



UNCLAIMED CHILDREN REVISITED
Working Paper No. 3

Towards Better Behavioral Health for Children, Youth and their Families

Financing that Supports Knowledge

Janice L. Cooper

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NCCP National Center for
Children *in* Poverty
Columbia University
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The National Center for Children in Poverty (NCCP) is the nation's leading public policy center dedicated to promoting the economic security, health, and well-being of America's low-income families and children. Founded in 1989 as a division of the Mailman School of Public Health at Columbia University, NCCP is a nonpartisan, public interest research organization.

**Towards Better Behavioral Health for Children, Youth and their Families:
Financing that Supports Knowledge**

by Janice L. Cooper

This working paper provides a broad overview of sources of funding (and their policy roots) that underwrite children's behavioral health services illuminating the flaws and prospects of various policy choices. It aims to stimulate debate that will bring about changes that put financing in the service of better mental health, social functioning and educational well-being for children and youth with behavioral health problems and those at-risk and their families. It concludes with recommendations for policy action to create and sustain a support federal and state fiscal environment.

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In 1982, Jane Knitzer's seminal study, *Unclaimed Children: The Failure of Public Responsibility to Children and Adolescents in Need of Mental Health Services*, called attention to the desperate state of the mental health system for children and adolescents with mental health problems and their families. The study became a turning point in the mental health field and led to a series of reforms. Twenty-five years later, the National Center for Children in Poverty (NCCP) has undertaken a national initiative, *Unclaimed Children Revisited*, to re-examine the status of policies that impact the optimal well-being of children, youth and their families. The initiative is guided by a stellar national advisory committee. It includes state case studies in California and Michigan, with separate state advisors. I am grateful for funding from the John D. & Catherine T. MacArthur Foundation, the Annie E. Casey Foundation, the California Endowment and the Zellerbach Family Foundation.

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Executive Summary

The money trail in children's behavioral health leads to strange and unexpected places. In a time of more and more information about effective practice and historically high levels of child behavioral health funding, it leads to community-level service shortages and poor quality combined with inadequate mechanisms for accountability. It leads to fiscal policy that is out of sync with the knowledge base on effective practices, with opportune times to intervene and with strategies that lead to improved mental health for children and youth. On occasion it leads to pockets of service excellence. Following the money in children's behavioral health also shows that opportunities abound for improving service quality-informed fiscal policy.

This working paper provides a broad overview of funding sources (and their policy roots) that underwrite children's behavioral health services, illuminating the flaws and prospects of various policy choices. It aims to stimulate debate that will bring about changes that put financing in the service of better behavioral health, social functioning and educational well-being for children and youth with or at risk for mental health and substance abuse problems and their families.

While the focus is on public funding for mental health and substance abuse services within the behavioral health arena, attention is also paid to related funding in education, child welfare and juvenile justice. However, this working paper does not represent a comprehensive review of funding in those areas.

Data for this working paper comes from multiple sources, including telephone and face-to-face interviews with key stakeholders, review of the literature and policy documents as well as preliminary data from *Unclaimed Children Revisited: Survey of State Children's Mental Health Directors*.

Multiple sources fund children's behavioral health.

Funding for children's behavioral health services come from a wide range of sources and represent a substantial increase since 1982, when Knitzer revealed the fail-

ures of public financing to support a coherent service delivery strategy despite obligations under the law. For example, at least \$14 billion was directed towards funding services to address the behavioral health needs of children and youth in 2001. While current funding is relatively small compared to overall behavioral health expenditures and even miniscule when seen in the context of total health care spending, it still represents historic levels. Yet, it fails to address current needs of identified children and youth and those at risk for mental health problems.

Children and youth with behavioral health problems and their families, as well as those at risk for behavioral health problems experience funding dedicated towards children's behavioral services differently depending on:

- the state they live in or in which they access services;
- the type of services they access; and
- the funding sources.

Despite overwhelming evidence supporting prevention and early intervention services, funding is heavily focused towards deep-end treatment like residential and intensive services. Moreover, state behavioral health authorities overwhelmingly support adult services over children's services, by a margin of more than three to one nationally.

The primary public funding sources for behavioral health services for children have increased access, and out-of-pocket costs for families have decreased, especially for the most troubled children and youth. Nonetheless, enormous service gaps remain. These are largely driven by the financing streams and their underlying policies. Medicaid's structural deficiencies, such as a diagnosis-dependent public payment system and a medical-model driven service delivery system, dominate the fiscal picture. These are compounded by recent efforts to further constrict the range of services that public financing will support. They also serve to significantly undermine efforts to address the gulf between the needs of children, youth and their families and improved behavioral health.

The following elements typify the fiscal policy framework in children's behavioral health services:

- over-reliance on residential treatment compared to community-based, family-guided care based on prevention, early intervention and treatment strategies;
- lack of access to, or the availability of, community-based treatment alternatives compounded by the ease of finding and funding immediate residential placement, and the urgency of the public safety concerns for the most troubled children and youth;
- fiscal practices, particularly through Medicaid, are inconsistent with the knowledge base about effective children's behavioral health services, and sometimes make it impossible to use that knowledge base, for example, some components of evidence-based models are ineligible for Medicaid reimbursement;
- insensitivity to prevention and early intervention and the supporting knowledge base, for instance, largely diagnosis driven, Medicaid does not reimburse for many prevention-related interventions;
- limited incentives to plan strategically and to support leadership informed by children's behavioral health knowledge at the state level;
- state-based service inequities driven by variation in the use of available Medicaid provisions;
- fiscal policies that are often out of sync with the developmental needs of children and youth;
- poor information technology that undermines accountability and the development of a quality-based system;
- inadequate alignment of fiscal policy with quality initiatives; and
- missed opportunities to seize the initiative at the federal level to embed best fiscal practices

There are opportunities for reform in the context of mounting evidence about effective practices. Three potential policy levers for change include: support for family choice in treatment decisions, creation of opportunities for family and youth empowerment in all aspects of care delivery and the national groundswell to implement a quality agenda in health care.

This working paper highlights state and local innovation in finance policy. These initiatives encompass broad fiscal reforms in states such as New Mexico, California, New York, Minnesota, Oregon, Arizona and Vermont. Also profiled are specific targeted interventions that focus on outcomes, reducing harmful and ineffective practices (for example in Kansas, Virginia, Alaska and West Virginia) and creating locally-based behavioral health investments in states and communities, including Michigan, Colorado, Florida, Missouri and Vermont.

These and other initiatives only scratch the surface of the vast need for services. They cannot flourish and attain the capacity required without a supportive federal fiscal environment. Strong federal policy action is therefore urgently needed.

NCCP recommends the following:

- 1) Attend to the lack of **capacity** at the community level;
- 2) Significantly raise the **quality of care** delivered in community-based and other settings for children, youth and their families;
- 3) Instill **accountability** for public financing of behavioral health; and
- 4) Legislate a new national paradigm to guide fiscal policy for children's behavioral health.

Introduction

A variety of sources and complex funding mechanisms support the delivery of children's behavioral health services. This fiscal labyrinth has roots in many fields including: medicine, public health, behavioral health, social services, child welfare, juvenile justice, education, early childhood, community development and labor. Its complexity is in part a function of the network of purchasers and suppliers of services and supports that range from large corporations to small community-based organizations and solo practitioners. Among this array are licensed and regulated entities including public health centers, community mental health centers, private for profit, not-for-profit and public agencies operating in homes, communities, and in-patient or residential facilities. An assortment of solo service providers also operate and include licensed and unlicensed clinicians, specialists, and community-based support workers.

Approximately 20 percent of children and youth in the United States need mental health services and supports.¹ Most of America's children, youth and families who need these do not receive them.² Fewer than 20 percent of children with mental health service needs and 9 to 13 percent of youth who need drug and alcohol treatment receive them.³ There is not enough money to meet the demand for services. Further there is wide variation in service access, use and outcomes based upon residency, race/ethnicity, income and insurance coverage.⁴ The reasons for the imbalance between needs and resources are a source of continuing and often contested debate. Opinions vary as to whether funding inadequacy lies at the root of the problem and about how to address the unmet need.

- Do policymakers face a fiscal environment characterized simply by insufficient resources?
- Do inefficiencies in their use contribute to the shortfall?
- Or does the problem with funding lie with a failure to provide incentives for effective interventions?

To begin to address these questions and to get a fuller understanding of children's behavioral health services financing, this working paper aims to:

- 1) provide an overview of child and adolescent behavioral health with a special focus on mental health financing and, to review major sources of federal funding for children's mental health services;
- 2) examine critically the pivotal role of federal fiscal support, particularly Medicaid, in behavioral health service delivery;
- 3) highlight perspectives on state and local emerging fiscal innovations; and
- 4) recommend fiscal policy solutions that support effective practices and positive outcomes for children and adolescents.

SECTION 1

An Overview of Children's Behavioral Health Services

Setting the Context

An estimated one-fifth of children and youth in the United States has a diagnosable mental health problem according to the United States Surgeon General.⁵ In addition, approximately 15 percent of adolescents test positive for substance abuse and up to 20 percent of substance abuse treatment admissions involve youth with a co-occurring mental health disorder.⁶ These estimates of prevalence of behavioral health disorders, while generally accepted in the behavioral health community, mask higher levels of need among children and youth involved with child welfare, juvenile justice and special education.⁷

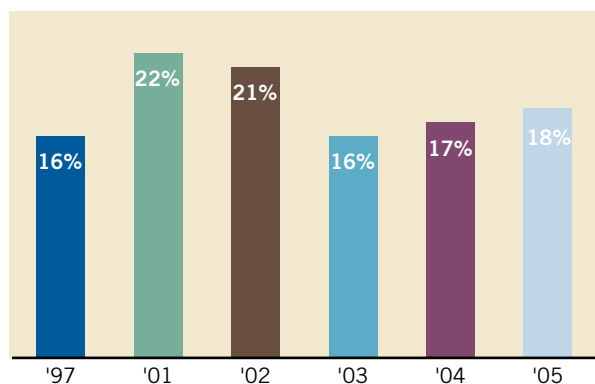
Funding paradoxes and challenges are not new. Historically, funding for mental health problems for children and youth has not met the prevalence rates found in the community. In fact in the first national policy study in 1982, Knitzer found that less than \$20 million was available to support children's mental health services.⁸ Access to Medicaid funding for community-based therapeutic services was limited. The existing Medicaid financing structure favored inpatient psychiatric services over community-based alternatives. In 1982, hospital and institutional-based care drove the financing of mental health services for children and adolescents. System observers characterized community-based funding as fragmented. According to Knitzer in 1982, "states had almost no capacity to provide non-residential care like day treatment and were not working to create these services."⁹ Many states provided minimal fiscal support for community-based programming for children and where they did, few demanded the type of accountability that would permit the most efficient use of existing resources. Knitzer also reported that while one-third of responding states could track children's mental health expenditures, only 15 percent could identify a children's mental health budget with specific information on service allocation. Overwhelmingly states (62%) were unable to identify child mental health funding as distinct from adult funding. Of the states that did have separate child mental health budgets, only 3 to 25 percent of the entire budget

was spent on children.¹⁰ Consequently, for the most part, the mental health needs of children, adolescents and their families remained largely unaddressed.

Today, some progress has been made and practice rhetoric has emphasized community-based care.¹¹ But the money trail tells a different story. In 2005, the Substance Abuse and Mental Health Services Administration (SAMHSA) appropriated almost \$400 million in support of community-based mental health.¹² In contrast, it is estimated that **over \$4.2 billion** was spent on residential treatment alone in 2002.¹³ Today, while progress has been made in addressing the gap between service needs and supply much remains to be done.¹⁴ The first fiscal analysis was done in 1982. Today much has changed. Much more is known about the fiscal underpinnings of the children's mental health system. Nearly all states can now track the dollar amounts spent on children's mental health, within the state mental health authority's purview.¹⁵ Further, states now invest more in mental health services for children and youth. For instance in 2004 on average states allocated 21 percent of their community mental health budgets on children and youth.¹⁶ More than half of all states spend at least 20 percent of their overall mental health budget to children and youth, and more than one-third spend at least 25 percent of their overall budget on children and youth.¹⁷ Spending by state mental health authorities for mental health services for children and youth hovered between 16 and 22 percent (higher for community-based services) of total mental health spending from 1997 to 2004 (see Figure 1). States also now fund family support and family and youth advocacy and allocate both their own funding and Medicaid to financing services in a variety of community-based settings such as schools, recreational settings, child care setting and the home.¹⁸ In addition, more children and youth are now identified with mental health problems and receive mental health services in non-specialty mental health settings such as primary care settings.¹⁹

At the same time, the sources of funding and their proportion allocated to children and youth have changed. Medicaid spending now dwarfs spending through state

Figure 1: SMHA-controlled Expenditures for Mental Health Services for Children and Youth, 1997-2005



Sources: SMHA-controlled expenditures for mental health services for children and adults, FY'97 and FY'01, Personal communication, National Research Institute. Table 16: SMHA-controlled mental health expenditures by age group and state: FY 2001, National Research Institute. Table 13: SMHA-controlled mental health expenditures by age group and state: FY 2003, National Research Institute. Table 13: SMHA-controlled mental health expenditures by age group and state: FY 2004 (in millions), National Research Institute. Table 13: SMHA-controlled mental health expenditures by age group and state: FY 2005, National Research Institute.

tax revenues, which simply was not an option when Knitzer wrote *Unclaimed Children*. Medicaid, in fact, is the most important driver of children's mental health fiscal policy. Taken together, these shifts in service delivery and new and reconfigured funding streams require a different approach to how a system for service delivery is conceptualized and financed. The bottom line is that persistent high unmet needs and variable access, quality and outcomes demand a better understanding of how states spend the estimated \$14 billion allocated to behavioral health service delivery for children, youth and families.

To set the stage for this analysis, first we highlight what is known about the current overall status of funding for children's behavioral health services, including mental health and substance abuse treatment.

A Portrait of Funding for Children's Behavioral Health Services

How much money is spent on children's behavioral health (including mental health and substance abuse)?

Estimates of spending for all behavioral health services, including treatment for substance use disorders, for children and youth can be conservatively made at \$14.07 billion for all behavioral health spending in 2001 (holding spending at 1997 rates).²⁰ Using these rough estimates, children's mental health services alone accounted for \$12.5 bil-

lion, leaving a paltry proportion of funding to support treatment for substance use disorders for adolescents.²¹ These figures, however only extend to the health and behavioral health sectors. To put these numbers in context, it is estimated (using 2001 data) that across all ages, total mental health and substance abuse treatment spending is at \$104 billion, with mental health accounting for \$85 billion (82%) of the total expenditures.²²

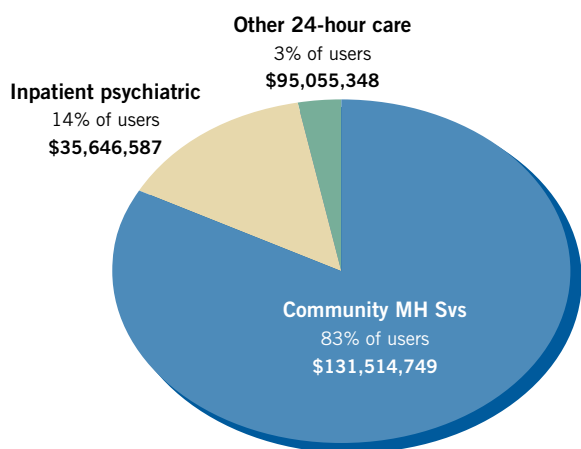
Mental health and substance abuse related services delivered in schools, social service agencies and juvenile justice agencies that are non-federally or non-third-party funded are not included in this figure. Consider that spending for mental health services in the education sector is estimated conservatively at \$3.8 billion (some of this is Medicaid).²³ In child welfare Medicaid alone contributes \$3.7 billion to support treatment and support including general health care.²⁴ In addition, local social service departments use their own monies and allocate some of their federal funding such as the social services block grant to support children's mental health services for children and youth in care. Funding also flows through public health agencies to support mental health services provided by primary care physicians, pediatricians, physicians' assistants, nurse practitioners, school nurses, federally qualified health centers, community mental health centers, school-based and early learning health centers, non-office-based settings such as mobile crisis and shelters, and general and specialty hospitals.

Where does this money come from?

A wide-range of sources makes up the more than \$14 billion that funds mental health and substance abuse services for children and youth. These sources include:

- state and local general revenue (including those from tribal jurisdictions);
- federal discretionary funds, entitlements and formula and block grants;
 - Medicaid and the State Children's Health Insurance Program (SCHIP), Temporary Assistance to Needy Families (TANF), Social Services Block Grant (SSBG);
 - federal categorical revenue allocated toward specific health and human service agencies, in particular but not limited to the federal Departments of Health and Human Services (DHHS), which includes SAMHSA Education and Justice;
 - Indian Health Service; and

Figure 2: Mental Health Expenditures and Service Use by Type of Service for Children and Youth in Maine, 2004



Source: Yoe, J. T., & Harvey, B. (2006). Exploring mental health service use and expenditures across state government: The Maine experience. Presented at the 16th annual conference on state mental health agency services research, program evaluation and policy research to inform the system transformation process. Baltimore, MD.

– a host of private payers including insurers and employers.

For substance abuse, it also includes:

- Substance Abuse Prevention and Treatment Block Grant;
- Medicaid and EPSDT;
- SCHIP; and
- Indian Health Service.

Despite this list of potential funding sources, one state study revealed that the majority of mental health services in the state were supported by two major sources: the mental health authority (41%) and Medicaid (54%) in 2004.²⁵ The total cost was over \$262 million. Fifty percent of the resources supported community-based services for children and youth. But a small proportion of users (17%) accessed inpatient and residential care and consumed a significant proportion of the resources. (See Figure 2.)

What do we know about per capita spending for children and youth?

Mental health median per capita spending for children and youth-related community mental health programs controlled by the state mental health authority in 2004 totaled approximately \$54 compared with \$61 overall. As Figures 3a and 3b show, states spending on children’s mental health

Table 1: Estimated Average Per Child Spending on Mental Health Services by Funding Source

Funding source	Estimated average per child spending
Child Welfare	\$5,216 ^a
Medicaid: Community-based mental health services	\$10,033 ^b
Medicaid: Community-based and inpatient services	\$38,000 ^c
Medicaid: Foster Care	\$4,336 ^d
Special Education	\$14,147 ^e
Substance Abuse: MH/SUD	\$6,000-\$13,000 ^f
Juvenile Justice	\$1,933 ^g
Medicaid Overall	\$1,400 ^h
Multiple: based on SOC site	\$4,256 ⁱ

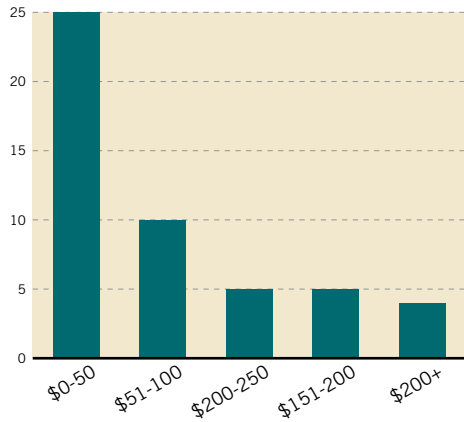
Sources:

- a. Per person spending based upon NRI’s Other State Agency Study (Lutterman, Yoe, Rivard, & Thomas, 2006).
- b. Per person spending based upon New Jersey Medicaid Study (Ireys & Cherlow, 2004).
- c. Per person spending based upon New Jersey Medicaid Study (Ireys & Cherlow, 2004).
- d. Per person spending based upon analysis of Medicaid funding of children in foster care (Genn, Sommers, & Cohen, 2005).
- e. Per person spending base upon analysis of special education funding for children with emotional disorders (Chambers, Shkolnik, & Perez, 2003).
- f. Per client spending in three states (Vandivort-Warren, Undated).
- g. Per person spending based upon NRI’s Other State Agency Study (Lutterman, Yoe, Rivard, & Thomas, 2006).
- h. Kaiser Family Foundation, 2006.
- i. Anderson, J. A., Meyer, R. D., Sullivan, W. P., & Wright, E. R. (2005). Impact of a System of Care on a Community’s Children’s Social Services System. *Journal of Child and Family Studies* 14(4): 505-520.

varied as a proportion of all spending as well as on a per capita basis. In 2003 and 2005, per capita mental health expenditures for children and adolescents were \$45.40 and \$52 respectively. Between 2001 and 2003 all states increased their per capita spending on children and adolescent mental health services, but overall funding levels remained relatively stable.²⁶ No data is publicly available on per capita spending for children and youth for substance abuse prevention and treatment, but per capita spending for substance abuse prevention and treatment for adults, children and youth in 2003 amounted to \$1.28 for prevention and \$3.97 for treatment.²⁷ There have also been studies of per child spending on mental health and related services by different funding sources. The data reveal wide variation by service sector and within funding categories: from \$1,400 per child per year in Medicaid payments for services delivered in primary care settings based on national data (Kaiser) to \$38,000 per child per year in payments for intensive community-based and inpatient mental health services based upon data from New Jersey Medicaid. (See Table 1).

Figure 3a: SMHA-controlled Mental Health Expenditures for Children and Youth, 2001

Expenditures per capita for children's mental health



Percent of SMHA mental health expenditure

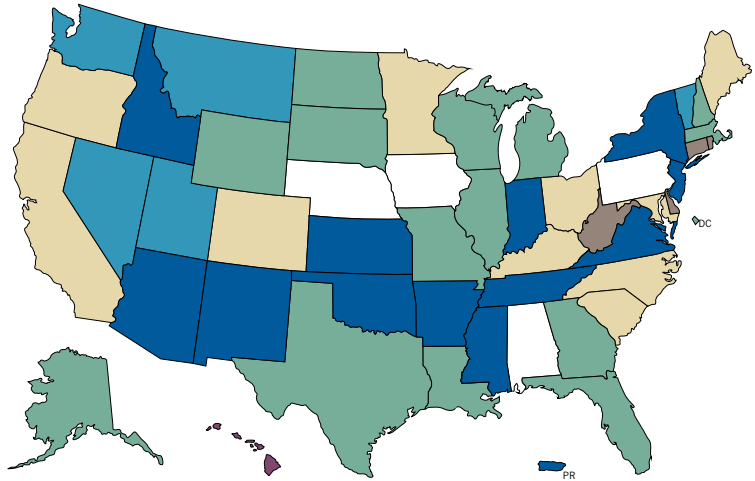
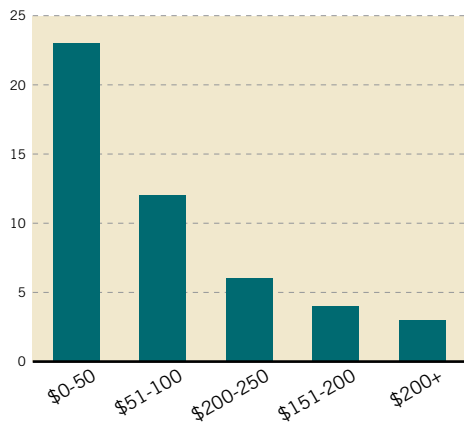
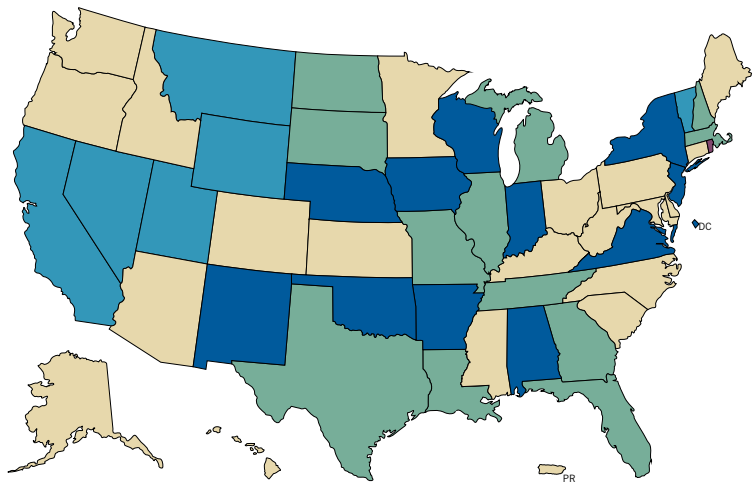


Figure 3b: SMHA-controlled Mental Health Expenditures for Children and Youth, 2003

Expenditures per capita for children's mental health



Percent of SMHA mental health expenditure



Source: National Research Institute. See Appendix A for table by state.

Few reliable estimates exist of how much revenue is spent by each child serving sector within a given state or nationally to support children's mental health services. A recent study of children's mental health financing by state health and human services agencies in six states found that only three of these six states could provide data on most of the potential funding sources. Across the six states studied, spending per user ranged from \$1,933 by juvenile justice to \$3,320 by Medicaid, and \$5,216 by child welfare.²⁸

A larger study of funding for children's mental health services in 18 states charted state variation in expenditures and overall reaffirmed other studies on geographic disparities in access to care. In particular, variation in access rested on three factors: Medicaid eligibility, state child psychiatric workforce capacity, and the proportion of African-American youth served. High expenditures in states also correlated with a high proportion of Medicaid eligible participants in the state and the proportion of children and youth in out-of-home placement.²⁹ Table 2 shows variation between high and low per child expenditures among states for Medicaid and state behavioral health authority spending. In Table 2 per child funding for office-based visits ranged from a low of \$32 to \$1,974 for state mental health authority funding and from \$177 to \$1,378 for Medicaid funding. Across the board, while vast variation existed between service types and settings, Medicaid reflected less variation than state funding. Figures 4a and 4b show total per youth spending based on data from three states for substance abuse services derived from both Medicaid and state behavioral health funding. Total spending per youth ranged from \$1,341 to \$1,710.³⁰ Residential treatment, the treatment type which represented the highest per youth costs, ranged from \$3,872 to \$5,529 and outpatient treatment ranged from \$311 to \$776.³¹

Figure 4a: Total Spending and Spending by Service Type per Youth with Substance Use Disorders (SUD)

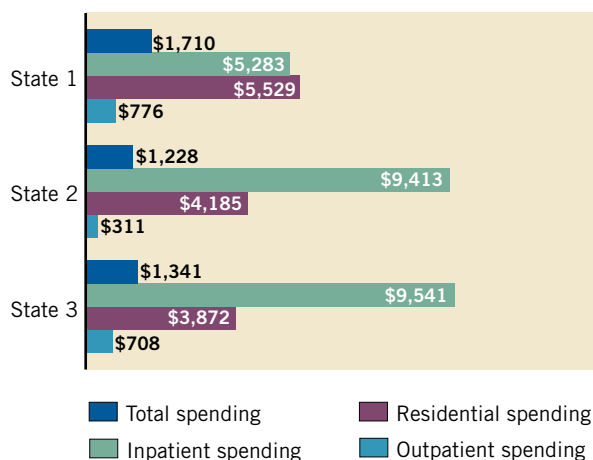
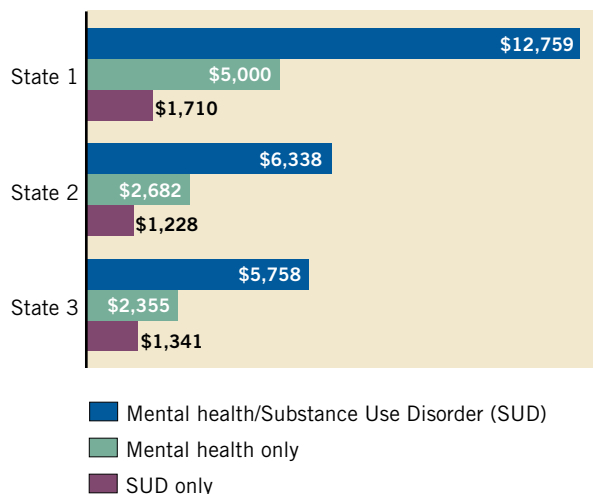


Figure 4b: Total Spending per Youth by Behavioral Health Disorder



Source: Coffey, R. M., Dilonardo, J. D., Vandivort-Warren, R., Graver, L. J., Schroeder, D., Miller, K., et al. (2006). *Expenditures in clients seeking treatment for both mental illness and substance use disorders: Results from an integrated database of mental health, substance abuse and Medicaid agencies for three states in 1997*. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Table 2: Medicaid and State Mental Health Authority Spending by Services for 18 States, 2001-2002

Funding source median expenditure per child	Office/clinic services	Day treatment	Case management	Emergency services
Medicaid	\$500	\$3,085	\$1,373	\$162
Low	\$177	\$250	\$317	\$48
High	\$1,368	\$8,778	\$2,592	\$2,441
State MHA	\$737	\$3,553	\$808	\$412
Low	\$32	\$37	\$25	\$50
High	\$1,974	\$22,796	\$5,682	\$7,923

Source: Dougherty Management Associates, 2003.

