



Coordinated System of Care Report to the Commission on Streamlining Government

March 4, 2010

Contents

1. Executive Summary.....	page 3
2. Introduction.....	page 7
3. Values, Goals and Population of Focus.....	page 9
4. Process and Timeline.....	page 10
5. Strategies for Designing CSoC.....	page 14
6. CSoC Models	page 19
7. Medicaid Financing Strategies	page 29

1. Executive Summary

The state of Louisiana is undertaking the development of a statewide coordinated system of care (CSoC) for Louisiana's at risk children and youth with significant behavioral health challenges or co-occurring disorders. The CSoC project is an initiative of Governor Jindal and is being led by executives of the Office of Juvenile Justice, the Department of Social Service, the Department of Health and Hospitals, and the Department of Education.

The coordinated system of care (CSOC) is an evidence-based approach that is part of a national movement to develop family driven and youth guided care, keep children at home, in school, and out of the child welfare and juvenile justice system. A system of care incorporates a broad, flexible array of effective services and supports for a defined population that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, and has supportive policy and management infrastructure. An important CSoC goal is the reduction of highly restrictive out of home placements through the creation and maintenance of coordinated and effective community based services. CSoCs also create partnerships with public and private providers of services that target children, youth and their families in a multi-agency, multi-disciplinary system of services.

Recent estimates indicate the following percentages of these youth need behavioral health treatment:

- 40% of those placed in OCS foster homes
- 70% of those in OJJ out of home placements
- 20% of children and parents served in their home by OCS
- 50% of children and parents served in their home by OJJ

It is widely acknowledged that the needs of these children and families are currently being served through a fragmented service delivery model that is not well coordinated, is many times inadequate to meet the families' needs and is often difficult to navigate. Further, state departments are not currently pooling resources and leveraging the 'smartest' financing to provide a coordinated system of behavioral health services. This too often results in Louisiana's children with the highest level of need often detained in secure or residential settings, which are proven the highest cost services with the poorest outcomes.

Goals of the Louisiana System of Care Implementation include:

- Reduction in the current number and future admissions of children and youth with significant behavioral health challenges or co-occurring disorders in out of home placements.
- Reduction of the state's cost of providing services by leveraging Medicaid and other funding sources as well as increasing service effectiveness and efficiency and reducing duplication across agencies
- Improving the overall outcomes of these children and their caretakers being served by the coordinated system of care

CSoC efforts have been shown to address common problems found in states and communities throughout the nation, including:

- Lack of home and community-based services and supports
- Patterns of utilization – racial/ethnic disparity and disproportionality
- High cost
- Administrative inefficiencies
- Poor outcomes
- Rigid financing structures
- Deficit-based/medical models, limited types of interventions

(Source: Pires, S. (1996). Human Service Collaborative, Washington, D.C.)

Population of Focus and Goals

Louisiana's Coordinated System of Care will initially serve children and youth that have significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement. Out of home placements are defined as the following:

- Detention
- Secure Care facilities
- Psychiatric hospitals
- Residential treatment facilities
- Development disabilities facilities
- Addiction facilities
- Alternative schools
- Homeless as identified by DOE
- Foster care

Process, Timeline and Strategies for System Design

The initiative is directed and overseen by the CSoC Leadership Team composed of highest level agency executives and stakeholder leaders. The planning for the system design and development work of the initiative is being conducted by the Planning Group. The Planning Group is composed of agency key staff and external stakeholders, including family members, advocates, and providers. Additional workgroups to further engage stakeholders are being formed to ensure broad participation in all aspects of system design. CSoC implementation is anticipated for early 2011.

Early planning efforts of the CSoC Leadership Team and the Planning Group identified the need to reassess the use of out-of home placements and institutional services that haven't worked for many at-risk children and youth in favor of serving them and their families in homes, schools, and communities. Some of the preliminary service gaps identified include a range of services:

- Targeted case management
- Mobile response
- Therapeutic peer support
- Family-based in home programs
- School base services
- Family education and support
- Addiction services
- Licensed independent practitioners
- Respite

Over the coming months, the Planning Group will facilitate a thorough discussion of service needs and identify the evidence based and promising practices that should be included in Louisiana's CSoC service array.

CSoC Models

The Planning Group and Leadership Team are examining successes in other states. New Jersey, Milwaukee, Maryland and North Carolina offer examples of successful CSoC delivery systems and financing models. New Jersey has a statewide SOC; North Carolina is implementing the CSoC model statewide through its Local Management Entities (quasi-governmental units); Milwaukee's CSoC is county-based; and Maryland has a regional model. Each target population is uniquely defined by the state or, in the case of Wraparound Milwaukee, by the County. Common components/functions of successful systems have been identified as:

Local Care Management Entities (CME) whose functions include:

- Organize and manage provider network (broad array of services and supports)
- Staff and manage child and family team process
- Intensive care management with small staff: child ratios
- Utilization management/utilization review
- Quality assurance
- Outcomes management /monitoring
- Management Information System
- Link families and youth to peer support and to Mobile Response and Stabilization Services

Family Support Organizations who serve in these roles:

- Family Liaisons
- Care Coordinators
- Family Educators
- Specific Program Managers
- Youth Peer Mentors

Contracted Systems Administrator/Administrative Services Organization (ASO) whose functions include:

- Registration
- Screening for self-referrals
- Tracking
- Assessment of appropriateness for Care Management Entity enrollment
- Authorization of services

Medicaid Financing Strategies

A critical step that follows identification of the system design and service array is determining how to finance the desired services, including strategies that:

- reallocate resources from the inappropriate use of out-of-home placements/institutional care to more effective and efficient community based programs
- leverage existing state funding to obtain federal financing.

This step includes the task of "mapping" and cross-system analysis of current services and funding sources to identify the State general funds that Louisiana can leverage to generate

federal funding. The exercise will also identify potential resources that could be reallocated to new services when at-risk children/youth currently served in out-of-home placements begin the transition to home- and school-based interventions.

Once the mapping and analysis process is complete, Louisiana's leaders can make a determination of the changes in the Centers for Medicare and Medicaid Services (CMS) authorities needed to obtain federal dollars possible as a "match" to State general funds. By replacing State general funding for at-risk children with federal funds, the State can substantially expand the funding base for children's programs, provide stable revenues, and free up State and local funds for other services not eligible for federal financing, such as prevention.

In order to be Medicaid reimbursable, a service must be:

- Covered under the state's Medicaid agreement with the federal government (i.e., the State Plan or a waiver of that State Plan).
- Provided to clients who are eligible for Medicaid.
- Provided by a qualified and enrolled Medicaid provider.

The initiative will also examine potential options that could improve accountability for the newly developed federally-funded services and ensure effective utilization management strategies to support long term sustainability. For example, creating a single payment system for all CSoC expenditures through the State's Medicaid Management Information System may ensure that providers are not paid duplicative payments across payment systems, and that each provider is paid the same rate for the same service throughout the CSoC. Another option is using a non-prepaid program model [i.e., administrative contract, strategic planning and cost management (SPCM) or non-risk contract] to ensure more accountability in the early years of a program expanding Medicaid reimbursement to previously state-funded providers who may not be accustomed to federally required documentation. This could be accomplished with a care management/utilization review contractor experienced in CSoC system change. Effective care management and utilization review protocols are tools that offer states the opportunity to assess the appropriateness of care plans and match services to the child youth and family's expressed needs.

