

CHCS

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Resource Paper

Contracting for Coordination of Behavioral Health Services in Privatized Child Welfare and Medicaid Managed Care

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Executive Summary

This Resource Paper explores the issue of coordination between privatized child welfare initiatives and Medicaid managed care systems for the delivery of behavioral health care services for children and families in the child welfare system.

The study described in this Resource Paper involved two objectives: 1) to assess how states' expectations as embodied in their contract documents are actually happening during program implementation; and 2) to identify promising approaches and creative problem-solving techniques for delivery of coordinated behavioral health care services and contracting that can be shared with other stakeholders, such as state child welfare, behavioral health, and Medicaid agencies, managed care organizations, family organizations, and state and Federal policy makers. The paper highlights real world experiences and "lessons learned" for others to use when designing and implementing similar contracts for systems of care.

The study analyzed the content of Medicaid managed care and privatized child welfare contracts that specify requirements for care coordination and interagency collaboration and conducted interviews with key stakeholders to explore how these "paper" requirements were playing out in "practice." Medicaid managed care and privatized child welfare contracts were analyzed and site visits were conducted in El Paso County, Colorado; Franklin County, Ohio; Massachusetts; and Missouri.

Key Findings of the Contract Analysis

- While the child welfare contracts vary in the degrees of scope and specificity of language regarding collaboration and care coordination, all encompass service delivery expectations that acknowledge the importance of having access to an array of behavioral health services for children and their families (including supportive wraparound services) to maximize the likelihood of achieving successful permanent placements within shorter periods of time.
- All of the child welfare and Medicaid contracts cover "standard" behavioral health treatments (e.g., short-term hospitalization, crisis services, outpatient counseling, etc.). Specialized services, such as domestic violence treatment and sexual abuse/offender treatment, were far less likely to be covered in the contracts, particularly the Medicaid contracts.

Key Findings from the Site Visits

- The success of interagency collaborations depends largely on key leadership having the authority, and taking the responsibility, for developing and implementing programs that stress a coordinated approach to holistic care that integrates health, behavioral health, and permanency issues.

- The long-term success of interagency collaborations often depends on their institutional ability to survive the departure of the key leaders responsible for their creation and implementation.
- Multiple categorical funding and reimbursement streams can create treatment “silos” that can hamper care coordination when children are perceived as “belonging” to one funding stream or another.
- Even well-written contracts cannot overcome shortages of providers with child and adolescent treatment expertise that result from low reimbursement rates and/or under-funding and under-staffing of public and private child welfare and behavioral health systems. Effective monitoring and feedback systems must be instituted to continuously ascertain whether contract implementation is being hindered by factors beyond the control of contractual provisions.

Perhaps the most significant finding is that agencies and contractors are encountering difficulties fulfilling their contractual care coordination obligations, largely due to external factors such as the inadequate supply of specialized treatment providers and insufficient case rates and Medicaid reimbursements. While contracts can affect provider supply by virtue of incorporating high or low reimbursement rates, the value of interagency collaborations is that they bring together decision-makers who can formally and informally apprise their colleagues of the intended and unintended effects of their mutual and individual actions on their own programs.

This study serves as a caution to state and local purchasers that contract specifications, while critical, are only an essential first step to ensure effective care coordination for children with behavioral health needs and their families. Ongoing attention must be paid to implementation issues, how contract requirements are playing out in actuality, and to the factors that impede adherence to contract specifications and potentially threaten the achievement of positive outcomes for children and their families.

Introduction

This Resource Paper explores the issue of coordination between privatized child welfare initiatives and Medicaid managed care systems for the delivery of behavioral health care services for children and families in the child welfare system.

- “Behavioral health” includes mental health and substance abuse prevention and treatment services.
- “Privatized child welfare initiatives” refers to the practice of state and/or county child welfare agencies (often in collaboration with other state and/or county government agencies) entering into contractual arrangements using managed care techniques with for-profit and not-for-profit organizations for the purpose of arranging and delivering child placement activities and/or health and behavioral health care services for children and families who have come into the child welfare system. The intent is to increase the efficiency, lower the cost, and streamline such activities while maintaining the goals of safety, permanency, and well-being for children.
- “Medicaid managed care” refers to the practice of state and/or county Medicaid agencies entering into contractual arrangements with managed care organizations for the delivery of health and behavioral health services for persons enrolled in Medicaid.
- The use of managed care techniques, such as risk-based financing tied to performance, prior authorization requirements, and utilization management, is intended to result in lower costs for the public contracting agency and enhanced scope and continuity of care for children and families enrolled in Medicaid and/or involved in the child welfare system.

The study on which this Resource Paper is based examined child welfare privatization and Medicaid managed care contracting specifications related to the coordination of behavioral health services and investigated actual practice in light of these contractual requirements. The study ascertained how state and local purchasers were addressing the issue of coordination in contract language and the extent to which care coordination was occurring once programs were implemented.¹

The Importance of Care Coordination for Children and Families Involved in Child Welfare Systems

The removal of a child from his or her home due to abuse or neglect results in an emotionally charged upheaval that requires multiple systems of care to react and interact to meet the needs of the child and family involved. The goals of this interaction are to

¹ Part of the impetus for this study were findings from the Health Care Reform Tracking Project that there was a reported disconnect between managed care policy intent as reflected in purchasing specifications and what actually was occurring during implementation. See: Pires S., Stroul B., and Armstrong M. *Health Care Reform Tracking Project: 1999 Impact Analysis*. University of South Florida, 2000. Available at: <http://www.fmhi.usf.edu/institute/pubs/bysubject.html>.

protect family and child safety, to assure effective and appropriate efforts toward permanency, and to provide access to a spectrum of health care and other social services that support and enhance well-being. This interaction often is required over a period of many months until a stable permanent placement for the child is achieved, whether it be reunification with birth parents, adoption, guardianship, or another type of permanent placement.

The types of health care services needed by children and families span both the physical and behavioral dimensions, the latter including both mental health and substance abuse prevention and treatment services. A child in the child welfare system, like any other child, has regular physical health needs (e.g., immunizations, well-child check-ups, dentistry), and also may experience acute and/or chronic physical health conditions (e.g., asthma, diabetes) that require both urgent and ongoing treatment. Numerous studies using population samples have documented that children involved in child welfare systems have more severe and complex social and health care needs than children in parent care. These studies have shown, for example, that an estimated 80 percent of children in foster care have at least one chronic medical condition and that an estimated 30-70 percent of them have severe emotional problems. This also intuitively makes sense, given that histories of child abuse and neglect (possibly fueled by domestic violence, deprivation, parental substance abuse, or mental illness), as well as multiple changes in placements within the child welfare system, leave emotional (and sometimes physical) scars that require intensive and sustained treatment services in order to achieve recovery and stability.²

In January 2002, the Urban Institute published the results of the first national quantitative overview of the well-being of children involved with the child welfare system. Using data from the 1997 and 1999 National Survey of America's Families, the authors found that 27 percent of children ages six to 17 involved in child welfare systems had high levels of behavioral and emotional problems, as compared to seven percent of children in parent care. Twenty-eight percent of children involved in child welfare systems had limiting physical, learning, or mental health conditions, as compared to eight percent in parent care. Ten percent of children involved in child welfare systems experienced poor or fair health status, as compared to four percent in parent care.³

² McCarthy J. *Meeting the Health Care Needs of Children in the Foster Care System: Summary of State and Community Efforts, Key Findings*. Georgetown University Child Development Center, 2002. Available at: <http://gucdc.georgetown.edu/foster.html>.

³ Kortenkamp K. and Ehrle J. *The Well-Being of Children Involved with the Child Welfare System: A National Overview*. The Urban Institute. 2002. Available at: <http://newfederalism.urban.org>.

