Introduction to the Symposium

- Three segments on three different strategic financing opportunities
  - Use of Federal Mental Health Block Grant Funds
  - Use of Affordable Care Act (ACA)
  - Use of Medicaid
- Presentation of new information in each segment
  - Environmental scan on Block Grant
  - Environmental scan of ACA implementation
  - New Informational Bulletin on Medicaid
- Discussion

Environmental Scan 2013

- Conducted by Georgetown National TA Center for Children’s Mental Health in collaboration with the National Association of State Mental Health Program Directors (NASMHPD)
- Explored use of Block Grant funds for children, adolescents, and young adults with mental health conditions and their families
- Respondents primarily the children’s mental health directors from 50 states, DC, and Guam (52 respondents)
- Explored only use of Block Grant funds for various activities
- States may be using other resources to support some of these activities, e.g., state general revenue, federal system of care (SOC) community or expansion grants, grants from the Centers for Medicare and Medicaid Services (CMS) related to health reform implementation

Allocation and Use of Block Grant Funds

- Most states (89%) allocate Mental Health Block Grant funds to children’s mental health
  - All of these allocate funds to children and adolescents
  - Half (48%) also allocate funds to youth and young adults of transition age
- About one-third of total Block Grant is allocated by states to children, youth, and young adults (37% of Block Grant)
- Wide range in the percentage of total Block Grant funds allocated – 10% to 83%

Uses of Block Grant Funds

- Funds are used for multiple purposes
- Most common is financing services and supports (90%)
- Nearly two-thirds use funds for activities to support family and youth involvement (62%)
- More than half use funds for planning related to children's mental health services and SOCs (58%)
- More than half use funds for training (58%)
- Less than half use funds for performance and outcome assessment (46%)
- About one-third use funds for strategic communications (35%)
**Services and Supports**

- Nearly all use Block Grant dollars to fund services and supports (90%)
- Most frequent use is for services and supports not covered by Medicaid or other sources (58%)
- Specific services cited:
  - Family and youth peer support
  - Services for children not eligible for Medicaid
  - Respite
  - Wraparound services planning process

**Family and Youth Involvement**

- Supporting family and youth participation was the next most frequent use (62%)
  - Most of these states use resources to contract with family organizations (88%)
  - Nearly half use funds for contracts with youth organizations (47%)
  - Uses for families at the service delivery level:
    - Financing services provided by family members that are not covered by other sources, such as peer support and education (62%)
    - Financing training and certification programs for family peer support providers (47%)
  - Uses for youth at the service delivery level:
    - Financing services provided by youth that are not covered by other sources (47%)
    - Financing training and certification for youth peer support providers (47%)

**Planning and Infrastructure Development**

- More than half the states (58%) use Block Grant funds to develop plans and build infrastructure needed to support children’s mental health services and SOCs
- Strategic uses, such as piloting new approaches for eventual expansion (43%)
- Support planning for children’s mental health services related to implementation of the ACA (17%)

**Training and Workforce Development**

- Block Grants used in more than half the states (58%) to train providers in the SOC approach
- Funding for workforce development for future workforce (33%)
  - Funding for a structure for ongoing training and TA, such as an institute or center (20%)

**Performance and Outcome Measurement**

- Block Grant funds used by nearly half the states (46%) to finance activities to assess system performance and/or outcomes of children’s mental health services and SOCs

**Strategic Communications**

- Least frequent use of Block Grant funds is for strategic communication activities designed to build awareness and support for children’s mental health services and SOCs (35%)

- Strategic Communications:
  - Social marketing campaigns
  - Developing information and materials targeted at policy makers and other key stakeholders
Integrating Mental Health and Substance Use Services

- States have option to submit a single Block Grant application for both mental health and substance use services
- Nearly half reported that their state submitted an integrated application (44%)
- About half reported Block Grant funds would be used for integrated mental health and substance use services (53%)

Desired Use of Block Grants Funds

- Most frequent desired use is to finance new or expanded services (44%), such as wraparound and mental health promotion and prevention
- Block Grant funds have not been used for support prevention and promotion to date
- Resources are targeted to adults and children with serious mental health conditions
- Set-aside has been proposed to allow funding of prevention and promotion activities in the future

Environmental Scans 2013 and 2014

- Conducted by the National TA Center in collaboration with NASMHPD to explore implementation of health reform through lens of children, adolescents, and young adults with mental health conditions and their families
- Component of “health reform tracking project” to monitor implementation of the ACA provisions in states that specifically include and address children’s mental health services
- Respondents primarily children’s mental health directors in 50 states, DC, and Guam