Each of these strategies – single payment system, use of a non-pre-paid program model in early stages, care management/utilization management protocols, and financial risk management strategies – must be designed to address the vision and goals of Louisiana's CSoC. Because the CSoC model is research based and has proven outcomes, when coupled with effective accountability strategies, it can offer the State assurances that children, youth and their families are served effectively and efficiently.

Next Steps

As stated previously, it is anticipated that CSoC implementation will begin in early 2011. As the Leadership Team and Planning Group progress through the work process, consistent effort will be made to garner broad stakeholder input through a series of public meetings, as well as targeted focus groups and surveys. Additionally, regular updates will be made available to the Legislature regarding the recommended system design, financing strategies and needed state plan amendments, waivers, BA-7s or other actions requiring Legislative approval.

1. Introduction

The state of Louisiana is undertaking the development of a statewide coordinated system of care (CSoC) for Louisiana's at risk children and youth with significant behavioral health challenges or co-occurring disorders. The CSoC project is an initiative of Governor Jindal and is being led by executives of the Office of Juvenile Justice, the Department of Social Service, the Department of Health and Hospitals, and the Department of Education.

The coordinated system of care (CSOC) is an evidence-based model that is part of a national movement to develop family driven and youth guided care, keep children at home, in school, and out of the child welfare and juvenile justice system. A system of care incorporates a broad, flexible array of effective services and supports for a defined population that is organized into a coordinated network, integrates care planning and management across multiple levels, is culturally and linguistically competent, builds meaningful partnerships with families and youth at service delivery, management, and policy levels, and has supportive policy and management infrastructure. An important CSoC goal is the reduction of highly restrictive out of home placements through the creation and maintenance of coordinated and effective community based services. CSOCs also create partnerships with public and private providers of services that target children, youth and their families in a multi-agency, multi-disciplinary system of services.

Why does Louisiana need a Coordinated System of Care?

Left untreated, mental health disorders in children and adolescents lead to higher rates of suicide, violence, school dropout, family dysfunction, juvenile incarcerations, alcohol and other drug use and unintentional injuries. Children and youth who are referred for service to the juvenile justice and child welfare agencies have increased rates of behavior disorders needing treatment. Today, approximately 54,000+ children and families interface with the child welfare and/or juvenile justice systems in Louisiana. Annually over 8,100 of these children receive foster care services and 8,700 children receive residential or probation and parole services through the juvenile justice system.

Recent estimates indicate the following percentages of these youth need behavioral health treatment:

- 40% of those placed in OCS foster homes
- 70% of those in OJJ out of home placements
- 20% of children and parents served in their home by OCS
- 50% of children and parents served in their home by OJJ

It is widely acknowledged that the needs of these children and families are currently being served through a fragmented service delivery model that is not well coordinated, is many times inadequate to meet their needs and is often difficult to navigate. Further, state departments are not currently pooling resources and leveraging the 'smartest' financing to provide a coordinated system of behavioral health services. This too often results in Louisiana's children with the highest level of need often detained in secure or residential settings, which are proven the highest cost services with the poorest outcomes.

CSoC efforts have been shown to address common problems found in states and communities throughout the nation, including:

- Lack of home and community-based services and supports
- Patterns of utilization – racial/ethnic disparity and disproportionality
- High cost
- Administrative inefficiencies
- Poor outcomes
- Rigid financing structures
- Deficit-based/medical models, limited types of interventions

(Source: Pires, S. (1996). Human Service Collaborative, Washington, D.C.)

With this initiative, Louisiana is following a documented path of system reform through implementation of a Coordinated Systems of Care. Characteristics of these CSoC reform efforts have been found to include the following

From a System Characterized by:	To a System Characterized by:
Fragmented service delivery	Coordinated service delivery
Categorical programs/funding	Blended resources
Limited services	Comprehensive service array
Reactive, crisis-oriented	Focus on prevention/early intervention
Focus on “deep end,” restrictive	Least restrictive settings
Children/youth out-of-home	Children/youth within families
Centralized authority	Community-based ownership
Fostering “dependency”	Building on strengths and resiliency

Source: Pires, S. (2002). Building systems of care: A primer. Washington, D.C.: Human Service Collaborative.

2. Goals, Values and Population of Focus

The Louisiana Department of Social Services, Department of Health and Hospitals, Office of Juvenile Justice and Department of Education are working in collaboration to develop a Coordinated System of Care that will offer an integrated approach to providing services for at-risk children and youth served within the child welfare and juvenile justice populations.

This proposed system must develop and finance services and supports for at risk children and youth to keep them in their family homes and schools, out of detention and achieve optimal health and functioning in community settings. It must comprehensively provide for the behavioral health needs of at risk children and youth and their caretakers by reinvesting current funds in the system into a more organized system of care.

In a recent planning retreat, over forty agency and stakeholder leaders agreed as follows on the goals, values and population of focus for the Coordinated System of Care.

Values and Principles:

- Family-driven and youth-guided
- Home and community based
- Strength-based and individualized
- Culturally and linguistically competent
- Integrated across systems
- Connected to natural helping networks
- Data-driven, outcomes oriented

Population of Focus:

Louisiana's Coordinated System of Care will initially serve children and youth that have significant behavioral health challenges or co-occurring disorders that are in or at imminent risk of out of home placement. Out of home placements are defined as the following:

- Detention
- Secure Care facilities
- Psychiatric hospitals
- Residential treatment facilities
- Development disabilities facilities
- Addiction facilities
- Alternative schools
- Homeless as identified by DOE
- Foster care

Goals of System of Care Implementation include:

- Reduction in the current number and future admissions of children and youth with significant behavioral health challenges or co-occurring disorders in out of home placements.
- Reduction of the state's cost of providing services by leveraging Medicaid and other funding sources as well as increasing service effectiveness and efficiency and reducing duplication across agencies
- Improving the overall outcomes of these children and their caretakers being served by the coordinated system of care

3. Process and Timeline

Organization of the System of Care oversight and planning process:

The initiative is directed and overseen by the CSoC Leadership Team. The Leadership Team receives and acts on recommendations developed and submitted by the Planning Group regarding system design and implementation strategy. The Leadership Team is staffed by the Project Manager and assures departmental staff and external stakeholders work jointly in planning the Coordinated System of Care. The Leadership Team makes consensus-based decisions and is composed of the following individuals:

- Secretary Kristy Nichols, DSS
- Deputy Secretary Tony Keck, DHH
- Secretary Mary Livers, OJJ
- Assistant Superintendent Donna Nola Ganey, DOE
- Deputy Medicaid Director, Randy Davidson, DHH
- Assistant Chief of Staff Tammy Woods and Policy Director Camille Conaway, Governor's Office
- Vee Boyd, parent, and Executive Director, Louisiana's Federation of Families for Children's Mental Health
- Sharon Dufrene, parent and advocate
- Michael Teague, Executive Director, Jefferson Parish Human Services Authority
- Representative of Supreme Court