The Impact of Managed Behavioral Health Care and Child Welfare Financing and Service Delivery Changes

In order to adequately meet the complex needs experienced by children and families involved in child welfare systems, a multitude of state and local government agencies have individual and overlapping responsibilities for care of these children and families: child welfare agencies, Medicaid agencies, public assistance agencies, mental health and substance abuse departments, public health departments, juvenile justice agencies, courts, and schools, to name a few. Coordination of service delivery by these systems is essential to ensure that the needs of these children and their families are adequately met. Child welfare agencies and Medicaid agencies are essential components of this nexus of systems, since virtually all children who enter the child welfare system are eligible for Medicaid benefits.⁴

As of 2003, the Administration for Children and Families of the U.S. Department of Health and Human Services (DHHS) has approved 30 Title IV-E demonstration waivers for 21 states to enable child welfare agencies to introduce flexibility into their operations, for example by entering into contractual arrangements with private and public sector organizations to handle the necessary placement and health care duties for children in state custody.⁵ According to mid-2002 data published by the DHHS Centers for Medicare and Medicaid Services, 47 states (the exceptions being Alaska, Mississippi, and Wyoming) currently have implemented Section 1115 or 1915(b) waivers to enroll Medicaid-eligible persons in some form of managed care organization (MCO) for the financing and delivery of their health care, involving 57.6 percent of nearly 40.1 million Medicaid-eligible children and adults as of mid-2002.⁶ In many states, children involved in child welfare systems are both enrolled in Medicaid managed care (or disenrolled from managed care when entering the child welfare system) and also are involved in child welfare privatization initiatives. Both Medicaid managed care and child welfare privatization initiatives have behavioral health service delivery and coordination responsibilities often affecting the same populations of children and families.

The goals of both privatized child welfare initiatives and Medicaid managed care are to streamline access to services, to enhance continuity of care, and to achieve cost savings by introducing financial incentives that reward efficient and effective allocations of

⁴ Only a small percentage of children involved in the child welfare systems are not eligible for Medicaid as a result of having their own resources which places them above a state's asset/income threshold level eligibility test. Eligibility determinations vary by state (e.g., a trust fund).

⁵ Administration for Children and Families, DHHS. Available at: <http://www.acf.dhhs.gov/programs/cb/initiatives/cwwaiver.htm>. See also, "Waiver Watch," a collaborative multi-year project of the American Public Human Services Association and Cornerstone Consulting, Inc. designed to monitor the progress of the Title IV-E waiver program. Available at <http://www.aphsa.org/cornerstone/default.asp>.

⁶ Detailed information regarding Medicaid waivers and enrollment can be found at <http://www.cms.gov>.

resources to meet the needs of the children and families they serve.⁷ Coordination and collaboration between these two systems enable informed decision-making and enhance the likelihood of positive outcomes. Care coordination and system collaboration have been identified by experts as two of 11 critical components of a community-based health care system capable of meeting the physical, mental health, and developmental needs of children in child welfare systems, as shown below:

Critical Components for Meeting the Needs of Children in Foster Care

1. Initial screening and comprehensive assessment.
2. Access to health care services and treatment.
3. Management of health care data and information.
4. Coordination of care.
5. Collaboration among systems.
6. Family participation.
7. Attention to cultural issues.
8. Monitoring and evaluation.
9. Training and education.
10. Funding strategies.
11. Designing managed care to fit the needs of children in the child welfare system.

* **Source:** McCarthy J. *Meeting the Health Care Needs of Children in the Foster Care System: Summary of State and Community Efforts, Key Findings.* Georgetown University Child Development Center, 2002. Available at: <http://gucdc.georgetown.edu/foster.html>.

Description of the Scope and Intent of the Research

This study builds on a 1999 analysis of a sample of purchasing agreements for managed child welfare services conducted for the Substance Abuse and Mental Health Services Administration by the Center for Health Services Research and Policy (CHSRP) of the George Washington University School of Public Health and Health Services. Among other findings, the authors stated that:

[M]any of the most important intersections between Medicaid managed care and the child welfare system (whether or not managed) may develop through informal interactions among contractors themselves. We believe that a systematic study of how multiple contractors serving children in

⁷ For a discussion of the history and relative merits of privatization of social services, see: Kammerman S. and Kahn A. *Privatization, Contracting, and Reform of Child and Family Social Services.* Report prepared for the Finance Project, 1998. Available at <http://www.financeproject.org>. See also, Winston P. and McConnell S. *Privatization of Welfare Services: A Review of the Literature.* Prepared for the DHHS Office of the Assistant Secretary for Planning and Evaluation by Mathematica Policy Research, Inc., 2002. Available at: <http://aspe.hhs.gov/hsp/privatization02/>.

the child welfare system resolve the coverage, treatment, data exchange, network, and other issues that inevitably arise for these children would add immeasurably to the strength of future collaborative efforts among agencies.⁸

Following this recommendation, we undertook this study to examine how contracting for child welfare and behavioral health care services facilitates cross-system collaboration and service coordination, not only as evidenced in contract documents themselves, but also as reported by stakeholders in the field. States that have embarked on these efforts have created contractual relationships with various entities to provide these services.

This study involved two closely-linked objectives: 1) to assess how states' expectations as embodied in their contract documents are actually happening during program implementation; and 2) to identify promising approaches and creative problem-solving techniques for delivery of coordinated behavioral health care services and contracting that can be shared with other stakeholders, such as state child welfare, behavioral health, and Medicaid agencies, managed care organizations, family organizations, and state and Federal policy makers. This is not a comparative study aimed at characterizing one system as better or worse than another. Rather, our goal in this paper is to highlight the real world experiences and "lessons learned" that others may draw upon when designing and implementing similar contracts for systems of care.

Research Methods

We conducted analyses of care coordination and interagency collaboration requirements in a sample of 10 state and/or county contracts for privatized child welfare initiatives and the 10 Medicaid managed care contracts for these same states. These contracts describe states' visions of how cross-system collaboration should occur and how behavioral health services for children and families in child welfare systems are to be coordinated. They are essential legal documents that define the nature and scope of service benefit coverage and expectations of care coordination across systems.

There are, however, factors that are beyond the reach of contracts that affect contractors' abilities to meet contract requirements to provide, and children and families' ability to access, covered services. For example, the availability of qualified providers and their willingness to treat children and families involved in the child welfare system, inter- and intra-organizational turf issues, changing governmental policy and budgetary priorities, turnover in personnel responsible for programmatic decision-making and service delivery, and local economic conditions, among others, have profound effects on whether agencies are able to provide the social, health, and behavioral health care services articulated in the contracts. Thus, this review of contract provisions related to care coordination and collaboration is supplemented by four case studies that included on-site interviews with key stakeholders in child welfare, Medicaid,

⁸ Wehr E., Rosenbaum S., Shaw K. and Valencia R. *Managing Child Welfare: An Analysis of Contracts for Child Welfare Service Systems*. DHHS Publication No. (SMA)99-3348, 1999. Available at <http://www.samhsa.gov>.

and behavioral health care sectors to illustrate how contractual expectations are playing out in practice.⁹

Analysis of Contract Language Regarding Collaboration and Care Coordination Requirements

Table 1 provides an overview of how the selected 1999-2000 privatized child welfare and Medicaid managed care contracts address interagency collaboration, care coordination, and delivery of specific physical and behavioral health care services. Appendix A provides contract language excerpts for the three domains that are the focus of this report: interagency collaboration, enrollment and eligibility terms, and care coordination and case management duties.