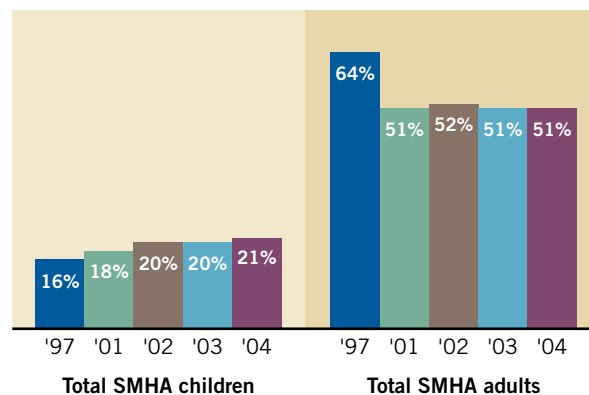
Such variation is even more noticeable *across* behavioral disorders. Figure 4b shows that total funding for youth who received treatment for co-occurring disorders (mental health and substance use disorders) were significantly higher than for treatment for either disorder alone. In addition, it reveals disparities in treatment costs from per youth spending of \$5,758 to \$12,759 for co-occurring disorders, \$2,355 to \$5,000 for treatment for mental health disorders only, and from \$1,228 to \$1,710 for substance abuse treatment.³² When examined across child serving settings for three states, one study found that compared to state funding Medicaid was more likely to support youth in treatment for mental health (38.6%) or co-occurring disorders (19%) than youth with only substance use disorders (SUD) (8.6%).³³ States were more likely to carry the burden of funding youth with SUD only (69%).³⁴

To what extent do children and youth get their fair share of mental health resources?

The issue of fair share of resources for children’s mental health is a long standing one. Today, as in 1982, fueled in large measure by estimates of disproportionate rates of unmet needs, questions on proportional funding between children and youth and adults with mental health problems persist.³⁵ Figure 5 shows the proportion of spending allocated specifically to adults compared to children and youth between 1997 and 2004. While the disparities between community-based funding for children and adults have declined, the proportion of funding specifically directed toward adult programming is vastly greater than funding for children and youth. Whether the analysis involves the proportion of federal funding devoted to mental health services for children relative to the proportion of children and youth insured by Medicaid, or at the state level, the proportion of child and adolescent beneficiaries with identified mental health disorders and intense needs and significantly lower expenditures, all point in the same direction: spending on adult mental health outstrips spending for children and youth.³⁶

The continuing uneven allocation of mental health resources between adult and children and youth despite similar rates of prevalence raises considerations beyond equity to include effectiveness, efficiency and accountability.³⁷

Figure 5: SMHA-controlled Mental Health Expenditures for Community-based Programs. Proportions Allocated for Children and Adults, 1997-2004*



Note: Some expenditures not allocated by age.

Sources: SMHA-controlled expenditures for children and adults in state psychiatric hospitals, community programs, and total SMHA expenditures, FY'97-FY'03. National Research Institute. SMHA-controlled expenditures for mental health expenditures for children and adults, FY'97-FY'01. National Research Institute. Table 15: SMHA-controlled mental health expenditures at community-based programs by age group and state: FY 2004 (in millions). National Research Institute.

How well does funding support a balanced set of services that address prevention, early intervention and treatment?

Recent research suggests that funding for children’s mental health services and supports should cover not only treatment for children and youth but also prevention, early recognition and early intervention strategies. Moreover, for a range of adult mental health problems with their onset during childhood and adolescence, treating children and youth *represents* prevention and early intervention. The evidence is clear that children and youth with behavioral health problems who access services and supports earlier fare better than those who do not.³⁸ This latter factor is largely absent in mental health fiscal policy. Further, spending on children’s mental health is not consistent with what has been termed a public mental health paradigm.³⁹ It neglects to take a universal approach to mental health that is more prevalent in other forms of health care, with specific targeting for those most at-risk and those with identified problems. For example, in Maine, data reveals fully half of all funding underwrote the cost of inpatient psychiatric and residential treatment services for less than one fifth of users in 2004.⁴⁰ Policymakers in substance abuse, largely through the provisions of the block

grant, have embedded a heavy emphasis on prevention. Twenty-per cent for the block grant must be spent on prevention. This modeling by the federal government had ripple effects. All states met this benchmark in 2003, and 23 states spent in excess of 20 percent of their block grant dollars on prevention.⁴¹ In addition, while on average only 6 percent of state only funding was directed towards prevention, three states spent 20 percent or more of their own funding on prevention. There is no comparable language in the mental health block grant.

What do we know about variation in total expenditures across states?

In 2003, overall state mental health authorities allocated 20 percent of community-based program funding specifically to children and adolescents. Some states spent almost half of their budget on children and adolescents while others devoted less than 5 percent to children's mental health services.⁴²

Among the states that spent greater proportions of their mental health budgets on children, the proportion spent on children ranged from 25 to 62 percent in 2001, to between 27 and 98 percent in 2003. Some states have completely separate adult and children's systems and report this data separately. Between 2001 and 2003 the proportion of spending devoted to children and adolescents among the states that spent the lowest proportion of their spending on children and adolescents did not change significantly.

SECTION 2

An Overview of Federal Behavioral Health Funding Streams and Their Impact

Children's behavioral health care services are funded through federal health block grants, targeted system of care grants, Medicaid and to a lesser extent, State Child Health Insurance Program (SCHIP). In addition, there are many categorical grant programs targeted to address, usually for a short term, particular issues (such as trauma). Described below are the major funding streams, their contributions to increasing capacity and brief summaries of related challenges.

Mental Health-Specific Funding Streams

*While the Substance Abuse and Mental Health Services Administration (SAMHSA) stands as the main federal agency legislatively mandated to oversee children's mental health services, the agency's funding represents a tiny fraction of the total amount of federal funding that supports children's mental health.*⁴³ Overall, SAMHSA, part of the Department of Health and Human Services (DHHS) supported children's mental health services in 2005 through an estimated \$395 million that funded 640 grants.⁴⁴ SAMHSA also directs over \$400 million in grants to states through the federal community mental health block grants. Federal, state and local governments allocate funding through a wide spectrum of additional sources for children's mental health.

Federal Community Mental Health Block Grants

*Of the \$420 million allocated to states in FY 2001 through the Community Mental Health Block Grant program, according to one survey, on average 35 percent (\$147 million) was devoted to children and adolescents with severe emotional disturbance.*⁴⁵ By 2004 the Block Grant increased to \$434 million.⁴⁶ Historically the Community Mental Health Block Grant program (commonly called the federal block grant) has spurred statewide mental health service capacity expansions.⁴⁷ Federal block grant funding grew from \$370 million in 2001 to \$406.5 million in 2006.⁴⁸ It offered cash-strapped state mental health programs funding

to adopt new strategies or new policies. Block grant administrators credit the program with stimulating the over three-fold increase in state funding per block grant dollar (from \$8.35-\$38.59) for mental health from 1983 to 2001.⁴⁹ In addition through funding requirements, 5 percent of the federal block grant was set aside for technical assistance, data management and evaluation. By 2004, total funding for the federal block grant was \$434 million.⁵⁰ On average, in 2004, 23 percent of states reported spending 50 percent or more of their federal block grant dollars on children's mental health services and supports. Through this small but pivotal funding mechanism grant administrators in partnership with state directors attempt to promote change at the state and local levels. Specific conditions for the use of federal block grant funding include:⁵¹

- restrictions on its use for institutional-based care;
- maintenance of effort; and
- attention to special populations like the homeless, or services targeted at consumer and family support and rural communities.

Unlike the substance abuse block grant, there is no prescribed focus on prevention.

Some states have used the federal block grant to institutionalize through law and regulations special foci. For example in Minnesota, until recently, state law required a 25 percent set-aside from federal block grant funds to support mental health care to Minnesotans of Native American descent.⁵² States have also used the block grant funds to test out innovative models for care delivery and support. Preliminary data from *Unclaimed Children Revisited: State Children's Mental Health Directors' (UCR: SCMHD) Survey* shows that most states support their statewide family advocacy organization using the block grant. Several states use the block grant to support implementation of evidence-based practices in pilots or limited geographic areas. Other uses include to support strategies to address the needs of youth transitioning into adulthood, funding school-based mental health

services, supporting training in cultural competence and leadership, funding mechanisms to track outcomes, and implementing a system-of-care in communities.

The federal block grant also fosters increased accountability from states by promoting a uniform reporting system, adopting evidence-based practices and mental health information technology.⁵³ Unfortunately, there has been no specific analysis of the impact of the block grant on improving children’s mental health.⁵⁴ Further, a recent report from the Office of Management and Budget found the program lacked accountability, as required under the Government Performance and Results Act (GPRA). In response to the assessment, the federal block grant is currently undergoing an independent evaluation.⁵⁵ In 2000 legislatively mandated changes to the block grant resulted in the federal performance partnership with states through the block grant. In exchange for greater flexibility, states would move toward greater accountability. By 2004 SAMHSA emphasized data and accountability by funding data infrastructural grants and thorough the establishment of the national outcomes measures (NOMS). Through the NOMS SAMHSA established 10 measures in various aspects of behavioral health on which states must report. These measures target morbidity reduction, school engagement or employment, reduction in juvenile justice involvement, stability in living situation, social connectedness, service capacity increase, treatment retention, perception of care, cost effectiveness and implementation of evidence-based practices.⁵⁶

Federal Comprehensive Community Mental Health Services for Children and Families Program (System of Care Grants)

In contrast to a broad-based mental health financing source like the federal block grant, SAMHSA’s Comprehensive Community Mental Health Services for Children and Families Program represents a targeted federal initiative. Currently funded through the Children, Adolescent and Family Branch of the Center for Mental Health Services, and widely known as the system of care (SOC) initiative, it represents the most significant federal investment targeting children with the most severe mental health needs.⁵⁷ Federal investment in SOC development moved from \$1.5 million in 1984 to a nearly \$5 million appropriation in 1993 authorized through the Public Health Service Act, Title V, Part

E, Section 561, as amended, Public Law 102-321 (see Table 3).⁵⁸ Its current annual budget totals over \$104 million, and since its inception 121 SOC grantee communities have been funded.⁵⁹ In addition, states and localities are required to contribute matching funds on a graduated scale. Table 4 shows local, state and federal match ratios based on current guidelines for a hypothetical site. Collectively, local and state funding, when matched with this federal funding, represents significant investments in children’s mental health systems beyond the estimated \$104 million allocated in grants.

Table 3: Comprehensive Community Mental Health Services for Children and Families Annual Appropriations, 1993-2007

Fiscal year	Final appropriations
1993	\$4,900,000
1994	\$35,000,000
1995	\$60,000,000
1996	\$60,000,000
1997	\$70,000,000
1998	\$73,000,000
1999	\$78,000,000
2000	\$83,000,000
2001	\$91,700,000
2002	\$96,459,000
2003	\$98,053,000
2004	\$102,353,000
2005	\$105,112,000
2006	\$104,078,000
2007	\$104,078,000
TOTAL	\$1,165,733,000

Source: Personal communication with Michelle Herman, project officer, Child, Adolescent and Family Branch, SAMHSA, Gary DeCarolis, former branch chief, Child, Adolescent and Family Branch, SAMHSA and Chris Koyanagi, policy director, Bazelon Center on Mental Health Law.

Table 4: Local: Federal Match for Hypothetical Site

Year in grant cycle	Local/state	Federal	Local match: Federal match site X based on \$ hypothetical \$\$
Year 1	\$1	\$3	\$333,333: \$1,000,000
Year 2	\$1	\$3	\$500,000: \$1,500,000
Year 3	\$1	\$3	\$666,666: \$2,000,000
Year 4	\$1	\$1	\$2,000,000: \$2,000,000
Year 5	\$2	\$1	\$3,000,000: \$1,500,000
Year 6	\$2	\$1	\$2,000,000: \$1,000,000
Total site X	\$8	\$12	\$8,499,999: \$9,000,000 (\$17,499,999)

Computed based on current funding match. Luanne Southern contributed to creating this table.

The SOC initiative grew out of federal efforts to make operational and expand the concept of systems of care, first called for by Knitzer in *Unclaimed Children* and further developed and refined by Stroul and Friedman.⁶⁰ At that time, Knitzer reported that only seven states had started developing systems of care.⁶¹ A system of care was defined as “a comprehensive spectrum of mental health and other necessary services and supports that are organized into a coordinated network to meet the multiple and changing needs of children and their families.”⁶² The SOC concept was intended to address major problems with the children’s mental health system.⁶³ These problems included over-reliance on institutional care and limited intensive community-based alternatives, inadequate mental health services for children in the juvenile justice and child welfare systems, fragmented care, and most dismaying, the disrespectful and dismissive treatment of families and their culture. The consensus principles governing systems of care have played an important organizing and vision-setting role for families, clinicians and policymakers across the country. While the original definition did not focus only on children with the most severe disturbances, the

SOC dollars are targeted exclusively to children with serious emotional and behavioral disorders.

Through the specific grant program many states and local communities have adopted the SOC framework as a catalyst for reform, including fiscal reform. Central to building and sustaining SOC efforts are changes to how services are funded, purchased, managed and delivered. SOC sites have engaged in a variety of fiscal reform strategies. Through their fiscal initiatives they have:

- developed cross-agency analyses of funding sources, mandates and reimbursement methods;
- implemented strategies to reallocate existing revenue away from out of home placement and into community-based alternatives;
- established refinancing mechanisms including integrated funding and braided funding; and
- provided flexible funds under the direction of a family and service team guided by a single care plan.

In addition to fiscally-driven strategies, service-related changes have also been core to the heart of these reform efforts. In particular, communities have adopted the wraparound process as a core approach that links strengths and needs with services and supports. The wraparound process requires multi-disciplinary care planning and service teams with children, youth, and families as equal partners in service delivery and supports.⁶⁴

On the whole, federally funded SOC sites hold mixed records in spurring broad-based fiscal reforms at the state level. The federal funding role has been pivotal in some communities and states and less influential in others. On the one hand, federal SOC grants have ignited the development of integrated service delivery systems, cutting through barriers created by individual agencies and their rules. They often provide some local communities the needed freedom to chart a new direction, thus serving as a linchpin for reform.

The Dawn Project in Indianapolis used the grant to bridge funding silos and foster innovative funding strategies.⁶⁵ Other projects have redirected substantial resources from institutionally-based and residential care.⁶⁶ Still others have assumed administrative and/or care management responsibilities for a range of non-traditional health and mental health services and sup-

Box 1: System of Care

System of Care Values

- Child Driven and Family Focused
- Community-based
- Culturally and linguistically competent
- Family Driven

System of Care Principles

Access to:

- Comprehensive Service Array
- Individualized Services based on Individualized Needs and Service Plans
- Clinically-appropriate, Least Restrictive Service Settings
- Families as Full Partners in Service Planning, Decision-making and Delivery
- Integrated Service Delivery
- Case Coordination and Seamless Service Delivery
- Early Identification and Intervention
- Seamless Transitions to Adulthood
- Culturally Responsive Services and Supports
- Youth and Family Rights and Advocacy

Source: Lourie, I. (1994). *Principles of Local System of Development: For Children, Adolescents and Their Families*. Chicago, IL: Kaleidoscope; Stroul, B. A., & Friedman, R. M. (1996). *The System of Care Concept and Philosophy*. In B. A. Stroul (Ed.), *Children's Mental Health Creating Systems of Care in a Changing Society*. Baltimore, MD: Paul H. Brookes Publishing Co.

ports. Some SOC sites generated savings in one system through appropriately managing services' utilization in another sector.⁶⁷ Other effective strategies used by SOC sites were designed to maximize Medicaid revenues. They include developing infrastructure supports such as information technology and management information systems to interact with Medicaid, changing state plans to include language on empirically supported practices, technical assistance to providers, and leveraging of partner agencies' contribution for the state match for Medicaid.⁶⁸ Further, other systems have recognized the value of the SOC approach and have embedded the concept in the functioning of their systems or ironically in some cases, created their own SOC initiatives rather than building upon current efforts.⁶⁹

On the other hand, some grants have yielded other unintentional consequences such as:

- serving as a disincentive to cooperate with the state's mental health authority on its own priorities and initiatives, since funding by passes state mental health authorities and, absent state involvement, deters state-wide replication;
- creating community ill will, as an enriched service array for a limited number of youth is perceived as inequitable and unsustainable among community stakeholders; and
- failing to sustain post grant services and supports once grant funding is exhausted.

There have been efforts to correct these problems through new language in procurement requirements. It mandates closer interaction between grant communities. Additionally, it requires technical assistance efforts that stress closer community engagement and emphasis on sustainability from the beginning of the grant process.⁷⁰

Other frequently reported challenges from the federal SOC initiatives include:

- poor fiscal integration between agencies that fund mental health services;
- limited engagement of education agencies as partners;
- difficulty in spreading fiscal reforms beyond the public mental health system;
- fledgling efforts to spark reinvestments in community-based services, prevention and early intervention; and

Box 2: Examples of Innovative Fiscal Approaches in Systems of Care

Wraparound Milwaukee, a former federally funded SOC site, currently administers three separate Medicaid waivers through which children, youth and their families access a comprehensive array of mental health services based upon the SOC philosophy targeted to the most seriously in need children and youth.

- Through a 1915(a) waiver approved over a decade ago, the agency manages a \$33 million integrated funding pool that blends funds from Medicaid, mental health, juvenile justice and child welfare to serve nearly 700 children and youth with serious mental illness who have needs that must be addressed by multiple agencies.
- A separate waiver approved in 2004 allows Wraparound Milwaukee in partnership with Abri Health Plan, a local health maintenance organization, to manage behavioral health services for over 3,400 children and youth in foster care. Wraparound Milwaukee operates under a risk-based sub-capitation. These fiscal and clinical arrangements afford a continuum of care for children with serious mental disorders who are current or graduated foster care recipients.
- The agency also manages behavioral health services for approximately 200 children and youth with developmental disabilities enrolled in a home and community-based waiver in Milwaukee County.

Source: Personal communication. Interview Bruce Kameradt, Wraparound Milwaukee, June 30, 2006.

Tampa Hillsborough Integrated Network for Kids (THINK). Through an administrative services organization, the Children's Board of Hillsborough County Florida, THINK provides choice and control over the service array and individual family services' budgets for children, youth and their families.⁷¹ One year after federal funding, THINK's funding pool increased by one-third, the number of credentialed network providers was up by two-fifths and the array of services increased by more than 40 percent.⁷² Even in this case however, THINK partners ceased to contribute significant amounts of revenue after the federal grant ended.

Source: Personal communication. Amy Petrilla, THINK project director, Sept. 1, 2006.

- continued focus on children and youth with the most severe mental disorders.⁷³

The most central limit related to systems of care grants, however, is that they have not been a catalyst for states to replicate the strategies throughout each state, nor provided incentives for such expansion. Further, while many sites continue functioning after the federal grant has ended, few operate at the same level of intensity attained during the grant period. Even fewer maintain the partnerships and cross-agency engagements that were developed to conduct functions associated with grant requirements.

Finally, SOC initiatives reach a relatively small number of children, youth and families (approximately 70,000 children and youth were served by this initiative through 2005).⁷⁴ As such, they lack the scale to significantly impact the broader service delivery system or alter mental health outcomes for most children, youth and their families. In short, absent in large measure from these programs' legacies are the broad, statewide changes expected by the creators and other champions of national reform efforts.⁷⁵

Mental Health Transformation State Infrastructure Grants

Nearly \$93 million was awarded to seven states in 2005 to develop their mental health infrastructure to support the reforms called for in the President's New Freedom Commission report.⁷⁶ Two additional states were later awarded. The nine states include:⁷⁷

Connecticut	Missouri	Oklahoma
Hawaii	New Mexico	Texas
Maryland	Ohio	Washington

All nine states report that they have included their children's mental health systems as integral components of these efforts. Preliminary data from the *UCR: SCMHD Survey 2006* indicates that four of these states are heavily focused on capacity assessment and development. Two other states are placing equal emphasis on clinical capacity development and fiscal reforms. One state is working on fiscal reform and coverage expansion. Another state has emphasized workforce development and clinical capacity expansion through evidence-based practices. One state is using its grant to tackle child welfare, embed evidence-based practices and enhance its relationships with academic centers.

Substance Abuse Specific Funding

In 2007 funding for substance abuse prevention and treatment through the Substance Abuse and Mental Health Services Administration totaled \$1.758 billion.⁷⁸ From 1986 to 2003 spending in substance abuse treatment represented an annual growth rate of approximately of 5 percent.⁷⁹ All of this growth has occurred in the public sector.⁸⁰ Medicaid funding for substance abuse grew by 8 percent and substance-abuse related funding in Medicaid represented 14 percent of all

Medicaid funding. Unlike in mental health, most of the funding for substance abuse (85%) is directed at specialty providers and facilities. In 2003, state and local funding represented 40 percent of all public funding.⁸¹ State substance abuse prevention and treatment funding increased by 13 percent from 2000 to 2003.⁸² Support for substance abuse prevention and treatment funding was shared equally by states through their revenues and federal substance abuse and treatment block grant and other discretionary funding.⁸³

Federal Substance Abuse Prevention and Treatment Grants

The federal substance abuse prevention and treatment grants (SAPT) amounted to \$1.759 billion in 2006.⁸⁴ The block grant includes several requirements including set-asides: a set-aside of not less than 20 percent for *primary prevention activities*; a 5 percent set-aside for HIV related early intervention strategies; and a 5 percent set-aside for administrative activities. It also has two provisions for maintenance of effort on expenditures for women with dependent children and pregnant women and for state funding.

In addition to the funding for prevention within the SAPT block grant, the Center for Substance Abuse and Prevention (CSAP), which administers grant programs related to substance abuse prevention, also funds 23 discretionary grant programs making over 994 awards that totaled \$344 million in 2004.⁸⁵ These included scores of drug-free community grants and 17 state infrastructure grant programs. Similarly, the administering agency for the substance abuse treatment component of the block grant, the Center for Substance Abuse Treatment (CSAT), oversees 30 discretionary grant programs, making over 564 awards that totaled \$193 million in 2004.⁸⁶ These grants included seven screening, brief intervention, referral and treatment initiatives (SBIRT), seven state infrastructure grants for co-occurring mental health and substance use disorders and 32 data infrastructure grants. In recent years the SAPT block grant has seen cuts, some in response to an evaluation (known as a PART assessment) from the Office of Management of Budget that deemed some components of its programming inadequate.⁸⁷ The PART assessment gave the SAPT block grant program a poor rating mostly based on the slow progress toward outcome measures. It is not clear what proportion of the block grant funds services

to children and adolescents. However, preliminary analysis that NCCP conducted on discretionary funding from CSAP and CSAT awarded in 2005 identified 76 grants totaling over \$19.7 million. Over 60 percent of these grants and 57 percent of all the funding focused on children, youth and their families.⁸⁸

Amidst the news of public funding dominance in substance abuse prevention and treatment is the realization that 91 percent of youth who needed alcohol treatment and 87 percent of youth who needed treatment for illicit drug use did not receive services.⁸⁹ In fact youth represent a small fraction of those served (8%) by the nation's treatment facilities where the vast majority of the treatment resources are directed. Of the specialty treatment that youth received for substance use disorders, 87 percent was delivered on an outpatient basis, and non-hospital residential care and inpatient hospital care represented 12 and 1 percent of all youth admissions respectively.⁹⁰ According to one national study, 2.6 million youth who needed specialty treatment did not receive it.⁹¹ Moreover the treatment that youth received in adolescent facilities often did not meet the field developed consensus-based standards on best practices. Mark and colleagues found in a review of substance abuse treatment programs that many operated below par on elements of effective care.⁹² For example, while the vast majority of substance treatment providers conducted comprehensive assessments for substance abuse disorders (97%) only *half* also conducted comprehensive mental health assessments. Service integration also proved to be an area of weakness, with only 50 percent of programs providing integrated treatment for the dually diagnosed and only 20 percent providing integrated treatment for pregnant and newly parenting youth. While the programs were particularly strong in discharge planning, only half of the programs offered youth assistance with getting social services including Medicaid, despite Medicaid's crucial role in accessing services.⁹³

Funding that Supports Mental Health and Substance Abuse

Indian Health Service

Indian Health Service's (IHS) mission is to address the health care needs of the over 1.9 million American-Indians and Alaska Natives (AI/AN) who belong to

the nation's 562 federally recognized tribes. Services are provided both directly from IHS funded facilities and entities that contract with IHS. The IHS system includes approximately 50 hospitals, 247 health centers, five school-based health centers, 34 urban clinics and over 300 health stations.⁹⁴ In FY 2006, the budget for IHS totaled \$3.9 billion.⁹⁵ Approximately \$58.5 million was allocated for mental health and \$143.2 million for alcohol and substance abuse related programming.⁹⁶ Consequently, less than 7 percent of IHS' budget supported mental health and substance abuse services in 2006.⁹⁷

The impact of IHS on increasing service capacity and financing of behavioral services for children, youth and their families is limited due to the following factors:

- under-funding;
- poor Medicaid billing;
- lack of access for many potential users; and
- inadequate behavioral health capacity to meet the service needs.