The planning for the system design and development work of the initiative is being conducted by the Planning Group. As stated above, the Planning Group works at the direction of the Leadership Team and is facilitated by the Project Manager. The Planning Group is responsible for developing recommendations for submission to the Leadership Group. The Planning Group is composed of agency key staff and external stakeholders, including family members, advocates, and providers. The Planning Group will form workgroups as needed to perform activities necessary to meet the goals and timeline of the project workplan; workgroups may be time-limited to accomplish specified planning tasks and objectives and include broader representation than formal Planning Group members. Current workgroups include the following:

- Current Systems Mapping
- Family Engagement
- Communications
- Administrative Design
- Service Array
- Data Collection and Analysis

System of Care Workplan

Objective	Action step	Activity	Responsible Party	Timeline
Mapping of current system strengths, opportunities and weaknesses relevant to population of focus	Identify state agency systems/programs serving population of focus, including existing systems/ programs, and those in development or pending implementation that may impact SoC implementation (e.g., Medicaid, child welfare, juvenile justice, mental health and substance abuse, etc.) – ID strengths, weaknesses and opportunities	Self assessment within departments	Planning Group with support of project manager and HSC expert consultants	March 15
	Assess federal legislative and agency initiatives	Research, inventory and analyze federal opportunities	Planning Group and expert consultants	
	Assess private foundation/other private sector opportunities	Research, inventory and analyze opportunities		
Determine recommended system design	Identify array of desired services and supports including evidence based and effective practices	Research and evaluate possible approaches in terms of needs of population; evidence base; cost; current system strengths and weaknesses and other relevant factors	Planning Group with support of HSC expert consultants	May 31
	Establish common practice model, eg family centered practice			
	Determine ideal overall system design including mechanisms for customization of services and supports and intensive care management for high utilizing sub-populations			

Identify needed infrastructure	Design governance structure	Identify best practices, existing models, innovative approaches and implementation issues; determine most efficient and effective mechanisms to support recommended system design	Planning Group With support from HSC expert consultants	July 1
	Identify providers - types and training and capacity building needed			
	Design quality measurement and improvement processes			
	Determine mechanisms for ongoing and expanded partnerships with families/youth organizations at policy, management and service levels			
	Identify and design needed information technology capacity, including EHRs			
	Design utilization management process			
Conduct cross-system analysis of service utilization, expenditures and financing related to population(s) of focus (e.g., Medicaid service utilization and expenditures, child welfare service utilization and expenditures, etc.)	Determine number of target population served historically	Inventory and analysis of data submissions from state departments	Mercer; with input from HSC expert consultants to inform analysis and interpret results	August 1
	Determine expenditures per child/youth and total spending, including expenditures on "poor outcome and/or high cost" services			
	Define demographics of population served including identification of disparities and disproportionality			
	Identify current funding streams			
	Identify services used, including any evidence-based, credentialed services			
	Determine re-direction and refinancing opportunities within Medicaid	Assessment of current systems and unutilized options that would support system design		
	Identify potential reallocation of other federal funding streams (child welfare, prevention, special education, block grants, etc)			
	Identify potential redistribution of state general funds			

Analyze, determine final system design and financing strategies.	Medicaid waiver/s	Development of strategy to support system design and manage utilization	Mercer; with input from HSC expert consultants for analysis and recommendations	August 15 for analysis and recommendations to Executive Steering Committee
	Medicaid state plan amendments			
	IV-E waiver			
	Redirection of state general funds			
	Redirection of other federal funds Blended or braided funding			
Submit needed state plan amendments, waivers, other applications, BA-7s	Develop drafts	Write needed applications or other documents	Mercer; with input from HSC expert consultants and others as needed	September 30
	Conduct public input process	Present to legislature, present at community meetings and other public venues	Executive Steering Committee	October 31
	Submit applications		DHH and other state agencies	November 15
Development implementation plan	Develop policies and procedures	Determine most efficient and effective implementation steps with shortest reasonable timeline, responsible parties and required resources	Planning Group with support from Project Manager, HSC expert consultants, Mercer, and other consultants as needed	December 31
	Promulgate rules as required			
	Develop reimbursement rates			
	Develop RFPs or Enroll Providers			
	Develop training and capacity building plan			

4. Strategies for Designing CSoC

Nationally, states use a variety of strategies to develop, implement and manage CSoC. Key strategies include:

- engaging youth, families and stakeholders to reassess the available services;
- redesigning the service array to make available more evidence-based and promising practices associated with better outcomes;
- identifying financing strategies that support the CSoC; and
- developing accountable administrative and delivery systems that are effective and efficient.

Early planning efforts of the CSoC Leadership Team and the Planning Group identified the need to reassess the use of out-of-home placements and institutional services that haven't worked for many at-risk children and youth in favor of serving them and their families in homes, schools, and communities. Some of the preliminary service gaps identified include a range of services:

- Targeted case management
- Mobile response
- Therapeutic peer support
- Family-based in home programs
- School based services
- Family education and support
- Addiction services
- Licensed independent practitioners (licensed social workers, licensed professional counselors, etc.)
- Respite care

Over the coming months, the Planning Group will facilitate a thorough discussion of service needs and identify the evidence based and promising practices that should be included in Louisiana's CSoC service array.

A critical step that follows identification of the service array is determining how to finance the desired services, including strategies that:

- reallocate resources from the inappropriate use of out-of-home placements/institutional care to more effective and efficient community based programs
- leverage existing state funding to obtain federal financing.

This step includes the task of "mapping" and cross-system analysis of current services and funding sources to identify the State General Fund (SGF) or state funding that Louisiana can leverage to generate federal funding. The exercise will also identify potential resources that could be reallocated to new services when at-risk children/youth currently served in out-of-home placements begin the transition to home- and school-based interventions.

Once the mapping and analysis process is complete, Louisiana's leaders can make a determination of the changes in the Centers for Medicare and Medicaid Services (CMS) authorities needed to obtain every federal dollar legally possible as a "match" to SGF. By replacing SGF for at-risk children with federal funds, the State can substantially expand the funding base for children's community based programs, provide stable revenues, and free up State and local funds for other services not eligible for federal financing, such as prevention.

Specifically, the opportunities for obtaining federal funding exist where state-funded programs utilize qualified providers to deliver the following services for at-risk children:

- Evidence-based and promising practice for at-risk children, including alternatives to institutional care and family friendly evidence-based practices such as psycho-educational services may be permitted under the Medicaid State Plan or waiver authorities. Other states are currently funding services such as mobile response and stabilization services; intensive in-home services; family peer support; therapeutic foster care; behavioral management consultation and skills training. Intensive-in home services; Multisystemic Family Therapy, Functional Family Therapy, High Fidelity Wraparound Services, youth partners (peer support) and family psychoeducation through their Medicaid programs.
- Targeted case management (TCM) to arrange for care for at-risk children where the functions are not a fundamental requirement in the foster care program could potentially be reimbursed by Medicaid.
- Care by licensed and unlicensed mental health and substance abuse practitioners in outpatient hospitals, clinics, mental health rehabilitation agencies, as well as private practitioners and other independent and agency providers currently providing care to children through State-only funded programs by OJJ, OMH, OCS and OAD could be eligible to be reimbursed by Medicaid.
- Residential mental health and substance treatment services may continue to be required for a small number of children and youth. Louisiana could draw down Medicaid funds for services provided in accredited facilities directed by physicians. This could leverage funds allocated by the Office of Juvenile Justice (OJJ), Office of Mental Health (OMH), the Office of Community Services (OCS), Office of Addictive Disorders, (OAD) and other State funding targeted to residential treatment. Also, by drawing down Medicaid funds during a transition period while new home and community based services are under development, Louisiana could free up State funds currently used for these services to expand the CSoC service array.
- Residential mental health and substance abuse treatment in unaccredited facilities or accredited facilities that are not physician directed where the facilities have fewer than 16 beds can also be funded through Medicaid. (While Medicaid will pay for treatment in these facilities, payments for room and board will be excluded.) Leveraging SGF would allow resources to be reallocated to newer services in the CSoC service array.