Domain	El Paso County, Colorado		Massachusetts		Missouri		Franklin County, Ohio	
	Child Welfare	State Medi-caid Managed Care	Child Welfare	State Medi-caid Managed Care*	Child Welfare	State Medi-caid Managed Care	Child Welfare	State Medi-caid Managed Care
Interagency collaboration	■		■	■	■	■	■	■
Enrollment & eligibility terms	■	■	■	■	■	■	■	■
Care coordination, case management	■	■	■	■	■	■	■	■
<i>Medical services</i>								
EPSDT	■	■				■		■
Medication management	■		■	■				
Dental services	■		■			■		■

⁹ To protect the privacy of interviewees, no names of family members were taken at the time of the interviews, full informed consent procedures were followed, and only written notes were taken of their focus group meetings. All interviews with officials and subject matter experts were treated as confidential, informed consent procedures were followed, and only written notes were taken. No individual information that personally identifies an individual by name is published in this paper. This research project was reviewed for human subject protections by the George Washington University Medical Center Institutional Review Board and received approval on August 13, 2002 (IRB# U070202ER).

Domain	El Paso County, Colorado		Massachusetts		Missouri		Franklin County, Ohio	
	Child Welfare	State Medi-caid Managed Care	Child Welfare	State Medi-caid Managed Care*	Child Welfare	State Medi-caid Managed Care	Child Welfare	State Medi-caid Managed Care
<i>Behavioral health services</i>								
Individual therapy	■	■	■	■	■		■	■
Group therapy	■	■	■	■	■		■	■
Family therapy	■		■	■	■		■	
Mental health and substance abuse screening and assessment	■	■	■	■	■	■	■	■
Crisis care			■	■	■	■	■	■
Detoxification treatment		■		■		■		■
Domestic violence services	■							
Outpatient counseling	■	■	■	■	■	■	■	■
Inpatient mental health	■	■		■		■		■
Inpatient substance abuse	■			■		■		■
Partial day treatment	■			■	■		■	■
Short-term residential				■	■	■	■	■
Respite care	■				■		■	
Sexual abuse treatment			■		■	■		
Sexual offender treatment	■		■		■			
Wraparound services	■	■	■	■	■	■	■	■

* The Massachusetts contract used for this analysis was its Medicaid behavioral health carve-out contract. Other health services, e.g., EPSDT and dental care, are referenced in its Medicaid general services contract.

It should be noted that the absence of an indicator in a cell in Table 1 does not necessarily mean that a particular health care service is not included in a benefit package. A service may fall within the scope of a broadly defined benefit without being specifically mentioned, depending on how the benefit is described and interpreted by the contracting agency. Contracts may, for example, stipulate that “any and all necessary

mental health and substance abuse services” be provided without an itemization of individual services such as individual or group therapy or partial day treatment. To the extent, however, that there are mentions of specific service obligations, this can serve to indicate the levels of importance and detail that contract drafters wish to convey in regards to contractors’ duties.¹⁰

Discussion of Contract Domains Regarding Collaboration and Care Coordination

Interagency Collaboration

All contracts, with the exception of Colorado’s Medicaid managed care contract, stipulated some form of organizational collaboration, including interagency agreements and requirements for contractors to collaborate with a variety of state and local government agencies with health and/or social services responsibilities for persons involved in the child welfare system. The Medicaid contracts tended to have fewer child welfare interagency requirements than the child welfare contracts. State Medicaid agencies serve great numbers of beneficiaries who are not part of the child welfare system and in many states, Medicaid managed care programs operate in only selected counties/localities. In addition, whether a contracting agency includes requirements for interagency collaboration may depend on the structure and organization of the agency itself. In El Paso County, Colorado, for example, the Department of Human Services comprises several agencies under the purview of a single director (e.g., child welfare, county Medicaid, public assistance, food stamps, etc.).¹¹ State and county purchasers may view this centralized jurisdictional authority as mitigating the need to require interagency collaboration such as would occur in states or counties where these functions are spread across different agencies with separate regulatory and financial authorities.

The Massachusetts child welfare contract includes detailed requirements for contractors to consult and collaborate with the Department of Social Services and its Administrative Services Organization, ValueOptions, including further development and refinement of the Commonworks system (see “Summaries of Site Visits” for a description of Commonworks).

The Lead Agency shall designate a representative to act as liaison with the Department of Social Services and *ValueOptions/Commonworks*. The representative shall be responsible for:

1. Representing the Lead Agency on all matters pertaining to the Lead Agency Principal Contract and this Agreement. The representative shall be authorized

¹⁰ Contracting agencies that utilize generally defined service requirements are at great risk, however, of there being disagreements with contractors regarding exactly which services are to be delivered within the payment rate. While overly specific contract requirements may inadvertently limit clients to too narrow a range of services, open-ended general definitions are not recommended.

¹¹ El Paso County, Colorado Department of Human Services home page. Available at: <http://dhs.elpasoco.com/humansvc/default.asp>.

- and empowered to represent the Lead Agency regarding all aspects of the Principal Contract;
2. Monitoring the Lead Agency's compliance with the terms of the Lead Agency Principal Contract;
 3. Receiving and responding to all inquiries and requests made by the Department or *ValueOptions/Commonworks* in the timeframes and format specified by them per applicable contract requirements, or in the case of ad hoc requests, within a reasonable timeframe;
 4. Meeting with representatives of the Department and *ValueOptions/Commonworks* on a periodic or as-needed basis to resolve issues which may arise;
 5. Working collaboratively with the Department and *ValueOptions/Commonworks* in the further development and refinement of the Commonworks system;
 6. Coordinating requests from the Department and *ValueOptions/Commonworks* to assure that Lead Agency staff with the required expertise are available to participate in Department and *ValueOptions/Commonworks* activities and respond to reasonable requests by the Department and *ValueOptions/Commonworks* which may include, but not be limited to, requests to participate in training as well as requests to meet with the state agency representatives or other parties;
 7. Making best efforts to resolve any issues identified by the Lead Agency, the Department or *ValueOptions/Commonworks* that may arise in connection with the Lead Agency Principal Contract;
 8. Meeting with the Department at the time and place requested by the Department, if the Department determines that the Lead Agency is not in compliance with the requirements of the Principal Contract;
 9. Ensuring that all reports, contracts, subcontracts, agreements and any other documents subject to the Department's prior review and approval are provided to the Department no less than 10 business days prior to execution or implementation, as applicable;
 10. Unless otherwise provided in the Contract or by the agreement of the Department, the Lead Agency shall submit to the Department any and all documents, reports, and other materials requested by the Department that fall within the scope of the Lead Agency Principal Contract within 10 business days of any such requests.

The Missouri child welfare contract requires contractors to have documented working agreements with other human services agencies, including the Divisions of Youth Services, Psychiatric Services, Mental Retardation and Developmental Disabilities, and Alcohol and Drug Abuse, although the content of these working agreements is not described. This requirement was derived from the establishment of Missouri's Interdepartmental Initiative, a multi-agency collaborative effort that presently includes the Department of Social Services and the Department of Medical Assistance (Medicaid) (see "Summaries of Site Visits" for a full description).

The Franklin County, Ohio Children Services Managed Care Project was based on the Franklin County Children Services (FCCS) agency agreement with the county Alcohol, Drug Abuse, and Mental Health (ADAMH) Board and was intended to facilitate better

access to behavioral health services by children and families in the child welfare system. The agreement focused on payment, enrollment, and access to services issues. Although the agreement is no longer in effect, it represented an effort to cross organizational boundaries between two county agencies that operate under different authorities but that serve many of the same children and families who have extensive health and social services needs.

Contractual requirements for inter-organizational collaboration and consultation varied across sites and were highly dependent on the inherent structure of government agencies and authorities themselves. Such requirements serve to document the policy drivers that underpin and provide administrative support for other contractual requirements for coordinated service delivery (e.g., integrated case management that includes development of treatment and placement plans with input from other health and social services case managers).¹²

Enrollment and Eligibility Terms

As previously mentioned, virtually all children entering the child welfare system are eligible for Medicaid benefits. In some states, if they were enrolled in a Medicaid health plan prior to coming into state custody, they are disenrolled from the health plan and receive their Medicaid benefits on a fee-for-service basis. This is the case in Ohio. In Missouri, children entering the child welfare system continue to receive managed physical health care services from their Medicaid health plan, however all behavioral health care services are managed and paid for by the contracted child placement agency within its case rate. In El Paso County, Colorado, and Massachusetts, most children in state custody are enrolled in a managed behavioral health organization (MBHO) that also serves children enrolled in Medicaid who are in parental custody. Coordination of enrollment and eligibility information across programs is vital for ensuring that case managers and providers access the appropriate funding streams for payment of services and refer to the relevant network of providers.