IHS' financing is integrally linked to Medicaid including Medicaid reforms. A perpetual state of under-funding, estimated at 40 percent, makes Medicaid critical to its operations.⁹⁸ The consequences of this funding shortfall include substantial gaps in the provision of health services by the IHS, particularly, as inpatient and out-patient behavioral health services, recently identified by the GAO.⁹⁹ Despite its need for diverse funding sources including Medicaid and Medicare, in FY 2006, IHS facilities collected less than \$645 million in reimbursements, the largest proportion which came from Medicaid and Medicare.¹⁰⁰ This low reimbursement rate reflects under-enrollment of AI/AN individuals in Medicaid. For example one report notes that less than 300,000 AI/AN children and youth are enrolled in Medicaid.¹⁰¹ Additional problematic factors are lackluster collection rates and high rates of non-acceptance of Medicaid payments even among some IHS and tribal-related behavioral health providers.¹⁰²

Many AI/AN individuals do not access IHS facilities. Only between 20 to 50 percent of AI/AN individuals receive their care through IHS facilities or contracted entities.¹⁰³ Of those who use IHS, only an estimated 280,000 are Medicaid enrollees.¹⁰⁴ IHS service capacity is hampered by staffing shortages. One study estimates that only 14 percent of the IHS mental health workforce is trained to work with children and adolescents and

only one-third of IHS areas even have child and adolescent mental health providers.¹⁰⁵ Compounding the impact of the workforce shortage issue on service capacity is the tie between state reform efforts and Medicaid benefit delivered through IHS providers. Although IHS and tribal governments are eligible for 100 percent of federal Medicaid match, they are subject to state established eligibility criteria and benefit package. So if a state narrows its eligibility criteria the AI/AN facilities and the individuals they serve are affected. In addition, urban Indians not served by IHS do not benefit from the enhanced federal match nor do non-IHS referral points.¹⁰⁶

Child and Adolescent Mental Health and Substance Abuse State Infrastructure Grants

SAMHSA's Center for Substance Abuse Treatment and Center for Mental Health Services jointly fund a grant program designed to strengthen states' ability to develop and sustain services for youth with co-occurring mental health and substance use disorders. The five-year, \$5.3 million grant was awarded to six states and one tribal government.¹⁰⁷ Grants total \$750,000 per year and cannot be used for services (Personal communication. Diane Sondheimer, Center for Mental Health Services, Dec. 12, 2007). They are used to support infrastructure development, collaboration, and a range of efforts that target service expansion in Arizona, Georgia, Nebraska, Nevada, the Puyallub Tribe in Washington, South Carolina and Utah. Key efforts include:¹⁰⁸

- outreach to the state's 21 tribal nations and – memorandum of understanding across child-serving systems in Arizona;
- fiscal mapping in Georgia;
- developing early intervention and treatment capacity in early childhood and maternal depression in Nebraska;
- embedding enhanced capacity to address co-occurring disorders in the state's behavioral health reform efforts in Nevada;
- strengthening capacity to meet the needs of youth with co-occurring disorders in the state's IHS system in Washington;
- expanding non-clinical service capacity and supporting local and state reforms in South Carolina; and
- enhancing clinical competence, fiscal integration and information technology in Utah.

Five of the seven grantees are building on current or past SOC initiatives.¹⁰⁹ Noted strengths according to federal officials include strong leadership, focus on sustainability and coordination.¹¹⁰ Key factors that contribute to current challenges range from the need to increase family engagement and cultural and linguistic competence, uptake of evidence-based practices and financing of services not covered by Medicaid.¹¹¹

Medicaid Funding and Children's Behavioral Health

Medicaid is the most important driver of children's mental health policy. This section provides an overview of Medicaid provisions that are most relevant for funding children's mental health services and highlights some of the impacts. Box 3 provides basic information about the role of Medicaid and SCHIP in supporting health care for low-income children, including mental health.

Medicaid and Children's Behavioral Health

Medicaid is now the largest financier of child mental health services.¹¹² Changes in Medicaid significantly increased access to services for children, including those with mental health needs, many children and youth in child welfare, children and youth who have been adopted and children from families whose income in the past would have made them ineligible for coverage. Medicaid's dominance is so firm that in several states it represents the sole funding source for a majority of children with intensive mental health needs and a significant source for those receiving high cost services.¹¹³

Medicaid is also a program with a great deal of flexibility. In effect, there are really 50 state Medicaid programs, whether the lens is all child health, or just behavioral health. In part this is a function of how the overall program is structured, which:

- allows for optional services (although through Early Periodic Screening, Diagnosis and Treatment [EPSDT] there is an obligation to provide all necessary services);
- requires different state fiscal contributions to participate;
- provides for demonstrations and waivers; and
- allows for divergent interpretation of Medicaid rules at the regional level.

Box 3: Setting the Context: Medicaid and the State Children's Health Insurance Program

- Children and adolescents represent nearly half of all enrollees (49%) in the Medicaid program, supporting over 28.3 million children at a cost of \$29.8 billion in 2005.^a
- An additional \$4 billion underwrote coverage for 6.2 million children and adolescents through the State Child Health Insurance Program (SCHIP) across the country in 2005 and 2007 funding is expected to top \$5 billion.^b (See Table 5).
- Coverage for children's health (including mental health) still represents a disproportionately small share of total funding. In 1985, children represented 12 percent of total Medicaid expenditures. By 2003 they represented 17 percent of total expenditures.^c
- Between 1989 and 2002, among all children, the proportion of children with Medicaid coverage doubled from 9.2 percent to 20.8 percent.^d
- More recently concerns about structural changes to Medicaid and SCHIP's structure and fiscal shortfalls threaten to undermine some of these gains.^e

Sources:

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Table 5: SCHIP Final Appropriations

Fiscal year	SCHIP final appropriations (in millions of dollars)
1998	\$4,295,000,000
1999	\$4,275,000,000
2000	\$4,275,000,000
2001	\$4,275,000,000
2002	\$4,275,000,000
2003	\$3,150,000,000
2004	\$3,150,000,000
2005	\$4,050,000,000
2006	\$4,050,000,000
2007	\$5,000,000,000
TOTAL	\$40,795,000,000

Source: McClellan, M. "The State Children's Health Insurance" Senate Subcommittee on Health of the Committee of Finance. July 25, 2005. Retrieved Aug. 31, 2006, from <www.cms.hhs.gov/appps/media/press/testimony.asp>.

Medicaid funds mental health services and supports for eligible children and youth. In general, the range of services that Medicaid covers for children and youth in need of mental health services and supports is dependent on two factors: the state's Medicaid plan and the federal requirements for EPSDT. For children's behavioral health, Medicaid covers inpatient treatment, residential treatment and a range of community-based services and supports. State Medicaid plans describe which services are covered, which providers can receive reimbursement and at what ages children qualify for services. Whether these services are reimbursable and what the payment rates are vary across the states.¹¹⁴ In some states Medicaid payment reflects market rates. In many others, payments fall well below the prevailing rates. Higher payment rates have been associated with indicators of increased access such as likelihood of regular stable source of care, and with provider participation in Medicaid.¹¹⁵

The state's Medicaid plan lists the covered services for which Medicaid will reimburse. Through EPSDT, all medically necessary services must be covered by the state's Medicaid program for eligible children and youth. Over the last two decades, the courts have compelled some states to take the EPSDT mandate more seriously. Most recently, two lawsuits, Katie A. and Rosie D. were settled by Los Angeles County and the State of Massachusetts plaintiffs respectively, predicated on the state's obligation under EPSDT.¹¹⁶ It is anticipated that these decisions will significantly impact children's mental health.

In substance abuse treatment, Medicaid is the primary funding source. While youth represented a mere 8 percent of substance abuse treatment admissions, they accounted for 20 percent of all Medicaid funded admissions, and only 7 percent funding from private or other sources.¹¹⁷ Medicaid drove funding in other ways. For example, Medicaid eligible youth who entered substance abuse treatment were five times more likely than non-Medicaid eligible youth to access to mental health services.¹¹⁸

The Impacts

For children and youth with behavioral health disorders, Medicaid has led to dramatic increases in capacity and access across the spectrum of intensity of need.

Despite low reimbursement rates, access has increased, with more referrals to both specialty and intensive ser-

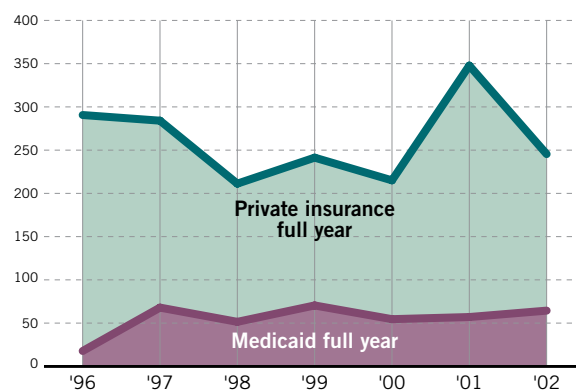
vices.¹¹⁹ For children with mental health diagnoses, Medicaid coverage increased two-fold, from 18.8 percent to 28.1 percent.¹²⁰ Expanded insurance coverage facilitated a significant increase in the rate of diagnosis of any mental health disorder among children and adolescents between 1987 and 2002 and the proportion of all primary care visits for children between ages 4-17 with a mental health diagnosis more than tripled.¹²¹ Additionally, the proportion of these visits where prescriptions for psychotropic medications were written increased three-fold.¹²²

Even in states with slow SCHIP uptake for mental health services and with administrative barriers, the program has expanded services for children and youth (Personal communication. Sue Ross, Florida Department of Children and Families, Aug. 9, 2006). This expansion, however, is tempered by the fact that nearly half of all state SCHIP programs place limits on inpatient and outpatient mental health services.¹²³ From 1992 to 2001, the proportion of emergency room visits for children with a mental health diagnosis more than doubled. Similarly, between 1987 and 1996 the proportion of children with a mental health diagnosis and inpatient stay increased.¹²⁴ Among youth with co-occurring mental health and substance use disorders, transition-age youth experienced among the highest rates of emergency room use rates.¹²⁵ Among youth with more intensive mental health needs, this expanded health insurance also coincided with an increase in the use of specialty mental health services.

As access to insurance has expanded, there has been a decrease in disproportionately high out-of-pocket expenses for families.

Expanded access to publicly funded health insurance has reduced the out-of-pocket financial burden on families. From 1987 to 2000 the out-of-pocket share for mental health, which was higher than general health at the beginning of the period, dropped dramatically (see Figure 6) and by 2000, were less than for general health, in part because these families were more likely to have access to health insurance.¹²⁶ One study of both mental health and substance abuse out-of-pocket costs attributed not only an increase in coverage but also parity of mental health and substance abuse coverage with reducing out-of-pocket spending.¹²⁷ But parents of children and youth with mental health problems still

Figure 6: Average Out-of-pocket Mental Health Costs for Children and Youth (4-17)



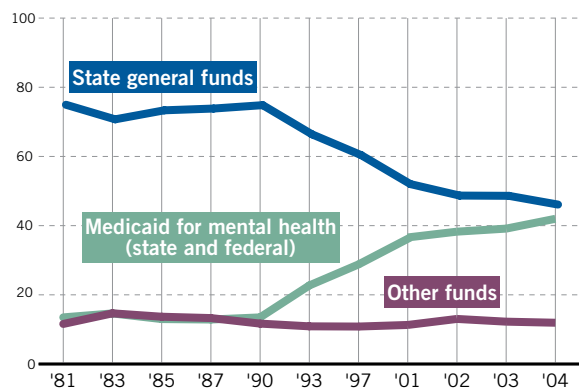
Sources: Frank, R. and Glied, S. (forthcoming). Chartbook.

incurred a range of other costs related to their children's conditions. In particular for families with private health insurance, the financial burden is significantly higher for those with a child with mental health problems than with other disabilities.¹²⁸ Even with lower out-of-pocket costs, loopholes in parity mandates at the state and federal level mean that families may exhaust private insurance benefits and face significant fiscal hardships, many also continue to confront the potential of custody relinquishment in order to access services for their children and youth. According to the GAO, an estimated 12,000 families were compelled to relinquish custody of their children and youth in order to access needed mental health services and supports for them.¹²⁹

Medicaid Mental Health Funding: Asset and Drain for State Budgets

Medicaid's importance as a funding source for adult and children's mental health proved particularly evident when states faced severe economic crises. From 2001 to 2003 the Medicaid proportion of state-controlled revenues increased by almost 12 percent according to the National Research Institute (NRI), compared to state revenues, which increased by 5.2 percent.¹³⁰ As a result of the recession in 2002 and 2003 the state-financed share of mental health budgets declined. Even under these circumstances, revenues for community-based mental health increased. The proportion of Medicaid funding increases dwarfed those of state revenues (14.4% from Medicaid versus 4.6% from state revenues).¹³¹ This and other evidence suggest that increas-

Figure 7: SMHA-controlled Revenues by Source as a Percent of Total Funds, 1981 to 2004



Source: National Research Institute. 2006.

ingly Medicaid has substituted state funding rather than augmented state funding for mental health.¹³² The net result has been less state investments in children’s mental health, particularly for those groups of children without any health insurance and those with insurance coverage that support limited mental health benefits. See Figure 7, where data from NRI shows that as a proportion of all funding for mental health, state general funds have declined, other funds have remained flat, while Medicaid has grown sharply (from 13% in 1981 to 42% in 2004).

At the same time, there is increasing concern at the state and federal level about the costs of Medicaid. In FY 2006, Medicaid again surpassed education as the largest proportion of state budgets.¹³³ Today, the cost of the state share of Medicaid threatens to bankrupt states. In the face of economic downturns, Medicaid substitutes for private insurance for some children and youth as parents lose jobs or as fewer companies offer dependent health insurance coverage.¹³⁴ Structural problems with Medicaid also persist. These encompass macro program issues, such as anticipated costs increases related to the aging of the baby boomers and their increased health care needs, and projected costs associated with addressing infrastructural shortcomings, such as rudimentary information technology. These structural problems also extend to considerations that more directly impact children’s behavioral health, such as whether Medicaid expenditure funds the most vulnerable, whether there are sufficient providers and whether payment rates are adequate. These factors take on added significance

because of Medicaid’s dominance.¹³⁵ In mental health, Medicaid funding represented over 61 percent of all new revenues from 1990 to 2000.¹³⁶

Medicaid and Children and Youth with Behavioral Health Needs in Other Child-serving Systems

Medicaid and Child Welfare Systems

Substantial evidence suggests that Medicaid contributes significantly to underwriting behavioral health treatment and support for children and youth in the child welfare system.¹³⁷ These children and youth are eligible to access primary and behavioral health care through Medicaid and, those who do, are over-represented among Medicaid users with high expenditures. Recent estimates of Medicaid expenditures for youth in foster care in 2001 and 2002 totaled \$3.7 billion, more than half of which represented the federal share. Medicaid spending for foster care youth greatly exceeded their proportion among enrollees.¹³⁸ Among child and adolescent enrollees supported by Medicaid, children in foster care represented fewer than 4 percent of enrollees, but accounted for more than 12 percent of expenditures. While on average Medicaid spending per child/adolescent in foster care was \$4,336, it varied significantly by state and service (from \$1,309 in Arizona and \$19,408 in Maine).¹³⁹

Medicaid funded children and youth in foster care were over-represented among those Medicaid enrollees who received intensive services. Four main service categories accounted for over two-fifths of all Medicaid spending for children and adolescents in foster care, including: inpatient psychiatric services, general inpatient services, rehabilitation services and targeted case management.¹⁴⁰ Children and youth in child welfare were also among Medicaid users with the highest costs associated with inpatient psychiatric and residential treatment, with nearly one-third of all Medicaid expenditures for inpatient psychiatric services. Among Medicaid child and adolescent enrollees, those in foster care accounted for almost half (46%) of all inpatient psychiatric Medicaid expenditures.¹⁴¹ Despite this funding, most children and adolescents in child welfare do not access needed mental health services.¹⁴² Moreover those children in child welfare who remain in their homes are even less

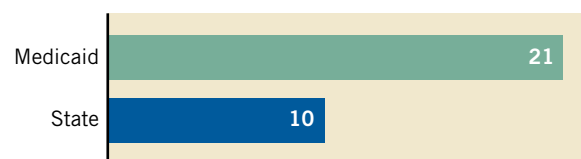
likely to access Medicaid coverage for services.¹⁴³ This disparity between the high volume of services purchased and high levels of unmet need in child welfare propels assertions that mental health policymakers have not aggressively pursued expanded Medicaid funding for child welfare.¹⁴⁴ The data does not substantiate these charges for children and youth in child welfare, but rather raises the question of whether these resources could be used in ways that result in better access and outcomes.

In addition to Medicaid, other state and federal child welfare funding is used to purchase services that address the safety, permanency and well-being of children and youth involved with the child welfare system. In some cases, states tap into other federal entitlement dollars to support child mental health service delivery. For instance, nationally over \$85 million in social service block grants supported residential treatment for children and youth with mental health needs in 2003.¹⁴⁵ Other examples prevail, such as in New York, where the state uses Temporary Assistance to Needy Families (TANF) funding to support mental health services for all children and youth in school-based health centers (Shauneen McNally, partner, Weingarten, Reid and McNally. Unpublished White Paper, New York State Coalition for School-based Primary Care, 2006).

Medicaid and Juvenile Justice Systems

Estimates of the proportion of youth with mental health problems in juvenile justice range from 67-70 percent. For youth in juvenile justice, access to Medicaid-funded behavioral health services remains limited in most states.¹⁴⁶ Federal law prohibits incarcerated youth from receiving Medicaid-financed services and supports while they are committed to juvenile justice facilities.¹⁴⁷ However, implementation of the regulation is ambiguous so that states interpret the laws governing Medicaid funding for pre-adjudicated and adjudicated youth differently.¹⁴⁸ Consequently, states vary in how they deal with this prohibition. Some have developed mechanisms to classify youth in juvenile justice facilities according to levels of security and provide Medicaid funding for youth at lower risk levels. These states often also use state funds to support youth committed to correctional facilities where Medicaid funding is prohibited. Figure 8 shows, based on preliminary results from *UCR: SCMHD Survey 2006*, that 21 states reported that they restricted Medicaid reimbursement for youth

Figure 8: Number of States that Report Restricting Reimbursement for Youth in Juvenile Justice by Medicaid and State Funding



Source: UCR SCMHD Survey, 2006.

in juvenile justice. Only 10 states reported that they prohibited the use of state mental health funding.

A memorandum dated Dec. 12, 1997, from the Centers for Medicare & Medicaid (CMS) may have contributed to this variation in state interpretation.¹⁴⁹ CMS notes “two criteria” for deciding whether Medicaid funding for an individual is prohibited: (1) the beneficiary must be an inmate; and, (2) the beneficiary must live in a public institution. Further the CMS memo states that “an exception to this prohibition exists when an inmate becomes a patient in a medical institution. This occurs when an inmate is admitted as an inpatient in a hospital, nursing facility, juvenile psychiatric facility, or intermediate care facility.”¹⁵⁰ More recently, proposed regulations by CMS on the rehab option clarify the prohibition against Medicaid funding for behavioral services delivered to children and youth who are “involuntarily confined.”¹⁵¹

Disparate lines of responsibility and authority further exacerbate funding barriers to behavioral health services presented by Medicaid prohibitions in juvenile justice. In two-fifths of the states, local and county governments bear responsibility for providing mental health services in juvenile justice.¹⁵² Of the remainder, the state mental health authority is either jointly or solely responsible (40%), or sole authority rests with the state juvenile justice or the state’s authority for children’s services (20%).¹⁵³ This complicated mix makes ameliorating access to Medicaid-supported services even more complex. Federal policies may amplify the problem. For example, recently CMS challenged reimbursement claims by some states for case management delivered to children and youth with juvenile justice involvement, charging that these coordination functions were intrinsic to the goals of the juvenile justice program and would be undertaken irrespective of mental health involvement.¹⁵⁴

Data on the high prevalence of behavioral health needs, mental health and substance use disorders suggest that services are required for youth when they are incarcerated.¹⁵⁵ A recent study documented that nearly 48 percent of juvenile justice facilities report that they conduct standardized assessments for substance use disorders.¹⁵⁶ An estimated 60 percent provide substance abuse groups and 22 percent provide specialized programming for substance use disorders. However, fragmented and fragile funding mechanisms result in questionable service quality.¹⁵⁷

The law is unequivocal that young people can access Medicaid once they are no longer incarcerated. Yet many states fail to develop the infrastructure to rapidly or automatically re-enroll these youth upon their release. Cuellar and her colleagues found that only 26 percent of state Medicaid agencies had a policy of re-enrolling youth upon release from detention, although 46 percent admitted that youth were removed from Medicaid upon entry into juvenile detention.¹⁵⁸ Further, despite these obstacles some states support an array of effective treatments and supports in juvenile justice using their own funding. One example is Washington State. (See Box 4.)

Box 4: Improving Mental Health Services in Juvenile Justice: Washington State Strategies

- In Washington State, the Juvenile Rehabilitation Administration spent approximately \$10.8 million on behavioral health related services and supports in 2005 (\$3.5 million for mental health and the rest for substance abuse services).
- The state's juvenile justice agency supports the use of five evidence-based practices in the state in addition to funding mental health treatment personnel and medication for youth in residential placement in juvenile justice:
 - functional family therapy (FFT);
 - functional family parole;
 - family interactive therapy;
 - dialectic behavioral therapy; and
 - aggression replacement therapy.
- In fact, one Washington State child welfare administrator noted that building capacity for FFT in their system began when they tapped unused juvenile justice resources. Recently, the state of Washington made a decision not to build a juvenile justice facility based upon cost-benefit analyses of the comparative advantages of these community-based treatments.

Source: Personal communication. Dan Schaub, mental health program administrator, State of Washington Juvenile Rehabilitation Administration on Aug. 28, 2006).

Medicaid and Other Funding of Mental Health Services in the Schools and Early Childhood Settings

The Larger Challenge

School-linked mental health funding falls into two categories: funding for services to children without diagnosed problems, often called preventive services, and funding for children with identified problems. Despite widespread calls for more funding for early childhood and school-based mental health, calculating the total current expenditures for school-based mental health services and support has proved difficult.¹⁵⁹ Funding from education and in partnership with other organizations, Title IV and Safe and Drug Free Schools of the federal Department of Education's budget represent the most common way most schools (57%) report that they support mental health-related prevention services.¹⁶⁰ State and local revenues and special education funds also support prevention related activities in the schools (32% to 43%).¹⁶¹ Medicaid represents the least used funding source for prevention activities. Increasingly, schools have refined their ability to tap into Medicaid financing. Almost two-fifths of schools report that Medicaid is a significant source of funding.¹⁶² This has called into question the delineation of services funded by Medicaid that are essential to the school's programming and those specific to the functioning of a student with mental health problems (see discussion of the Rehab Option). For intervention type programs, special education, particularly IDEA (Individuals with Disabilities Educational Act), and local and state funds are readily used by schools.¹⁶³ The "Safe Schools Initiative" is not widely used to support children and youth with intense mental health needs.¹⁶⁴

Children and youth with *identified* mental health needs with Individualized Education Plans (IEP) or Section 504 plans can access mental health services through the schools. The estimated cost of educating children with emotional disturbances (ED) in the school year 1999-2000 related to their disability was \$3.8 billion.¹⁶⁵ The per pupil cost of educating a child with an emotional behavioral disorder (EBD) in the 1999-2000 school year was estimated to be between \$11,905 and \$16,588 with \$14,147 representing the average per-pupil cost.¹⁶⁶ Children with mental health needs may also be categorized under the "other health

Figure 9a: Average per Pupil Spending for Special and Regular Education by Average SE Student, Student with ED and Student with OHI

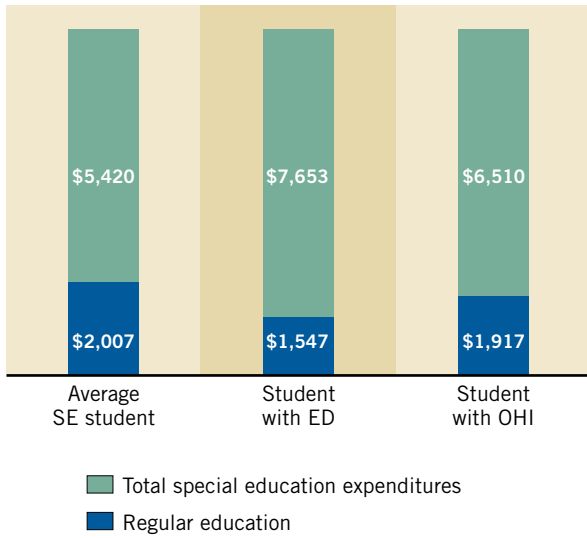
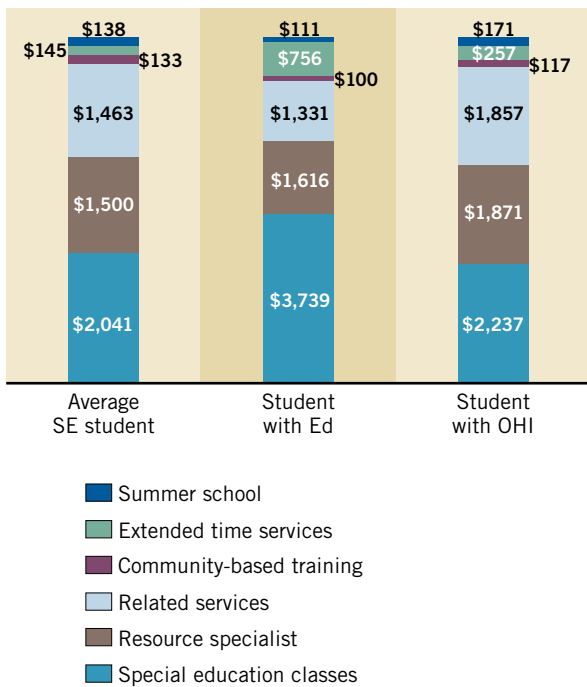


Figure 9b: Average per Student Spending for Components of Special Education by Average SE Student, Student with ED and Student with OHI



SE = Special education
 ED = Emotional disturbance
 OHI = Other health impairment

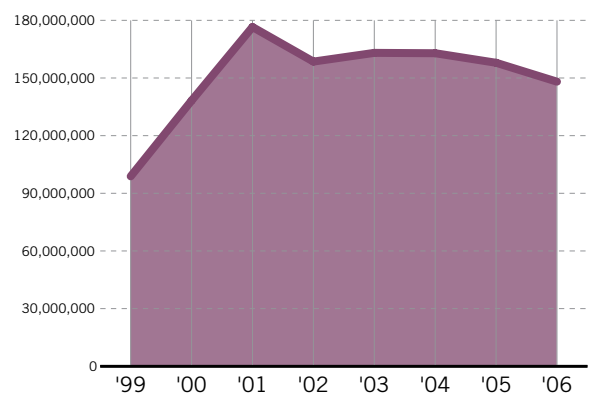
Source: Chambers, J. G., Shkolnik, J., & Perez, M. (2003). *Total Expenditures for Students with Disabilities, 1999-2000: Spending Variation by Disability*. Washington, DC: American Institute for Research.

impairment” (OHI) group, which is how many children with attention-deficit/hyperactivity disorder (ADHD) are classified.¹⁶⁷ Children with OHI category averaged slightly less than children with ED at \$13,229 per pupil per year.¹⁶⁸ Of the total per-pupil spending in education for a child with ED, 83 percent was devoted to special education and the balance was allocated to regular education.¹⁶⁹ Figure 9a shows average per-student spending for a child with ED, a child with OHI and an average special education student. Figure 9b presents a breakdown of the per pupil special education related cost for a child with ED, a child in the OHI category and an average child in special education.

