skilled Professional Medical Personnel/Administrative Medical Case Management:** Medicaid funding may be used to reimburse for administrative case management when the case management is provided by Skilled Professional Medical Personnel (SPMP). SPMP may provide services such as administrative medical case management, intra/interagency coordination, collaboration and administration, training, program planning and policy development, and quality management.

**State Children's Health Insurance Plan (SCHIP):** Under Title XXI of the Balanced Budget Act of 1997, the availability of health insurance for children with no insurance or for children from low-income families was expanded by the creation of SCHIP. SCHIPs operate as part of a State's Medicaid program.

**System/Site:** Any state, tribe, territory, region, county, city, community, or organization that is designing a comprehensive financing strategy to build a system of care.

**Systems of Care:** A comprehensive spectrum of mental health and other necessary services which are organized into a coordinated network to meet the multiple and changing needs of children and their families.

**Target Population:** The specific population of people a particular program or practice is designed to serve or reach.





**Targeted Case Management:** Medicaid term for case management services covered under Title XIX of the Social Security Act (as of November 1995). Federal law defines Targeted Case Management as services that will assist individuals eligible under the state Medicaid plan in gaining access to needed medical, social, educational and other services.

**Intensive Care Management:** intensive community services for individuals with severe and persistent mental illness designed to improve planning for their service needs. Intensive care management includes outreach, evaluation and support services. Case managers are generally advocates and arrangers of services and supports, but also provide teaching of community-living and problem-solving skills; modeling productive behaviors and helping individuals help themselves.

**Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA):** TEFRA is a specific Medicaid eligibility option available to states that allows the provision of home and community-based services for children who meet SSI disability criteria and who, without the home and community-based services, would require institutional placement. Parental income is not considered in determining the child's eligibility. If a state uses this option, there is no limit on the number of children who can be served, and it creates an entitlement for all children who qualify based on their disability and care needs. It is also known as the Katie Beckett option in some states.

**Telehealth (Telemedicine):** Professional services given to a patient through an interactive telecommunications system by a practitioner at a distant site.

**Title IV-E Demonstration Waiver (Child Welfare Demonstration Projects):** Provides States with an opportunity to design and test a wide range of cost-neutral approaches to improve and reform child welfare by waiving certain requirements of Title IV-E. The general objectives of the waivers include the development of family-focused, strengths-based, community-based service delivery networks that enhance the child-rearing abilities of families, to enable them to remain safely together when possible, or to move children quickly to permanency; and development of better results for children and families.

**Utilization Management:** A system of procedures designed to ensure that the services provided to a specific individual at a given time are cost-effective, appropriate, and least restrictive.

**Utilization Review:** Retrospective analysis of the patterns of service usage in order to determine means for optimizing the value of services provided (e.g. minimize cost and maximize effectiveness/appropriateness).

**Youth-guided:** A term meaning youth having a role in guiding their own care. For older youth, it may mean directing their own care.

## APPENDIX E

# Financing Strategies Survey

Financing Strategies for Behavioral Health Services and Supports:  
Serving Children and Families in the Child Welfare System

### Background

The Children, Youth, and Families Division of the National Association of State Mental Health Program Directors (CYFD) and the National Association of Public Child Welfare Administrators of the American Public Human Services Association (NAPCWA) have formed a collaborative workgroup to achieve better services and outcomes for children and families involved in the child welfare system. Recognizing the importance of providing appropriate behavioral health services\* and supports for parents and care givers, as well as for children, the workgroup has chosen to focus its initial efforts on financing strategies for meeting the needs of the whole family, from its first contact with the child welfare system through reunification or other permanent placement, including ongoing supports when needed.

This survey has been developed by workgroup members from NAPCWA and CYFD, NAPCWA staff, and the National TA Center for Children's Mental Health at the Georgetown University Center for Child and Human Development.

### Purpose of Survey

This survey is intended to learn how states and communities finance behavioral health services and supports for children, youth and families involved with the child welfare system, including those who may not be eligible for Medicaid or may not meet the medical necessity criteria for specific behavioral health services.

It seeks to understand challenges and solutions for providing behavioral health services and supports in both the child and adult systems. The survey asks about funding sources for specific services and supports and how states, communities and tribes find or adapt resources when traditional funding streams do not cover needed services. The findings will be shared with all respondents and used to inform federal, state and tribal governments about these complex issues.