2013 Plans and Activities for Implementation of the ACA

- Respondents primarily children’s mental health directors in 50 states, DC, and Guam
- In 2013, approximately two-thirds of the states reported that they were planning to use one or more provisions of the ACA to address the needs of children, youth, and young adults with mental health conditions and their families
- States were in very early stages of planning and implementation:
  - Most were still exploring potential use of ACA provisions (35%)
  - Fewer were in the process of developing plans (19%)
  - Fewer still reported that implementation has begun (13%)
- Health homes and Money Follows the Person were furthest along in planning and implementation

January 2014 Environmental Scan

- In 2014, second scan to learn about progress in planning and implementation and approaches
- Focused in on specific provisions and only those that specifically include children’s mental health
- For each provision, determined if:
  - Not being considered for children’s mental health at this time
  - Under exploration
  - Plan is under development
  - Plan is developed, implementation has begun
January 2014 Environmental Scan

- Found progress in planning and implementation:
- Largest group are not considering using the provisions for children’s mental health (36%)
- Found progress in implementation – more states moved from planning to implementation phase

Use of ACA Provisions

<table>
<thead>
<tr>
<th>Implementation Progress:</th>
<th>Health Homes</th>
<th>Medicaid and CHIP Expansion</th>
<th>Money Follows the Person</th>
<th>1915(i) State Plan Amendment</th>
<th>Accountable Care Organizations</th>
<th>Early Childhood Home Visiting Programs</th>
<th>1915(c) Medicaid Waiver (not ACA)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not Being Considered for Children’s Mental Health at This Time</td>
<td>11 22%</td>
<td>14 21%</td>
<td>21 43%</td>
<td>18 38%</td>
<td>21 47%</td>
<td>11 24%</td>
<td>22 46%</td>
</tr>
<tr>
<td>Under Exploration</td>
<td>14 29%</td>
<td>11 22%</td>
<td>14 21%</td>
<td>14 29%</td>
<td>12 27%</td>
<td>7 15%</td>
<td>4 8%</td>
</tr>
<tr>
<td>Plan Under Development</td>
<td>13 26%</td>
<td>6 13%</td>
<td>6 13%</td>
<td>13 26%</td>
<td>13 26%</td>
<td>4 8%</td>
<td>15 32%</td>
</tr>
<tr>
<td>Plan is Developed, Implementation Has Begun</td>
<td>13 26%</td>
<td>21 43%</td>
<td>10 21%</td>
<td>13 26%</td>
<td>22 43%</td>
<td>10 21%</td>
<td>21 43%</td>
</tr>
</tbody>
</table>

Health Insurance Exchange Benefits

- Explored if any of the insurance plans in the state’s Health Insurance Marketplace (Exchange) includes benefits beyond outpatient and inpatient services that address the needs of children and youth with mental health conditions (e.g., home- and community-based services, wraparound, etc.)
- Only 24% of states reported these benefits, but likely to be less
- Examination of qualitative explanations showed that most additional benefits were in Medicaid benefit or waiver programs, not necessarily in Marketplace insurance plans
- Most reported no additional benefits or respondents did not know

Health Homes
- Medicaid option to better serve persons with chronic illnesses, serious mental health conditions, and/or addiction disorders
- Provide primary care and disability-service needs in one location
- Provide care management and coordination for all needed services
- Children with serious mental health conditions comprise an eligible population

Medicaid and CHIP Expansion
- Vehicle for delivering health and behavioral health services to more children
- Enrollment estimated to increase 33% by 2019
- States will be able to expand access to behavioral health services to children, youth, and young adults who are currently uninsured or under-insured

Children’s Mental Health Expertise in Planning

- In 2013, little involvement of children’s mental health experts:
  - Largest group of states reported that individuals with expertise were somewhat included (39%)
  - 25% reported no involvement of children’s mental health experts
  - Substantial involvement in only 4 states
- In 2014, slightly improved:
  - Substantial involvement in 15 states (31%)
  - Largest group now is moderate involvement (33%)
  - Comments indicated primarily partnerships with Medicaid

Money Follows the Person
- Medicaid option that allows states to reduce reliance on institutional care and develop community-based, long-term care alternatives
- Target population includes children and youth with serious emotional disorders who have been in psychiatric hospitals or psychiatric residential treatment facilities (PRTFs)