But even with these funding streams, schools report fiscal constraints such as insufficient community mental health capacity, funding restrictions and competing priorities amidst limited resources.¹⁷⁰ By far the most pervasive barriers are systemic and most need comprehensive strategies to overcome them. In particular, schools report that these problems may be addressed by proposing strategies that tie funding with educationally-linked outcomes and allow for increased flexibility in spending.¹⁷¹

Other students without a diagnosis or a functional assessment who qualify for services access a range of prevention, mental health promotion and other interventions through school-based and school-linked strategies. Several federally-funded grant programs support these interventions. For instance, the Safe Schools Healthy Students initiative funds states to develop school-based mental health interventions and supports. Between 1999 and 2005, the federal government made available \$898.3

Figure 10: Safe Schools Healthy Students Grants by Year



Source: SAMHSA (Personal communication: Susan Keyes. March 12, 2007).

million for this initiative.¹⁷² Figure 10 shows significant declines in total funding while the number of states that receive funding increased. A recent source of concern has been that, at a time of increased calls for prevention-related services and supports, thinly spread resources cannot support needed infrastructure enhancements. Medicaid funding for very young children with challenging behaviors has been particularly difficult. Besides primary care, these children are often in early care and learning settings. Services and supports often require the young child, the parent along and the caregivers. But most Medicaid agencies (over 75%) restrict the range of providers who can be reimbursed for diagnosing and treatment a young child.¹⁷³ Moreover, some state Medicaid agencies explicitly restrict funding of services in early care and learning settings (*UCR: SCMHD Survey 2006*).

Other Medicaid Provisions that Impact Children’s Behavioral Health Across the Systems

Rehabilitation Option

Data are not available on the proportion of rehab option services that fund children’s services exclusively. However, several states tap into the rehab option to fund substance abuse treatment for youth with substance use disorders. Nearly all states fund children’s mental health services through the rehab option. The rehabilitation option (rehab option) was created to allow the states flexibility to design a set of services and supports for “the maximum reduction of physical or mental disability and restoration of an individual to

the best possible functional level.”¹⁷⁴ The services can include: “other diagnostic, screening, preventive, and rehabilitative services, including any medical or remedial services (provided in a facility, a home, or other setting) recommended by a physician or other licensed practitioner of the healing arts within the scope of their practice under State law.” The rehab option has been a major lever for building community based supports for more troubled children and youth.

According to CMS, 44 states funded community mental health services using the rehab option.¹⁷⁵ In 1997 spending for services under the rehab option accounted for \$891 million.¹⁷⁶ By 2001 revenues from the rehab option to states amounted to over \$1.34 billion (as reported by only 21 states) for mental health services and accounted for 17 percent state and federal Medicaid revenues.¹⁷⁷ Using this proportion Medicaid revenues through the rehab option could conservatively be estimated at over \$1.76 billion for 2003 based upon reported revenues.¹⁷⁸ More recent figures are unavailable. Given that Medicaid funding for all rehabilitation services totaled \$5.7 billion in 2005, one would expect that revenues for rehab option services to be at least \$2.28 billion in 2005 using projections by observers that 40 percent of individuals who qualify for a disability do so on the basis of a psychiatric diagnosis (Personal communication with Karen Tritz, Congressional Research Services, Sept. 22, 2006).

Real Choice

Twenty-one of Real Choice grants were directed specifically toward children and youth with serious mental

Table 6: Real Choice Grants by Number of Grants that Focus on Children and Youth

Grant name	Number of grants (# children with SED) funded	Total amount funded	Proportion of total funded for SED
Family to Family Health Care Information and Education Centers	29 (2 SED)	\$4,484,750	7%
Mental Health System Transformation	12 (2 SED, 2 SED/MI)	\$4,143,445	14%
Respite for Children	6 (3 SED)	\$573,673	52%
Community-based Treatment Alternatives for Children	6 (all SED)	\$592,421	100%
Real Choice Systems Change*	51 (4 SED)	\$77,808,997	9%
Quality Assurance/Quality Improvement	28 (1 SED)	\$13,538,094	4%
EPSDT Portals to Adult Supports	2 (all include SED)	\$999,649	100%

* An additional 10 Real Choice Systems Transformation grants were awarded in 2005 totalling \$26.8m; none specifically cited children with SED as their target population.
Source: Center for Medicaid & State Operations. (2006). Real choice: Systems change grants. Retrieved July 5, 2007, from <www.cms.hhs.gov/RealChoice/downloads/compendium.pdf>.

disorders. Since 2001, CMS has directed Real Choice, another funding stream based on the principles of independence and consumer choice. Real Choice is funded through a separate funding stream and has provided

approximately 247 Real Choice grants to states, totaling over \$195 million. Maine and South Carolina, under the auspices of the Real Choice Systems Change grants, received the highest awards to date specifically for chil-

Table 7: Summary of Home and Community-Based Waivers by State

State	Year approved	Entry criteria	Target pop. (age)	# Children/youth served	Cost per child	Services covered	Capacity	Savings/anticipated per child savings ^a
IN	2003	At-risk of hospitalization; state criteria for SED	5-17 (up to 22 under certain conditions)	35 users (capacity for 100)	\$22,190	Independent living skills, respite, family support and wraparound facilitation.	9 counties	\$34,500
KS	1998	Clinical & fiscal criteria: At risk for state psychiatric hospitalization & qualifying scores on CBCL or CAFAS	4-18 (under 4 & 19-22 under certain conditons)	2000 users	\$14,626	Wraparound facilitation, parent support, respite, independent living skills, mental health service array (case management, attendant care, individual therapy, medication mgt), vision, medical & dental.	State	\$12,649 based upon independent evaluation ^b
NY	1996	At risk of hospitalization/institutional care; parents/guardians capable & willing to participate in waiver & support child/youth in community	5-17 (under certain conditions up to age 21)	876 slots for 5500 users (2006-07 expanding by 450 slots or 675 users)	\$46,608 upstate per slot \$48,925 downstate per slot	Case coordination, crisis respite, family support, intensive in-home services, skills-building, MD care medication.	61/62 counties	\$90,784
VT	1982	Children & youth with SED at risk of psychiatric hospitalization/institution where other options for treatment fully explored	0-22	80 children/youth per yr, coordinated with similar ISP (N=150 in both programs)	\$30,000-\$40,000	Respite foster care stipend for therapeutic foster care. All services available in state plan including: case coordination specialized rehab skills building & therapy.	State	\$1,418
MI	2005	Risk of placement in a state psych hospital & a Child and Adolescent Functional Assessment Scale (CAFAS)	0-18	43 projected initial users plans to expand	\$53,625 (projected)	Respite, family training/support, therapeutic foster care, wraparound facilitation, community support, community living supports, therapeutic camp, skills development, staff assistance, medication administration, transitional services.	9 counties	\$23,759
IA*	2005	SED diagnosis at-risk for hospital level care	0-18	269 users (capacity for 300)	\$17,000	In-home therapy, community supports, respite, home/vehicle modification, targeted case management.	Limited areas	\$30,650
WY	2006	SED diagnosis at risk for hospital level care	4-20	Approved to serve 250	\$12,000 (projected)	Family care coordination, family training/support, respite.	3 counties	\$20,000

* Iowa Waiver: This is an 1115 waiver where one component uses the home and community-based waiver principles.

a. Based upon cost neutrality figures submitted to CMS.

b. Barfield, S. T., Holmes, C., Chamberlain, R., Corrigan, S. K., & Barket, A. (2005). *Home and Community-Based Services: Mental Health Waiver for Children and Youth with Severe Emotional Disturbance*. Lawrence, KS: The University of Kansas School of Social Welfare, Children's Mental Health Research Group.

Source: Personal communication. Liz Miskell, WY, Lin Christensen and Mary Mohrhauser, IA, Gary Hook, N.Y., Charles Biss, VT, Cheryl Shearer, IN, Steve Erickson and Krista Morrison, KS, Bruce Kameradt, WI, and Jim Wotring, MI. 2006.

dren and youth (\$2.3 million each). Table 6 shows Real Choice’s mental health and related funding for children, youth and their families.

Home and Community-Based Waivers

Through Section 1915(c) of the Social Security Act, also known as the home and community-based waiver, children and youth with severe mental disorders access a range of services and supports that have demonstrated effectiveness and are designed to keep them from entering out-of-home placement. This waiver enables children and youth to access services and supports that otherwise would not be available to them. Table 7 shows the states with waivers and the services available to children and adolescents. Nationally an estimated 8,000 children and youth with mental health needs benefit from the 1915(c) waiver. Expenditures for children and youth with serious mental health disorders and for adults with mental illness represent less than half of one percent of the overall \$21.2 billion total revenue spent on home and community-based waivers.¹⁷⁹

TEFRA

Despite its potential to expand coverage for children and youth, the Tax Equity and Financial Responsibility Act (TEFRA) remains a less frequently used Medicaid option.¹⁸⁰ Less than 2,200 children benefiting from TEFRA had a primary mental health diagnosis. Also known as the Katie Beckett Law, this act permits a higher income level threshold for Medicaid coverage. Additional eligibility criteria for TEFRA include a Supplemental Security Income (SSI) level of disability and level of care requirements equivalent to a hospital, intermediate care facility for individuals with mental retardation or nursing home. Only 20 states exercised the TEFRA option in 2001, with only 10 of these states permitting children and adolescents to qualify for benefits based on their mental health disability.¹⁸¹

Other Financing Trends in Medicaid

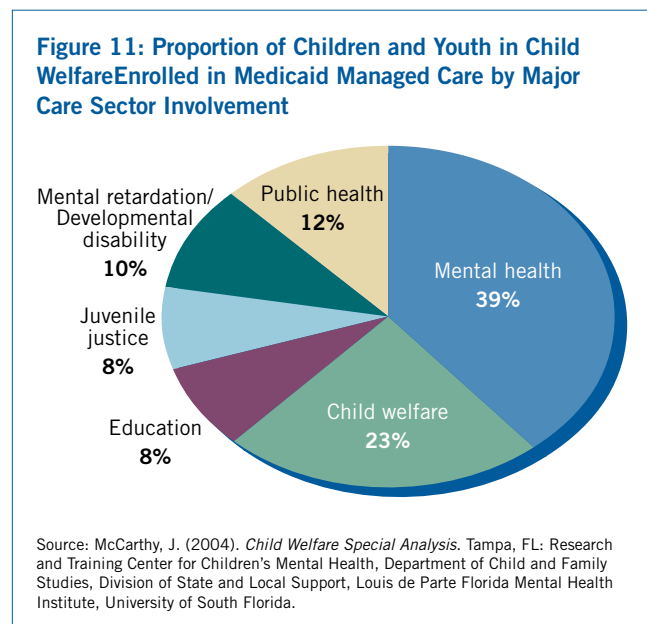
Medicaid Managed Care

As states have attempted to maximize Medicaid revenues to fund mental health services they have also sought to meet cost containment goals by enrolling users in managed care. These arrangements are structured

differently across the country. The main reasons for using managed care strategies are to:

- increase consumer access and choice of service providers;
- gain efficiencies in how resources are managed and authorized;
- centralize functions associated with provider reimbursement, contract management and provider network development;
- improve the coordination of services;
- track fiscal and clinical outcomes, and service utilization;
- raise the level of fiscal accountability; and
- monitor the quality of care provided.

According to the Kaiser Family Foundation, as of June 2005, only Alaska, Wyoming and the US Virgin Islands had no enrollees in Medicaid managed care.¹⁸² Currently, 65 percent of all individuals enrolled in Medicaid receive their services through managed care arrangements, and 45 states and territories have more than half of their Medicaid recipients involved in managed care.¹⁸³ As with other populations, enrolling children and adolescents with mental health needs in Medicaid managed care plans has varied across the country, with most states implementing some form of managed care for specific segments of the child and adolescent population.¹⁸⁴ State Medicaid represents by far the largest source of funding for behavioral managed care entities. (See Figure 11).



Data on access to services within a managed care environment for children and youth with intensive mental health needs are mixed. Stroul and her colleagues report that:¹⁸⁵

- initial access to managed behavioral health care for children and adolescents increased from 2000 to 2003;
- while 21 percent of managed care plans reported significant service expansions in 2003, a greater proportion of managed care systems for children and adolescents (37%) reported limited capacity to expand home and community based services;
- case management ranked high among the services with expanded capacity;
- access to extended behavioral health services during the same period increased by 15 percent to 26 percent, respectively.¹⁸⁶

In a survey of managed care programs Stroul and her colleagues showed close alignment with SOC principles and adoption of evidence-based practices. Behavioral health carve-outs showed greater adherence to evidence-based practices than integrated models.¹⁸⁷ Other research with child and adolescent enrollees with behavioral health disorders shows that managed care reduced access to intensive institutional and community-based services including specialty mental health care, school-based services, and day treatment programs.¹⁸⁸ Additionally, managed care did not lead to increases in juvenile justice contacts for Medicaid eligible youth with mental health problems despite fears to the contrary, and had no effect on the outcomes for children and youth with substance use disorders.¹⁸⁹

Managed behavioral health organizations differed from integrated care models both in their service capacity and to the extent they incorporated SOC principles into their business models. Carve-outs were more likely to expand service capacity, encourage interagency treatment planning and employ the wraparound approach.¹⁹⁰ Research on the impact of carve-out models on service delivery outcomes presents a picture rife with nuances. Generally behavioral health carve-outs are associated with more generous benefits packages, significant cost reductions and increased probability of receiving guideline level care.¹⁹¹ However one longitudinal study of behavioral health carve-outs focused on children and youth showed that access to residential treatment,

hospitalization and community-based specialty mental health care diminished relative to children and youth enrolled fee-for-service over time.¹⁹² But even in this study, researchers acknowledged increases in utilization of case management prompted by support from Medicaid.

While some states have shied away from managed care approaches, most have tried to build buffers into their contracting processes in order to protect service beneficiaries from lapses in care.¹⁹³ For example, Magellan Behavioral Health of Florida recently responded to a Request for Proposal to enroll children and youth with mental health needs who are involved in Florida's child welfare system into managed care.¹⁹⁴ To ensure access and quality, the managing entity promised to provide a range of evidenced-based practices, family support services, and to incorporate SOC principles as a contractual expectation for providers of care. Respite, therapeutic foster care, multi-systemic therapy, functional family therapy, wraparound and school-based services are among the practices that Magellan will offer. So despite some concerns among states with regards to provider capacity, network development and access to care, Florida has adopted purchasing strategies to stimulate innovation in managed behavioral health care for vulnerable children and youth.

As with Florida, other states have focused on the child welfare population. The proportion of behavioral managed care entities that included children and youth in child welfare systems as part of their covered populations has doubled.¹⁹⁵ Over two-fifths of behavioral managed care entities bear responsibility for screening children with mental health issues in the child welfare system. States vary in the proportion of the children and adolescents in foster care who are enrolled in a managed care plan with capitation.¹⁹⁶ In 18 states, over three-quarters of children and adolescents in foster care were enrolled in managed care plans with capitation, and spending for children in capitated plans was 9 percent higher than in plans that did not receive a capitation rate.¹⁹⁷

In the area of family-driven care, approximately two-fifths of managed care entities used family advocates and increasingly family and youth are being paid to perform roles in service delivery in over one-third of managed care plans.¹⁹⁸ Managed care's performance in improving the family voice must be measured against other efforts. Even SAMHSA, with its bully pulpit,

only devoted 4.3 percent of all grant funding for family advocacy through statewide family network grants.¹⁹⁹

As with traditional fee-for-service, few managed behavioral health care entities (less than 25%) serve young children with mental health problems in a comprehensive manner.²⁰⁰ While most managed behavioral health care entities reported facilitating flexible and individualized care, there was a marked increase in the number of care entities who found it increasingly more difficult to provide such flexibility.²⁰¹

Managed care organizations (MCOs) also faced some of the same challenges as fee-for-service providers in adopting evidence-based practices. Only 60 percent of MCOs promote or create incentives for the adoption of evidence-based practices within their care networks.²⁰² As with administrators of fee-for-service mental health, managed care organizations have not uniformly adopted data driven decision-making. Nearly one-third of behavioral managed care entities lacked adequate data pertinent to child and adolescent mental health to support decision making on a clinical or management level.²⁰³

Managed care remains a work in progress. As Mechanic and McAlpine point out, as managed care experience with behavioral health service delivery grows, the tradeoff between quality and cost become more stark and harder to make for policymakers.²⁰⁴ For example, the pre-reform challenges such as disparities in access to services or outcomes based upon race, ethnicity and linguistic competence remain.²⁰⁵ In addition, many of the techniques and business practices once touted by managed care entities have not been used extensively. While managed care represents the most extensive and far-reaching reform effort in publicly financed mental health services for children and youth, other initiatives are also worthy of, and increasingly demanding, attention.

Broad State Waivers

Through waiver options, states are re-crafting traditional Medicaid programs. States' efforts to gain control over health costs include new configurations of how Medicaid operates as a payer. Largely uncertain that managed care can yield additional significant savings, states are borrowing from private health insurance models that attempt to reduce demand for services by making consumers face the true costs of services. For

example, Florida recently received approval from CMS, which regulates Medicaid, to radically alter the way it manages and purchases Medicaid funded services. The state's new system is premium-based, with families receiving a risk-adjusted premium to purchase services for their children.²⁰⁶ While this strategy will initially be implemented in Broward and Duval counties, its impact will be felt among all programs that serve children and youth in the state, given the requirement for overall cost neutrality. Of greatest concern is whether families and youth have the necessary information to make informed choices about services.²⁰⁷

Similarly, in Vermont the state's waiver permits it to operate under a global budget with an annual cap on spending and a commitment to index growth in Medicaid expenditures. For a state with a long tradition of interagency collaboration, there is also concern that a global budget curtails the flexibility required to meaningfully collaborate. For example the inability to bring money to the table when warranted may undermine collaborative efforts. How these efforts will impact children's mental health is not clear yet.

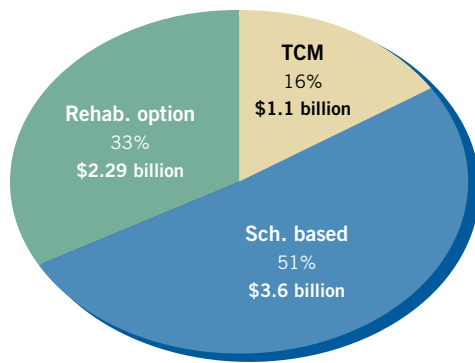
The Deficit Reduction Act of 2005

The DRA

In 2006, Congress enacted the Deficit Reduction Act of 2005, whose centerpiece was to restore "integrity" to the Medicaid program by redefining how and which services are financed. CMS, some members of the Medicaid Commission and many Congressional leaders believed that the Medicaid revenue maximization strategies that states undertook disadvantaged the federal government and put the federal state partnership in jeopardy.²⁰⁸ The DRA has been described as the most significant Medicaid restructuring since its inception.²⁰⁹ The federal government anticipates that it will save \$7 billion through the DRA provisions from 2006 to 2010.²¹⁰ (See Figure 12.)

A major theme of the legislation is gaining control over alleged "fraud and abuse." It required CMS to hire an additional 100 auditors to conduct reviews and promote program integrity, at a cost of \$75 million by 2010.²¹¹ Between FY 2006 and FY 2009, an additional \$180 million will be appropriated to support Medicaid

Figure 12: Projected Savings from Proposed DRA Changes



Source: Marron, D. (2006). Letter to Congressman Joe Barton, chairman, Committee on Energy and Commerce, U.S. House of Representatives, *Additional information on CBO's estimate for the Medicaid provisions in the Conference Agreement for S. 1932, the Deficit Reduction Act of 2005*. Washington, DC: Congressional Budget Office, U.S. Congress.

fraud investigations conducted by CMS. Moreover, the Inspector General's work plan for 2006 included four mental health related audits.

Even prior to the law's enactment, CMS sought to curb Medicaid spending, eliminate "questionable financing arrangements" on the part of states and re-establish oversight.²¹² CMS focused on those Medicaid options that proved most flexible, particularly, (1) the rehab option, (2) administrative costs, (3) school-based services, and (4) targeted case management. These are the very same services that the children's mental health community, based on both evidence and family preference, are working to increase.

Table 8 shows a list of federal audits of children and youth services provided within state Medicaid programs in FY 2005. As the table shows, the federal funding disallowed represented significant resources in 2005 and 2006. Not shown are disallowances totaling \$6,340,527 as a result of four audits of children's services in Iowa in 2004.²¹³

The audits conducted in Iowa proved instructive to identifying gaps in perspectives between the federal auditors on the one hand and mental health state and federal policy makers on the other. The difference in understanding the purpose of the rehab option between that state (and presumably most state mental health agencies) and CMS auditors proved critical to the audits' results. Examples of discrepancies between federal and state interpretations include:

- a focus on a narrow medical model, (the part of federal auditors) what many in mental health refer to as "deficit-based" rather than a psycho-social rehab model, an orientation referred to in mental health as recovery, resilience and rehabilitation (by state implementers); and
- a focus on traditional "office based" treatment settings (by federal monitors), rather than home- or community-based locations with services provided in more "normative" environments (by state implementers).²¹⁴

A wide range of disallowances hinged on services that the auditors considered had failed the test of being

Table 8: Sample of OIG Audits: Children and Youth Health and Related Medicaid Funded Services, January 2005-June 2006

State	Medicaid program	Amount disallowed (federal)	Date
ME ^a	School-based services	\$3,044,211	January 12, 2005
VT ^b	School-based services	\$1,463,395	January 18, 2005
KS ^c	School-based admin. costs	\$347,047	April 4, 2005
OK ^d	Admin. cost; TCM	\$10,875,782	April 4, 2005
PA ^e	Under 21 Institutes for Mental Disease	\$1,694,148	July 5, 2005
IL ^f	School-based admin. costs	\$22,976	August 4, 2005
MA ^g	Targeted case management	\$86,645,347 (additional \$13,460,989 possible)	May 19, 2006
MN ^h	School-based admin. costs	\$9,739,500	September 8, 2006
NJ ⁱ	School-based services	\$51,267,909	May 19, 2006
KS ^j	School-based services	Uncalculated	May 23, 2006
KS ^k	Bundled rate development	\$18,500,000	June 30, 2006

Sources: a. Office of Inspector General, 2005d; b. Office of Inspector General, 2005g; c. Office of Inspector General, 2005b; d. Office of Inspector General, 2005f; e. Office of Inspector General, 2005e; f. Office of Inspector General, 2005c; g. Office of Inspector General, 2006e; h. Office of Inspector General, 2006d; i. Office of Inspector General, 2006c; j. Office of Inspector General, 2006b; k. Office of Inspector General, 2006a.

rehabilitative. These included behavioral training/parent education and teaching skills on how to secure a job. Additionally, staff qualifications featured prominently in the audit, in direct contradiction to the movement in the child and adolescent mental health field to use a range of professional and paraprofessional staff in many instances. Based upon these and other assessments, the auditors ruled that Iowa was out of compliance with Medicaid statutes. The problem is that what was fraud to the auditors in Iowa is seen by many experts as what care ought to be.

These audits are of great concern to the children's mental health policy and advocacy community. They put Medicaid policies on a collision course with emerging scientific evidence about best prevention, early recognition and intervention and treatment strategies and to undo many of the hard won gains (see next section) that are being implemented with Medicaid dollars across the states.

Meanwhile states seek guidance from CMS on what is allowable under murky rules, and subject to the policy winds of the moment. Consider a particular case in point. CMS itself less than three years ago touted the use of the rehab option as a mechanism to fund evidence-based practices and held up as best practice the case of children's services funding in New Jersey.²¹⁵ Yet recently one of its leaders announced plans to prevent cost shifting by states based on those same billing practices for rehab services.²¹⁶ As one Medicaid director explained, "in the process of sharing our strategy we became aware that we were out of compliance and might be subject to an audit" (Personal communication. State Children's Mental Health director, name withheld, 2006). Any attempt to amend a state Medicaid plan opens up the state to scrutiny, disallowances and the prospects of Medicaid paybacks that could amount to huge sums of money simply because the rules may have changed since the last time the plan was amended.

On the positive side, the DRA provides opportunities for funding flexibility. For example, states can amend their Medicaid plans and introduce home and community-based services, previously provided only under a waiver. In addition, states can also allow higher income parents to buy into the Medicaid program. Preliminary results from the *UCR: SCMHD Survey 2006* shows that seven states indicated interest in pursuing state plan

Box 5: Significant Negative Consequences of DRA Documentation Requirement on American Indians/ Native Alaskans

New documentation requirements under DRA for Medicaid enrollment and re-enrollment negatively impact American Indian/Alaska Native (AI/AN) citizens since many do not have federal or state issued proof of citizenship and because of widespread confusion regarding the types of tribal documents required.

CMS requires the following relevant to AI/AN citizens:

Acceptable proof of citizenship:

- Department of Homeland Security issued American Indian Card with the classification code "KIC"
- Census tribal census records from the Bureau of Indian Affairs tribal census records of the Navaho Indians, Seneca Indian tribal census record*
- A statement signed by the physician or midwife who was in attendance at the time of birth

Acceptable proof of identity (significantly lower level of documentation):

- Certificate of Indian Blood, or other U.S. American Indian/Alaska Native tribal document

Preliminary evidence suggests pre-implementation fears realized.

- After the enactment of DRA related documentation requirements, enrollment in Medicaid for Native youth in one school dropped from 99 percent to 35 percent.

Implications:

- Given the well-recognized under-enrollment of AI/AN in the Medicaid program stemming from barriers such as poor relationships between tribal governments and local, state and federal governments and mistrust of the federal government these documentation requirements further impede access to health care for AI/AN children and youth.

*No other proof of tribal enrollment is recognized as proof of citizenship despite the existence of prior policies that recognized tribal enrollment cards from all federally recognized tribes.

Sources: Davidson, V. (2007). Tribal technical advisory group to the Centers for Medicare & Medicaid Services letter to Leslie V. Norwalk, acting administrator, Washington, DC: For External Use Documentation of Citizenship for Medicaid Recipients and Applicants that Declare they are U.S. Citizens Frequently Asked Questions. Retrieved Dec. 12, 2007, from: <<http://machc.com/Documents/Public%20Forums/CMS%20FAQs.pdf>>; Langwell, K., Laschober, M., Melman, E., & Crelia, S. (2003). *American Indian and Alaska Native Eligibility and Enrollment in Medicaid, SCHIP, and Medicare: Individual Case Studies for Ten States*. Washington, DC: Bearing Point, Inc and Westat, Inc.

amendments or Medicaid buy-ins. The most significant positive opportunity for some state administrators who oversee services to children and youth with mental health problems is the demonstration project for alternatives to psychiatric residential treatment facilities (PTRF).

Under the DRA \$218 million was allocated to fund up to 10 states to develop community-based alternatives to residential treatment services for up to five years.²¹⁷ In 2007, CMS awarded grants to Arkansas, Florida, Georgia, Indiana, Kansas, Maryland, Mississippi, Montana, South Carolina and Virginia.²¹⁸ According to CMS, an estimated additional 11,000 children and youth with SED will be served.²¹⁹ A review of the demonstration projects reveals that only one specifically proposes fiscal reform.²²⁰

The irony of under cutting the rehab option's flexibility, while creating a new demonstration program to reduce the use of residential treatment, apparently has been lost on CMS. From a policy perspective, the overall impact of these changes is that they will eventually, absent reversal, undermine efforts to create a more responsive children's behavioral health system with effective practices and services.