- Inpatient care for children residing in secure facilities but admitted to state and community hospitals that may be funded by state funds could potentially be covered by Medicaid funding if the children are eligible for Medicaid. This would result in a shift from State funding to Medicaid funding and free up funds for more community-based services.

The table below includes a listing of the allowable Medicaid State Plan service categories, the preliminary funding information collected from Louisiana’s child/youth serving agencies that corresponds to each Medicaid allowable service category, and options for State Plan amendments that could increase federal financing. This table will be updated during the planning process and eventually list all the desired CSoC service components and Medicaid funding options. Many of the service components of evidenced-based practices appropriate for CSoC will likely fit into the Medicaid categories listed below, specifically in Physician Services, Other Licensed Practitioner, Rehabilitation, Targeted Case Management, and EPSDT, as well as other cost effective alternatives to inpatient services.

Medicaid State Plan Services	Current Financing	Annual Expenses by Agency*	Potential Financing Strategy
Inpatient Psychiatric Care in a general hospital and mental hospital	Medicaid funding State Funding through OMH and OCS	Medicaid – \$20M for children during 2008 OMH - \$9.3M for FY 2009 OCS - \$2.3M SGF	Medicaid will continue to fund If more cost-effective services are developed, funds may be allocated to other services
Residential Treatment for Children in accredited facilities which are physician directed	State funding through OJJ, OMH, DSS and OAD	DSS – \$25.3M (\$6.6M IV-E, \$2.8M SSBG, \$15.9M SGF) OJJ – Non-secure care (\$30M) OAD – \$5.2M OMH - \$115K	Medicaid leveraging potential for the small number of children/youth appropriately requiring this level of care; also would free up state dollars to transition children/youth currently using these services due to lack of home-based alternatives
Outpatient Hospital	Medicaid funding	Medicaid – \$2.5M in 2008 is primarily for ER and lab/testing services	If possible, move services provided by licensed practitioners under this section to “Other Licensed Practitioner” and services provided by unlicensed practitioners and paraprofessionals to the “Rehabilitation” service category. This would allow services to be provided in multiple settings and not solely in an outpatient hospital setting.

Medicaid State Plan Services	Current Financing	Annual Expenses by Agency*	Potential Financing Strategy
Clinic Services	Medicaid funding	Medicaid – \$4.2M for Medicaid Clinic Option Medicaid – \$4.2M for FQHC/RHC	Keep FQHC/RHC under Clinic. Move services provided by licensed practitioners in the OMH clinics to "Other Licensed Practitioner" service category. Move unlicensed practitioners and paraprofessionals to the "Rehabilitation" service category. This would allow services to be provided in multiple settings and not solely in a clinic. It also provides flexibility to deliver evidence-based practices
School-Based Services**	Department of Education	DOE – Staffing Expenses Therapists/Counselors - \$50.9M School Nurses (RNs) - \$23.1M	Medicaid will cover behavioral health (BH) services in an IEP and some 504 services as well as some EPSDT BH screenings. Use "Clinic" service category for FQHC services provided in school clinics that are part of the FQHC; use "Other Licensed Practitioner" for services provided by licensed practitioners not affiliated with an FQHC. Use the "Rehabilitation" service category for other qualified services provided by unlicensed practitioners. Use the "EPSDT" service category for other services.
Physician	Medicaid funding	Medicaid – \$11.1M for Medicaid Physician services with primary diagnosis as MH	Keep as is in State Plan
Other Licensed Practitioner (OLP)	Licensed practitioners paid for by State funding through OJJ, OMH, DSS, OAD	Portions of the DSS, OJJ, OMH, or OAD spending in the rehabilitation category may fall under this section for the licensed practitioners.	Medicaid leveraging potential for licensed practitioners providing evidence-based practices (intensive in-home supports, cognitive behavioral therapy, Dialectical Behavior Therapy, trauma informed treatments)

Medicaid State Plan Services	Current Financing	Annual Expenses by Agency*	Potential Financing Strategy
Rehabilitation	Limited Medicaid funding for particular agencies with limited services and MST (implemented as SED/SPMI only, not as medically necessary) Unlicensed practitioners paid for by State funding through OMH, OAD, DSS, OJJ	Medicaid – \$25.4M for Rehabilitation Option DSS – \$9.3M (\$3.4M SSBG, \$4.6M SGF, \$1.3M TANF) OJJ – \$27.6M (\$14.7M day treatment, \$13M other contracts) OAD – \$3M OMH - \$2.7M Federal Block Grant, \$11.3M SGF	Medicaid leveraging potential for evidence based and promising practices provided by unlicensed practitioners, such as family and youth partners – and other services essential to a CSoC
Targeted Case Management (TCM)	Not covered under Medicaid		Medicaid case management for severe and persistent mental illness/serious emotional disturbance (SPMI/SED) would ensure care coordination.
Early Periodic Screening, Diagnosis, and Treatment (EPSDT)	Limited to Psychological and Behavioral Services (PBS) for children with Pervasive Developmental Disorders (PDD) Child-specific services paid for by State funding through OMH, OAD, DSS, OJJ		Medicaid leveraging potential for a range of child/youth home and community evidence-based and promising practices essential to a CSoC.
Additional services out of State or plan savings or as an alternative to institutionalization or for individuals meeting a State-established need criteria	N/A		Ability to keep funds in the system to develop alternatives to care Medicaid funding of family friendly evidence-based practices services such as psycho-educational services is permitted under this authority

*Note: Data collection remains an ongoing activity. Numbers quoted are based on current information from each agency and subject to update.

**Further examination of school-based services is required to determine the services that may be Medicaid reimbursable for Medicaid eligible children.

5. CSOC models

New Jersey, Milwaukee, Maryland and North Carolina offer examples of successful CSOC delivery systems and financing models. New Jersey has a statewide CSOC; North Carolina is implementing the CSOC model statewide through its Local Management Entities (quasi-governmental units); Milwaukee's CSOC is county-based; and Maryland has a regional model. Each target population is uniquely defined by the state or, in the case of Wraparound Milwaukee, by the County. Louisiana will examine these model organizational structures and functions in the context of current structures existing in the state.