The El Paso County, Colorado child welfare contract requires that children who do not have an established relationship with a physician be enrolled in a community health center (CHC) with related requirements for coordination with the Medicaid Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) Program. The Franklin County, Ohio FCCS agreement with the Alcohol, Drug Addiction, and Mental Health (ADAMH) Board contains specific descriptions of eligibility, enrollment, and tracking requirements for both children and their families:

Persons eligible for services under this AGREEMENT are children and families with open cases, including Family Preservation cases, with CHILDREN SERVICES and assessed by the ADAMH system as in need of behavioral health

¹² For more information regarding the need for inter-organizational collaboration in child- and family-serving systems, see: Pires S. *Health Care Reform Tracking Project: Promising Approaches for Behavioral Health Services to Child and Adolescents and Their Families in Managed Care Systems*. University of South Florida, 2002. Available at: <http://www.fmbi.usf.edu/institute/pubs/bysubject.html>.

care services. All persons enrolled in the ADAMH system through this process will be eligible to receive any of the behavioral health care services currently available and contracted for in the ADAMH system of care, and shall be given the same priority for provision of services as those persons ADAMH is statutorily mandated to serve. [...] The ADAMH Board agrees to enroll and track all eligible children and families in its data system for both the Partnership and the Children Services Managed Care Project.

The Massachusetts Commonworks contract, while it does not guarantee a specific level of referrals to its contractors, does state that, if a contractor has available capacity, a child referred to that contractor will be accepted. There also is an appeal process if a contractor does not believe that a referral is appropriate, with the final decision vested in the Department of Social Services (DSS). The contract also requires contractors to notify DSS of any change in a child's placement to ensure that it has the most current information about a child's location in the child welfare system:

Client Referrals. This Subcontract does not guarantee the Subcontractor of any level of referrals. However, subject to the availability of space in light of the limits of capacity specified in Exhibit A, the Subcontractor shall accept for service all Referred Clients. [...] The Lead Agency will place a youth within two (2) weeks of receipt of appropriate referral and/ or appropriate referral packet. The Lead Agency may appeal the appropriateness of a referral by written notification to the Department's appropriate Regional Office. If that appeal is not successful, the Lead Agency may appeal to the Department's Director of Residential and Adolescent Services indicating that the referral, in their opinion, does not meet the criteria set forth in the Lead Agency Principal Contract. The decision of the Department's Director of Residential and Adolescent Services (or designee) will be binding.

The Department is interested in assuring that current information on the placement address for all Commonworks clients is available in Family Net. The following procedures have been established to ensure that a client's placement address is readily available on Family Net to Department staff. The Lead Agency will complete a *Commonworks Enrollment and Change of Client Location Form* and fax the completed form by close of the business day to *ValueOptions/* Commonworks whenever:

- a) a client has moved from one placement address to another.
- b) a client has been discharged from placement.
- c) a client is AWOL for more than one day.
- d) a client has been hospitalized for medical or psychiatric treatment.

Care Coordination and Case Management

This section examines requirements for care coordination at the level of delivery of individual services. All four child welfare contracts include care management and treatment planning duties that extend beyond child welfare case management activities that focus on child safety and permanency issues. The child welfare agency contracts require that care managers adopt a collaborative approach to treatment and permanency

planning and monitoring by soliciting and including input from a variety of stakeholders, including family members, behavioral health care managers and providers, school districts, courts, child care agencies, and community-based organizations.

The Massachusetts contract assigns primary responsibility for case coordination and treatment planning to its contractors, however specific roles and responsibilities also are delineated for DSS and the Administrative Services Organization (ASO). The contract requires that contractors hold all potential subcontractors to the same required care coordination and treatment planning conditions. A specific clinical protocols manual is referenced as the standard to be utilized in coordination and planning, as well as standards for reporting and information-sharing to monitor progress. The following excerpt shows the contractors' care coordination duties and responsibilities, including requirements for any subcontracted providers and caseload levels for care coordinators and education coordinators:

Active and focused treatment planning assists the client in achieving his/her permanent goal as quickly as possible. Treatment planning and review of client progress is a primary responsibility of the Lead Agency in collaboration with their network providers. The case coordination and treatment planning process developed for Commonworks is the result of significant collaborative effort by *ValueOptions/Commonworks*, the Lead Agencies, network providers, and the Department. The following expectations supplement those outlined in the Commonworks Adolescent Services Program RFP forming a part of the Lead Agency Principal Contract, providing greater detail on responsibilities for Commonworks treatment planning and service provision.

[...]

Lead Agencies

1. The Lead Agency is responsible for compliance with all Commonworks policies and procedures related to case management and treatment planning specified in the *Commonworks Clinical Protocols Manual*.
2. The Lead Agency, with the assistance of *ValueOptions/Commonworks* is responsible for ensuring that all providers with which it subcontracts are trained on applicable policies and procedures related to treatment planning, case management and service provision within Commonworks, and kept apprised of any changes therein.
3. The Lead Agency is responsible for participating in all required case conferences as delineated in the Commonworks Treatment Planning Manuals for Placement and Aftercare.
4. The Lead Agency is responsible for updating the Department on the treatment plans and progress toward achievement of treatment goals for each client within their Network.
5. The Lead Agency is responsible for ensuring that **all** Commonworks Service Delivery Reports and Treatment Planning are completed by subcontractors in a timely manner.
6. The Lead Agency is responsible for ensuring that appropriate Treatment Planning forms are provided to subcontractors during times of transition. This includes the Initial Referral Plan completed by the Lead Agency in new Commonworks referrals as well as the Discharge Plan Summary

completed by the client's last Commonworks placement subcontractor and forwarded by the Lead Agency to the next placement subcontractor or aftercare subcontractor.

7. The Lead Agency is responsible for reviewing client Treatment Plans and Quarterly Progress Reviews to ensure that the needs of the client are being addressed and that continued progress toward treatment planning goals is achieved. Lead Agency review of client treatment plans and progress is documented on the *Lead Agency Review Form*.
8. The Lead Agency is responsible for implementing the Commonworks Level of Care criteria as set forth in the implementation plan, and for ensuring that subcontractors comply with their responsibilities therein.
9. The Lead Agency is responsible for ensuring that all services outlined in the client's Treatment Plan are available to the client.
10. The Lead Agency is responsible for coordination of appropriate educational placements in the least restrictive environment to meet the client's needs.
11. The Lead Agency is responsible for ensuring that Case Management Forms (*including all Initial Referral Plan, Treatment Plan Summaries, Treatment Progress Reviews, Discharge Plans, Lead Agency Review Forms and Service Delivery Report - Part 2*) are entered into the Commonworks Client Information System during both placement and aftercare in a timely manner.
12. The Lead Agency, with the assistance of *ValueOptions/Commonworks* are responsible for ensuring that their data entry staff are trained on Commonworks policies and procedures and on entering client data into the Commonworks Client Information System, and for providing ongoing supervision on the same.

[...]

F. Care Coordination and Utilization Management

Coordinated care and effective management of utilization support timely achievement of client outcomes and efficient use of Commonworks' resources. Working in collaboration with the Department's Area and Regional Offices, the Lead Agency has primary responsibility for ensuring that Commonworks' resources are used creatively and flexibly to enhance the services received by clients and to maximize the number of clients who may be served.