Current experiences by states include delayed access to services for children and youth as a result of documentation of eligibility, reduction in staff and services and a negative impact on coalitions and collaboration efforts. Access problems, particularly reductions in the number of enrollees, posed by documentation requirements were also reported by the General Accountability Office (GAO) as one of the negative consequences.²²¹ It documented that half of the states reported declines in enrollment and another one-fifth of states were unable to determine the impact of the requirements. (See Box 6.) Together with preliminary data from *UCR: SCMHD Survey 2006* this recent GAO report suggests that difficult times lie ahead. More than 50 percent of state children's mental health directors responded that they anticipated, or their state had already experienced, a negative impact of DRA (27 states responded to the question). States in the *UCR: SCMHD Survey 2006* also reported that they anticipated loss of flexibility, loss of revenues, cost shifting and being compelled to unbundle services. One state reported that it anticipated a positive impact of the DRA. Of equal concern, however is that more than one-third of states reported that they did not know or had not analyzed the impact of the DRA on their service system.

There is also growing anecdotal evidence of Medicaid-related problems in child welfare related to the DRA. One national child welfare expert listed 25 states that would be in significant financial trouble as a result of

DRA and their obligations to more vulnerable children and youth. Preliminary results from the *UCR: SCMHD Survey 2006* suggests states stand to lose millions of dollars: projections ranged from \$3.5 to \$43 million. This expert pointed to two states that have already restructured their child welfare services as a result of upcoming regulations on case management (Personal communication. Carl Valentine, national child welfare consultant, June 1, 2007). Chief among the changes DRA portends are reversals in small trends some states experience in moving from residential-based to more community-oriented systems. In summation, the major casualties of the DRA projected by state experts in the field are: loss of revenues, flexibility and ability to maintain a community-based focus.

Section 1915(i)

Section 6086 of the DRA established a new section in the Social Security Act, 1915(i) as a mechanism to afford states flexibility to create a program that covers intensive home and community-based services without a waiver application. It requires that the state establish a needs-based criteria for access to the benefit, estimate the number of individuals who would receive the service, and base eligibility criteria on an independent assessment and on an individualized care plan.

Proposed New Regulations on the Rehab Option

Recently, CMS drafted new proposed rules that clarify the definition and parameters of service provision financed under the rehab option.²²² The goal of these rules is to preserve the "fiscal integrity of claimed Medicaid expenditures." The federal government projects savings as a result of the proposed rehab rules as high as \$2.2 billion, all of which will be shifted to states, localities and individual consumers and families. In effect, these proposed regulations further undermine the use of the rehab option for children and youth. There are some positive aspects of the proposed changes. Among these include the following requirements:

- state determination of provider qualifications consistent with the state Medicaid plan;
- services developed in conjunction with family members and youth service users based upon attaining the maximum reduction in mental health impairment and improvement in mental health functioning;

Box 6: Details on Section 1915(i)

Based on the home and community-based waiver 1915(c) referenced earlier, its core service components consist of:

- Case Management
- Homemaker
- Home Health Aide Services
- Personal Care Services
- Adult Day Health
- Habilitation
- Respite
- Extended State Plan Services
- Other*

*The "other" component is not available in the 1915(i). The law regarding 1915(i) explicitly permits approval for day treatment, partial hospitalization services, psychosocial rehabilitation services, and clinical services for individuals with serious mental health problems.

The advantages of this new benefit include:

- unlike the 1915(c) waiver, it does not require proof of cost-neutrality or that persons meet an institutional level of care. This has been often provided for children's mental health by documenting that the child or youth needed a psychiatric residential treatment level of care;
- it can be written as part of a state plan amendment, no waiver application is required;
- it mandates a written individualized care plan based upon an assessment;
- it does not have to be offered statewide; and
- the established benefit sets a minimal threshold so individuals with greater levels of severity or need can access the benefit.

Among the limitations of the 1915(i) include:

- it can not be applied to individuals with Medicaid eligibility above 150% of the federal poverty level; and
- it can not target populations, for example, specify children and youth with mental health problems. Concerns about the inability to bundle services and the need to cover some services once presumed appropriate for the rehab option, have prompted some states to consider the 1915(i).

Currently, Iowa is the only state with an approved 1915(i). Iowa's 1915(i) benefit covers between 3,700 to 5,000 individuals, based upon a set of risk factors and needs-based criteria focused on mental illness.

Sources:

Bosstick, S. (2007). Medicaid rate setting and unbundling services. 2007 SAMHSA/CMS invitational conference on Medicaid and mental health services/substance abuse treatment. Sept. 28, 2007. Baltimore, MD.; Iowa Medicaid Enterprise. (2007). 1915(i) HCBS state plan services administration and operation. Retrieved Nov. 21, 2007, from <www.ime.state.ia.us/HCBS/HabilitationServices/documents.html>; Personal communication. Kathryn Poisal, Centers for Medicare & Medicaid, Nov. 21, 2007; Tritz, K. (2006). *Medicaid's Home and Community-Based Services State Plan Option: Section 6086 of the Deficit Reduction Act of 2005* (No. OCRS22448). Washington, DC: Congressional Research Service, The Library of Congress.

- services designed through a goal-oriented family services planning process that results in a written rehabilitation plan;
- services planned based on a comprehensive assessment of needs;
- services' scope, amount, duration and frequency recorded in a written rehabilitation plan;
- rehabilitation plan evaluated yearly to ascertain concordance with goals set and re-calibrated based on assessment; and
- services in schools, outpatient and other community settings and mobile crisis vehicles permitted.

But the positive impacts of some of these provisions are outweighed by more negative aspects of the proposed rules, which:

- prohibit funding through the rehabilitation option for behavioral health services to youth who are incarcerated or involuntarily confined;
- forbid payment for services deemed "intrinsic" to meeting the "social, educational or developmental goals" of a non-medical program. Examples given by CMS included adoption, foster care and reunification services, payment for recruitment of foster parents, payments for supervision of classroom or recess aides;
- limit funding for services provided for programs other than Medicaid including child care, juvenile justice, child welfare, vocational training and education;
- reinforce Medicaid rules that do not allow payment for room and board;
- limit payments to schools;
- reduce reimbursement for case management; and
- eliminate the ability of schools to claim administrative costs related to any school-based mental health services except where those services are conducted by state employees or employees of the Medicaid agency.

Overall, the potential impact of the proposed changes is regressive.

The effort to separate services deemed intrinsic to a specific non-mental health child-serving entity serves as a disincentive to collaboration and to early interven-

tion and prevention. For example, education, child care, child welfare or juvenile justice all deliver services that are simultaneously intrinsic to behavioral health and education, child development, stability and justice goals. Financially driving unnatural divisions seems counter to much of the cross-systems work that has dominated mental health and related disciplines for the past two decades. Also threatened are the emerging efforts across the states to develop mental health consultation strategies for pre-school youngsters in early care and learning settings in response to evidence that young children are being expelled from these settings at higher rates than children and youth in K-12 grades.²²³ Compelling states to employ an “intrinsic” filter or test to services delivered in these settings will, according to national early child health care expert Kay Johnson, “have a chilling effect on expansion of this use [health and mental health consultation] of these funds” for this group of children (Personal communication. Kay Johnson, Project Thrive director, Sept. 16, 2007).

The proposed rules on provider qualifications narrow the flexibility states have to use non-traditional providers or to use clinicians in flexible ways, and will force states to rely more on traditional providers. Yet, many states do not have enough traditional providers or are expanding the provider networks to deliver culturally and linguistically appropriate services. It will also exacerbate state and geographic disparities. Prior research suggests that geographic variation in access is at least in part due to psychiatric provider capacity.²²⁴ The rule change can lead to situations that defy common sense. For example, the proposed qualification rules mean that providers of rehab option funded services in one state may be unqualified to provide these same services in another state with implications for service quality and access based upon geography.

The proposed regulations also serve as a disincentive for taking evidence-based practices to scale. The provision requiring that service packages be unbundled and billed as separate components will also make it harder to pay for service combinations built into specific evidence-based practices. This is exactly counter to the recommendations in a recent Institute of Medicine report, and is likely to threaten model fidelity and quality.²²⁵ It also potentially compromises the built-in service efficiencies and the cumulative practice advantages of the models.

Finally, when enacted, the proposed regulations will negatively impact school-based mental health services, reversing prior policies that have strengthened the critical role of the school in helping children with emotional and behavioral problems.²²⁶ Although the regulations reaffirm schools as a legitimate locus of care for mental health and related services, the proposal to eliminate Medicaid reimbursement for administrative costs associated with the provision of these services totally undermines the affirmation.

The regulations also propose to limit coverage of costs for transportation between home and school for children and youth with individualized educational plans (IEP) and individualized family service plans (IFSP). CMS’ proposed rules on transportation assumes that the only medical services provided on school premises will be provided during hours when the child or youth will already be in school. CMS contends that current administrative and transportation claims violate the principle of “proper and efficient administration of the State Medicaid plan” since strategies and services covered may not directly benefit the Medicaid program, would be implemented anyway as they further the schools’ educational mission, and because some coverage for transportation is not directly to or from a medical provider. This logic sorely misses the point of a financing strategies that support research-informed, developmentally appropriate mental health policy.

CMS’s intent is clearly stated in the proposed rules to “establish the proper and efficient administration” of a state’s Medicaid plan. The federal government estimates that it will save approximately \$3.6 billion over five

Box 7: The Proposed CMS Rules and School-based Mental Health Services

Activities that would no longer be eligible for reimbursement under administrative costs include:²²⁷

- Medicaid outreach;
- eligibility determination;
- transportation arrangements related to medical/mental health services;
- translation services;
- program planning, policy development and interagency coordination;
- medical/Medicaid related training; and
- referral and coordination.

years if these rules are implemented.²²⁸ How much it will lose in terms of youth whose condition worsens or who become involved with juvenile justice is not part of the calculus. In this string of proposals, CMS undermines years of effort and future attempts to create an integrated care model that includes all the major players in a SOC for children, youth and their families.

Proposed New Regulations on School-based Administration and Transportation

Among the implications of these proposed changes include the following:

- by deeming outreach and eligibility services performed by non-state employees and Medicaid personnel in the school setting as ineligible for reimbursement under the administrative costs, CMS will eliminate an important avenue for Medicaid enrollment. Yet, many studies document difficulty in enrolling eligible children;
- through these proposed rules CMS curtail an important source for supporting linguistically competent direct services. But, state mental health authorities routinely rank lack of language access to services as among one of the greatest challenges they face in addressing racial/ethnic disparities;
- The proposed regulations would eliminate federal participation despite the critical need for infrastructural supports for school-based mental health services. Medicaid underwriting through administrative costs enable training to support effective practices, including training on Medicaid related procedures; and
- two sets of activities stand out as essential to providing direct services in the schools, integrated planning and coordination and service referrals. Already under financial strain, schools will not be able to fully participate in inter-agency collaborative efforts or support service coordination and planning under the proposed changes.

Box 8: Elimination of Medicaid Reimbursement for Transportation-Related Costs

The draft rules also prohibit reimbursement of transportation services not related directly to the transportation of the child from home or school to a non-school-based medical office. Medicaid will no longer cover transportation related to services provided in the schools including those services provided before, during and after school hours.

The draft rules on transportation reinforce Medicaid's position in two areas. First, there is an unwillingness to underwrite services for other sectors even if such funding results in increased efficiencies in other sectors. Second, the focus on a narrow medical-model dictates the parameters of eligible services. For example, Medicaid would not cover transportation to a non-clinical component of the service outlined in a wraparound plan.

In late December 2007, Congress proposed and the president signed into law a six-month moratorium on implementation of the proposed rules on the rehabilitation option school-based administrative costs and transportation.*

* S.2499. (2007). An act to amend titles XVIII, XIX, and XXI of the Social Security Act to extend provisions under the Medicare, Medicaid and SCHIP programs and for other purposes. Retrieved Jan. 5, 2008, from <www.govtrack.us/data/us/bills/text/110/s/2499.pdf>.

SECTION 3

Fiscal Innovation in States and Local Communities

The current federal fiscal framework offers both challenges and opportunities to states as they seek to improve the outcomes for young children, school-aged children and youth with emotional and behavioral problems that impair their ability to learn, relate to others and enjoy life. Drawing on both the literature and on NCCP's preliminary data from the *UCR: SCMHD Survey 2006*, below we highlight examples of emerging state innovative efforts, some of which focus on broad, systemic fiscal reform, others, more typically, on specific problems.

Overall, 24 states report that their state child mental health authority has undertaken innovative fiscal policies. These range from:

- broad-based fiscal reforms (New Mexico, Oregon and New York);
- Medicaid enhancement strategies (Delaware and Florida);
- pooling resources across sectors as in New Jersey and Vermont;
- home and community based waivers (Michigan and Kansas);
- underwriting service-specific initiatives including crisis services in Illinois and Georgia; and
- access to improved psychiatric expertise in Massachusetts.

Below we highlight a range of efforts that include broad system initiatives (New Mexico, California, New York, Minnesota, Oregon and Arizona). All of these efforts include a focus on bringing a primary prevention and early intervention framework into the mainstream of health and behavioral health financing. We also profile other specific strategies that include outcomes-based management, innovations designed to increase service delivery capacity and prevent the practice of custody relinquishment, and new efforts to more directly link local funding sources with best practice.


Broad System Reform Efforts

A handful of states have embarked on ambitious reforms that in general combine fiscal innovation with incentives for prevention and early intervention and or the use of evidence-based treatment. At least one builds specifically on system of care (SOC) principles. They are also all grappling with how to build accountability mechanisms that capture quality and outcomes for children and their families more effectively than is typically done now. While these initiatives are all relatively new, and are “works in progress,” they also have implications both for other states and for how to improve children’s behavioral health policies and fiscal practices at the federal level.

New Mexico

In 2005, New Mexico embarked on an ambitious set of reforms to try to bring together and rationalize the use of all revenue streams for children’s mental health using a purchasing strategy that realizes the efficiencies of scale of combining funding streams. In addition, duplicative services are eliminated. In 2005 the Human Services Department awarded ValueOptions of New Mexico the contract to manage the financing for the statewide Behavioral Health Purchasing Collaborative. Early lessons from this new approach to purchasing and service delivery suggest the importance of a shared vision. Despite startup problems, which impacted provider payment and other aspects of administering the program, a one-year report suggests overall compliance with the state’s Medicaid standards.²²⁹ For system observers a key component of that shared commitment to change was a six-month “hold harmless” provision.²³⁰ The collaborative plans to blend over 15 funding streams in a manner that sustains promising practices, retains competent providers and builds the infrastructure to support positive outcomes for children, youth and their families. New Mexico has the opportunity to employ a comprehensive fiscal strategy that aligns its funding with a developmentally and ecologically-based approach. The funding streams to be blended span health, housing, corrections, prevention and behavioral health.

California

 California's Mental Health Services Act (MHSA) represents a second example of a bold state-driven change initiative. Following decades of advocacy stakeholders in California secured passage of Proposition 63, which mandated a dedicated tax (1% on the incomes of individuals who make more than \$1 million) to support new mental health services.²³¹ The net amount of new dollars was expected to total \$2.53 billion over the first three years.²³² A robust economy and revised estimates of the number of millionaires in California is expected to significantly increase the projected amount available.

The MHSA highlights include a 20 percent allocation to prevention services and an intensive county-based community planning process.²³³ Guidelines for the use of prevention funding have yet to be released but the gubernatorially-appointed Oversight and Accountability Commission established a child, youth and family framework for the prevention funding. Over 51 percent of prevention funding must support strategies that target children and youth (birth to 25 years old). There is a small county exclusion that applies to approximately 6 percent of the population.

The state has also identified 15 areas for policy intervention at the county level and six statewide strategies that reflect best practices and stakeholder recommendations.²³⁴ These priority areas include disparities in access, trauma, developmentally appropriate services, prevention with a focus on children, youth and young adults, outcomes and leveraging resources.


To date allocations have totaled an estimated \$61 million per year in prevention funding.²³⁵ Already \$430 million has been disbursed to counties to support community services, with another \$114 million anticipated this year. Other funding expected this year includes \$400 million in housing, \$600 million for information technology and \$200 million for workforce development. California has attempted to apply fiscal policy that matches closely with what policy makers believe will improve outcomes for children, youth and families. However, as with changes at the federal level, many observers still believe that relative to California's and its local governments' budgets, the presenting fiscal incentives may be too small to effect the expected change. According to the California Institute for Mental Health,

the amount represents an estimated 12 percent of state-wide funding for mental health.²³⁶

California has also had to grapple with tough issues early in the evolution of the initiative, such as deciding how to make operational its commitment to prevention and how to release funding to facilitate existing plans that lead to service capacity enhancements. In addition, state officials and their advisors struggle over how to manage the allocation of resources to ensure planned and intentional strategies rather than time-limited disbursements that compel one-time non-sustainable projects. They also deliberate on how to ensure adherence to legislative prerequisites, including a prohibition on supplanting funds.

There are already some signs that the law is having a positive impact. For example, in the area of cultural and linguistic competence, early lessons resulted in closer alliances with tribal communities and increased participation in community services planning efforts by Californians of American Indian/Alaska Native descent. Recently, the state also initiated additional mechanisms to elicit youth input whose participation in the earlier efforts to solicit community input appeared spotty.²³⁷

New York

 In New York State officials recently began a major initiative, representing the largest single investment in children's mental health in the state's history. Through *Achieving the Promise for New York's Children and Families* the State started ClinicPlus, a \$33 million program to support access for over 400,000 children and youth to empirically supported early identification and intervention efforts.²³⁸ The initiative grew out of evidence that there were high rates of "no shows and drop outs" for community mental health centers for children and youth (Personal communication. David Woodlock, deputy commissioner and director of Children and Family Services, New York State Office of Mental Health, Apr. 4, 2007). Approximately \$11 million represents state general revenue funding. In addition, the state made available funding for 36,000 children and youth to access treatment and for an additional 22,400 slots for home and community-based waiver-type services. Through this financing the state increased the basic funding for assessments and in-home treatment by

\$50 per visit with expanded visit capacity for assessments, home-based and community services. It also included a state funded offset for non-Medicaid eligible children and youth. By investing in case finding and early intervention, the state is compelling change in service delivery.²³⁹

New York State established criteria to access these resources that included an agreement to use standardized assessment tools, integrated use of evidence-based practice and requirement to expand capacity to serve children and youth in community-based mental health settings. New York also committed \$620,000 per year to the operation of a statewide National Institute of Mental Health (NIMH) funded evidence-based dissemination center. To date, over 400 clinicians have been trained in trauma-focused cognitive behavioral therapy

New York's Governor Spitzer recently proposed language to redress this oversight. All the state's school-based health centers will be able bill Medicaid for relevant mental health services delivered to children and youth they serve.²⁴⁰ Also included is a mandate to insure through Medicaid all current and former youth until age 21. As for early childhood, unfortunately, New York remains one of the states without a comprehensive early childhood mental health consultation strategy.²⁴¹

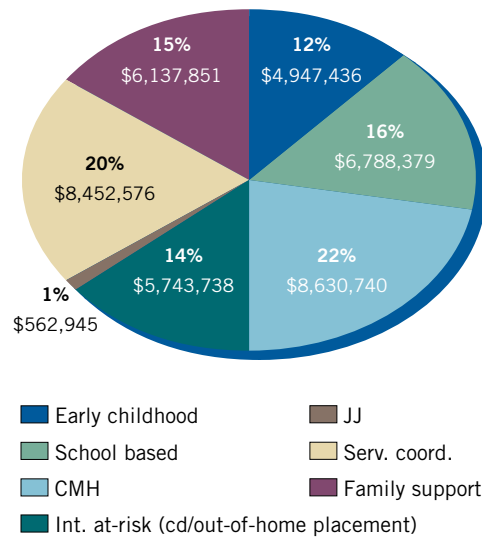
Minnesota

Spurred by a Robert Wood Johnson Foundation grant and a long-standing law supporting local children's mental health SOC development, Minnesota invested in infrastructural supports designed for systems change.²⁴²

Through the Children's Integrated Mental Health Fund a local time study initiative was created. The initiative was based upon a "random moment study" that calculated the labor contributions of personnel involved in the collaborative. At its height in 2005, the Minnesota Local Collaborative Time Study generated over \$41 million in new revenues that supported prevention and early intervention strategies for children and youth at-risk for developing mental disorders and those with identified mental health needs. It also sparked cross-agency service delivery changes as shown in Figure 13.

Today, proposed changes in the DRA threatened collaborative initiatives such as this one (Personal communi-

Figure 13: Minnesota Local Collaborative Time Study Funded Programs in 2005



Source: Task Force on Collaborative Services. (2006). *A Report to the Minnesota Legislature*. St. Paul, MN: Minnesota Departments of Human Services and Education.

cation. Amalia Mendoza, program consultant, Minnesota Department of Human Services, Aug. 3, 2006).


Oregon

Policymakers in Oregon seized upon the lessons learned from previous systems of care efforts to create the Children's Systems Change Initiative. Through this initiative, the state initiative superimposes SOC principles onto a managed behavioral health carve-out (Personal communication. Bill Bouska, Oregon's children's mental health director, June 16, 2006). Without any new funding, the state, in partnership with stakeholders, created a results-based system with significantly enhanced capacity to track resources and outcomes. Policymakers relied on an extensive planning process to identify the infrastructure needed to support and sustain the type of systemic change necessary to enable innovation at the service delivery level. Policymakers undertook extensive administrative changes including new rulemaking to ensure all the clinical procedural codes needed were in place, and that in each community, care coordinators were accessible to address children's mental health needs. In addition, the state has used its policymaking and purchasing to leverage changes focused on increasing family voice in all levels.²⁴³ An independent evaluation concluded

that the State of Oregon completed significant steps for the infrastructure supports necessary to sustain reforms.²⁴⁴ Even in this overall favorable review however, evaluators challenged the state to aggressively pursue its policy goals for cultural and linguistic competence and cross-agency fiscal policy.²⁴⁵


Oregon's Children's Systems Change Initiative coincides with a mandate to gradually enhance clinical capacity through the infusion of evidence-based practices.²⁴⁶ In 2003, Oregon enacted a law that requires that up to 75 percent of state funded programs in juvenile justice, mental health and other social services will be evidence-based.²⁴⁷ To build the infrastructural supports, state policymakers developed new administrative rules defining level of need, and created a definition of evidence-based treatment to meet their legal mandates that allows for flexibility in implementation. They have also sought to build on the local SOC infrastructure. Advocates and other stakeholders have used the challenges and opportunities of a statewide mandate for evidence-based practices to document empirical support for locally-inspired, family and youth-driven, and culturally competent mental health care (Personal communication, Barbara Friesen, Director, Research and Training Center on Family Support and Children's Mental Health, Portland State University, Oct. 12, 2006). While take-up has been slow, the effort to get knowledge in sync with practice and build a sustainable approach to improving quality is clear (Personal communication, Bill Bouska, cited above).²⁴⁸

Arizona

 Largely as a result of a lawsuit, stakeholders in Arizona embraced SOC principles to build a regionalized managed behavioral health system for children, youth and families.²⁴⁹ State policy leaders integrated the SOC principles, evidence-based practices and quality assurance with keen attention to supportive and accountable fiscal practices. In addition, clinical guidelines and protocols were developed to address the health and well-being of children involved with the child welfare system.²⁵⁰

Arizona began statewide implementation of wrap-around as a response to the Jason K settlement.²⁵¹ In addition, in recent years the regional behavioral health authorities (RBHA) implemented other evidence-

Box 9: Substance Abuse Financing in Vermont

 In Vermont, an intentional child- and youth-focused strategy to address the service delivery and policy gaps began in 1999, driven by an initiative of the Governor. It began with a summit to develop a deliberate plan for developing age-appropriate and research informed services. Since 2001 funding for all substance abuse, both adult and youth, has grown by over 165 percent, from \$11.7 million in federal and state funding, to \$31.2 million cumulatively. State appropriations alone have more than quadrupled.²⁵² Project Deter, (Drug Education, Treatment, Enforcement and Recovery), the mainstay of the state's substance abuse initiative, included a robust fiscal strategy that sought to blend the state's resources, maximize and draw upon federal resources including Medicaid, and strategically use its purchasing authority to development and reinforce and evidence-based service delivery structure. Specific adolescent related highlights of this fiscal strategy include:

- \$1.6 million to underwrite adolescent substance assistance programs;
- \$1.2 million Medicaid support for community care;
- \$1.7 million in Medicaid contribution to blended funding pool to finance; adolescent residential treatment;
- \$300,000 to fund five adolescent treatment clinicians;
- \$281,000 special funding from uninsurance funding and children and family services; and
- \$60,000 to establish a family advocacy organization for adolescents with substance use disorders.

It also focused on how to build a range of community-based options for prevention, early identification and treatment and recovery support, change community awareness about the nature of the substance abuse problems the state faced, and to better integrate primary care and behavioral health care. These include:

- an estimated 30 to 40 pediatric practices trained to use a validated substance abuse screening tool and to refer to backup specialty addiction treatment professionals;
- 102 schools with student assistance programs with capacity to identify using a validated screening tool and make referrals to backup specialty addiction treatment professionals;
- established centers of excellence; and
- statewide implementation of state of the art, validated screening tools (CRAFFT, MAYSI, GAINS, JASAE, PADDI and TASI)* and treatment modalities (CBT, MI, ACRA) among clinicians.

*CRAFFT;MAYSI=Massachusetts Youth Screening Instrument; GAINS=Global Appraisal of Individual Needs; JASAE=Juvenile Automated Substance Abuse Evaluation Tool; PADDI=Practical Adolescent Dual Diagnostic Interview; TASI=Teen Addiction Severity Index. CBT=Cognitive Behavioral Therapy; MI=Motivational Interviewing; ACRA=Adolescent Community Reinforcement Approach.

Source: Personal communication. Michael McAdoo, Children and Family Services chief, Vermont Department of Health, Nov. 8, 2007.

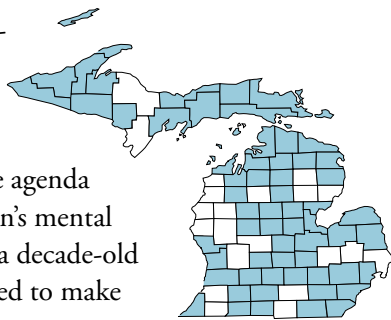
based practices. In Maricopa County for instance, the RBHA is using multi-dimensional treatment foster care (MDTFC), multi-systemic therapy (MST), functional

family therapy (FFT) and brief strategic family therapy (BSFT). The state, in partnership with these managing entities, allows maximum flexibility around billing, setting rates as benchmarks so that intensive treatment options like some of these evidence-based treatments can be reimbursed at or close to cost. Additionally, the state supports the promotion and dissemination of best policy and clinical practices through web-based technical assistance documents (TADs) and practice improvement plans (PIPs) (Personal communication. Robin Trush, vice president, ValueOptions Behavioral Health, Maricopa County, June 2, 2006).

Focusing on Outcomes

Michigan's Level of Functioning Project

Many states and communities, and indeed the federal government, rank positive outcomes high on the agenda for addressing children's mental health. In Michigan, a decade-old initiative has attempted to make outcomes-based management a way of life for community mental health providers in children's mental health (Personal communication. Jim Wotring, Michigan Department of Community Health. Nov. 6, 2007). Through a state and county mental health partnership, outcome indicators were developed and a performance measurement system established. Among the outcomes chosen include those that relate to improvement in functioning, reduction in overall impairment, appropriateness of care, reduction in behaviors that limit children and youth's ability to function in "normal environments," and no severe impairments at when they exit care.²⁵³ Outcomes focus on individual and system level benchmarks.