Key components/functions of these successful systems include:

Local Care Management Entities (CME) whose functions include:

- Organize and manage provider network (broad array of services and supports)
- Staff and manage child and family team process
- Intensive care management with small staff: child ratios (e.g. 1:8-10)
- Utilization management/utilization review
- Quality assurance
- Outcomes management /monitoring
- Management Information System (tracks children, services, dollars)
- Link families and youth to peer support and to Mobile Response and Stabilization Services

Family Support Organizations who serve in these roles:

- Family Liaisons
- Care Coordinators
- Family Educators
- Specific Program Managers (respite, etc)
- Youth Peer Mentors

Contracted Systems Administrator/Administrative Services Organization (ASO) whose functions include:

- Registration
- Screening for self-referrals
- Tracking
- Assessment of appropriateness for Care Management Entity enrollment
- Authorization of services

Wraparound Milwaukee

Wraparound Milwaukee provides an example of a county-operated CSoC where state and local funds are integrated at the county level. The program goal of Wraparound Milwaukee is to keep children with severe emotional disturbances in the community.

Target population: Wraparound Milwaukee, established in 1994, targets children and youth who are residents of Milwaukee County and meet all of the following criteria:

- They have a serious emotional disturbance
- They are involved in two or more service systems, e.g., mental health, child welfare and juvenile justice; or they have exceptional educational needs
- They are having challenges functioning well at home, in school or in the community
- They are at risk for an out-of-home placement in a residential treatment facility, juvenile corrections or mental health hospital

Wraparound Milwaukee System of Care Goals

- Be child-centered, family-focused and community-based
- Create a locus of management accountability and intensive care management for high-need populations of children
- Manage utilization
- Track outcomes
- Change provider practices to system of care focus
- Change financing structures

Care management model: Wraparound Milwaukee is administered by Milwaukee County's Behavioral Health Division, which acts as a Care Management Organization and has a network of nearly 210 provider organizations that provide over 80 types of mental health and support services. Care is coordinated through a team of professional care coordinators that partner with the family and their support system (child and family teams) to create a plan of care designed to support the child or youth in a safe and integrated way in the community. The care management process includes the following activities:

- Conducting assessments using standardized tools performed during intake, 6-months, 12-months and at discharge
- Providing care coordination that is family driven and youth guided
- Developing a service plan and crisis/safety plan
- Referring to a wide array of evidence-based practices and support services
- Establishing monthly case rates to support the service plan
- Partnering with schools, families and child-serving agencies to enhance success of the service plan
- Monitoring utilization and tracking outcomes to promote efficiency and effectiveness

Financing strategy: Wraparound Milwaukee uses a mix of local, state and federal funds, which are pooled to create a flexible source of funding to best meet the needs of children, youth and their families. Funds come from four different sources: capitated funding from the State's Medicaid program; FFS funding for crisis intervention and crisis stabilization services from the State's Medicaid program; a case rate from the Wisconsin Department of Children and Families; and fixed funding from Milwaukee County's Delinquency and Court Services Division. These funds, pooled at the county level, are used to establish a monthly case rate per participant that range between \$2000 and \$4300 per participant per month.

The Medicaid capitated portion of the program was implemented on March 1, 2007, as a mental health/substance abuse prepaid inpatient health plan using a risk-based capitation model under a voluntary contract authority. Included Medicaid services are: crisis, emergency, IMD, inpatient and outpatient mental health services, Community Support Program (CSP), inpatient and outpatient substance use disorder services, medical day treatment, mental health rehabilitation services, residential and support services and targeted case management (TCM).

The Medicaid populations that are voluntarily enrolled are: American Indian/Alaskan Native; blind/disabled children and related populations; foster care; Section 1931 (AFDC/TANF) children and related populations; and Title XXI CHIP participants. There are no populations that are mandatorily enrolled. There are certain subpopulations that are excluded which are enrolled in another MC program: Medicare dual eligibles and those who participate in home- and community-based services waivers.

Lessons learned: A goal in 2008 was to broaden the target population and increase the number of Medicaid-eligible youth in the program through the creation of the REACH program, a new initiative to help youth before they become court involved. Wraparound Milwaukee created capacity to address the needs of children and youth before they become court involved and substantially increased the number of Medicaid-eligible youth it served. REACH also began to address the needs of youth leaving the program and make a successful transition into young adulthood.

Sources:

1. http://www.milwaukeecounty.org/ImageLibrary/Groups/cntyHHS/Wraparound/wraparound_milwaukee_2008.pdf
2. <http://www.milwaukeecounty.org/WraparoundMilwaukee7851.htm>
3. 2008 CMS Medicaid managed care enrollment report
Louisiana Coordinated System of Care Stakeholder Meeting Presentation, January 26, 2010, Baton Rouge. Sheila Pires, Human Service Collaborative; Bruce Kamradt, Wraparound Milwaukee; and Michelle Zabel, Maryland Innovations Institute

New Jersey CSOC program

New Jersey operates a statewide CSOC FFS program that focuses on keeping children in their families and in their communities.

Target population: The original target population was children with serious emotional and behavioral disturbances and their families across the Department of Human Services (DHS) child-serving systems, including children eligible for child welfare, mental health and/or Medicaid services, ages 0–18 and youth 18–21, transitioning to the adult system. In 2006, the State added children who may also be involved with JJS or receiving substance abuse services in addition to their involvement with a DHS agency or contract provider.

New Jersey System of Care Goals

Provide care based on core system of care values of:

- *Individualized service planning, family partnership*
- *Culturally competent services and a strengths-based approach*
- *Provide a broad array of services and supports*
- *Organize and manage services*
- *Increase funding for children's behavioral health care*
- *Through re-direction, maximizing Medicaid and new legislative dollars)*

Care management model: The New Jersey CSoC has

a contracted service administrator (CSA) that provides the following functions:

- Conducts uniform screening of children through a single point of access
- Assesses children using standardized assessment tools
- Refers children to the appropriate level of care
- Provides care coordination or refers children with complex multi-system involvement to designated non-profit care management organizations (CMOs)
- Relies on utilization management methodologies that ensure rapid access to services and emphasizes provider accountability to treatment goals and objectives
- Maintains a network of providers, including CMOs, community agencies, family support organizations and youth partnerships

Financing strategy: Medicaid funding accounted for 84 percent and 83 percent of total New Jersey SOC expenditures in 2004 and 2005. Traditional Medicaid services in New Jersey include acute inpatient hospital services, residential treatment care, outpatient treatment and partial care. The SOC added the following Medicaid services: assessment, mobile crisis/emergency services, group home care, treatment homes/therapeutic foster care and intensive face-to-face care. Less than 5 percent of services are delivered in out-of-home settings. In its first year of SOC operation, the Division of Child Behavioral Health Services (DCBHS) pooled approximately \$167M across child welfare, juvenile justice and mental health, by restructuring the publicly-funded systems that serve troubled children. New funds of \$39M were included in DCBHS in its first year and over \$100M were added over the following four years (2006 IA).

Lessons learned: A baseline audit conducted for period 7/1/2000 to 6/30/2002 found that internal controls were lacking. To address the audit findings, the State currently pays all SOC expenditures through the Medicaid Management Information. This new system ensures:

- duplicate payments through multiple systems – same child, same service, same provider, same day and time, multiple payments – are avoided;
- that the system edits to prevent or identify inappropriate payments and to provide a means to verify that services have been rendered before payments are made; and
- payments are made consistent with contractual provisions.