1915(i) State Plan Amendments
- Amendments of state Medicaid plans that allow states to offer home- and community-based services to more individuals including children with serious emotional disturbances
- Children up to 150% of the poverty level can receive “waiver-type” services such as respite, wraparound facilitation/intensive care management without meeting criteria for institutional care
**ACA Provisions**

**Accountable Care Organizations**
- Structures responsible for providing, managing, and coordinating the total care of a defined population of 5,000 or more
- Created by linking a group of providers within a single entity with shared governance and clinical and financial incentives to provide high-quality health services at reduced cost

**Navigator Programs**
- Assist consumers to apply for, select, and enroll in health plans
- Navigators typically focus on specific under-reached populations but may provide support to all
- Educate and raise awareness

---

**Example: IOWA**

**Pediatric Integrated Health Home**

**Scope**
- Integrated Health Home (IHH) started 7/13 with three-phase implementation plan to become statewide
- Currently serving 2,545 children in 5 Phase 1 counties – 17,000 potentially eligible statewide

**Population**
- Children under age 18 who meet criteria for SED (diagnosable disorder with functional impairment)
- Managed care organization (MCO) determines eligibility (currently Magellan)

**Services**
- Care coordination, family peer support, nursing care manager, health and wellness education, resource direction, family support services, transitional care support, wraparound on individual basis
- Providers have received training in wraparound and SOC practices

---

**Example: RHODE ISLAND**

**CEDARR Health Home**

**Scope**
- Comprehensive Evaluation, Diagnosis, Assessment, Referral, and Re-Evaluation (CEDARR)
- Started 10/1/11, serve 2,600 children at a given time – 3,100 unique users since inception

**Population**
- Children diagnosed with SED or two or more other chronic conditions (e.g., substance use disorder, asthma, diabetes, heart disease)
- Must be Medicaid eligible
- Health home provider determines eligibility

**Services**
- Comprehensive care management, care coordination, health promotion, transitional care, individual and family support services, referral to community and social supports
- All medical and mental health services are provided by others, health home role is to identify needs, refer to providers, and monitor services
- Use family-centered approach similar to wraparound

---

**ACA Provisions**

**Early Childhood Home Visiting Program**
- Grants to 48 states, 5 territories and DC to start Maternal, Infant, and Early Childhood Home Visiting (MECHV) Programs
- Visitors meet with at-risk families in their homes, evaluate the families’ circumstances, and connect families to needed help
- Includes infant and toddler services, parenting education, school-readiness, delinquency prevention, and other services
- Opportunity to add mental health screening and referral pathways to home visiting programs

**1915 (c) Medicaid Waiver (Not ACA)**
- Eligible population must be at-risk for institutional level of care in an inpatient hospital, or ICF/IDD
- Must be Medicaid eligible
- Opportunity to add mental health screening and referral pathways
- States: 1915(c) Waivers covering groups of individuals with mental health needs or developmental disabilities
**Example: OREGON**

**Accountable Care Organization**

**Scope**
- Oregon Coordinated Care Organizations (CCOs) implemented in 2012 by Medicaid agency to replace Medicaid managed care for health and behavioral health carve out – 16 in the state
- Defined as network of all types of health providers (physical, mental health, addictions, and sometimes dental) that work together to serve Medicaid population
- Goals include integrating health and behavioral health care, reducing costs (especially high utilizers), moving toward outcome-based system

**Population**
- At least one of the above, such as receiving 3 or more outpatient services, outpatient therapy with or without medication, school and community treatment, day treatment, therapeutic family or foster care, respite
- Youth who have been served in PRTFs for at least 90 days with a CANS score above 16 in the state
- Care coordination and child and family team for high-need children, fidelity wraparound in some areas, family and youth peer support, flex funds for informal supports

**Performance Measurement**
- Collect encounter, utilization, and cost data, family and youth satisfaction

**Money Follows the Person**

**Example: OREGON**

**Accountable Care Organization, Continued**

**Providers**
- Primarily are private sector Medicaid MCOs, three CCOs are operated by public community mental health centers
- Each CCO has a network of service providers, community mental health centers are part of the provider networks
- Contract with state family organization ensures family support services

**Payment**
- Each CCO has global budget for all covered health and behavioral health services, can receive incentive payments for meeting performance benchmarks
- CCO has flexibility to use funds for wide array of services and supports
- Providers most often paid on FFS basis