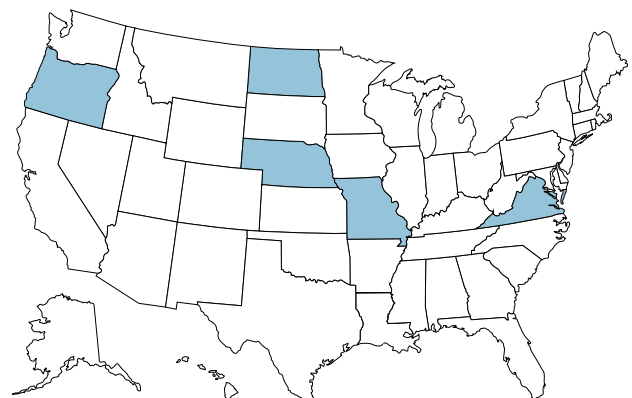


The state contracts with a Michigan-based researcher who supports the implementation of a system for outcomes management. Based on a validated assessment and service planning tool, the Child and Adolescent Functional Assessment Scale (CAFAS), community mental health centers report their data electronically and receive monthly, quarterly and semi-annual reports. Each system receives a report card on its performance. This outcomes-based system has several clear advan-

tages. The reports it generates function as strength-based tools for quality improvement. It has replicated the advantages of public reporting through a report card system on performance for agencies and counties, without the associated shaming that comes with public reporting. It has created a platform and demand for the use of effective or evidence-based practices.

Preventing/Reducing Custody Relinquishment

Although identified as early as 1982, there has still been no national response to the reality that in order to get help for their children, too many parents have to give up custody as a condition of getting services. A recent GAO report estimated that more than 12,000 families relinquished custody of their children in order to access mental health services.²⁵⁴ (United States General Accountability Office (GAO), 2003). Sadly, repeated efforts to enact federal legislation to address this cruel response most recently embodied in the Keeping Families Together (S. 1704, H.R. 3243) have failed.²⁵⁵ A handful of states, however, have taken action on their own. Other states have passed legislation to outlaw custody relinquishment in exchange for accessing mental health services or provide financing to avert custody relinquishment. These include **Nebraska, North Dakota, Oregon, Missouri and Virginia.**²⁵⁶ Virginia and other states have begun to tackle placement of children and youth with mental health problems out-of-state through an outcomes-driven and fiscal accountability perspective.



- The state of **Kansas**, in conjunction with the state-wide family advocacy organization, partnered to expand community-based services to eliminate the need for custody relinquishment for parents whose income or insurance put them at higher risk of custody relinquishment in exchange for services.²⁵⁷

- In **New York State** the Council on Children and Families' Workgroup established a registry for all out-of-state facilities and has begun to examine the cost and benefits associated with care out-of-state.²⁵⁸ The workgroup focused on the estimated 1,400 youth in out-of-state placement that cost the state an estimated \$200 million in combined educational and residential expenditures. These and other efforts helped to build momentum for increasing New York's investment in expanding community-based mental health treatment capacity.
- In **Virginia** in-depth research showed that the state's estimated 186 youth placed out-of-state in 2004 cost the state almost \$13 million (on average \$70,000 per child).²⁵⁹ In recognition of the need to change the system, the state has prioritized funding towards increasing service capacity and increasing the size and competency of the workforce. In particular, the state appropriated \$2 million to develop four system-of-care initiatives that explicitly use evidence-based practices.²⁶⁰ Current budget proposals call for tripling the number of sites. In addition, since 2006 the state has allocated \$2.13 million to provide mental health screening and treatment in juvenile detention.²⁶¹
- In **Alaska**, the Bring the Kids Home program put the steep rise in out-of-state placement at the forefront of policy priorities.²⁶² In 1996, the state placed 83 youth out of state. By 2004, nearly 750 children were placed in 18 states at a cost of \$37.8 million.²⁶³ The state developed a 12 year plan for capacity development for in-state residential and community-based services designed to reduce out-of-state residential placement.²⁶⁴
- In **West Virginia**, since 1995, the KidsCare Initiative has highlighted out-of-state placement.²⁶⁵ It reduced the numbers of children placed out-of-state from 107 in 1996 to 19 in 2005. Expenditures for out-of-state placement peaked at \$5.4 million in 2003 and declined to \$1.9 million in 2005.
- In **Montana**, the state's recent commitment to reverse its trend of placing the over 100 youth (many with costs in excess of \$6,000/month) in facilities in other states led to its successful application for a federal grant to develop alternatives to psychiatric residential treatment for children with SED.²⁶⁶

Going Straight to the Taxpayers

In communities in three states – Colorado, Florida and Missouri – children's mental health advocates have successfully pursued mechanisms to access local fiscal support for mental health services and supports.²⁶⁷ In **Colorado**, advocates for improved mental health successfully secured passage of SB 59, which created a special mental health district. Historically, Colorado has created special districts with taxing authority to fund basic services like water, fire service and recreation. Proponents of SB 59 sought to boost funding to support mental health using this mechanism. They attempted to bypass a logjam created by anti-spending laws that limited policymakers' ability to fund services even when there was a need. The special district law permits localities to create funding for mental health and substance abuse through local taxes. According to Chris Habgood of the Mental Health Association of Colorado, SB 69 was unique in that it allowed the levying of either sales taxes or property taxes. In addition, proponents left it up to local jurisdictions to define what mental health and substance abuse services they wish to fund (Personal communication. Interview Chris Habgood, Vice President Public Policy, Mental Health Association of Colorado, Sept. 8, 2006). While a full proposal has not come before the voters yet, this move represents an opportunity to significantly restructure funding for mental health services for children and families at the local level.

Hillsborough County Florida stands out as another example, where THINK, the local children's SOC site, is funded through special taxing authority for the creation of the children's board.²⁶⁸ Hillsborough County's Children's Board is one of 16 children's services councils (Personal communication. Amy Petrilla, THINK project director, Sept. 1, 2006). Supported through legislation, the councils oversee their own funding which comes directly from taxpayers. THINK's focus is mostly on prevention and early intervention services. In 1998, using this base of developmentally appropriate care, THINK applied for and received a SOC grant from SAMHSA. It turned its attention to mental health for children, youth and families. This taxing authority generated \$30 million for children's services in 2005 and facilitated service provision to over 87,000 children, youth and their families.²⁶⁹ According to one project source, with the end of federal funding THINK moved

to expand the SOC concept beyond mental health to early childhood.

In **Missouri**, state law permits the passage of ‘mil’ taxes in order to support mental health services. Twelve counties and St. Louis have mil taxes that support children’s mental health.²⁷⁰ In St. Louis, the Mental Health Board funds a range of services from the approximately \$2.2 million it receives in mil tax revenues.

These local efforts primarily target expanding the capacity and sustainability of current service delivery models and seek to loosen the hold of fragmented and erratic funding streams that are often unresponsive to local needs. While improved practices are frequently associated with these initiatives they are not the nexus of these initiatives.

Some states are more and more focused on how to match fiscal strategies with best practices. Many states are providing institutional support for empirically supported practices, for family-directed and youth guided care, for service and funding integration, and for developmentally appropriate and culturally and linguistically competent care. However, a large gulf remains between the rhetoric promoting evidence-based practices and fiscal policies that support their widespread adoption.

The consequences of typical fiscal strategies in many child serving systems go far beyond the inappropriate, overuse of residential treatment. Funding imbalances between residential and community-based treatment services are primarily a function of reactive financing environments. Two types of fiscal policies dominate. One is largely characterized by flexible funding streams that are time-limited, difficult to sustain and often fraught with complex administrative requirements. The other enables funding (although much more difficult to access in the past) for costly and often ineffective residential treatment. Under these scenarios creating the climate to stimulate reform becomes extremely challenging. This is particularly the case where there is no funding to transition a system dominated by funding imbalance.

Summary

The fiscal initiatives highlighted focus on different strategies, some generate new revenue, others use current revenues more effectively and others respond to specific service related challenges in innovative ways.

While commendable, the profiled efforts to drive improvements in the public response to children and families in need of behavioral health services, overall, impact relatively few states and relatively few children and youth (with the *potential* exception of New York and California). These examples notwithstanding, many states and communities lack comprehensive tools, evidence-based system-change strategies and, in some cases, the political will to underwrite an accountability and outcomes-based delivery system. Even among reform-minded policymakers and practitioners the need for more tools to support fiscal reform emerges. Federally-funded former and current SOC site leaders identified specialized technical assistance on financing as a major resource need.²⁷¹ Financing strategies need to rise to the challenge embedded in the New Freedom Commission to tackle mental health with “same urgency as physical health,” and, to address the unique needs posed by financing appropriate mental health promotion, prevention, early intervention, treatment and support strategies especially for children, youth and their families.

SECTION 4

Taking Stock: Challenges and Opportunities

Each of the major federal funding streams has provided an impetus for positive change for children's behavioral health policy and practice. Through the federal block grant children's mental health benefited from small but needed flexible funds. The Comprehensive Community Mental Health Services for Children and Their Families, the SOC targeted funding stream, has focused attention on the most seriously troubled children and youth. In the Substance Abuse Prevention and Treatment block grant, emphasis on prevention has produced a public framework. Medicaid/SCHIP's involvement significantly expanded access to services. At the same time, both separately and collectively, these funding streams pose significant challenges to maximizing the use of public resources in ways that are consistent with best and emerging scientific evidence. The fiscal policy framework, particularly through Medicaid, drives what states can and cannot do to help young children, school-age children, adolescents and youth aging out of the public systems with, or at risk of, serious emotional and behavioral problems. It also shapes what supports can be offered to families, other caregivers and teachers to better help the children. The problem, as we show below is that it often drives states in the wrong direction.

Ten Fiscal Policy Problems

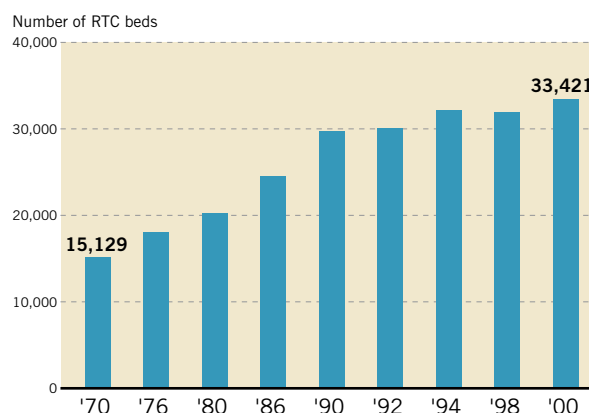
1 The fiscal framework favors residential treatment compared to community-based, family-guided care based on prevention, early intervention and treatment strategies. Consequently, there is an over-reliance on residential treatment that: lacks an evidence base, siphons money that might be used for effective community-based practices, and refuses to reconfigure its business model and become part of a comprehensive service system.

As in 1982, residential treatment remains relatively easy to pay for compared to a range of community-based practices, despite the absence of evidence about its effectiveness and despite evidence that many parents do not want to place their children, but have to. This is true across multiple funding streams. Residential treatment is in effect, the default option for children with serious

challenges. As noted in Section 1, spending for residential treatment surpasses spending for community-based alternatives. Moreover, despite the large sums expended, residential treatment has not been associated with positive mental health outcomes for children and adolescents.²⁷² This is inconsistent with the rhetoric of the systems of care philosophy, and it undercuts repeated calls for using "evidence-based" treatment and the best available knowledge about child development.²⁷³

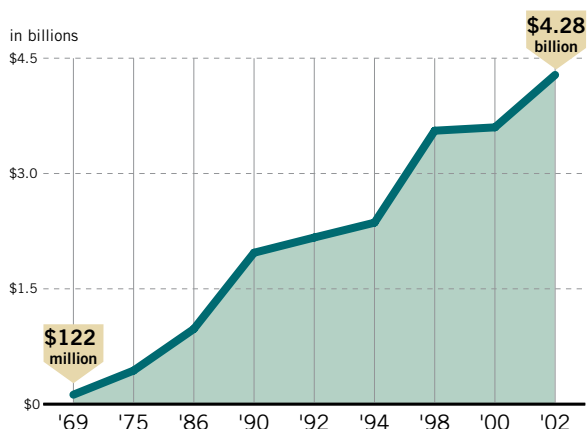
Much of the system reform rhetoric calls for reducing out-of-home placement as a sound component of a fiscal strategy to support effective care. Clearly, in some circumstances residential treatment is the treatment of choice, and some programs are high quality. But too often, that is not the case, or the placement disconnects the child or youth from families and community service plans. The money spent for inappropriate residential placement represents funds that might support expanded community-based care. In theory, for example, Medicaid funds can be used to purchase empirically supported services. Yet, funding for residential treatment keeps growing. In 2002, the United States spent over \$4.2 billion on residential treatment for over 33,000 beds representing 11 percent of total spending on all mental health organizations.²⁷⁴ (See Figure 14a). Between 1970

Figure 14a: Number of Residential Treatment Beds for Children/Adolescents with SED, 1970-2000



Source: Atay, J. & Survey and Analysis Branch, 2006.

Figure 14b: Expenditures for Residential Treatment for Children and Adolescents with SED, 1969-2002



Source: Atay, J. & the Survey and Analysis Branch, 2006.

and 2000, the number of residential treatment centers for children with serious needs increased over 120 percent.²⁷⁵ While the rate of growth slowed dramatically during the decade between 1990 and 2000, from 1969 to 2002, funding for residential treatment centers for children with serious needs increased over two thousand fold. As Figure 14b shows the rate of growth slowed to less than 2 percent from 1998-2000. By 2002, there was once again an increase of 19 percent in expenditures on residential treatment for children and adolescents with serious mental health needs.

Further, the children and youth who are placed in residential care are more likely to be African-American or Latino, males, have juvenile justice involvement and complex mental health, substance abuse and trauma histories.²⁷⁶ Two compelling factors often tip the scales for policymakers and practitioners: access to community-based alternatives and the urgency of the public safety concerns for youth who pose a danger to themselves or others.

2 Most systems lack access to, or the availability of, sufficient community-based treatment alternatives. The consequences are often tragic. Thus youth with mental health needs are inappropriately placed in juvenile justice as they wait treatment.²⁷⁷ Equally disturbing, according to a national mental health advocacy organization, the National Alliance on Mental Illness (NAMI), nearly 20 percent of families of children with mental health problems are advised to give up custody in exchange for intensive mental health services.²⁷⁸

- It is simply easier and often quicker to fund residential services than to develop and sustain community-based alternatives. For example, the situation of a youth in crisis may demand immediate action and readily available placement options. This may be complicated by clinical considerations, perhaps the need to remove the youth from the home to de-escalate a situation or the lack of availability of intensive mental health services. In large measure, this may explain the failure to make headway in reducing residential treatment-related costs. It is also important to acknowledge that there have been many cases where purchasers allow the ratcheting down of inpatient mental health, or day treatment without a concomitant expansion of community-based practices.
- The case for changing this fiscal framework is clear, both from a child and family perspective, and perhaps from a cost perspective. Some states are, in fact, trying to change the framework. For example, recently, the State of Washington provided a model for research informed decision making rooted on the principle of community-based care. It elected to invest more funding in community-based evidence-based treatments for juvenile justice-involved children and youth, based on a cost-benefit analysis of juvenile crime. The analysis revealed that continued and increased use of evidence-based treatment alternatives and support could avert the need for a new prison construction.²⁷⁹ However, absent federal incentives through Medicaid, making this kind of shift at the state level remains very difficult. When Medicaid is unable or lacks flexibility to support effective community-based practices but can purchase an infinite number of residential treatment beds in the state and across states, the market signals are clear.

3 Current fiscal practices, particularly through Medicaid, are inconsistent with the knowledge base about effective children's mental health services, and sometimes make it impossible to use that knowledge base.

There is a wide gulf between the knowledge base in children's behavioral health practice and a traditional medical model that Medicaid supports. The latter primarily reflects narrow, clinical, even office-based services delivered by psychiatrists and psychologists. The gulf is dramatically illustrated by the Iowa audits described earlier, where auditors disallowed practices through the rehab option deemed by the field to represent qual-

ity care. While SAMHSA in recent years did support the development of an “implementation resource kit” or toolkits for children with disruptive behaviors, this only scratches the surface in terms of what communities need.²⁸⁰ It is striking that there are few incentives for states and communities trying to implement evidence-based practices, manifested in the lack of support for start-up costs, enhanced rates, continuous training, monitoring and provider feedback, licensing and consulting fees. Rhetorical calls and marginal demonstration programs of the efficacy of community based services and supports to the highest risk families are not enough. Absent more intentional research-informed strategies, incentives and Congressional oversight, this is unlikely to change.

Several factors shape the challenge of correcting the mismatch between funding structures and support for evidence-based practices.

- **Effective strategies challenge and often confound current payment mechanisms.** It is too hard to pay for evidence-based treatments, even for the most troubled children and youth. Most evidence-based treatments go beyond the usual and customary single focused individual treatments. Both multi-dimensional and often involving multiple providers with divergent skills sets, these treatments do not converge with the way most services are currently billed and reimbursed. Generally, methods for reimbursement rely on billing for units of service based on single provider types. Multi-faceted evidence-based treatment modalities like multi-systemic therapy, functional family therapy or multi-dimensional therapeutic foster care use multiple components and approaches and different provider types with various levels of provider expertise within a given treatment model. Billing based on units of service constructed using brief time increments are not conducive to delivering these types of services. However, time-limited cycles (generally 15 minutes) also prove administratively burdensome. Even if states have figured out how to pay for the actual treatment, they need to find funding to pay for start-up costs, including the need to provide initial and on-going training and support to clinicians.
- **Effective strategies often include non-clinical components that are ill-suited to inflexible fiscal structures.** In most states, it is difficult to pay for

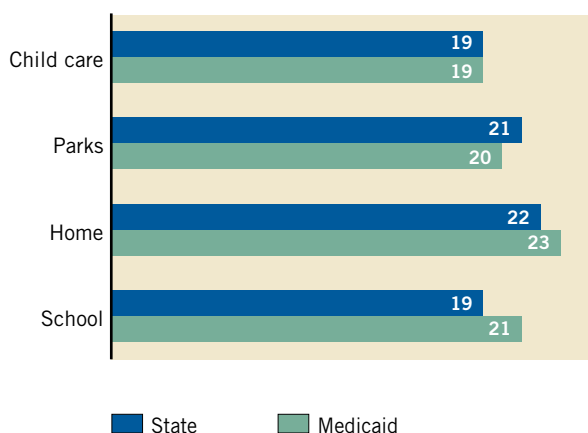
the non-clinical aspects of treatment that are key to successful engagement and retention: family involvement, case coordination for child welfare involved children and youth, and additional outreach and contact strategies for low-income families.²⁸¹ Other components of service delivery, for example room and board, or sustaining a therapeutic milieu in the case of treatment foster care deemed non-medical, are not eligible for Medicaid financing.²⁸²

- **Effective strategies are often based on a developmental, ecological based framework.** The parameters of current financing strategies, particularly Medicaid, present two major problems that make them incongruent with a developmental, ecological framework. First, the medical model on which they are based narrowly construes the eligible population and services. Research demonstrates that children and youth benefit from care that is focused on all domains and individuals in those domains. Yet failure to learn these lessons from research has led to the current service delivery quandary: an inability to meet mental health needs and poor outcomes even where health insurance coverage is available. Second, they are individual-participant focused. This limits the ability of states to finance treatments designed to address intergenerational mental health issues, such as depression, through a family lens. This is especially challenging when family members or caregivers of the “indicated client” are not Medicaid eligible.

Many evidence-based treatments and best practices require that services be delivered in a variety of settings including the most natural (where children and families are likely to feel most comfortable), such as, in the home, school, recreational settings and away from traditional office-based settings. They also often require the use of a range of providers with different skill sets. With respect to settings, *UCR: SCMHD Survey 2006* shows (based upon preliminary data) that states are most likely to permit Medicaid reimbursement in home and school settings than park/recreational and child care settings, but overall up to 11 states do not permit Medicaid funding for services provided in these settings and nine states do not allow their own state funding to be used (depending on the setting). As Figure 15 shows, schools and homes are the most likely to be reimbursed.

Even more obstacles exist in some states when it comes to ensuring reimbursement for a range of

Figure 15: Number of States that Permit Reimbursement in National Service Settings Medicaid and State Funding



Source: UCR SCMHD Survey, 2006.

provider types beyond the licensed clinician – mostly physician. For example, among agencies that control public dollars that support mental health practice with young children, more than three-quarters said they restricted the range of providers who can receive reimbursement for diagnosis and treatment of young children. Only 56 percent extended reimbursement to non-physician providers with early intervention specialties.²⁸³ In school-based settings some providers of mental health services that are reimbursed in an office-based mental health setting will not be reimbursed or receive a lower reimbursement for an office visit that occurs in the school. Further, in some states reimbursement rules will declare a provider “unqualified” to provide service in one setting but not another.

- Effective strategies aren't cheap and require fiscal commitment over time. Attending to the requisite infrastructural costs associated with implementation of evidence-based practices is essential. This includes a long-term, intentional and proactive plan for financing effective treatments and the information systems required to facilitate its most efficient use.

The proprietary nature of most of the widely-used evidence-based practices subject public systems to a never-ending quest to find funding. Many public systems cannot afford to purchase the licenses required for full-scale implementation of some evidence-based treatment models. In addition, training costs include initial training, booster sessions, supervision and consultation and replacement of direct

care workers during training. Figures 16a-d show projected costs for several well-known and widely used evidence-based treatment models. Figuring out a way to put some of these practices in the public domain and make them available to all children and youth who need them and not simply the states and localities that can afford them is a task that requires urgent leadership.²⁸⁴ While some states have begun to attend to the associated fixed costs of evidence-based practices for children's mental health, many have yet to grapple with how essential these are to the long-term fiscal picture.

- Efforts to pay only for evidence-based practices may prove counter-productive. A vastly different concern about states' efforts to advance evidence-based practice is a danger that there will be pressure to pay for *only* evidence-based treatment. In preliminary results from the *UCR: SCMHD Survey 2006* nine states report that they have legislation that mandates using evidence-based treatments. Some states are trying to steer a responsive course recognizing that evidence-based practices are an important tool, but not the only tool among a range of strategies to improve mental health outcomes. In a few cases, officials and service providers alike also acknowledge the lack of an empirical basis for use of many of these practices among diverse cultural groups and point to the importance of having an array of effective services available.

In the face of all these challenges, some states are trying to overcome barriers to more widespread fiscal support. (See Section 3.) Why the major funding sources for children's mental health like Medicaid should pose an obstacle, rather than provide incentives is clearly an issue in need of serious scrutiny.

- Fiscal policies remain largely unresponsive to prevention and early intervention and the supporting knowledge base:

The major federal funding streams, particularly Medicaid and the Comprehensive Community Mental Health Services for Children and their Families target *only* children and youth who have diagnoses. In the case of the latter, children and youth who have severe impairments comprise the population of focus. While concentrating on this vulnerable population is important (it was totally non-existent in 1982) the failure to provide

Figure 16a: The Incredible Years (ICY) – Implementation: Start Up and Ongoing Costs

The Incredible Years is an early intervention/prevention evidence-based model for young children ages 2 to 8 at risk for or with early onset conduct problems. The primary short-term goals of The Incredible Years are to reduce conduct problems and promote social, emotional, and academic competence in children, with the long-term goal to prevent delinquency, drug abuse, and other more serious issues. The Incredible Years is a series of interventions aimed at teachers, parents and children across settings – school, work, and home. A recent study* found that mean per child costs for the major 3 components are as follows:

- Parent training (6 children): \$1,579
- Child treatment (6 children): \$1,164
- Teacher training (20 children): \$289

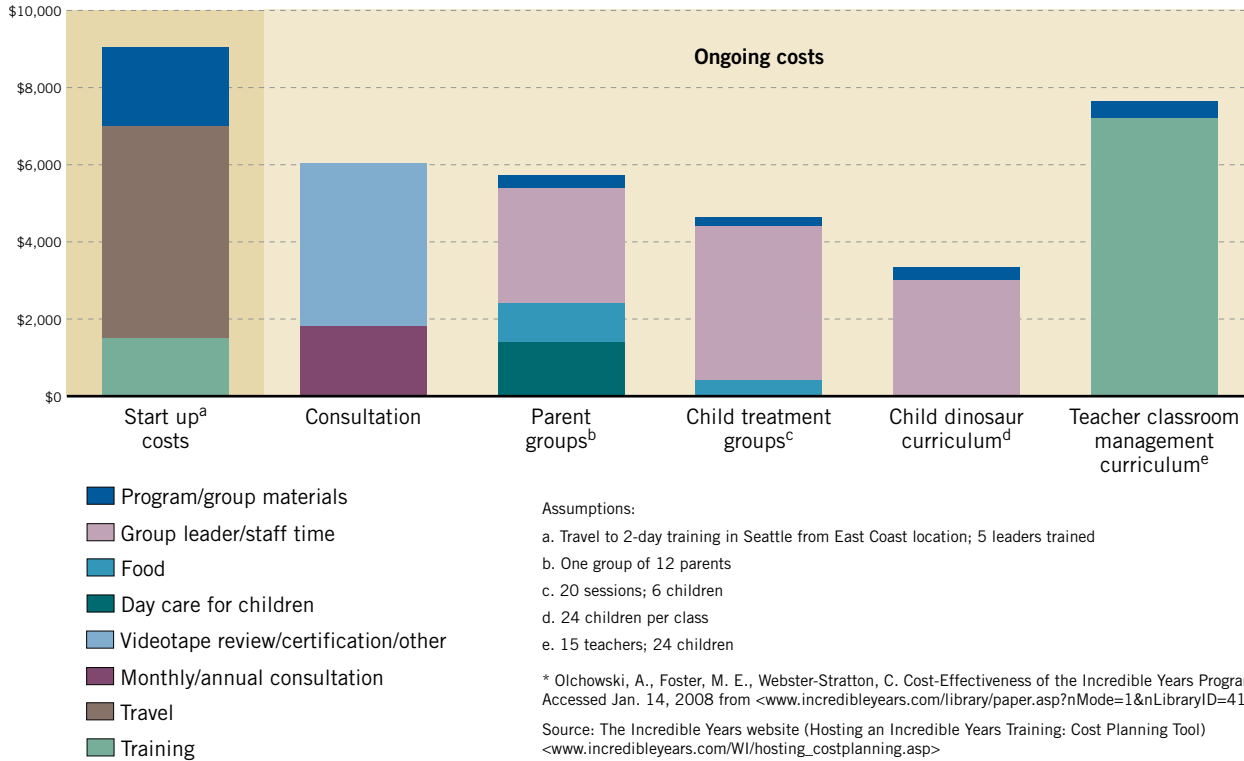


Figure 16b: MST – Implementation: Start Up and Ongoing Costs

Multisystemic Therapy (MST) is an evidence-based community- and family-based treatment model for youth with serious behavioral problems. The goal of MST is to reduce antisocial behavior in youth. MST engages multiple settings which impact a youth (schools, peers, caregivers, etc.) to promote change. Per child costs of MST in Maryland have ranged from \$5,000-8,000.*