Recommendations will be made for funding strategies to improve access to behavioral health services and supports for children and families involved with the child welfare system.

*\*In this survey "behavioral health" refers to a combination of mental health and substance abuse services and supports.*



## Instructions

### For all respondents:

1. The survey asks you to report *separately* on specific financing strategies that your state is developing or has implemented. The section entitled “Individual Strategy Description” includes a set of questions (6.a.-6.z.) that are to be answered for *each* financing strategy that you describe. The survey provides instructions as to how to respond about more than one strategy.
2. This survey has been sent to the child welfare director and the children’s mental health director in each state. *We prefer to receive one combined response from each state;* however, if that is not possible, you may submit separate responses.
3. We encourage you to *forward this survey to other jurisdictions*, including tribes, with effective financing strategies. You may include their responses in one combined state response, or they may respond separately and directly.
4. The survey is due **June 30, 2006**.
5. We have provided a Word version of this survey so you can print it to share with others. You may also complete the survey in Word, rather than on-line.

### For respondents using the Word Document:

1. When you save it, include your state or jurisdiction as part of the file name
2. To choose the box ( ☐ ), simply click on it.
3. To provide a narrative response, click on the gray shaded box (  ) and start typing (there is no character limit)
4. Send the completed survey to Kerry Fay Vandergrift at [kerry.vandergrift@aphsa.org](mailto:kerry.vandergrift@aphsa.org) or 202/289-6555 (fax).

### For respondents using the web-based survey:

1. When using SurveyMonkey you do not have to complete the survey all at once and you may change your answers at anytime until the close of the survey.
2. If you close the survey and return by clicking the link in the e-mail, you will return to the last section completed. You can change your previous answers by clicking on “prev” at the bottom of the screen.
3. You may also forward the e-mail link by simply forwarding the e-mail or cutting and pasting the link that was sent to you (<http://www.surveymonkey.com/s.asp?u=753331713723>). We encourage you to forward this survey to other jurisdictions, including tribes, for them to complete the survey either to be included in the state response or separately and directly.
4. When you received this link via e-mail, you also received the survey as a Word document. You may print the survey and distribute it to others. If you choose to respond to the survey by completing the Word document and not responding online, please e-mail it to [kerry.vandergrift@aphsa.org](mailto:kerry.vandergrift@aphsa.org) or fax the document to 202-289-6555.



## Confidentiality

- 1.a. The survey results are not intended to be confidential. The survey provides an opportunity for peer to peer learning. Financing strategies used in one jurisdiction will be shared with other jurisdictions, both specifically and as part of a summary.

Please indicate whether you agree to sharing information about your state.

☐ Agree

☐ Disagree

- 1.b. If you do not want your state to be identified, the information you provide will be included in the results without your state's name listed. We hope that you will still complete the survey. You may also contact Jan McCarthy at 202-687-5062 or Kerry Fay Vandergrift at 202-682-0100 to discuss this issue.

Please provide comments below, in the gray box.



## Respondent Information

For each respondent, please provide contact information.

### 2.a. 1st Respondent

Name	<input type="text"/>
Title	<input type="text"/>
Department/Division	<input type="text"/>
Mailing Address	<input type="text"/>
E-mail	<input type="text"/>
Fax number	<input type="text"/>
Phone number	<input type="text"/>

### 2.b. 2nd respondent

Name	<input type="text"/>
Title	<input type="text"/>
Department/Division	<input type="text"/>
Mailing Address	<input type="text"/>
E-mail	<input type="text"/>
Fax number	<input type="text"/>
Phone number	<input type="text"/>

### 2.c. 3rd respondent

Name	<input type="text"/>
Title	<input type="text"/>
Department/Division	<input type="text"/>
Mailing Address	<input type="text"/>
E-mail	<input type="text"/>
Fax number	<input type="text"/>
Phone number	<input type="text"/>



## Demographic Information

3. Are you responding about statewide financing strategies?  
(This is a note to online survey users.) *Please note, you must answer this question to move forward on the survey. You may change your answer by returning to the question.*

☐ Yes

☐ No

- 4.a. Name of jurisdiction where strategy applies, including state name. If you are responding about a statewide strategy, the state name is sufficient.

- 4.b. Identify the department and division (in the jurisdiction where the strategy applies) where each of the following services are located.