Sources:

1. Final Report: Independent Assessment of New Jersey's Children Behavioral Health Care System, October 5, 2006. Submitted to the New Jersey Division of Child Behavioral Health Services, Louis de la Parte, Florida Mental Health Institute. Prepared by: Mary I. Armstrong, PhD; Karen A. Blase, PhD; Beth Caldwell; Wendy Holt, MPP; Tara King-Miller, MA; Anne Kuppinger, MEd; Carol Obrochta; Donald N. Policella, MS; Frances Wallace, MPH.
2. New Jersey State Legislature, Office of Legislative Services, Office of the State Auditor, Department of Human Services Children's System of Care Initiative, July 1, 2000, to June 30, 2002, Richard L. Fair State Auditor. Audit dated September 11, 2002.
3. Louisiana Coordinated System of Care Stakeholder Meeting Presentation, January 26, 2010, Baton Rouge. Sheila Pires, Human Service Collaborative; Bruce Kamradt, Wraparound Milwaukee; and Michelle Zabel, Maryland Innovations Institute.

North Carolina CSoC program

North Carolina has been implementing its CSoC program statewide since March of 2006 when the General Assembly allocated recurring funds to support a System of Care Coordinator in each of its then 30 Local Management Entities (LMEs).

A statewide Community Collaborate began planning efforts that resulted in establishing a local Community Collaborative in all LME service areas, which are staffed by the LME SOC Coordinators. In addition LMEs have pursued the development of SOC through federal grants.

Target population: Each LME determines the target population based upon local planning and needs.

Care management model: Child and Family Teams contracted by the LMEs develop person and family centered plans. Utilization management for State funded services is provided by the LMEs through contracts with the Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Utilization management for Medicaid services is provided by a national managed behavioral health care vendor through a non-risk bearing contract for administrative services for most LMEs. The Piedmont LME operates a NCQA accredited pre-paid program under 1915(b) (c) Medicaid waivers, providing care management and utilization management and assuming full risk for the cost of services and manages both State general funding and Medicaid. North Carolina released a Request for Application on February 17, 2010 for up to two additional LMEs to operate as pre-paid programs. The LME selected from this procurement will have responsibility for care/utilization management of State and Medicaid funds.

Financing strategy: A combination of Medicaid financing, State General funds and grants support the SOC efforts across the State. Most SOC services are funded through the Medicaid State Plan and include: Screening, Triage, Referral; Basic Outpatient Services; Mobile Crisis Services; Diagnostic Assessment; Community Support; Intensive In Home; Multi-systemic Therapy; Child and Adolescent Day Treatment, and Substance Abuse Intensive Outpatient Program; Psychosocial Rehabilitation, Partial Hospitalization and some Residential Care; Respite is paid by State general funds. LMEs that operate under the 1915(b)(c) waivers have (or will have once selected) additional flexibility in providing cost effective services. State general funds currently support 35 SOC coordinators located in the LME service areas.

North Carolina received the following System of Care grants from the Center for Mental Health Services: "The North Carolina Families and Communities Equal Success (FACES) Project implements a community-based, family-driven system of care in four geographically and socio-economically diverse North Carolina sites. The project ensures individualized service planning and delivery and utilizes a holistic approach to fully integrate child- and family-serving agencies, nonprofit, business, and neighborhood "communities" to establish and maintain family-driven, community-owned systems of care.

North Carolina System of Care Goals

A System of Care aims for success, safety and permanence in home, school and community. It offers:

- *Responsive & coordinated referral and treatment*
- *An inclusive & flexible system*
- *Culturally responsive & competent services*
- *Family friendly supports*
- *Family & community education*
- *Resource development*
- *Shared planning processes*
- *Memorandum of Agreements to support operations*

The partners collaboratively design and receive state-of-the-art training and technical assistance relying upon in-State resources that have been developed over time and out-of-state experts that State-level staff have identified. Parents participating in locally supported advocacy/support groups ensure family voice and equity in system design, management, service delivery, training, and technical assistance at the local level. An independent State family organization focuses on provision of pertinent information from the State capital to the local sites and provides education based on that received from local family organizations to relevant parties at the State level. Collaborative bodies in the NC FACES Initiative include representatives from State and local public health, child welfare, juvenile justice, education, mental health, State universities, and local and State family organizations.”

<http://mentalhealth.samhsa.gov/cmhs/childrenscampaign/grantcomm.asp#north%20carolina>

The Durham and Mecklenburg LMEs have SOC that are considered model programs by the State. Their SOC were initially developed through federal grants and continue to operate through the use of State general funds and Medicaid.

Lessons Learned: North Carolina experienced challenges related to use of community support services where costs for these Medicaid financed services for children and adults more than tripled in the course of a year. The cost increases occurred following a change in the service definition that resulted in excessive use of non-licensed staff providing daily contacts that did not appear to have a treatment or rehabilitation focus. As a result, North Carolina revised the service definition to include credentialing requirements for staff and standards for the percentage of services that must be delivered by mental health professionals. Changes in utilization management practices and the rate structure for this service also occurred. Furthermore, the State is moving towards requiring use of evidence-based practices that have proven outcomes.

Sources:

1. Interview with Mark O'Donnell, North Carolina Department of Mental Health, Developmental Disabilities and Substance Abuse Services, February 22, 2010. Summary of System of Care Coordinator Functions
2. Children's Services Update, Division of MHDDSAS DHHS. Michael Lancaster, MD and Susan E. Robinson, M.Ed. June 2007
3. Division of Medical Assistance Clinical Coverage Policy No.: 8A, Enhanced Mental Health and Substance Abuse Services Revised Effective Date: April 1, 2010; Original Effective Date: July 1, 1989; [http:// www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm](http://www.ncdhhs.gov/mhddsas/childandfamily/index-new.htm)
[Sources 1, 2, 3 downloaded February 19, 2010.](#)
4. Centers for Mental Health Services website on SOC summarizing SOC grants to North Carolina, downloaded February 19, 2010.
<http://mentalhealth.samhsa.gov/cmhs/childrenscampaign/grantcomm.asp#north%20carolina>

Maryland CSOC

Maryland is implementing a statewide CSOC using regional care management entities (CMEs). Maryland created a CME in each of three regions to serve as an entry point for children, youth and families with intensive needs. The purpose of the program is to assist children and youth achieve the goals of safety, permanency and well-being through intensive care coordination using a wraparound service delivery model and provision of home- and community-based services. The State intends to expand the availability of the CME structure statewide. An Administrative Services Only (ASO) established under a Section 1115 Medicaid waiver, contracts with the CMEs on behalf of the State.

Target population: Children and youth with serious emotional disturbances that are in or at risk of placement in a group home or a residential treatment center (RTC).

Care management model: A CME is a FFS administrative entity that serves as a “locus of accountability” for youth with complex needs and their families. CMEs support the organization, management, delivery and financing of services across multiple systems and providers. CMEs are not providers, but rather assume responsibility for the development and care management of services to meet the child’s/youth’s Plan of Care objectives.