1. The Lead Agency is responsible for making decisions on level of care to meet the educational, behavioral and social needs of clients in the least restrictive setting.
2. The Lead Agency is responsible for ensuring the continuity of client care to facilitate smooth transitions between levels of placement and into Aftercare services.
3. DSS Regional Clinical Review Teams will be the final arbiters should disagreements between the Lead Agency and the Department's Area Office occur in regard to decisions on level of placement services or discharge from placement services.
4. *ValueOptions/Commonworks* is responsible for reviewing utilization management with the Lead Agencies as a component of the Quarterly Quality Improvement Planning meetings.

5. *ValueOptions/Commonworks* is responsible for providing training opportunities for providers and Lead Agencies on effective utilization management.
6. *ValueOptions/Commonworks* is responsible for analyzing and reporting on service utilization data to support enhanced utilization management by the Lead Agencies. (Commonworks Service Program, FY 2002 Addendum).

[...]

Care Coordination.

Resources for Care Coordination are included in the administrative line of the Lead Agency contract. Care Coordinators are funded in FY'03 for an annual salary of [\$xx,xxx]. Care Coordination is based on 50 pro-rated consumers in placement to 1 Care Coordinator. The Lead Agency will receive a check based on the PV line amount for Care Coordination from the SMO after DSS deposits funds into the DSRA.

Education Coordination.

Resources for Education Coordination are included in the administrative line of the Lead Agency contract. Care Coordinators are funded in FY'03 for an annual salary of [\$xx,xxx.] Education Coordination is based on 90 pro-rated consumers in placement to 1 Education Coordinator. The Lead Agency will receive a check based on the PV line amount for Care Coordination from the SMO after DSS deposits funds into the DSRA. (Fiscal Year 2003 Financial Management Manual, July 2002).

The El Paso County, Colorado child welfare contract specifies that contractors employ case management techniques that include concurrent planning and service delivery with oversight conducted by the DHS case manager assigned to each child. As with the Massachusetts contract, El Paso County contractors are assigned primary responsibility for care coordination with requirements to communicate on a regular and ad hoc basis with the DHS case manager. The contract also requires that a copy of a child's medical and dental records be maintained in his or her case file maintained by the contractor:

Concurrent planning and service delivery must be a normal part of case management of all cases because of the shortened timelines for permanency. Concurrent planning must consider kinship placement as well as potential adoption by the foster family. [...] The Department will maintain staff skilled in child welfare services who will monitor the CONTRACTS and cases assigned to the various Contractors. The case monitor will meet formally with the CONTRACTOR at least monthly to resolve any issues between them. Every case will be reviewed quarterly. The monitor will secure required Department approvals within 5 working days of the request. [...] The Department and Contractor will work collaboratively on the overall process, but the Contractor will assume primary responsibility for coordinating functions and for informing the Department in a timely manner as to whether data is being adequately received for processing. Data Presentation will occur not less than at 6-month intervals. [...] The child's medical and dental records will be maintained in the child's file. All required medical and dental services will be acquired for the child and documented in the child's health passport.

Missouri's child welfare contract expands on the traditional concept of "case management" by referring to enhanced integrated activities as "care management." Contractors are designated as Care Management Organizations (CMOs). The contract provides the following definition, and conditions discharge upon successful performance in achieving plan of care objectives:

Care Management Process: The CMO shall design and implement a comprehensive, individualized care management process. Under a 'No eject, no reject' policy, success for this initiative is highly dependent upon care management that assumes financial and operational control of a Plan of Care and actively works with all available resources to maintain household stability and anchors the child and family to the community. 'No reject' is defined to mean any child referred by the IT [Interagency Team] must be accepted for treatment. 'No eject' is defined to mean a child shall not be disenrolled from care until all Plan of Care objectives are met and the Interagency Team has approved disenrollment.

The Franklin County, Ohio child welfare contract specifies that case management duties encompass assisting clients in obtaining coordinated services, including traditional behavioral health care treatment modalities as well as a variety of wraparound and other supportive services.

Case management includes but is not limited to: activities related to a child and/or his/her family assessing risk to the child and the results of care or services; supporting the management of care or service referral to or arranging for care or services; planning or supervising care or services; supporting access to care of services; assessing results of care or services; placement of a child; preparation or and participation in judicial determinations; preparing custody petitions; assisting with voluntary placement agreements; and preparing for the safe return of a child to the family or for permanent placement of a child. [...] Direct Services: Services received by children and their families and services received by foster parents, including, but not limited to: case management, individual, group or family counseling, mentoring, arrangement for and transportation to and from school and physical and medical treatment, recreational activities, day care, respite, foster parent support services, crisis stabilization, in and out of home care, and transportation.

Responsibility for coordinating health care that spans both physical and behavioral health needs is addressed in the Medicaid managed care contracts. This is typically accomplished by requiring contractors to impose communication and collaboration requirements upon their contracted providers to avoid potential gaps between primary and specialty care. The Ohio Medicaid managed care contract describes the roles and responsibilities of primary care providers, specialists, case managers, and referral mechanisms. Enrollment of children in the child welfare system in a Medicaid health plan in Ohio is optional and these care management provisions would not apply in the Medicaid fee-for-service delivery sector. Thus, the coordination of behavioral health care services for children and families involved in the Franklin County, Ohio child

welfare system is primarily the responsibility of the contracting child placement agency case managers.

Summary of Contracts Analysis

- While the child welfare contracts vary in the degrees of scope and specificity of language regarding collaboration and care coordination, all encompass service delivery expectations that acknowledge the importance of having access to an array of behavioral health services for children and their families to maximize the likelihood of achieving successful permanent placements within shorter periods of time. The Massachusetts contracts specifically and clearly delineate the care coordination roles and duties of DSS, its ASO, and its contractors and subcontractors, including adherence to specific clinical protocols for care management. The contracts also elucidate the policy and service rationales for coordinated care management, thus giving contractors valuable insights into agency objectives. Explaining why a particular contractual requirement is included underscores its importance more effectively than simply stating the requirement alone.
- Although the detailed contract language regarding delivery of individual service components is not provided in this report, a review of Table 1 reveals that all of the child welfare and Medicaid contracts cover “standard” behavioral health treatments, (e.g., short-term hospitalization, crisis services, outpatient counseling, etc.). Specialized services, such as domestic violence treatment and sexual abuse/offender treatment, were far less likely to be covered in the contracts, particularly the Medicaid contracts. This is probably due to the high cost of such services and the impact they would have on the case rates paid to child placement agency contractors, the lack of Medicaid reimbursement for such care, and the lack of specialist providers qualified to deliver such care.
- All contracts provide some types of wraparound services, although the term “wraparound” can have different meanings in child welfare and Medicaid. In the latter case, the term has generally been used by state Medicaid agencies to refer to translation, interpretation, transportation, other “enabling” services that assist clients in accessing care, as well as the need to deliver services in culturally competent ways. In the child welfare and child mental health contexts, “wraparound” is understood as a process used to coordinate a variety of services, including traditional and non-traditional supportive treatment services, (e.g., mentoring, parent education, anger management, school aides, etc.). The child welfare contracts’ recognition of the importance of these services is notable since it reflects an awareness of how contract requirements change practice patterns by expanding services beyond traditional clinically-based treatments.
- Only the El Paso, Colorado child welfare contract and the Massachusetts Commonworks and Medicaid contracts contained references to medication

management. This is of particular concern, since children who are receiving psychotropic drugs to treat behavioral disorders and conditions should be monitored on a regular basis. These drugs can have serious physical side effects (e.g., liver damage), and there can be potential adverse interactions for children who are on other medications to treat chronic physical conditions (including interactions between different psychotropics themselves). Effective medication management results from ongoing communication between primary care physicians and specialist behavioral health providers, and the overall absence of this type of coordination in the contracts signals a need to focus future improvements in contracting for coordinated care for children and families involved in child welfare systems.