Child Welfare	<input type="text"/>
Mental Health (children)	<input type="text"/>
Mental Health (adults)	<input type="text"/>
Substance Abuse (children)	<input type="text"/>
Substance Abuse (adults)	<input type="text"/>
Medicaid	<input type="text"/>

- 4.c. Number of children in your jurisdiction involved in substantiated abuse and neglect cases in the most recent fiscal year for which you have data available:

☐ 0-500

☐ 15,001-20,000

☐ 501-1,000

☐ 20,001-25,000

☐ 1,001-2,000

☐ 25,001-30,000

☐ 2,001-5,000

☐ 30,001-35,000

☐ 5,001-10,000

☐ 35,001-40,000

☐ 10,001-15,000

☐ 40,001+

Indicate fiscal year:

- 4.d. Number of children currently in custody state-wide

☐ 0-500

☐ 10,001-15,000

☐ 501-1,000

☐ 15,001-20,000

☐ 1,001-5,000

☐ 20,001+

☐ 5,001-10,000



## Financing Strategies

- 5.a. In this section, we want to learn about useful funding strategies your state or jurisdiction uses to promote access to behavioral health services and supports for children and families involved with the child welfare system. For example, you may have implemented or be in the process of developing one or more of the strategies listed below.

Please check all that your state is developing or has implemented.

Strategy	Developing	Implemented
financing community-based behavioral health services and supports for children and families in their own homes that might prevent them from entering more restrictive placements	<input type="checkbox"/>	<input type="checkbox"/>
financing behavioral health services and supports for family members of children who are in custody, especially if the family members are not eligible for Medicaid	<input type="checkbox"/>	<input type="checkbox"/>
funding behavioral health screening and comprehensive assessments for children in custody	<input type="checkbox"/>	<input type="checkbox"/>
funding behavioral health services for children in custody who do not meet medical necessity criteria	<input type="checkbox"/>	<input type="checkbox"/>
funding to meet the mental health needs of very young children	<input type="checkbox"/>	<input type="checkbox"/>
financing child and family team service planning meetings funding individualized and culturally appropriate services that are targeted to meet the needs of each child	<input type="checkbox"/>	<input type="checkbox"/>
funding the expansion of the pool of qualified behavioral health providers	<input type="checkbox"/>	<input type="checkbox"/>
funding the development, provision and monitoring of evidence based practices for children in the child welfare system	<input type="checkbox"/>	<input type="checkbox"/>
continuing to fund behavioral health services for children and families after reunification	<input type="checkbox"/>	<input type="checkbox"/>
funding behavioral health services for youth who age out of the foster care system and into the adult system	<input type="checkbox"/>	<input type="checkbox"/>
funding for co-location of child welfare and mental health staff	<input type="checkbox"/>	<input type="checkbox"/>
funding family-run organizations to provide child/family services and supports	<input type="checkbox"/>	<input type="checkbox"/>
other (you will describe these in detail in the next section, "Individual Strategy Description")	<input type="checkbox"/>	<input type="checkbox"/>





- 5.b. If you currently have *no specific financing strategies in place and are not developing any*, please check here:

☐ We have **no** specific strategies.

If you do not have any specific strategies, you have finished the survey. Please send the survey via e-mail or regular mail to the address at the end of the survey.

- 5.c. We would like to know *how* you have implemented or plan to implement the strategies identified above. Please check all below that apply.

Strategy	Developing	Implemented
identified current spending and utilization patterns	<input type="checkbox"/>	<input type="checkbox"/>
realigned funding streams and structures	<input type="checkbox"/>	<input type="checkbox"/>
maximized federal entitlement funds	<input type="checkbox"/>	<input type="checkbox"/>
redirected spending from “deep-end” placements to community-based services	<input type="checkbox"/>	<input type="checkbox"/>
pooled, blended, or braided funds across different child-serving systems	<input type="checkbox"/>	<input type="checkbox"/>
offered incentives to providers to locate in certain areas of the state	<input type="checkbox"/>	<input type="checkbox"/>
Other (please describe below)	<input type="checkbox"/>	<input type="checkbox"/>

If you chose “other” in the question above (5.c.), please describe how you implemented or plan to implement the strategy.



## Instructions for Completing the Individual Strategy Descriptions

The next series of questions asks more detail about *each* of the financing strategies. You will be asked questions about target populations, number of individuals served, systems involved, types of funding, and other questions specific to a particular strategy.