**Administration**
- Medicaid agency administers contracts with CCOs, mental health and addictions agency works with Medicaid on contract language, management, and monitoring

**Performance Measurement**
- Collect encounter, utilization, and cost data, family and youth satisfaction
- Data on 33 metrics including 17 metrics used for incentive payments

---

**Example: Montana**

**1915(i) Home and Community Based State Plan Program**

**Scope**
- Effective 1/1/13 – 37 enrolled as of 10/13, with 56 anticipated by end of 2014

**Population**
- Youth ages 5-17 who meet criteria for serious emotional disturbance (up to age 20 if in secondary school), and community resources do not meet needs
- At least two risk factors, such as one admission in last 12 months to a PRTF, outpatient hospital for behavioral health, therapeutic group home, or at risk of PRTF placement without services, OR
- At least one of the above and at least one of the following, such as receiving 3 or more outpatient services, outpatient therapy with or without medication, school and community treatment, day treatment, therapeutic family or foster care, respite
- Any provider can provide auxiliary services

**Services**
- Clinical and therapeutic services, supplemental supportive services, education and support services, family support, high-fidelity wraparound, in-home therapy, transportation, peer-to-peer services, respite, specialized evaluation services, co-occuring services, crisis intervention

**Performance Measurement**
- Money Follows the Person, continued

**Example: Indiana**

**Money Follows the Person, continued**

**Scope**
- Money Follows the Person Psychiatric Residential Treatment Facility Program for Youth (MFP-PRTF)
- Goal to reduce length of stay and recidivism
- Start date was 1/13 – 25 served as of 11/13, 40 anticipated by end of 2014, expected expansion to 100 in 2015

**Population**
- Youth who have been served in PRTFs for at least 90 days with a CANS score of 4, 5, or 6

**Services**
- Intensive community and home-based services are provided based upon system of care philosophy and wraparound principles
- Services based on individualized service plan and may include habilitation, respite, consultative clinical and therapeutic services, flex funds, non-medical transportation, training and support for unpaid caregivers, wraparound facilitation, wraparound technician

**Performance Measurement**
- At the client level, both the Child and Adolescent Needs and Strengths (CANS), Adverse Childhood Experience (ACE), the plan of care are utilized
- At the provider level, a Quality Improvement Strategy Management process is used to monitor performance
Opportunities in Medicaid
Informational Bulletin

Covering Home- and Community-Based Mental Health Services Under Medicaid
Jim Wotring, M.S.W

Issued jointly by the Center for Medicaid and CHIP Services and the Substance Abuse and Mental Health Services Administration in May, 2013
Purpose to assist states to design a benefit that will meet the needs of children, youth, and young adults with significant mental health conditions


Background for Development of Informational Bulletin

Substance Abuse and Mental Health Services Administration’s (SAMHSA) Children’s Mental Health Initiative (CMHI)
Centers for Medicare and Medicaid (CMS) Psychiatric Residential Treatment Facility (PRTF) Waiver Demonstration Program

Benefit Design

Intensive Care Coordination: Wraparound Approach

• Assessment and service planning
• Accessing and arranging for services
• Coordinating multiple services
• Access to crisis services
• Assisting the child and family to meet basic needs
• Advocating for the child and family
• Monitoring progress

Wraparound Approach

• Form of intensive care coordination for children with significant mental health conditions
• Team-based process to develop and implement individualized care plans
• Focuses on all life domains
• Includes clinical interventions and formal and informal supports
• Wraparound “facilitator” is the intensive care coordinator who organizes, convenes, and coordinates the process
• Child and family team for each youth that includes the child, family members, involved providers from child-serving agencies, key members of the child’s formal and informal support network

Components
• Individual and family therapy
• Skills training
• Behavioral interventions

Intensive In-Home Services

• Combination of therapy from licensed clinicians and skills training and support from parapersonalists
• Small caseloads to allow them to work with the child and family intensively
• Therapeutic interventions delivered in homes and other community settings
• Improve youth and family functioning and prevent out-of-home placement in inpatient or residential treatment settings
• Typically delivered by a team
• Gradual transition to other formal and informal services and supports
Regular contact between team and family to
• •
• Goal to address acute mental health needs
Residential crisis stabilization provides
• •
• Crisis stabilization period with transition to
• •
• Provided in the home or any setting where
Prevent unnecessary out-of-home
• •
• Defuse and de-escalate difficult mental health
• •
• Crisis stabilization period with transition to
• •
• Residential crisis stabilization provides
• •
• Goal to address acute mental health needs
• •
• Regular contact between team and family to
Peer Support Services Include:
• •
• Developing and building with formal and informal supports
• •
• Instilling confidence
• •
• Assisting in the development of goals
• •
• Serving as an advocate, mentor, or facilitator for resolution of issues
• •
• Teaching skills necessary to improve coping abilities