Contracts embody a purchasing agency's expectations of the mutual and discrete service delivery and care coordination obligations that contractors assume when awarded a contract. The extent to which expectations translate into reality is dependent on many factors that can serve to facilitate or impede actual care delivery and coordination. The purpose of the site visits, described in the next section, was to learn from stakeholders about how contractual obligations translate from paper to practice.

Summaries of Site Visits

Site: El Paso County, Colorado (Colorado Springs), November 4 – 5, 2002

Background and Context

The El Paso County child welfare agency is located in the county Department of Human Services (DHS), which also includes offices of economic assistance (Temporary Assistance for Needy Families (TANF), food stamps, welfare, etc.), Medicaid, senior services, and child care. Maternal and child health, EPSDT, and behavioral health services are located in the county Department of Health and the Environment. Medicaid in Colorado is state-administered but eligibility determinations are handled by counties. El Paso County, like other Colorado counties, receives a capped child welfare allocation from the state and is given increased flexibility to spend funds, negotiate rates, services, and outcomes.¹³ The Medicaid managed care contract for behavioral health services is held by Colorado Access, which has a managed behavioral health subsidiary, Access Behavioral Care Pikes Peak (ABC). ABC was selected by the state to serve as the Mental Health Assessment and Services Agency (MHASA) responsible for purchasing all Medicaid-covered mental health services for Medicaid eligible county residents. DHS has negotiated an agreement with ABC to provide behavioral health services to children in family foster care or group care (financed by transferring all dollars earmarked for therapeutic services from the rates paid to contracted child placement agencies (CPAs) to the MHASA) so that provision of behavioral health services is clearly lodged with

¹³ For more information regarding Colorado's county child welfare allocation system, see: Beveridge J. "Optimization Model for Funding Child Welfare Services in Colorado." 2002. Contact: Office of Child and Family Services, Colorado State Department of Human Services, 1575 Sherman Street, Denver, CO 80203.

one entity. The major public provider of community behavioral health services is the Pikes Peak Mental Health Center, which has a MHASA provider contract with ABC. When a child is being considered for foster care, a therapist at Pikes Peak, acting as a care coordinator, performs a mental health needs assessment that is used to determine the appropriateness of the placement. The Pikes Peak mental health care coordinator visits the county's contracted CPAs on a weekly basis and coordinates care with DHS, ABC, providers, and family members, including participation in the development of individualized family service plans.

The DHS vision and mission statements reflect a belief that child welfare and economic assistance are linked anti-poverty efforts that must be streamlined and coordinated to enhance access to services for the support and preservation of families and the prevention of abuse and neglect of children. The Child Welfare Division operates with a philosophy that combines child safety with a goal of permanency and well-being. Child welfare privatization efforts were greatly expanded in the county in 1997-98 following the 1996 national welfare reform efforts that "de-linked" receipt of cash assistance and Medicaid eligibility. The goals of the privatization efforts are framed within an overarching philosophy of safety, well-being, and permanency: 1) reductions in placements and lengths of stay in group residential treatment centers and inpatient hospital settings; 2) preferred use of regular and specialized foster care homes as opposed to group residential placements; and 3) expansion and enhancement of intensive family preservation prevention, reunification, and intervention services. Use of community-based wraparound services by traditional and non-traditional providers is widespread as a cost-efficient and effective alternative to standard clinical interventions. These goals are supported by interagency partner agreements with the Mental Health Division, Medicaid managed care organizations, the Division of Youth Services, Public Health, and school systems, each of which may be providing services at one time or another to children and families in the child welfare system.

The county has entered into contracts with 12 CPAs that are responsible for arranging and providing all necessary placement and behavioral health services for children and families assigned to their care. By law, supervisory casework management duties reside in the county Child Welfare Division since it is the legal custodian of a child until permanency is achieved (i.e., as long as a case is deemed open). In their contracts, CPAs are expected to achieve the DHS goals by providing timely assessments of child and family needs and provision of appropriately coordinated types and levels of care services focused on individual child and family needs. CPAs may provide these services in-house or may enter into individual provider agreements, depending on the size of the CPA and the services needed.

There are two types of CPAs contracting with the county. "Option A" agencies are those that have integrated therapeutic services in their programs (credentialed by ABC) and also are given the option to enter into provider agreement with ABC to directly provide therapeutic services for the children in their care. Option A agencies accept as full reimbursement a negotiated case rate developed jointly by DHS, the CPAs, and

ABC. The county currently has three contracted Option A CPAs. “Option B” agencies are those that either do not meet the requirements to be an Option A CPA or do not elect to use that option. ABC purchases treatment services from network providers for children and families in Option B CPAs. In short, mental health services are provided by Pikes Peak Mental Health Center, Option A CPAs, and ABC’s private provider network. DHS and Pikes Peak Mental Health Center provide program management. ABC provides utilization management, provider credentialing, claims processing, and management information services (which track service utilization, service costs, and outcomes.)¹⁴ There are, to varying degrees of specificity, care coordination requirements in the CPA contracts, Medicaid and CPA provider contracts, and DHS inter-agency agreements and a variety of formal and informal mechanisms to facilitate coordination and to monitor performance.

Significant Findings

Despite recent financial woes in county government (departmental budget reductions), DHS has succeeded in keeping together the interagency agreements that form the foundation for delivery of coordinated child placement and behavioral health services by CPAs and Medicaid managed care. Numerous interviewees credited the vision and dedication of the DHS Director to this form of integrated social services delivery. This is an example of the importance of personal and professional leadership vested in a government official who has the authority and takes on the responsibility to shepherd this type of program through conception to implementation. Interviewees cited his ability to create platforms that bridge agency turf and budgetary boundaries and to communicate the need for cooperation to enable holistic and creative approaches to family-centered care. This vision also is supported in the higher echelons of county and state government.

Interviewees noted that care coordination has vastly improved through the managed child welfare and Medicaid initiatives. DHS has a designated CPA Care Coordinator who functions as the mental health liaison with the CPAs. This coordinator also maintains a strong relationship with the MHASA staff. Each CPA has a designated care coordinator who works closely with their own and DHS caseworkers as well as ABC’s and DHS’ care coordinators (which requires that primary care providers communicate with any specialists involved in a child’s care). With a few exceptions, families (both birth and foster) are actively engaged in the creation and management of treatment plans for children. Regular team meetings are held for Family Service Plans, which include discussion of physical and mental health issues as a unified treatment plan. Process and outcomes performance measures that cover placement and health goals are tracked electronically, although interviewees noted there is a need to improve compatibility of reporting systems between entities with change to ABC.

¹⁴ “El Paso County Child Placement Agency Project – Program Description.” For more information, contact El Paso County Department of Human Services, Colorado Springs, CO.

Option A CPAs, their providers, and families enrolled with them reported that care coordination was more seamless and easier to accomplish than did Option B CPAs. This is partly due to the inherent structure of Option A CPAs whose larger size permits use of in-house behavioral health staff. Option B families typically use the Pikes Peak Mental Health Center, and they reported difficulties accessing services, particularly long waits for therapist appointments and inadequate crisis services. One Option B foster parent reported she was not given a list of Medicaid providers participating in the plan and also was unable to access in-home services. Another foster parent reported not being consulted in the development or management of her child's treatment plan and felt it was created and mailed to her by the CPA after the fact. DHS is initiating the Casey Foundation Family-to-Family program, and interviewees expressed satisfaction with their involvement in the development of it, as well as their desire to form a viable Foster Parent Association to share information and learning about their experiences coordinating care with each other. Parents can call the CPA and request ad hoc staffing meetings, which typically involves them, caseworkers, home supervisors, probation officers, guardians ad litem, court appointed special advocates, and possibly school representatives.

Some Medicaid-funded health services that interviewees noted were in short supply or difficult to access included:

- Dental services.
- Treatment for children with developmental delays.
- Respite care.
- Medication management and psychiatric services.
- Treatment for attachment disorders.
- Sexual offender treatment.
- Mobile mental health crisis response services.
- Ambulance transport.
- Outpatient substance abuse treatment services (this is not covered by Colorado Medicaid which covers only short-term inpatient substance abuse detoxification).