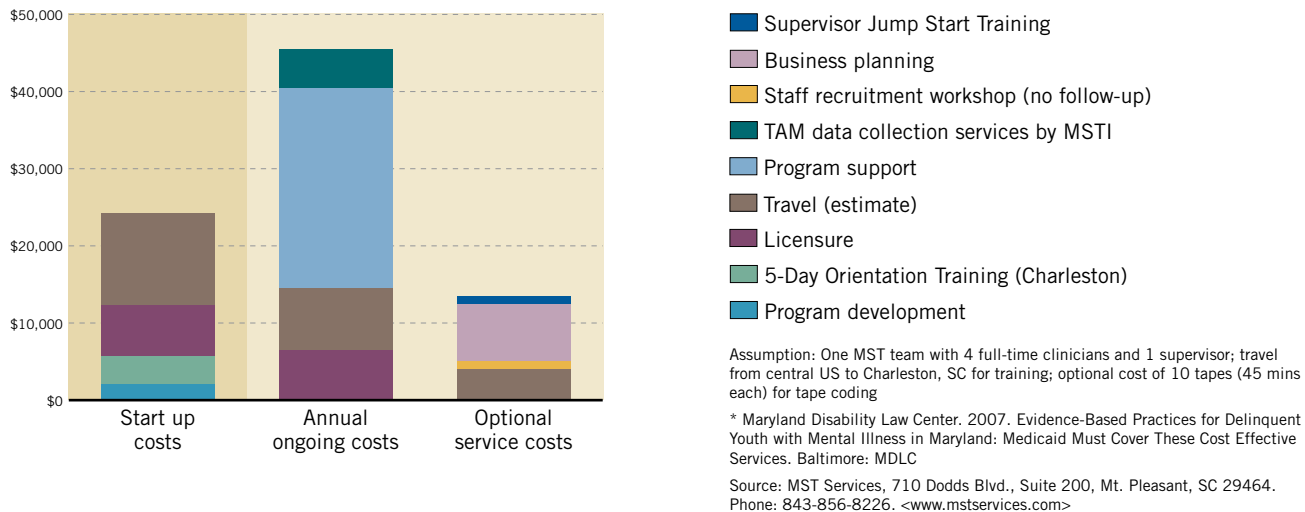


Figure 16c: MTFC-A – Costs for 5-Year Period

Multidimensional Treatment Foster Care (MTFC-A) is an evidence-based treatment for adolescents ages 12-16 with chronic disruptive behaviors or severe emotional disturbances. MTFC-A is intended as an alternative to regular foster care, group or residential treatment, and incarceration. The average total cost per child served is \$26,518. The treatment includes:

- behavioral parent training and support for MTFC foster parents
- family therapy for biological parents (or other aftercare resources)
- skills training for youth
- supportive therapy for youth
- school-based behavioral interventions and academic support
- psychiatric consultation and medication management, when needed

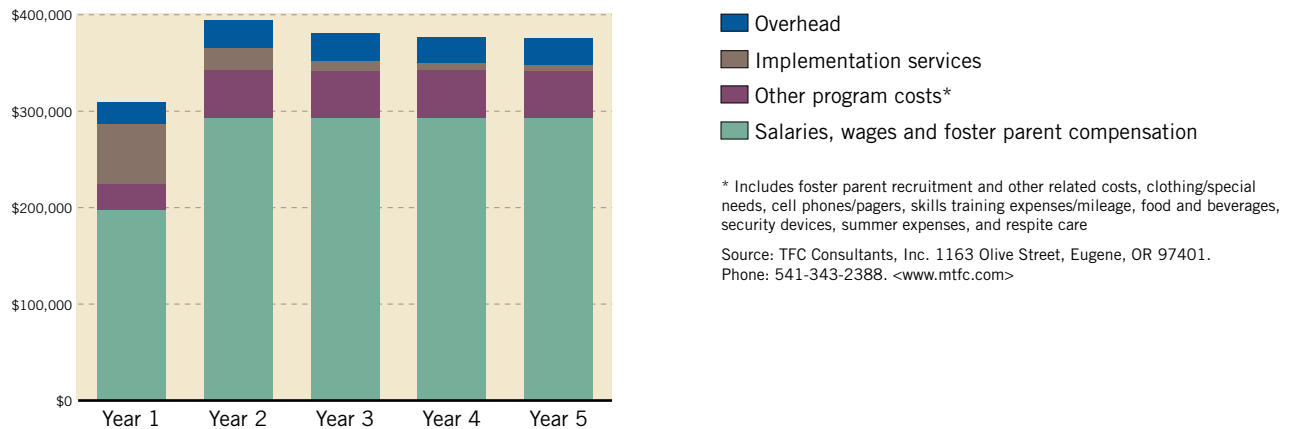
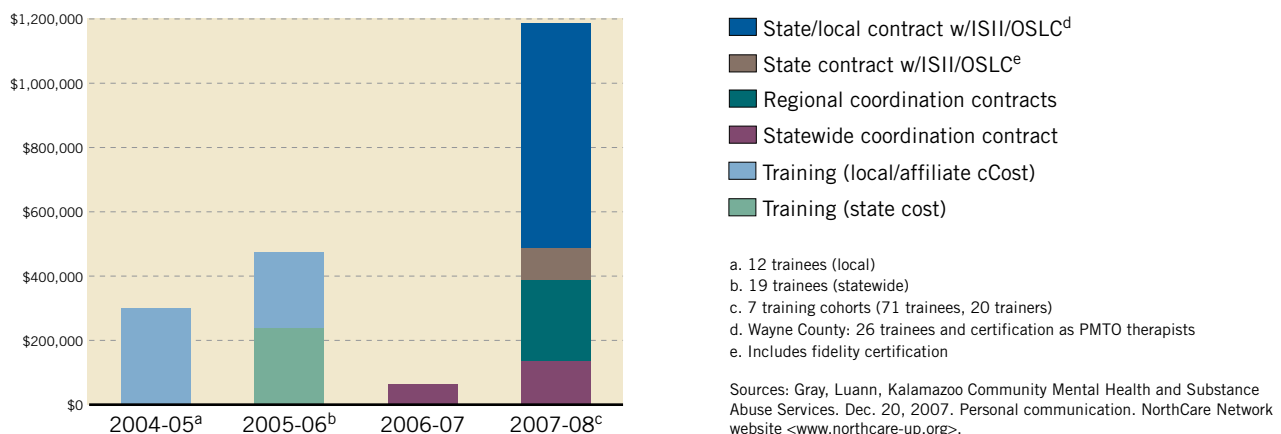


Figure 16d: Sample Case: Implementation of PMTO in Michigan

Parent Management Training-Oregon Model (PMTO) is an evidence-based family intervention designed for children and adolescents ages 4-12 with serious conduct problems. PMTO has been found to be especially effective in preventing noncompliance, substance use, and delinquency. The intervention focuses on five core parenting skills to improve behavior in children: encouragement, limit setting, monitoring and supervision, family problem solving, and positive parent involvement.

Since 2004, the State of Michigan has led the implementation of PMTO in conjunction with the developer of the model, Oregon Social Learning Center (OSLC), and Implementation Sciences International, Inc. (ISII). The costs described below are estimates of staff training, coordination, fidelity certification, and other related costs. The estimates do not include additional associated costs of the 18-day staff training, such as travel, lodging, loss of billable hours, and equipment and supplies for each trainee (e.g. computer, camera, DVD burner, books).



services to young children and children and youth who are at risk of serious problems, even as knowledge about the role of risk and protective factors increases, is short-sighted. It is also inconsistent with the calls for a public mental health paradigm as the guiding framework reflected in the President's New Freedom Commission report.²⁸⁵

5 Few incentives exist for strategic fiscal and programmatic planning and leadership informed by children's mental health knowledge at the state level:

Medicaid's expanded role in behavioral health financing has led to many positive improvements for children and youth with emotional and behavioral problems. There have also been some serious unanticipated negative system management consequences that need must be addressed.²⁸⁶ These include a vacuum in child mental health input in fiscal policy. One particular concern is that the payment structure in many states is largely divorced from any consensus on the most appropriate service array, or any strategic planning regarding service needs. Even with respect to EPSDT, which clearly requires responses to children showing signs of developmental problems (including emotional and behavioral problems without diagnoses), there is often, a total disconnect in how behavioral health is integrated into the EPSDT program.

- **A vacuum in child mental health stewardship threatens mental health quality.** In 2003, Buck pointed to a shift in the co-existence of two financing models that dominated public mental health policy.²⁸⁷ On one hand, the state represented the overseer of the safety net and preserver of the public good, while on the other hand it exercised its role as a purchaser to buy an insurance-based service delivery for all public systems. Buck warned that the purchaser role loomed larger. Today, increasingly public officials try to extract greater savings through their purchaser role. Simultaneously, in some states economic and political forces compel administrators to reduce personnel and deplete the states' ability to maintain its role as a guarantor of safety-net services. The concern becomes, as Frank and Glied have articulated, with whom does leadership rest for sound fiscal policy driven by the interests of children, youth and families?²⁸⁸ Are there active stewards of child mental health policy and are they equipped with mental health content knowledge *and* fiscal policy

acumen to play that role? Is there a role and political will for federal leadership to intervene when children and youth fall between the cracks?

- **Lack of vision and strategic planning undermines efforts to implement effective and high quality supports and services to vulnerable children and youth, and their families.** Increasingly, state mental health policy is ceded to the highest bidder. In the quest for more Medicaid funding, children's mental health policy expertise is weakened or lacks voice.²⁸⁹ Many, chiefly Medicaid policymakers, argue that federal statute prohibits state Medicaid, as the designated single state agency, from ceding "policymaking" to policy experts in mental health.²⁹⁰ Hence a stalemate has developed between many state Medicaid heads and a frustrated and increasingly beleaguered and diminished group of children's experts. The question is, does putting Medicaid, a financing tool, in the "service" of policy, whether behavioral health, aging, or HIV amount to Medicaid policymaking?²⁹¹ Can content experts in mental health, substance abuse or aging legitimately craft policy where Medicaid is the premier financing course? Preliminary data from *UCR: SCMHD Survey 2006* suggests that these decisions are not primarily made by mental health policy experts. It reveals that only four states reported that the state mental health authority or the state mental health director makes decisions regarding which mental health services are reimbursable by Medicaid. Twenty-one states reported joint decision making between Medicaid and the State Mental Health Authority, while 13 states reported that the decisions on service reimbursement *rested primarily with the state Medicaid authority* (52 states and territories reported).²⁹²

Who Decides When Mental Health Services are Medicaid Reimbursable?

- Four states reported that the state mental health authority or the state mental health director makes decisions regarding which mental health services are reimbursable by Medicaid
- 21 states reported joint decision making between Medicaid and the State Mental Health Authority
- 13 states reported that the decisions on service reimbursement rested primarily with the state Medicaid authority

Source: *UCR: SCMHD Survey 2006*. (38 states responded to this question).

State children's mental health policy that is void of children's mental health content expertise is less likely to reflect the knowledge base. Other system observers have also commented on how child mental health expertise in state mental health policy, developed after Knitzer's *Unclaimed Children*, appears increasingly discarded in favor of Medicaid leadership. Indeed, Frank and Glied warn that the absence of stewards in mental health makes the field vulnerable.²⁹³ Medicaid has contributed to fragmentation and in many cases it has substituted state funding rather than augmented state mental health funding.²⁹⁴

Medicaid has progressively substituted for state mental health funding. In three decades (1971 to 2001) according to Frank and Glied, Medicaid bore by far the largest share of mental health funding. Medicaid's share of funding almost doubled while state funding declined.²⁹⁵ As states have increasingly turned to Medicaid to fill gaps, they have cut their administrative capacity. In the case of at least one state, it reportedly slashed its administrative capacity simultaneous to reform efforts. Consequently, more than five years later, an independent evaluation labeled the mental health system as "growing haphazardly" with significant gaps, most of which require administrative support.²⁹⁶ The verdict from the public was even harsher and suggested a "complete system breakdown."²⁹⁷

6 Inequities across the states in access to services for children and youth continue, particularly when states do not maximize the impact of available Medicaid provisions:

Several studies highlight the disparities in investment in public behavioral health systems for children and youth. Variations in per child or youth spending are particularly problematic given these are amenable to policy fixes and in light of research that shows child serving systems have largely failed to meet the mental health needs of a large proportion of children and youth, and wide disparities in access exist.²⁹⁸ The resulting inequities complicate efforts to prospectively determine service costs and undermine efforts to systematically examine and develop comprehensive and deliberate strategies to improve access, quality and outcomes. What is the federal responsibility and leadership role to redress these imbalances?

Despite advocacy efforts to establish a nationwide standard, statewide variation in Medicaid plans persists. Current program flexibility, while suited to molding initiatives to meet local needs, creates havoc for systematic efforts to address problems such as unmet need, racial/ethnic disparities and poor outcomes. It also creates different levels of restrictiveness. However, even with a more restrictive state Medicaid plan, the law permits access to screening, assessment and treatment through Early Periodic Screening Diagnosis and Treatment (EPSDT). This, for example, would be one way to strengthen early intervention. Despite the availability of EPSDT, states' participation rates are widely divergent in general and based upon age.²⁹⁹ For behavioral health, some states provide a comprehensive array of services through various options, including EPSDT, while others provide a limited benefit set.³⁰⁰ For example, a federal district court judge recently compelled the State of Massachusetts to begin settlement proceedings in a class action lawsuit. The plaintiffs prevailed largely due to evidence from other states that used their Medicaid state plan to address mental health services for youth with serious mental disorders in a more comprehensive manner.³⁰¹ In addition, Los Angeles County recently settled a 2002 lawsuit requiring the provision of expanded EPSDT services to children involved with the child welfare system, to include wraparound services and therapeutic foster care.³⁰²

A state's fiscal health also impacts the type of Medicaid benefits available to enrollees. In recent years weak economic health at the state level has significantly impacted state fiscal policy and practice that support children's mental health. In 2002 and again in 2004 states faced severe fiscal problems.³⁰³ However few states used the relief they received from the federal government to prevent cuts in Medicaid.³⁰⁴ Even fewer states used the funding to fortify mental health services.³⁰⁵ The service system reflected these dire economic times and affected their cost containment strategies. More than 75 percent of child and adolescent behavioral managed care entities reported that state fiscal crises experienced in 2002 and 2003 "detrimentally" shaped the services and systems they operated.³⁰⁶ Larger reductions in Medicaid expenditures followed in FY '04, but they remain unrelated to efforts to balance state budgets.³⁰⁷

7 Fiscal policies are often unresponsive to the different kinds of services that children of different ages and stages of development need:

Under current fiscal practices two vulnerable age groups are particularly difficult to support. Fiscal policies too often ignore the needs of the youngest children from birth to age six and youth aging out of juvenile justice, child welfare and mental health agencies. Medicaid and other third-party insurers provide limited support for very young children. It is very difficult to pay for services to children without a formal diagnosis, even for young children. While half of state children's mental health agencies report that their agencies permitted Medicaid reimbursement for the treatment of young children who are at-risk for social-emotional delay, almost one-third did not allow reimbursement for these children and youth.³⁰⁸ Current Medicaid funding requirements also make it challenging to use the most appropriate assessment tools, particularly for young children, that is, infants, toddlers and preschoolers, showing signs of problems (e.g. DC 03R). Although according to one national study, more than three-fifths of state Medicaid agencies reported that they reimbursed for the use of standardized screening tools through Medicaid, two-fifths of respondents indicated that reimbursement rates were low and may influence the provider's reluctance to screen.³⁰⁹ Recent proposed Medicaid regulations that significantly curtail efforts to support Medicaid-funded interventions in child care settings threaten to increase the number of states unable to use Medicaid to pay for screening, services and supports for very young children. These draft rules specifically cite child care settings as loci of care where services provided under the rehab option may be deemed "intrinsic" to the functioning of the program and hence not eligible for reimbursement under the rehab option. (This is part of a larger problem, see below).

Largely absent too are fiscal policies that align with the needs of older youth as they make the transition into adulthood. A recent survey showed that 25 percent of child mental health system leaders and 50 percent of adult mental health system leaders reported that their systems provided no mental and supportive services for youth with mental health problems when they turned age 18 and transitioned to adulthood.³¹⁰ Even for those systems that did offer mental health services and supports, most were generally able to provide no more

than one service in an entire state.³¹¹ Failing to provide such services is short-sighted since most of these youth deteriorate until a safety-net provider – corrections, emergency health or homeless services – are compelled to respond at a stage and in conditions that require more intensive and costly interventions. Moreover, despite Congress' passage of the Chafee Foster Care Independence Act that expands Medicaid coverage for transition-age youth at the state option, only 17 states have taken advantage of this option and five states indicate that they will.³¹² The other 28 states report that they do, or plan to, use different methods for coverage. For these states though, the parameters (restrictions and eligibility criteria) appear far more stringent and in some cases, the same, as the general assistance population. Some states lead the way in how to address the needs of transition-age youth. In a handful of states, fiscal policy also supports developmentally appropriate practice for youth aging out of the child mental health system. Building on the Foster Care Independence Act (1999), these states extended Medicaid to youth aging out of care between ages 18 and 21. In addition, state policymakers in Iowa, Texas, Connecticut, Utah, and Maryland implemented a range of initiatives, from workforce investment strategies to post-secondary supports, including independent living allowances designed to comprehensively address the needs of transition-aged foster care youth (Personal communication. Pam Johnson, Administration for Children and Families, May 9, 2006).

Another flaw in most fiscal strategies that support mental health services for children and youth is that they tend to ignore the science on the development of mental health disorders and the role played by inter-generational transmission of mental health problems and risks. Many serious mental health problems cross generations and impact family members.³¹³ Research indicates that between 20 and 45 percent of children of individuals with mental illness are at heightened risk for mental health disorders.³¹⁴ Nonetheless few state mental health agencies implement policies to support the parenting roles and responsibilities of people with mental illness.³¹⁵ In addition, despite research that links the intergenerational nature of mental illness with negative effects of some mental illness on parenting, few Medicaid agencies (less than 15%) reimburse for maternal depression screening by pediatric providers.³¹⁶ Overwhelmingly Medicaid agencies report that they reimburse for treatment of parental depression but only

if the parent was a Medicaid enrollee.³¹⁷ Further, adult behavioral health systems are held harmless for poor access and inferior outcomes that impact children and youth mental health. This remains the case in the face of mounting evidence of the role of parental behavioral health on child and youth mental health.³¹⁸ However, in a small number of states the situation is different.³¹⁹ For example, Illinois provides presumptive eligibility for Medicaid and coverage for treatment post-partum for depression.³²⁰ Similarly a diagnosis-driven reimbursement system undercuts a prevention and early intervention approach to financing. For example, five states use the Diagnostic Classification of Mental Health and Development Disorders of Infancy and Early Childhood (DC: 0-3) in their Medicaid programs.³²¹

From research we know that the onset of behavioral disorders begins early.³²² Fiscal policy that is supportive of early identification, treatment and supports from early childhood through adolescence constitutes prevention and early intervention for adults.

8 Poor information technology impedes building an accountable, quality-based system:

Poor information technology represents a major barrier to fiscal innovation and the pursuit of quality through payment incentives in children's mental health. A fiscal strategy that supports quality requires significant investments in information technology.³²³ For example, many child mental health service providers and administrators do not have access to close to real time information on health histories, prior or current service use. This is also true across settings. Consequently, clinical and service-related decision making can be significantly compromised and chances for errors heightened. Evidence from other parts of the health care system suggests that both access and quality of care would be enhanced through more advanced mental health information infrastructure.³²⁴ This is a problem from a cross system perspective. Nearly 15 years since the development of the State-wide Automated Child Welfare Information Systems, (SACWIS, a child welfare case management tool), a substantial gap still exists in functional interface with payers like Medicaid.³²⁵ For juvenile justice, the level of automation is even lower.³²⁶ Attending to the requisite infrastructural costs associated with an outcomes-driven framework is essential. While some states are addressing associated fixed costs for children's mental health,

as with evidence-based practices, essential elements of long-term fiscal picture are ignored by many.

9 Lack of clarity about how to implement a fiscal agenda aligned with quality:

A clear vision has failed to emerge about what a quality fiscal framework means. Policymakers face a huge challenge in how to ensure access and quality in the current fiscal environment (that is likely to last into the foreseeable future). Who is accountable? How can care continuity be ensured? In the recent past, in some states, the mental health agency worked in concert with their state Medicaid offices to ensure uninterrupted access to services as children and youth moved in and out of eligibility. But right now the incentives are in a different direction.³²⁷ What kind of data would truly measure quality? How can states use the available funding streams, including Medicaid, as a tool to cross the quality chasm between knowledge and practice?

10 Missed opportunities in applying finance strategies:

Many managed care entities fail to adopt risk-based financing strategies such as risk adjustment to determine the relative value of financing options such as flexible funding, providing choice to families in which services they purchase, and providing cash to families, or paying for models that rest decision-making equally with families and providers. This represents missed opportunities both for current service users and for spurring the next generation of financing knowledge. Another missed opportunity is the failure to match emerging knowledge with available fiscal tools that would help build accountability into the care delivery system. Instead the current policy environment exposes a wide gulf between the knowledge base in children's mental health practice and a traditional medical model that Medicaid supports which primarily reflects narrow, clinical services. It is dramatically illustrated by the Iowa audits described above. Absent deliberate empirically-supported strategies and incentives, and Congressional oversight, this too is unlikely to change.

Potential Levers for Change

Promoting Family Choice and Involvement Through Fiscal Policies

Family Choice

An emerging concept that **needs to be embedded** in a fiscal framework is respect for family/parental choice. Child or youth consumer and family choice models are largely absent in children's mental health and publicly-financed children's systems.

Consistent with other consumer movements in health care, families and youth in mental health should have a delivery system that concurs with their values and full access to information about themselves and their health. While this is often an expressed value, in fact the dollars do not follow. Nor have states developed tools and ways of informing and educating families and young consumers on the relative merits of different treatment strategies.

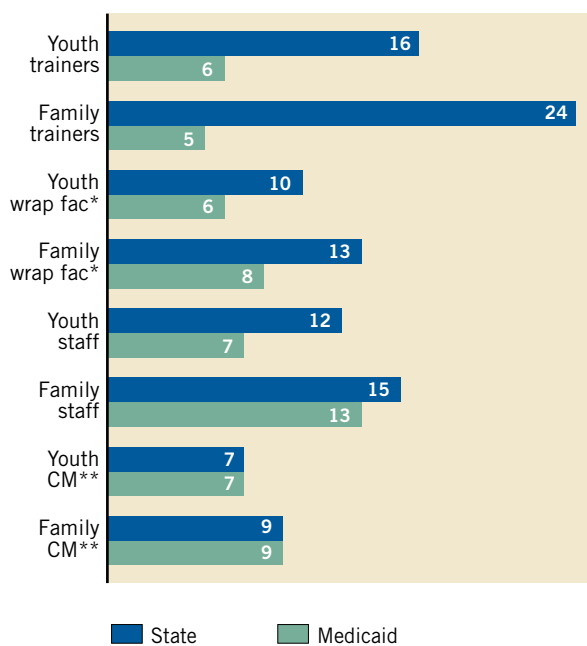
A choice-based system would mean that at the care delivery level, youth, their families and their partners in healthcare need to rely on evidence to make decisions, to prevent and reduce errors not only in medication but in placement, diagnosis and treatment. In addition, youth and their families would have a choice of providers, settings, strategies and practice enhanced by maximum collaboration among those who deliver care. A first step is the example in San Francisco. Through their SOC initiative, youth can fill out a form that outlines their preferences on the qualities they want in a mental health provider (Personal communication. Victor Damian, youth coordinator, San Francisco Department Public Health, Nov. 27, 2007. [See Appendix B.]) Families would also have access to information and opportunities to help them make choices that improve outcomes for their children. However, despite the rhetoric around evidence-based practices, few families and youth served know anything about these practices or their role in the delivery of quality services or of quality improvement.³²⁸ Further few examples exist of family members and youth as informed participants in the delivery of specific evidence-based practices.³²⁹ A recent guide to evidence-based practices developed by NAMI begins to bridge the knowledge gulf among families and youth when it comes to evidence-based practices.³³⁰

The complexity of the challenge is visible in two different approaches predicated on greater consumer choice taken by two states. The Kansas legislature recommended implementing demonstration projects that reward Medicaid enrollees for adopting health promoting behaviors.³³¹ These incentives could include reductions in co-payment or coverage of over-the-counter medication. West Virginia took a different approach. It mandated using responsibility contracts that adult Medicaid recipients were required to sign. These agreements had terms that included medication compliance, health improvement plan adherence and promises to keep appointments.³³² Medicaid recipients with signed agreements who failed to meet the conditions of these agreements may have their benefits reduced or eliminated. This plan has created considerable controversy, but the implications, which are complex and potentially harmful have not focused on the impact on children and youth.³³³ Parents, particularly mentally-ill parents, in West Virginia who sign these compacts risk not only their own health but put their children's care in jeopardy if they fail to meet these obligations. The lesson here is that although family choice is complex, children's mental health's strong history of family advocacy and engagement can be used to leverage family choice models that are congruent with family and youth empowerment.

Strengthening Family and Youth Involvement

A fairly well-established way of supporting family and youth involvement in children's mental health has been through family support programs and, increasingly, hiring family members. Recently, CMS provided guidance on how peer support may be Medicaid reimbursable. Many states allow funding, both Medicaid and state revenues, to support family therapy, family support and family members and youth in provider or staff roles. Overall, 21 states reported that they permit Medicaid reimbursement for families working in various practice related roles. For youth 14 states permit Medicaid reimbursement to youth in service related roles, based on preliminary data from *UCR: SCMHD Survey 2006*. Figure 17 shows the number of states that permit reimbursement for families and youth in specific professional roles. This is an area in which the draft DRA regulations may have a positive effect.³³⁴

Figure 17: Number of States that Reimburse for Families and Youth in Professional Roles (Medicaid and State Funding)



* Wraparound facilitators
** Case managers

Source: UCR SCMHD Survey, 2006.

Implementing a Quality Framework to Make Decisions

Might quality initiatives like pay-for-performance work in children’s behavioral health?

In recent years, the focus of financing and quality within the broader health care system has turned to pay-for-performance. Research however suggests mixed results. There is ample evidence to suggest that for some disease conditions (high risk obstetric cases, coronary disease, and surgical procedures, for example), pay-for-performance has yielded improvements in quality as measured primarily by clinical process indicators. Some research also points to improvements in screening procedures, although evidence from research of its success in primary care remains scant.³³⁵

There are also difficulties in untangling the net effect of pay-for-performance initiatives. Concerns about gaming rank high among the reasons for proceeding with care. In the United Kingdom, initial evaluation of pay-for-performance at the community health care level reveals

flaws in providing equity for payment for mental health services and significant potential for gaming such as setting low thresholds for achievement.³³⁶ In an overwhelmingly positive set of findings, concerns emerged over “easy targets” and significant cost increases to the payers. Eventually, the political fallout that emanated gained the tagline that taxpayers had rewarded physicians “just for doing their jobs.”³³⁷ Among the lessons is the need to fully fund these initiatives and to attend particularly to the increased administrative, information technology and workforce requirements.

In this country, a recent report on pay-for-performance in a behavioral health managed care entity offers more sanguine prospects. Anthem Blue Cross and Blue Shield’s decade-long experiment to incentivize behavioral health providers toward quality improvement that includes both child/youth and adult behavioral health participants shows improvements in measures (depression treatment, substance use disorder assessment and treatment, and coordination with primary care).³³⁸ Other positive findings comprise engagement strategies such as family involvement in child and youth treatment and patient satisfaction measures. Key components attributed to the program’s success include reimbursement tied to outcome measures that lend themselves to applicability across provider categories; easy access; assessment across categories of conditions or participants; and clinical relevance.³³⁹

Results from another study show significant improvements using pay-for-performance features for children with asthma and offer some key take-home messages for children’s behavioral health. These include the need to:

- institute individual-level and group level incentives; establish performance thresholds upon which all to reward everyone;
- require the use of evidence-based practices;
- assess performance based on the entire patient base; and
- enable transparency in provider performance data.³⁴⁰

Given the dearth of outcome tools and evidence effectiveness, the pressure is on for more widespread testing of pay-for-performance in community behavioral health.³⁴¹ The current situation, especially the poor alignment between fiscal strategies and effective care, demands that leaders in the field explore options to more systematically improve quality.