There are three CMEs for the following regions:

- Baltimore City Region: Wraparound Maryland, Inc.
- North Western Region (Allegany, Baltimore, Carroll, Frederick, Garrett, Harford, Howard, Montgomery and Washington counties): Choices, Inc.
- South Eastern Region (Anne Arundel, Calvert, Caroline, Cecil, Charles, Dorchester, Kent, Prince George’s, Queen Anne’s, St. Mary’s, Somerset, Talbot, Wicomico and Worcester counties): Wraparound Maryland, Inc.

The primary responsibilities of the CME are:

- Provide a single point of access
- Facilitate the Child Family Team (CFT) using the Wraparound model
- Provide care coordination, including use of assessment tools
- Provide referrals to network providers
- Monitor and review care
- Provide linkage to peer support partners
- Facilitate resource development
- Manage the provider network
- Facilitate access to community resources
- Provide a contract for family support partners and youth support partners
- Provide the information technology to support the care management process
- Administer discretionary funds
- Conduct utilization review
- Provide quality assurance and outcomes monitoring, including participation in multiple federal and State evaluation projects

Maryland System of Care Goals

- *Be child-centered, family-focused and community-based*
- *Create a locus of management accountability*
- *Intensive care management for high need populations of children*
- *Manage utilization*
- *Track outcomes*
- *Change provider practices to system of care focus*
- *Change financing structures*

Financing strategy: The CMEs receive a case rate of approximately \$1200 per child per month to provide care management and utilization management. Direct services delivered by network providers receive FFS payments.

Maryland was one of ten states awarded a Medicaid Psychiatric Rehabilitation Treatment Facility (PRTF) Demonstration waiver under the Deficit Reduction Act, known as the RTC waiver. The RTC waiver serves children and youth that meet the following criteria:

- Are 20 years old or younger at enrollment
- Meet Certificate of Need (medical necessity) to enter an RTC
- Can safely and appropriately be served in the community with waiver services and supports
- Choose (along with their family) to enter the waiver instead of an RTC
- Meet Medicaid waiver financial eligibility requirements (community/Medicaid eligible or eligible under Family of One)

There are currently 80 slots available for youth; this number is expected to increase in the next year. The waiver resources began statewide on December 28, 2009, on a rolling basis. Jurisdictions must have Medicaid-enrolled RTC waiver providers of caregiver peer-to-peer support, crisis and stabilization and respite services *prior to* youth being enrolled from that jurisdiction.

Maryland also has local System of Care grants. MD CARES serves youth from Baltimore City; Rural CARES will serve youth from the Eastern Shore. The grants are focused on youth in the foster care system at the point of initial diagnosis of serious emotional disturbance to prevent out-of-home placement or disruption of placement. There are approximately 40 slots for each of the grants. MD CARES began accepting referrals on December 28, 2009. Rural CARES will not be accepting referrals until October 2010.

Maryland also has a community services initiative (CSI) and a Medicaid Rehabilitation Option. Children's Cabinet Interagency Fund monies are designated to divert or return youth from out-of-state placements and in-state residential placements. There are priority populations for CSI and rehabilitation funding relating to the diversions and returns. The CMEs will be working with youth who are already in service with CSI and rehabilitation funds.

Maryland DJS Out-of-Home Placement Diversion is for youth ages 13–18 who are committed to the care and custody of DJS and who are:

- Identified by the court to be at-risk for an out-of-home community residential placement (group home)
- In pending placement status in a detention facility or in the community
- In a detention facility and likely to be identified to be in-need of an out-of-home placement
- In an out-of-home placement (in-state or out-of-state)

Youth must also not be eligible to be served under CSI, rehab option, RTC waiver, or Systems of Care Grant funds; or there must be no slots available to serve the youth under these funding streams at the time of application to the CME. There are 75 slots available statewide.

The CME works with the RTC waiver, MD CARES, Rural CARES, CSI, Rehabilitation Option and DJS Diversion. Youth were transitioned to the new CMEs in December 2009 when CMEs assumed full operation. Additional jurisdictions will be phased into the RTC Waiver on a rolling basis, as the required providers are enrolled.

For the purposes of the Medicaid 1915(c) RTC Waiver, the financing model is FFS, with the CME being funded through the Medicaid Administrative Claim while Medicaid eligible services are purchased from vendors on a FFS basis. Financial risk under the waiver is held by the Department of Health and Mental Hygiene, which is responsible for ensuring cost neutrality to the federal government under the waiver. There have been some instances in Maryland, however, where the CMEs have been supported by a case rate for a different population, for example, youth diverted from detention, which has allowed the CME to have added flexibility in its service delivery model.

Sources:

1. http://medschool.umaryland.edu/innovations/RTC_waiver.asp
2. <http://www.goc.state.md.us/SystemsOfCare.html>
3. The Maryland Care Management Model: Care Coordination using high-fidelity Wraparound to support the strengths and needs of youth with complex needs and their families
4. Presentation: Care Management Entity Regional Forums:
December 7, 2009 – Frederick
December 8, 2009 – Annapolis
December 10, 2009 – Baltimore City
5. Louisiana Coordinated System of Care Stakeholder Meeting Presentation, January 26, 2010, Baton Rouge. Sheila Pires, Human Service Collaborative; Bruce Kamradt, Wraparound Milwaukee; and Michelle Zabel, Maryland Innovations Institute

6. Medicaid financing strategies

Medicaid is an open-ended entitlement; thus, efforts to maximize federal reimbursements for at-risk children's services, with careful investment of state Medicaid spending have been part of policy and planning activity for over a decade. New Jersey, for example, funds 85 percent of its CSoC under its basic Medicaid fee-for-service (FFS) program.

In order to be Medicaid reimbursable, a service must be:

- Covered under the state's Medicaid agreement with the federal government (i.e., the State Plan or a waiver of that State Plan).
- Provided to clients who are eligible for Medicaid.
- Provided by a qualified and enrolled Medicaid provider.

Covered services

The Medicaid benefits package is broad. There are 30 categories of services for which federal Medicaid matching funds are available. Some of the services are mandatory for states to cover in their state Medicaid program, while other services are optional and may be covered at state discretion. In addition, federal law requires that any medically necessary health care service be provided to a child under 21 even if the service is not available to the rest of the Medicaid population under the state's Medicaid plan. Mandatory and optional state plan benefits have been used by states in combination with each other to create an enhanced, comprehensive package of services in support of a CSoC.

Comprehensive packages of services in support of a CSoC may also be created using other Medicaid funding authorities. For example, services not coverable under the basic Medicaid state plan, such as supported employment, prevocational training and respite, can be covered to some extent under the Section 1915(c) home- and community-based waiver (HCBW) services authority or 1915(i) state plan option for home- and community-based services. States may also utilize section 1915(b) Freedom of Choice waivers to fund services through savings. Each of these authorities may be granted by the federal government in addition to the Medicaid basic benefits in the State Plan.

Eligible children

In general, all individuals receiving federal Medicaid funding must fall into certain categories – children, the parent(s) or caregivers who live with them or persons with permanent disabilities. Eligibility for Medicaid coverage is means-tested, i.e., the applicant's income must be below a certain ceiling. With certain exceptions, states must also cover persons with disabilities who are receiving cash assistance under the Federal Supplemental Security Income program, children in foster care or placed in subsidized adoption, and those who would have been eligible for cash assistance under the former Aid to Families with Dependent Children (AFDC) program as it was configured in July 1996.