The county does provide treatment services for parents with substance abuse problems involved with the child welfare system using its DirectLink program, operated by Savio House, a private nonprofit agency. The program engages in early intervention services to treat parental addiction disorders to avoid out-of-home placement of a child or to facilitate reunification with a child who has been removed from his or her home.

Specific recommendations from interviewees for other states and communities regarding activities to ensure successful collaboration and care coordination include:

- Create formal and informal linkages between government agencies that have child care responsibilities.

- Encourage pooling of funding for programs – categorical funding stream silos can exacerbate treatment silos (thus inhibiting care coordination across systems).
- Communicate high-level agency commitment to care coordination through to the line staff responsible for treatment and case management.
- Integrate case management for placement issues with care management for health treatment issues into a unified holistic planning approach.
- Give private sector agencies both the authority and the responsibility for creative care coordination techniques and implement effective monitoring and problem-solving systems.
- Actively solicit and incorporate birth and foster family input in development and management of treatment plans – value their opinions as highly as those of clinical professionals.
- Create and monitor quality of care outcomes measures that provide evidence of care coordination effectiveness.
- Leverage resources for care coordination with a view to a preventive model of care, i.e., effective care coordination can prevent problems from escalating to expensive crisis levels.
- Structure treatment/placement team meetings on a regular basis with opportunities to utilize ad hoc problem-solving and conflict resolution – depends largely on actively fostering a climate of trust and open communications from the top down and throughout systems.
- Recognize that change takes time and that it is important to have the infrastructure in place to support this. It is important to provide training and opportunities for staff to learn the roles and responsibilities of peers in other child- and family-serving systems to facilitate working together.

Site: Missouri (Jefferson City and St. Louis), November 13 – 14, 2002

Background and Context

In Missouri, child welfare functions are the responsibility of the Division of Family Services (DFS) of the state Department of Social Services (DSS). DSS also includes the Division of Medical Services (Medicaid) and the Division of Youth Services (DYS) for juvenile corrections. There is a separate Department of Mental Health (DMH), which is at the same cabinet level as DSS. In 1997, the then-Directors of DSS and DMH formed the Interdepartmental Initiative for Children with Severe Needs (the Initiative) with funding from The Robert Wood Johnson Foundation, the Center for Health Care Strategies, and pooled funding from dollars provided by DSS and DMH.

The Initiative, a cross-agency collaborative partnership, was formed to address the problems many Missouri parents were having accessing mental health services for their children with severe emotional disturbances and complex behavioral health conditions. Many of these parents were voluntarily relinquishing custody of their children to DSS as the only means of securing adequate care for them. In addition, the child welfare practice pattern was perceived to be overly reliant on the use of group residential

treatment facilities with multiple changes in placement and lengths of stay that were unreasonably long. The Directors' intent was to begin changing practice patterns by encouraging the use of more community-based wraparound approaches with concomitant reductions in group residential facility placements and lengths of stay. The Initiative was designed to facilitate referrals of children and families to this program by DSS, DMH, and DYS, all of which have children with intensive behavioral health needs in their systems.

The RFP the state issued to implement the Initiative anticipated the creation of several Care Management Organizations (CMOs) that would, under fixed monthly case rates per child, bring together the necessary spectrum of permanency and behavioral health service arrays to meet the Initiative's objectives. Only one CMO responded to the RFP and was awarded a contract, the Missouri Alliance for Children and Families (the Alliance). Virtually all children enrolled in the Alliance are Medicaid-eligible. MC+, Missouri's Medicaid managed care program, provides managed physical health services (including pharmacy) for them, however all behavioral health services are the responsibility of the Alliance, which also is responsible for placement and permanency efforts and care coordination. The CMO case rate covers provision of placement and behavioral health services, which the Alliance manages on a risk basis. (This raises the larger issues of the relative merits of managed care systems that cover both physical and behavioral health care versus behavioral health carve-outs and their effects on care coordination.)¹⁵ The state also created a separate RFP for the creation of a Technical Services Organization (TSO) that would provide contract oversight and technical assistance to the CMOs. This contract was awarded to ValueOptions.

The first 18 months of the contract were difficult as the original Alliance directors had trouble developing the necessary array of community-based services as well as experiencing philosophical and operational disagreements with the TSO. The state did not renew the TSO contract with ValueOptions and now has moved these duties back into DSS. The current CMO contract with the Alliance is scheduled to end June 30, 2003. Its current director is the former Missouri child welfare director who brings both child welfare expertise and a dedication to DFS's objectives to the Alliance.

At the end of the original contract period (February 2002) two of the original Initiative agency partners elected not to participate in the contract extensions. DMH, citing budget difficulties, has withdrawn, as has DYS, which believed it duplicates the services provided by the Alliance. This also occurred shortly after the departure of the DSS and DMH Directors who were responsible for the creation of the Initiative. At present, only DFS and Medicaid are participating in the Initiative since DMH and DYS have ceased making referrals to the program. DFS plans to issue a new "family focused" contract in

¹⁵ For an in-depth discussion of carve-out issues, see: Stroul B. Pires S., and Armstrong M. "Health Care Reform Tracking Project: Tracking State Managed Care Reforms as They Affect Children with Behavioral Health Disorders and Their Families, 2000 State Survey." University of South Florida, 2001. Available at: <http://www.rtckids.fmhi.usf.edu>. See also Bazelon Center for Mental Health Law. *Effective Public Management of Mental Health Care: Views from states on Medicaid Reforms That Enhance Service Integration and Accountability*. 2000. Available at <http://www.milbank.org/bazelon>.

July 2003 and expects that the Alliance will likely bid and continue to participate. DFS is continuing to stress the need to move away from long-term residential placements and increased use of therapeutic foster homes and community-based support services.

The Alliance currently serves 300 “high-need” children in the St. Louis and Jefferson City areas. DFS refers children it feels would benefit from the Alliance’s approach under a “no reject/no eject” policy (i.e., the Alliance cannot refuse to accept a child and cannot discharge a child until all placement and treatment criteria have been met and the DSS treatment team agrees). The Alliance, composed of nine partner agencies (eight of which were traditional residential treatment providers and one is a mental health counseling agency), utilizes teams of care managers to coordinate the provision of all community-based placement and behavioral health services needed to achieve permanency for children. The Alliance currently has approximately 300 providers in its network including not only its nine partner agencies, but also community-based traditional and wraparound service providers.

Significant Findings

Despite the withdrawal of two of the original Initiative agency partners and the non-renewal of the TSO contract, the Alliance has reported significant success in meeting DSS’ objectives. Residential lengths of stay now last an average of 15 months and more children are in community placement. Alliance “Care Managers” (as they are called – note the distinction from “case managers”) develop Care Plans that reflect both permanency and behavioral health treatment issues. Each care manager works with about 10 families and is the Family Support Team facilitator responsible for developing with families the individualized care plans, coordinating services across all settings and provider type (including a child’s MC+ health plan for physical health care), and ensuring quality of care. The Alliance’s position descriptions for both Care Managers and their supervisors include specific care coordination duties that are considered integral to the success of permanency planning. Care Managers take the approach that “the issue is how to meet a child’s need, not what services are available.” For example, the Alliance holds a contract with an agency that supplies professionally-trained mentors who provide, when appropriate, a less expensive and often equally effective way for children to have an adult to discuss their problems with rather than (or in addition to) using traditional higher-cost clinicians such as psychiatrists and psychologists.