Changing the Federal Legislative Framework to Support Fiscal Policy Congruent with Knowledge

Has a weak federal legislative framework hampered children's behavioral health?

This analysis raises questions about the overall adequacy of the federal legislative framework for children's mental health that currently privileges attention to the highest risk children rather than support a comprehensive, balanced service system. A weak federal legislative framework has fostered piecemeal approaches. An historical review of federal legislative policy for children's mental health, for example, makes it clear that public dollars have in the past been allocated for, indeed required, services such as consultation to early child care and school-based programs.³⁴² Now, putting together funds to support these strategies is most challenging.³⁴³ Similarly, while there is often a lot of talk about the inadequacy of funding to support co-morbid conditions in youth, (as well as parents of young children) funding barriers make implementing this knowledge very difficult. The struggle to fund a basic public health framework suggests a fiscal policy with little grounding in science, common sense or the concept of spending smarter.

SECTION 5

Conclusions and Recommendations: Fiscal Policies in the Service of Knowledge

This document lays out on how resources are allocated at the federal level and across the states for children's behavioral health. Federal and state initiatives to respond to mental health and substance abuse needs primarily originated from gap-filling efforts and reflexive responses to unmet needs. Below, we step back and draw and discuss some conclusions that point to directions for reform. These address both long-standing and emerging issues and highlight ways in which states and local communities are seeking to address the challenges.

Towards the Future

The community-based SOC for behavioral health care for children and adolescents is fragile and decaying in many places. In some places it never really existed. A robust community mental health system requires fiscal support. Currently we get what we pay for, a system that significantly underpays service provision at the community level, rewards selection of high-end inpatient and residential services, and typically fails to pay for services based on outcomes or effectiveness of practices. To put fiscal policies at the service of knowledge requires that policymakers ensure fiscal support for knowledge-based capacity building; for continuous competence building and for ongoing accountability. However, a major challenge remains how to change the existing care delivery framework to reflect a quality orientation: one that uses our best knowledge about risk and protective factors, practices, settings and positive outcomes.

To begin with, the field needs to extract itself from the current quagmire that appears to engulf it. There is widespread debate about evidence-based practices in children's behavioral health. Yet, absent from the debate or any related policy actions are:

- efforts to systematically interpret the new knowledge, its relevance and application;
- concentrated foci on applying a developmental framework and the appropriateness of the knowledge from one developmental stage to another; and

- consistent consideration and practical steps to use the lessons from implementation research to support sustainable adoption.³⁴⁴

This review makes clear that addressing current system-based inadequacies require fiscal alignment that:

- radically reverses the imbalance between community-based services and supports, and inpatient and residential care;
- consistently underwrites prevention, early identification, intervention, treatment and supports irrespective of the service system;
- provides sustained incentives for adoption of culturally and linguistically competent evidence-based treatment and supports with prerequisite family and youth engagement strategies throughout the care system, irrespective of treatment setting;
- creates incentives for the use of unified service plans that are accepted substitutes for plans in all systems;
- requires and/or provides incentives for states to employ best practice/evidence-based financing strategies in their purchasing roles;
- supports research on performance-based contracting;
- creates and maintains the appropriate organizational climate and culture to allow new practices to flourish; and
- establishes and maintains the feedback loops necessary to inform practice and continuously improve quality.

Fiscal Policy In Sync with Sense and Science

To usher in a new framework for children's behavioral health, policymakers must recognize the extent to which children's behavioral health financing defies logic. One would expect that the science on child and youth development, behavioral health and the service needs of children and youth would guide child behavioral health policy, which in turn, guides fiscal policy. The reality is

quite contrary. Child behavioral health policy struggles to conform with fiscal policies and procedures that manage the fiscal tools we use to finance services. To advance fiscal policy that is consistent with the knowledge base, policy makers must tackle several overarching challenges and opportunities for action outlined below.

Conclusions

Conclusion #1

Medicaid's expanded role in behavioral health financing has led to many positive improvements for children and youth with emotional and behavioral problems. These include increases in access and reduction in out-of-pocket costs. Medicaid law and provisions under EPSDT have enabled legal advocates to seek relief in the court system and several landmark legal decisions have expanded access and shaped fiscal policies in many states.

Conclusion #2

Fiscal policy drives community-based service delivery capacity. Consequently, the dearth of community mental health capacity and its uneven quality reflects state and federal fiscal policy. Collectively, the current complex and haphazard array of funding is characterized by:

- over-reliance on residential care that lacks a solid evidence base instead of using alternatives with positive outcomes or empirical support;
- poor reimbursement rates for empirically-supported community-based mental health;
- a narrow focus of financing for the highest users, despite a knowledge base that attests to the efficacy and effectiveness of prevention and early intervention;
- a lack of capacity to fund a continuum of services to meet the mental health needs of infants, toddlers, preschoolers and their families despite evidence of the earlier onset of children's mental health disorders and the intergenerational transmission of problems; and
- a reluctance to fund a continuum of services that together are less costly and more effective.

Conclusion #3

Fiscal policy *determines* the poor quality that dominates much of community-based service delivery. From a competency perspective funding, policy is characterized by:

- a rejection of the knowledge base, particularly related to child and adolescent development that create widespread disincentives to pay for evidence-based services and supports for children, youth and their families with behavioral health needs;
- an inability to consistently fund developmentally appropriate standardized screening and interventions across all child-serving settings (such as early childhood, schools, homeless shelters, foster care, juvenile justice facilities and independent living);
- a focus on funding strategies based on individual children and youth, *not* on supporting and ensuring appropriate guidance from teachers, caregivers and caring adults;
- a poor service match for many children and youth in foster care, despite universal coverage;
- a lack of continuity of care for youth in juvenile justice despite having a "contained" population of focus;
- failure to support and promote the use of clinicians and non-clinicians with specific expertise in child and adolescent development; and
- mixed messages that impede the development of culturally competent family-directed, youth-informed and delivered services.

Conclusion #4

The service delivery and supports system lacks accountability for outcomes for children, youth and their families. From the lens of accountability, fiscal policy guiding children's behavioral health is characterized by:

- failure to hold systems accountable for improved outcomes for children, youth and families. Two examples illustrate this. First, children with behavioral problems experience the worse educational outcomes of all children with disabilities yet neither educational financing or behavioral health financing hold systems accountable for providing children and youth the tools and level of functioning they need for school success.

Second, no mechanisms exist between adult and child behavioral health, between mental health and substance abuse or mental health and special education to routinely track and jointly manage outcomes for those families for whom they are responsible;

- lack of planning or initiatives that support states with appropriate fiscal and infrastructural development expertise to design strategies supportive of effective practices;
- a plethora of “successful pilots” that are rarely brought to scale;
- multi-agency, multi-jurisdictional barriers to fiscal support for effective practices (such as the legal hurdles to shared information across domains);
- lessons from technical assistance partnerships are not routinely shared across states and sectors;
- weak and disconnected federal fiscal policy leadership that lacks substantive child behavioral health policy expertise; and
- a vacuum in federal policy leadership to address geographic, racial/ethnic and linguistic disparities between states.

Conclusion #5

A new national paradigm to guide fiscal policy for children’s mental health is desperately needed. This paradigm must be consistent with the recent call for a public mental health framework through the President’s New Freedom Commission on Mental Health. The existing federal legislative framework sends mixed signals, making it difficult for states to think strategically about service improvement. It is characterized by:

- inadequate guidance for supporting fiscally responsive and responsible policies that are linked to improved outcomes;
- reactive decision-making shaped by funding considerations beyond children’s services;
- failure to recognize the importance of a developmentally-appropriate, research-informed approach to financing and service delivery;
- poor support for infrastructure to strengthen use of best practices (such as training clinicians in new practices, improved use of technology, organizational levers that promote and sustain adoption);

- little fiscal support for outcome-driven flexibility in funding sets of services;
- difficulty in funding non-clinical services and supports essential to the viability of effective practice models (such as family engagement, service coordination, cultural brokers); and
- an absence of support for strong effective partnerships in decisions about children’s behavioral health funding between mental health and substance abuse policy experts and fiscal policy experts.

At no time has the high level of unmet need for behavioral health services been acceptable in the United States. The “failure of public responsibility” that Knitzer exposed in 1982 was so intolerable that it generated a national outcry and movement for change. Today we witness equally unacceptable high levels of unmet need. What sharpens the poignancy of today’s picture is the sharp contrast between the body of accumulated knowledge about effective practice and paltry efforts to support implementation of this knowledge through financing. We not only know what clinical practices work, we know about many that are ineffective. We also know about effective practice settings, and effective timing of interventions to produce maximum impact. Increasingly we know about effective targets of intervention, beyond the “indicated child” to the family, caregivers and significant others in the child’s or youth’s life. We also know about the impact of trauma on children’s behavioral health and the impact of mental illness in the household on children’s growth and development.

In the face of this evidence we see a national fiscal policy that appears in retreat mode. It is stuck in supporting a practice model that is interested in counting processes versus outcome and supporting service delivery that research suggests: (a) will not even retain children, families, and youth long enough to allow any practice to work, even if it’s effective; (b) will not be effective because it’s not based on evidence about what works; (c) will not be managed because it cannot appropriately account for outcomes, or measure systematically what is being done; and, (d) will not produce positive results because they continue to use products and processes that are rarely replicable in any systematic fashion.

Recommendations

The challenge for policy leaders is to act on the recognition that the failures of the behavioral mental health system are *fiscally driven*. Corrective action requires bringing fiscal policy in line with the knowledge base. NCCP urges *federal leadership now* by policymakers. We recommend that policymakers:

1) Attend to the lack of **capacity** at the community level by:

- redressing the balance between community and residential treatment by requiring that Medicaid, public and private payers reimburse community-based mental health services at market rates;
- providing enhanced reimbursement, *above* market rates, for empirically supported community-based services in mental health personnel shortage areas, low-income and underserved communities;
- reconfiguring fiscal incentives to reward short-term residential stays as part of a cohesive comprehensive individualized care plan;
- disbursing incentive grants to support states to develop models of care that integrate outcomes-focused residential and community care;
- developing in collaboration with states mechanisms for tying residential and community service delivery to important behavioral health and related outcomes for children, youth and families;
- implementing appropriate billing methods that enable the reimbursement of research-based prevention and early intervention strategies;
- permitting reimbursement for a continuum of services to meet the mental health needs of infants, toddlers, preschoolers and their families (such as screening and treatment of maternal depression, mental health consultation in early care settings, support for strategies based on multiple risk-factors, family-based treatment); and
- crafting fiscal methods that allow support for empirically supported models of care that require service bundling (such as multi-systemic therapy, multi-dimensional treatment foster care).

2) Significantly raise the **quality of care** delivered in community-based and other settings for children, youth

and their families by:

- requiring that Medicaid and all other public funding sources finance implementation of effective care. This includes: early identification, treatment and supports across the developmental span and in settings that children and youth frequent (such as the home, schools, child care, recreational and other community-based settings);

Specifically, this means:

- using a developmentally appropriate taxonomy that permits payment for screening assessment and treatment (for example the DC 0-3R);
 - financing supportive and early intervention services based on a number of risk factors;
 - reimbursing community-based providers, particularly in primary care, to screen parents for risk factors associated with childhood mental health problems and appropriately refer;
 - requiring primary care providers and other clinicians to develop competencies in early childhood development, mental health and appropriate diagnosis and treatment;
 - funding treatment and related strategies for every child within the context of their families and ensuring appropriate interventions with all important figures in the child’s care, especially teachers and caregivers;
 - mandating funding for services to transition-age youth with mental health problems until age 25. For youth who are employed, mandate employer coverage or buy-in to Medicaid to ensure that their mental health problems are addressed; and
 - providing federal participation through Medicaid for empirically supported services provided to youth in juvenile justice that will in the long-run improve the quality and reduce the costs of services to this population.
- improving the quality of care for children and youth in foster care;
 - making prevention a hallmark of both child and adult behavioral health by a prevention set-aside in all behavioral health related funding and providing Medicaid reimbursement for mental health promotion and prevention strategies with relevant reimbursement codes and guidance to ensure implementation;

- embracing quality as a way of doing business in children’s behavioral health through funding for economic incentive models to improve quality;
 - investing in research and evaluation efforts to determine the cost-effectiveness of strategies and interventions designed to improve the mental health of children, youth and their families;
 - giving financing priority to strategies that evaluate and apply the lessons learned of effective interventions and supports in eliminating racial and ethnic disparities, prevention and early intervention, workforce capacity building and cross-generational approaches to service delivery;
 - requiring that SAMHSA and its’ sister agencies in the federal government, including CMS, explicitly fund demonstrations of quality initiatives that include an economic evaluation component; and
 - allocating funding for each state to establish a fiscal policy center to evaluate the cost-benefit of state supported initiatives across health and social services.
- 3) Instill **accountability** for public financing of behavioral health by:
- requiring cross sector and cross generational program accountability and developmentally appropriate approaches to service delivery and related projects
 - mandating that SAMHSA develop mechanisms to evaluate both the adult and child behavioral health care systems based on outcomes of children of parents with behavioral health problems in these systems;
 - requiring that states provide developmentally appropriate adult mental health services for youth who become adults with mental health problems;
 - establishing fiscal equity for children and youth in mental health by setting benchmarks by which time children and youth should have funding parity;
 - addressing the vacuum in child behavioral health content expertise and leadership in fiscal policy;
 - requiring a comprehensive assessment of funding, evaluating the outcomes this funding generates, and making recommendations for effective use of the funding;
 - establishing cross-discipline benchmarks for improved outcomes;
 - tying financing to outcomes for children, youth and families;
 - bringing to scale successful pilots that improved children’s behavioral health;
 - resolving multi-agency, multi-jurisdictional barriers to fiscal support for effective practices;
 - supporting widespread dissemination of technical assistance efforts across states and sectors;
 - mandating federal fiscal policy leaders work with leaders who have substantive policy expertise in children’s behavioral health; and
 - creating a level playing field for all children and youth by identifying and addressing the factors associated with state variation in funding for children and youth and between child service sectors. In particular, develop incentives for addressing geographic disparities in access and outcomes.
- 4) Legislate a new national paradigm to guide fiscal policy for children’s behavioral health. Draft and pass legislation that:
- guides fiscally responsive and responsible policies that are linked to improved outcomes;
 - ensures financing and service delivery that is developmentally-appropriate and research-informed;
 - provides robust support for infrastructure to support use of effective practices including, building competency of clinicians, advancing use of information technology to improve clinical decision making and accountability, and creative incentives to support implementation and uptake of evidence-based practice;
 - generates legislative support for multi-dimensional evidence-based treatments;
 - funds aspects of service delivery that research demonstrates enhances access and effectiveness of evidence-based practice models;
 - requires children’s behavioral health experts at SAMHSA and fiscal experts at CMS jointly make decisions on financing that impact child behavioral health related policies; and
 - mandates that SAMHSA and CMS conduct a comprehensive assessment of child behavioral health financing and establish how current financing matches the knowledge base and a balance to address the gaps identified.

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on adults with mental illness and the CMS guidance alludes to this history, there is no mention of youth peer support and nothing in the guidance that prohibits Medicaid funding of youth peer support through the Rehab option or through a waiver program. Moreover some of agencies in the field with experience in peer support include family members and youth (See endnote 249).

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Appendix A: SMHA-controlled mental health expenditures for children and youth, 2001, 2003 and 2005

STATE	2001			2003			2005		
	Total (in millions)	Per capita	% of total SMHA MH expenditures	Total (in millions)	Per capita	% of total SMHA MH expenditures	Total (in millions)	Per capita	% of total SMHA MH expenditures
Alabama ^{b1, b2}	NA	NA	NA	\$11.30	\$10.20	4%	\$25.70	\$23.21	9%
Alaska	\$7.48	\$37.81	15%	\$7.55	\$70.67	25%	\$85.70	\$468.52	49%
Arizona	\$44.35	\$31.31	9%	\$172.40	\$113.47	25%	\$278.80	\$177.04	32%
Arkansas ^{a1, a2, a3}	\$5.86	\$8.29	8%	\$2.28	\$3.34	3%	\$6.90	\$10.04	7%
California ^{b1, b2, b3}	\$910.13	\$101.88	29%	\$1,203.10	\$127.72	31%	\$1,372.80	\$144.01	32%
Colorado	\$58.60	\$51.04	21%	\$81.92	\$71.07	27%	\$108.70	\$94.23	32%
Connecticut ^{b1, a2, c1, c2, c3}	\$0.00	\$0.00	0%	\$56.39	\$67.50*	11%	\$0.00	\$0.00	0%
Delaware ^{a1, a2, c1, c2, a3, c3}	\$0.00	\$0.00	0%	NA	NA	NA	\$0.00	\$0.00	0%
District of Columbia ^{b1, b2, b3}	\$24.45	\$222.45	11%	\$18.50	\$170.67	8%	\$24.70	\$213.14	11%
Florida	\$75.51	\$20.83	13%	\$90.27	\$23.00	14%	\$84.40	\$21.28	13%
Georgia ^{a1, a2}	\$68.10	\$30.55	18%	\$64.22	\$27.96	15%	\$57.80	\$24.10	13%
Hawaii	\$133.30	\$432.08	62%	\$44.80	\$150.81	29%	\$48.60	\$162.87	25%
Idaho ^{b1, b2}	\$1.29	\$3.21	2%	\$91.19	\$24.71	20%	\$15.30	\$39.63	28%
Illinois	\$113.62	\$35.43	14%	\$160.60	\$49.71	19%	\$199.00	\$61.70	19%
Indiana	\$35.70	\$22.29	9%	\$19.77	\$12.32	4%	\$89.10	\$56.63	17%
Iowa	NA	NA	NA	\$11.50	\$16.58	5%	\$10.20	\$14.36	4%
Kansas**	\$6.66	\$9.30	4%	\$20.94	\$30.13	10%	\$0.00	\$0.00	0%
Kentucky ^{a1, a2}	\$40.88	\$38.99	21%	\$42.08	\$42.33	20%	\$36.30	\$36.47	17%
Louisiana	\$22.44	\$17.34	11%	\$38.18	\$32.42	17%	\$33.60	\$28.78	13%
Maine ^{a3}	\$34.09	\$105.58	25%	\$43.70	\$152.40	26%	\$48.10	\$168.67	27%
Maryland ^{b1, b2, b3}	\$178.87	\$137.51	26%	\$236.80	\$171.84	29%	\$233.70	\$170.64	30%
Massachusetts ^{a1, a2, a3}	\$87.05	\$60.90	13%	\$95.80	\$64.42	14%	\$99.40	\$67.94	14%
Michigan ^{b1, b2, b3}	\$139.34	\$52.84	17%	\$1,333.80	\$52.70	14%	\$132.70	\$52.88	14%
Minnesota	\$120.04	\$90.79	23%	\$162.09	\$129.80	27%	\$163.00	\$129.31	24%
Mississippi	\$18.10	\$21.93	7%	\$59.47	\$78.13	22%	\$73.10	\$95.98	24%
Missouri ^{b1, b2}	\$49.74	\$34.52	15%	\$52.91	\$37.60	14%	\$60.20	\$42.58	15%
Montana	\$54.24	\$216.62	49%	\$50.62	\$234.60	45%	\$53.60	\$245.25	43%
Nebraska	NA	NA	NA	\$9.32	\$21.15	9%	\$5.50	\$12.36	5%
Nevada	\$52.44	\$101.22	44%	\$59.54	\$102.41	42%	\$46.90	\$76.42	31%
New Hampshire	\$19.06	\$60.56	14%	\$19.93	\$65.09	13%	\$21.00	\$69.57	14%
New Jersey	\$53.88	\$27.37	7%	\$89.15	\$41.82	8%	\$108.70	\$51.62	9%
New Mexico ^{a3, c3}	\$3.79	\$7.06	6%	\$2.49	\$4.97	5%	\$2.60	\$5.13	6%
New York ^{b1, b2, b3}	\$147.16	\$32.79	4%	\$178.80	\$39.45	5%	\$205.30	\$44.97	5%
North Carolina	\$99.78	\$50.58	23%	\$90.12	\$43.18	22%	\$510.00	\$241.42	50%
North Dakota	\$6.73	\$38.72	13%	\$6.40	\$43.59	13%	\$4.70	\$31.86	10%
Ohio	\$158.18	\$54.13	23%	\$163.11	\$57.94	23%	\$195.10	\$69.90	26%
Oklahoma	\$8.27	\$9.02	6%	\$8.20	\$9.34	6%	\$12.90	\$14.55	8%
Oregon ^{b1, b2}	\$51.22	\$58.07	25%	\$40.02	\$47.13	20%	\$192.60	\$226.75	44%
Pennsylvania ^{a1, a2, c1, c2, a3, c3}	NA	NA	NA	NA	NA	NA	\$0.00	\$0.00	0%
Puerto Rico	\$3.95	\$3.15	5%	NA	NA	NA	NA	NA	NA
Rhode Island ^{c1, c2, c3}	\$0.00	\$0.00	0%	\$93.37	\$382.58	98%	\$0.00	\$0.00	0%
South Carolina	\$74.43	\$69.67	25%	\$65.70	\$64.20	24%	\$65.70	\$63.79	23%
South Dakota ^{b1, b2, b3}	\$7.23	\$33.67	16%	\$8.49	\$43.43	17%	\$10.10	\$51.99	18%
Tennessee	\$26.07	\$18.32	7%	\$96.40	\$69.13	19%	\$120.90	\$84.65	23%
Texas ^{b3}	\$127.68	\$21.09	16%	\$145.90	\$23.38	17%	\$122.20	\$19.28	15%
Utah	\$52.19	\$63.43	33%	\$51.46	\$69.26	31%	\$57.60	\$74.26	36%
Vermont	\$36.68	\$236.51	46%	\$44.40	\$323.04	47%	\$51.30	\$377.72	47%
Virginia ^{b3}	\$42.73	\$24.56	9%	\$34.80	\$19.35	7%	\$73.20	\$40.59	14%
Washington	\$157.40	\$101.91	30%	\$144.30	\$96.43	26%	\$182.50	\$120.07	31%
West Virginia ^{b1, b2, b3}	\$0.00	\$0.00	0%	\$0.00	\$0.00	0%	\$2.10	\$5.40	2%
Wisconsin	\$41.38	\$29.13	10%	\$26.63	\$19.98	5%	\$19.50	\$14.76	3%
Wyoming	\$5.05	\$34.31	17%	\$17.83	\$147.63	35%	\$4.20	\$34.93	8%
Total	\$3,405.18	\$50.81	15%	\$4,209.23	\$57.63	16%	\$5,356.30	\$72.84	18%
Average (Mean)	\$70.94			\$84.18			\$105.00		
Median	\$42.05	\$34.42		\$44.60	\$45.36		\$53.60	\$51.99	

Note: In some states (CT, DE, and RI), a separate state agency is responsible for providing mental health services to children.

NA = Services provided but exact expenditures are unallocatable

a = Medicaid revenues for community programs are not included in SMHA-controlled expenditures (1) = 2001

b = SMHA-controlled expenditures include funds for mental health services in jails or prisons. (2) = 2003

c = Children's mental health expenditures are not included in SMHA-controlled expenditures (3) = 2005

* 2003 State Spending Plan and 6/35 CFSR for Riverview Hospital. Prepared Aug. 16, 2006 by Rick Rome and provided to Karen Andersson.

** Kansas Department of Social and Rehabilitation Services. (2004). Performance Partnership Block Grant Application: The FY 2005-FY 2007 Kansas State Plan.

Source: Table 16. SMHA-controlled mental health expenditures by age and by state: FY 2003. National Research Institute.

INSTRUCTIONS



City & County of San Francisco
 Department of Public Health
 Community Health Program
 Community Behavioral Health Services

Your Name: _____ Date: _____
 Address: _____ E-mail: _____
 Phone Number: _____

Choosing Your Therapist

Welcome! In order to help us match you with a therapist that you will feel comfortable with, please tell us a little bit about what you want.

1. Do you want your therapist to be a certain **gender**? (give us your 1st and 2nd choices)

<input type="checkbox"/> Male	<input type="checkbox"/> Transgender (please specify _____)
<input type="checkbox"/> Female	<input type="checkbox"/> Doesn't matter

2. Do you want your therapist to be a certain **age**?

<input type="checkbox"/> Younger	<input type="checkbox"/> Older	<input type="checkbox"/> Doesn't matter
----------------------------------	--------------------------------	---

3. Do you want your therapist to be a certain **race or ethnicity**? (give us your top 3 choices)

<input type="checkbox"/> White	<input type="checkbox"/> Mixed or bi-cultural	<input type="checkbox"/> Black	<input type="checkbox"/> Asian
<input type="checkbox"/> Latino	<input type="checkbox"/> Other (please specify: _____)	<input type="checkbox"/> Doesn't matter	

4. Do you want your therapist to be able to speak a certain **language**?

<input type="checkbox"/> English	<input type="checkbox"/> Spanish	<input type="checkbox"/> Chinese	<input type="checkbox"/> Vietnamese
<input type="checkbox"/> Pilipino	<input type="checkbox"/> Russian	<input type="checkbox"/> Other (please specify: _____)	

5. Do you want your therapist to have a certain **sexual orientation**? Do you want your therapist to be:

<input type="checkbox"/> Gay or lesbian	<input type="checkbox"/> Bisexual	<input type="checkbox"/> Straight	<input type="checkbox"/> Doesn't matter
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6. What would be the ideal place to have your therapy? (give us your top 3):

<input type="checkbox"/> Home	<input type="checkbox"/> Different places	<input type="checkbox"/> Outside	<input type="checkbox"/> School	<input type="checkbox"/> Office
<input type="checkbox"/> Restaurant	<input type="checkbox"/> Other (please specify: _____)	<input type="checkbox"/> Doesn't matter		

7. Are there any places that you **DON'T** want to have therapy?

<input type="checkbox"/> Home	<input type="checkbox"/> Different places	<input type="checkbox"/> Outside	<input type="checkbox"/> School	<input type="checkbox"/> Office
<input type="checkbox"/> Restaurant	<input type="checkbox"/> Other (please specify: _____)	<input type="checkbox"/> Doesn't matter		

8. Would you like your therapist to ask you if it's ok to take notes during your session? (check one)

<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> Doesn't matter
------------------------------	-----------------------------	---

Thank you for letting us know what you want. We will do our best to match you with a therapist that you will feel most comfortable with.

Instructions: Give form to youth at intake, before assignment of therapist. Keep form in chart after case is opened.

**** INSTRUCTIONS**



City & County of San Francisco
Department of Public Health
Community Health Program
Community Behavioral Health Services

DO YOU FEEL ME?

1. Right now, this is how I feel (circle one or more)



2. Please explain why:

**Other
(Draw Here)**

3. I am Hungry Not hungry

4. Right now I: Want to be here
 Don't want to be here
 Something else: _____

****Instructions:** Give form to youth at beginning of session. File one copy per month in chart if applicable.