Qualified providers

Under Medicaid, the State must outline the qualifications required for providers who then enroll in the program to provide covered services to eligible clients. It is particularly important for the State to include requirements for certification and training in child and family focused evidence-based practices and youth and family partner peer services.

Federal financing authorities

Medicaid provides financing for services to children that can be rendered on a FFS basis or through an alternative delivery system financing mechanism. Because the State of Louisiana is evaluating a CSoC approach that uses Medicaid financing in as optimal a manner as possible, the consideration of what is covered and how it will be delivered should be considered in tandem and in the context of how it will interact with current delivery systems.

For example, once the state has basic services approved in its State Plan with CMS, additional authorities may be obtained to gain more flexibility, services or coverage for individuals within the state. The waivers or additional authorities are “layered” and approved concurrently “on top” of the State Plan. Each additional authority has its own guidance and regulatory requirements. Each authority requires a separate request and has a different time frame for length of authorization (e.g., 1915(b) two years, 1915(c) three years with five-year renewals, State Plan until amended). This must be considered in the implementation of any new services or modifications to the delivery system as part of the implementation plan. These authorities are different from contract requirements, which must be consistent with the authorities granted by CMS. Authorities in addition to the State Plan include:

- Voluntary contracting authority allowing a State to contract with all qualified prepaid plans in which individuals may voluntarily enroll. The Wraparound Milwaukee program operates a prepaid health plan under this Medicaid authority.
- Additional home- and community-based services provided to individuals meeting a particular state-established need level or as an alternative to institutional care.
- Selective services contracting waivers that allow the State to contract with providers meeting additional criteria in addition to basic Medicaid requirements. This authority is often used when accountability is an issue. This authority may also be combined with mandatory enrollment programs where individuals are required to enroll. Maryland operates its larger managed care program under this authority.

CSoC Accountability and Utilization Management Strategies

The initiative will also examine potential options that could improve accountability for the newly developed federally-funded services and ensure effective utilization management strategies to support long term sustainability. For example, creating a single payment system for all CSoC expenditures through the State’s Medicaid Management Information System would be helpful to ensure that providers are not paid duplicative payments across payment systems, and that each provider is paid the same rate for the same service throughout the CSoC. Another option is using a non-prepaid program model [i.e., administrative contract, strategic planning and cost management (SPCM) or non-risk contract] to ensure more accountability in the early years of a program expanding Medicaid reimbursement to previously state-funded providers who may not be accustomed to federally required documentation. This could be accomplished with a care management/utilization review contractor experienced in SOC system change. Effective care management and utilization review protocols are tools that offer states the opportunity to assess the appropriateness of care plans and match services to the child youth and family’s expressed needs.

The provider reimbursement of children's services is directly related to the delivery system option selected by the State. Many program options utilize FFS reimbursement where the State maintains responsibility for paying claims and bears the risk of increases in service utilization. Program delivery system models that involve risk transfer from the State to an alternate delivery system entity typically involve prepaid reimbursement mechanisms and may be authorized under a variety of authorities.

Each of these strategies – single payment system, use of a non-pre-paid program model in early stages, care management/utilization management protocols, and financial risk management strategies – must be designed to address the vision and goals of Louisiana's CSoC. Because the SOC model is research based and has proven outcomes, when coupled with effective accountability strategies, it can offer the State assurances that children, youth and their families are served effectively and efficiently.

FFS provider reimbursement

FFS provider reimbursement is the traditional mode of financing for Medicaid children's service programs. In this model, the financing is handled consistent with the reimbursement methodologies outlined in the State Plan or the waivers. Providers are typically reimbursed according to a fee schedule or per diem based on cost report data (typical for inpatient hospital psychiatric services). The State pays claims for each unit of service rendered through the FFS system and retains risk for changes in utilization of services. Services are matched at the state's services federal matching assistance percentage (FMAP).

Outside of Medicaid, many state agencies rely on per diem or bundled payment arrangements to reimburse providers for services related to mental health or substance abuse. While this is the preferred mode in other payment systems, CMS has moved states away from using a bundled or per diem methodology for non-institutional providers. While CMS has more recently considered use of per diem rates, there continues to be close scrutiny and limits on how bundled reimbursement methodologies are used under FFS.

Administrative contract reimbursement

Administrative contracts operate alongside FFS reimbursement systems, where claims are paid FFS and the vendor is reimbursed an administrative fee for performing prior authorization or utilization review. The State retains the risk for utilization of services, although some programs include utilization incentives tied to service utilization. The State receives an administrative match on the vendor's case management fee. All expenditures for administrative contracts are matched at 50 percent federal financial participation by Medicaid. Services are matched at the State's services FMAP.

Specialty provider case management reimbursement

Specialty provider case management (SPCM) programs reimburse providers using the FFS reimbursement system and pay a vendor a case management fee for performing prior authorization or utilization review. The State retains the risk for utilization of services, although some programs include utilization incentives tied to service utilization. The key difference between the SPCM and the administrative contract is that under a waiver, the State could receive services match on the SPCM fee. Services and clinical case

management functions are matched at the State's services FMAP. Administrative functions are matched at 50 percent federal financial participation by Medicaid.

Non-risk reimbursement

Non-risk programs pay the case management and utilization review entity an upfront payment on a per member per month (PMPM) basis. Because it is a non-risk contract, there is a reconciliation based on actual utilization. The interim rates are not subject to actuarial soundness; however, payments under non-risk contracts are subject to an upper payment limit, which is what FFS would have paid for the services furnished plus some administrative costs. In the case of the Kansas non-risk contract, the entity is required to pay providers the FFS payment rates. This streamlines the reconciliation process, enhances data collection and ensures that the upper payment limit is never exceeded. Services are matched at the State's services FMAP. Administrative functions are matched at 50 percent federal financial participation by Medicaid.

Prepaid reimbursement

Prepaid reimbursement models are typically associated with at-risk contracts. In a prepaid model, the contractor is paid an upfront PMPM payment to provide all the services required under the contract. Federal regulations require the monthly insurance payments to be actuarially sound and certified by an actuary. The payments are calculated on a PMPM basis to reflect expected utilization and cost of services under the contract with consideration for contractor administrative costs. The contractor is at-risk if utilization of services exceeds the monthly payment. Services and administrative functions are matched at the State's services FMAP rate.

Prepaid contracts are afforded some flexibility in provider reimbursement in comparison to FFS programs. Contractors are allowed to reimburse providers using a variety of mechanisms, including per diems for residential services so long as the rates can be supported by documented utilization of Medicaid services. In addition, prepaid contractors may provide alternative services or may provide covered services using providers not meeting Medicaid requirements.

Prepaid providers can choose to purchase State Plan services covered in prepaid contracts from providers who fall under exclusions if quality of care concerns are met. For example, several states have inpatient psychiatric care in a general hospital covered in their prepaid contracts. To the extent that the care is delivered in a manner that guarantees quality of care, prepaid contractors may choose to purchase less expensive care for individuals in need from accredited residential treatment facilities.