### For respondents using the Word document:

For each strategy, please answer all the questions on the pages labeled “Individual Strategy Description.” The Word version of the survey provides space for you to describe one strategy. If you have more than one strategy to describe, please save the document with the same file name adding “Strategy Description 2[3,4, etc.]” You do not have to fill out the questions on pages 1-7 more than once.

### For respondents using the web-based survey:

You will be given the opportunity to answer these questions for up to five separate strategies. If you have more than five strategies to describe, please contact Kerry at 202-682-0100 ext. 224 or [kerry.vandergrift@aphsa.org](mailto:kerry.vandergrift@aphsa.org).

### Individual Strategy Description

- 6.a. Brief description: Please describe the strategy, including the purpose, the target population, how it works, the funding sources, and the most significant outcomes to date.

You can send via e-mail a description in place of, or in addition to, responding below. If you choose to do this, please indicate in the box below where the response can be found in the documents you are sending.

- 6.b. How long has this strategy been in place?

- ☐ less than 6 months  
☐ 6-12 months  
☐ 12-18 months  
☐ 18-24 months  
☐ more than 24 months

- 6.c. At what level has this strategy been implemented? Please check all that apply.

- ☐ State-wide  
☐ Regional  
☐ Local (county, city)  
☐ Tribal  
☐ Other (please specify)



### Individual Strategy Description

- 6.d. Describe the target populations served (e.g., children in custody, families of children in custody, youth aging out of foster care, children with CPS involvement who live in their own homes, total child welfare population, etc.)

- 6.e. Approximate number of children/youth served per year by this strategy.

- ☐ 0-50  
☐ 51-100  
☐ 101-200  
☐ 201-500  
☐ 501-1,000  
☐ 1,001+

- 6.f. Approximate number of families served by this strategy.

- ☐ 0-50  
☐ 51-100  
☐ 101-200  
☐ 201-500  
☐ 501-1,000  
☐ 1,001+

- 6.g. Which systems or agencies are involved in this strategy? Please check all that apply.

- |  |  |
|--|--|
| <input type="checkbox"/> Child Welfare                     | <input type="checkbox"/> Family Organizations                  |
| <input type="checkbox"/> Mental Health                     | <input type="checkbox"/> Tribal organizations                  |
| <input type="checkbox"/> Substance abuse                   | <input type="checkbox"/> Managed Care Entity                   |
| <input type="checkbox"/> Court                             | <input type="checkbox"/> WIA Office (Workforce Investment Act) |
| <input type="checkbox"/> Juvenile Justice                  |  |
| <input type="checkbox"/> Economic Assistance (TANF)        | <input type="checkbox"/> Vocational Rehab/Employment Services  |
| <input type="checkbox"/> Medicaid                          | <input type="checkbox"/> State Legislature                     |
| <input type="checkbox"/> Education (Primary and Secondary) | <input type="checkbox"/> City council/county supervisors       |
| <input type="checkbox"/> Higher Education                  | <input type="checkbox"/> Governor's Office                     |
| <input type="checkbox"/> Private business                  | <input type="checkbox"/> Mayor's Office                        |
| <input type="checkbox"/> Faith Community                   | <input type="checkbox"/> Executive Branch of Gov't             |
| <input type="checkbox"/> Primary Health/Public Health      | (state, county, city, and/or tribal)                           |
| <input type="checkbox"/> Early Childhood                   | <input type="checkbox"/> Housing Authority                     |
| <input type="checkbox"/> Developmental Disabilities        | <input type="checkbox"/> Other <input type="text"/>            |
| <input type="checkbox"/> Advocacy                          |  |



### Individual Strategy Description

6.h. Describe the range of services covered by this strategy.

You can send via e-mail a description in place of, or in addition to, responding below. If you choose to do this, please indicate in the box below where the response can be found in the documents you are sending.

Below you will be given an opportunity to identify multiple sources of funding for this strategy. The funding sources are divided by general categories, followed by more specific funding streams. The first question will ask in broad terms about funding, followed by more specific sources. Please choose the most specific answer possible.

6.i. Please choose all general funding sources that are used in this strategy.