Mobile Crisis Response and
Stabilization Services
• •
• Defuse and de-escalate difficult mental health
difficulties: placements, particularly hospitalizations
• •
• Provided in the home or any setting where
crisis is occurring
• •
• Crisis stabilization period with transition to
ongoing services
• •
• Residential crisis stabilization provides
intensive short-term, out-of-home resources to
avert need for psychiatric inpatient treatment
• •
• Goal to address acute mental health needs
and successfully return the child to the family
at earliest possible time with ongoing services
• •
• Regular contact between team and family to
prepare for the child’s return

Peer Services: Parent and Youth Support Services
• •
• Providers of peer support services are family
members or youth with “lived experience”
who have personally faced the challenges of
coping with serious mental health conditions,
either as consumer or caregiver
• •
• Provide support, education, skills training,
and advocacy in ways that are both
accessible and acceptable to families and youth

Respite Services
• •
• Intended to assist children with living in their homes and
community
• •
• Temporarily relieve primary caregivers
• •
• Provide safe and supportive environments on a short-term
basis
• •
• Provided either in the home or in approved out-of-home
settings

Flex Funds: Customized Goods and Services
• •
• Purchase non-recurring set-up expenses (furniture,
bedding, clothing)
• •
• One-time payment of utilities, rent or other expenses
as long as the youth and family demonstrate the ability
to pay future expenses
• •
• Academic coaching, memberships to local girls or boys
clubs, etc.
• •
• Particularly useful when a youth is transitioning from
residential treatment setting to family or independent
living
• •
• Available to individuals participating in various
Medicaid waivers and/or the 1915(i) program

Other Home- and Community-Based Services
• •
• States have also developed service definitions for a
variety of additional home and community-based
services, including:
• •
• Mentoring
• •
• Supported employment for older youth
• •
• Mental health consultation services
• •
• Can be provided through 1915(c) waivers and the
1915(i) program

Trauma-Informed Systems and Evidence-Based Trauma Treatments
• •
• Increased awareness of the impact of trauma
• •
• Children and youth with most challenging mental health
needs often have experienced significant trauma
• •
• States are providing training
and coaching for clinicians in evidence-based practices such as
TF-CBT
• •
• States are exploring new
policies and practices for trauma-informed systems of
care that will be less likely to re-traumatize children and youth

Adverse Childhood Experience
• •
• Study (ACES)
• •
• Reported short and long-term outcomes of childhood
exposure to trauma including
mental health, health and social problems

States are providing training
and coaching for clinicians in evidence-based practices such as
TF-CBT
States are exploring new
policies and practices for trauma-informed systems of
care that will be less likely to re-traumatize children and youth
Medicaid Authorities

1915(a) Targeted Case Management, Rehabilitative Services
1915 (c) Home and Community-Based Services Waiver
1915(b) Managed Care Waiver
1115 Research & Demonstration Waiver
1915(c) State Plan Amendment
Section 2703 Health Homes
Money Follows the Person Rebalancing Demonstration (MFP)
Balancing Incentive Program

Quality Reporting

CHIPRA
HITECH
Affordable Care Act

Importance of Informational Bulletin

For State Medicaid Agencies
For State and Local Mental Health and Substance Abuse Agencies
For Providers
For Family Advocacy Efforts
For Youth and Young Adults
For State and Local Child Welfare Agencies

Flexibility in Medicaid Program
States have significant flexibility in Medicaid program to cover mental health and substance use services for youth with significant mental health conditions

Federal Medicaid Guidance

7/11/13 State Medicaid Director’s Tri-Agency Letter on Trauma-informed Treatment
5/7/13 Informational Bulletin on Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions
3/27/13 Informational Bulletin on Prevention and Early Identification of Mental Health and Substance use Conditions
8/24/12 Informational Bulletin on Resources Strengthening the Management of Psychotropic Medications for Vulnerable Populations
11/21/11 State Medicaid Directors Tri-Agency Letter on Appropriate Use of Psychotropic Medications Among Children in Foster Care