- ☐ Department of Health and Human Services (DHHS)-general
- ☐ DHHS-Social Security Act (including TANF, Child Welfare, Medicaid, and SSBG)
- ☐ DHHS-Administration for Children and Families
- ☐ DHHS-Indian Health Services
- ☐ DHHS-Substance Abuse and Mental Health Administration
- ☐ Department of Education
- ☐ Department of Justice (DOJ)-general
- ☐ DOJ-Violence Against Women Act
- ☐ DOJ-OJJDP
- ☐ Department of Transportation
- ☐ Department of Agriculture—general
- ☐ Department of Agriculture—Food Stamps
- ☐ Department of Agriculture—Women, Infants and Children (WIC)
- ☐ Housing and Urban Development Department
- ☐ Department of the Interior—general
- ☐ Department of the Interior—Bureau of Indian Affairs
- ☐ Department of Homeland Security
- ☐ Underage Drinking (SAMHSA, OJJDP, NIAAA, NHTSA, CDC)
- ☐ Corporation for National and Community Service
- ☐ Department of Labor
- ☐ Department of Agriculture—Food Stamps
- ☐ Department of Agriculture—Women, Infants and Children (WIC)
- ☐ Housing and Urban Development Department

*(question continued on next page)*



### Individual Strategy Description

(Continued) Please choose all general funding sources that are used in this strategy.

- ☐ Department of the Interior—general
- ☐ Department of the Interior—Bureau of Indian Affairs
- ☐ Department of Homeland Security
- ☐ Underage Drinking (SAMHSA, OJJDP, NIAAA, NHTSA, CDC)
- ☐ Corporation for National and Community Service
- ☐ Department of Labor
- ☐ Vocational Rehabilitation
- ☐ Non-Medicaid State Matching Funds
- ☐ State General Revenue Flexible Dollars
- ☐ Other State General Funds
- ☐ Local Tax Funds
- ☐ Local Levies
- ☐ Gaming/Casinos
- ☐ Tobacco Settlement
- ☐ Private Insurance
- ☐ Foundation Funding
- ☐ Corporate Giving
- ☐ Social/Volunteer/Faith Organization Donations
- ☐ In-Kind Donations
- ☐ Other (please specify)



### Individual Strategy Description

6.j. For any Social Security Act (SSA) funding, please choose the specific sources below. Choose all that apply.

- ☐ We do not use any SSA related funding
- ☐ TANF—Title IV-A)
- ☐ Child Welfare—Title IV-B, Part 1, Child Welfare Services Program
- ☐ Child Welfare—Title IV-B, Part 2, Promoting Safe and Stable Families Act
- ☐ Child Welfare—Title IV-E, Foster Care and Adoption Assistance
- ☐ Juvenile Justice—Title IV-E
- ☐ Maternal and Child Health Block Grant—Title V
- ☐ Healthy Start Initiative
- ☐ Medicaid—general, Title XIX
- ☐ Medicaid—EPSDT
- ☐ Medicaid—Rehabilitation Option
- ☐ Medicaid—Targeted Case Management
- ☐ Medicaid—Fee for Service
- ☐ Medicaid—Waivers (general)
- ☐ Medicaid—Waivers, Section 1915(b)
- ☐ Medicaid—Waivers, Section 1915(b)(3)
- ☐ Medicaid—Waivers, Section 1915(c), Home and Community Based Waiver
- ☐ Medicaid—Waivers, Section 1115
- ☐ Medicaid—Waivers, Healthy Insurance Flexibility and Accountability Waiver
- ☐ Social Services Block Grants—Title XX
- ☐ State Children’s Health Insurance Program (SCHIP)—Title XXI
- ☐ Other (please specify)

6.k. For any funding through the Administration for Children and Families (ACF), please choose the specific sources. Choose all that apply.

- ☐ We do not use any ACF related funding
- ☐ System of Care Grants
- ☐ Head Start
- ☐ Early Head Start
- ☐ Child Care Development Fund
- ☐ Family Resource Support
- ☐ Developmental Disabilities
- ☐ John H. Chafee Foster Care Independence Program
- ☐ Other (please specify)



### Individual Strategy Description

6.l. For any funding through SAMHSA, please choose the specific sources.

Choose all that apply.

- ☐ We do not use any SAMHSA funding
- ☐ Substance Abuse Prevention Block Grant
- ☐ Substance Abuse Treatment Block Grant
- ☐ Mental Health Block Grant
- ☐ CMHS Local Services Grant
- ☐ Child State Incentive Block Grant
- ☐ Mental Health Transformation State Incentive Grant
- ☐ Co-Occuring State Incentive Grant
- ☐ Other (please specify)

6.m. For any funding through the Department of Education, please choose the specific sources. Choose all that apply.

- ☐ We do not use any Department of Education funding
- ☐ Title I-Improving the Academic Achievement of the Disadvantaged
- ☐ Individuals with Disabilities Education Act (IDEA)—general
- ☐ Individuals with Disabilities Education Act (IDEA)—Part B: preschool
- ☐ Individuals with Disabilities Education Act (IDEA)—Part B: State Grants
- ☐ Individuals with Disabilities Education Act (IDEA)—Part C: Infants and Toddlers
- ☐ Even Start—Family Literacy
- ☐ Even Start—Migrant Education
- ☐ Even Start—Indian Tribes
- ☐ Other (please specify)

6.n. What is the approximate breakdown of general funding categories for this strategy? The total percentage should equal 100.

- Federal
- State
- Tribe
- Local
- Non-Government
- Other



### Individual Strategy Description

- 6.o. Describe any arrangements that were made to include these funding sources. What did your state or community have to do differently, e.g., have funds been pooled, blended or braided; were case rates established; do provider contracts have fiscal incentives; did you obtain Medicaid or IV-E waivers; were there legislative mandates, etc.?

- 6.p. Were any partnerships created to implement this strategy? If yes, please list the partnering agencies/entities.

- 6.q. If partnerships were created, were they formalized? If yes, please describe how they were formalized (e.g., Memorandum of Agreement, inter-agency governance structure, regular planning meetings and forums for sharing information, funding agreements, etc.)

☐ N/A (no formal partnerships)

☐ No, we did not formalize partnerships

☐ Yes, we developed formal partnerships (please describe)

- 6.r. Were changes or updates to data/information systems made to implement this strategy? If yes, please describe the changes.

- 6.s. Describe the ways in which this strategy demonstrates accountability. For example, has it been audited by federal, state, local or other funding agencies? How do you meet typical reporting expectations of funding sources?

- 6.t. Has the strategy been institutionalized so that it doesn't disappear when the administration changes? If yes, please describe how.

- 6.u. Does this strategy enable you to meet child welfare timelines (e.g., ASFA, state policy, timely services)? If yes, please describe how.

- 6.v. List the major outcomes and accomplishments gained from this strategy.



**Individual Strategy Description**

6.w. Describe the challenges your state/community faced when implementing this strategy.

6.x. Describe the lessons learned by your jurisdiction during implementation of this strategy.

6.y. What do you see as the key elements for success related to this strategy?

6.z. Please list the contact information for the person or people associated with this strategy.

*Contact Information*

Name

Title

Department/Division

Mailing Address

E-mail

Fax

Phone number

May we publicize this contact information so that other states might make contact for more information about the strategy?

- ☐ Yes, the contact information may be shared.
- ☐ No, the contact information is for the survey developers only.

**Thank you for completing the survey. Please send all related materials to:**

Kerry Fay Vandergrift  
Sr. Project Coordinator  
American Public Human Services Association  
810 First Street, NE, Suite 500  
Washington, DC 20002  
Phone: 202-682-0100  
Fax: 202-289-6555  
kerry.vandergrift@aphsa.org

**Please return this survey by June 30, 2006.**



## APPENDIX F

# Collaborative Workgroup

The persons listed below are representatives of the National Association of Public Child Welfare Administrators or the Children, Youth, and Family Division of the National Association of State Mental Health Program Directors. Each person listed participated in one or more conference calls or meetings of the collaborative workgroup as it implemented the survey. Many provided substantial direction and leadership for the survey.

Sue Adams  
Nebraska

Lori Harder  
Nebraska

Frank Rider  
Arizona

Jackie Acosta  
California

Kaaren Hebert  
Louisiana

Barbara Putnam  
Washington

Uma Ahluwalia  
Maryland

Louise Johnson  
South Carolina

Sue Ross  
Florida

Jim Boeugher  
Maine

Carla Kessel  
North Dakota

Dave Sanders  
California

Susan Cycyk  
Delaware

Ken Martinez  
New Mexico

Jackie Shipp  
Oklahoma

Tina Donkervert  
Hawaii

Robin McIlvaine  
Washington

Joan Smyrski  
Maine

Glenace Edwall  
Minnesota

Dave Neilsen  
California

Bronwyn Vincent  
Washington

Sheri Falvay  
Michigan

Mary Nelson  
Iowa

Anne Wells  
Arkansas

Marty Gibson  
Louisiana

Becky Richard-Maley  
Nevada

Sue Williams  
Ohio

Chuck Halligan  
Idaho