The Alliance makes a significant difference in the lives of the children and families it serves. Upon referral, it quickly visits families, establishes a child and family team with the family, uses a wraparound approach, and coordinates care across all systems (although Alliance Care Managers reported some difficulties coordinating physical health care services with MC+ providers). Family Support Teams meet every 30 days, ensure that crisis plans are in place, and use family aides to support family structures. Alliance Care Managers and the partner agencies are fully “vested” in this care management approach and believe that the children and families they have served are

better served than they would have been without having benefit of access to this type of care delivery and coordination.

Many different interviewees credited the Alliance's success to the dedication and enthusiasm of the current Alliance Director to a coordinated wraparound approach and his ability to bridge organizational histories and boundaries to change practice. This is facilitated by cultivating an environment of "reciprocal accountability" whereby the Alliance is accountable to its providers and vice versa. An interview with one of the Partner Agencies (which was not part of the original Alliance) addressed the question of why a traditional residential provider would join the partnership knowing that the practice pattern was evolving toward less, rather than more, utilization of their services. The answer was that it was first seen as a defensive move to ensure continued participation in the market as well as a desire to prevent a large out-of-state health plan from entering. In addition, they found that the Alliance has been successful at educating them on the importance of focusing on permanency planning and including families in all aspects of care planning. This has increased the probability, in their view, that the family will eventually regain custody of its children. As a result, the provider has reduced lengths of stay and developed step-down options to facilitate quicker permanency decisions.

Family interviews included birth, foster, and adoptive parents. There was general consensus that the Alliance has met their care coordination needs well and they are very satisfied with the regular Family Support Team meetings and staffings. They noted that the Alliance has an accessible array of qualified providers and is successful at meeting a comprehensive array of needs (some felt that DFS should emulate the Alliance methods). One parent reported that the Alliance was able to keep her child with the family practitioner she already had and that thorough evaluations were conducted, including PAP and STD testing and random drug screens, with reports being sent back to the Alliance care manager. Other parents reported receiving assistance obtaining mentors and enrollment in recreational activities such as karate, fencing, and Scouting. There were mixed opinions about medication management processes with a few parents citing success and others feeling that they had to take the initiative to inform providers across systems about their children's medications. One parent reported being informed of the need to conduct regular liver panel assays for her child who was taking a psychotropic medication and that she also received training in medication management to monitor effects and side-effects.

Finally, one family voiced extreme concern about the future of the Alliance when the current contract ends on June 30, 2003. This family, whose child will require intensive care well past that date, fears that all progress made to date will be set back and that they will have to start over again with a new cadre of providers who may or may not be able to continue what they believe the Alliance has succeeded in doing for their child.

Physical and behavioral health services that interviewees noted were difficult to access included:

- Dental services (long waits and shortage of dentists who accept Medicaid).
- Neuro-psychological evaluations (rejected by Medicaid on medical necessity grounds).
- Optometry.
- Therapy for sexual abuse issues (only a few residential facilities for this treatment located out-of-state are available with a waiting list of 18 – 24 months).
- Crisis services (several crisis facilities have closed).
- Prevention services.
- Services for dually-diagnosed mental health/substance abuse.
- Treatment for children with mental retardation and/or developmental delays/disabilities.
- Long-term care services (Medicaid waiver Institutions for Mental Disease (IMD) slots are difficult to obtain or not funded).
- Substance abuse prevention and treatment services.

Interviewees also noted that court-ordered therapy can be problematic since it is based on an “old school” approach and may not recognize the value of alternatives to traditional treatments. They also reported difficulties bringing school-based services into the service mix.

Specific recommendations from interviewees for other states and communities regarding activities to ensure successful collaboration and care coordination include:

- For others considering an interagency partnership like the Initiative, allow at least two years of planning to involve all conceivable stakeholders and ensure that the case rate is adequate to cover all needed services plus the costs of coordination. Use lower cost alternatives and do not assume contracting agencies truly understand the treatment modality objectives at the beginning. Ensure there is more than one CMO and that the population size and case mix is adequate.
- Work for complete integration of children/families into all levels of treatment planning and proposed outcomes. View as therapy with, not to, children and families. Care management and planning must be individualized (i.e., no “cookie-cutter” approach).
- Ensure hiring of competent, caring staff in care management roles with ongoing attention to detail.
- Develop and maintain electronic availability of case notes and medical information with the ability to retrieve out of the office setting (e.g., via Internet connection on a laptop).
- Encourage creativity and flexibility in care management with ability to bring together a diverse array of traditional and non-traditional providers who communicate with each other and with care managers.

- Create flexible funding that allows for provision and coordination of services much more easily than categorical funding.
- Allow for the creation of individual contracts with providers for specific services who may not want an ongoing contract with the Alliance.

Site: Franklin County, Ohio (Columbus), November 19 – 20, 2002

Background and Context

Franklin County Children Services (FCCS) is the county agency responsible for child protection and child welfare duties. FCCS is an independent agency whose executive director reports to an executive board that is appointed by the County Commissioners. Governance is vested in the governing board of appointed officials. FCCS is the largest independently governed child welfare agency in Ohio. It is located in one of the three largest metropolitan areas in Ohio (Columbus), however the other two (Cleveland and Cincinnati) do not have governing boards but rather report directly to their respective County Administrators and County Commissioners. The Franklin County Department of Job and Family Assistance (DJFA) includes welfare, Medicaid, and other public assistance services. The DJFA director reports to the County Administrator and the County Commissioners. The Franklin County Alcohol, Drug Addiction and Mental Health Services Board (ADAMH), the Board of Health, and the Board of Mental Retardation and Developmental Disabilities each report separately to the county Board of Commissioners.¹⁶

Following passage of the federal Adoption and Safe Families Act (ASFA), which requires development of a permanency plan for a child within 12 months of entering the child welfare system, FCCS entered into a 1999 agreement with the ADAMH Board with the intent of increasing access to mental health and substance abuse (MH/SA) services for the child welfare population. FCCS recognized that these services are integral to effective permanency planning and that historic obstacles and shortages of child and adolescent MH/SA services in the county threatened its ability to meet ASFA mandates. The agreement ran for a term of 18 months and comprised a pooling of FCCS and ADAMH funds. FCCS' portion was \$1.4 million, and ADAMH's portion was \$5.5 million (of which \$2.1 million was designated for treatment of adult caregivers of children with open FCCS cases). Referral, enrollment, and tracking were to be done through ADAMH's database (MACSIS). The agreement contained forms to request ADAMH services, respond to the request, and to track progress of a case. The agreement ended June 30, 2000 and the ADAMH Board elected not to renew it (reasons for this are discussed below under "Significant Findings").

FCCS began contracting for privatized child welfare services using a lead agency model in 1999. Its initial RFP received seven bids and contracts were awarded to two agencies,

¹⁶ The Board of Commissioners directly controls levy requests, annual appropriations and labor-relations agreements as a matter of law, however they receive recommendations from the executive board. All other matters are the responsibility of the executive board.

the Ohio Youth Advocate Program (OYAP) and Permanent Family Solutions Network (PFSN). In its most recent re-bid this year, only OYAP and PFSN submitted bids and were awarded contracts. Until recently FCCS monthly referred approximately 60 new child welfare cases to its two contractors (30 cases per contractor per month) using a randomized allocation algorithm intended to ensure an equitable distribution of the case mix. This resulted in approximately 26 percent of FCCS' total caseload being managed by the private contractors. New agreements recently negotiated have reduced the referral rate to 27 cases per contractor per month at the urging of the providers during contract negotiations.

Contractors are paid a fixed monthly case rate per child and are expected to assume responsibility for coordinating and providing all placement and health services needed to expeditiously and safely move a child into permanency. CareSource holds the state Medicaid managed care contract, however children entering the child welfare system, if they were already enrolled in CareSource, are automatically disenrolled and receive Medicaid services on a fee-for-service (FFS) basis. Child placement contractors have the option of enrolling or re-enrolling children in the managed care system, however interviewees stated that this option is never exercised, primarily because the Medicaid managed care system provides a narrower range of services than does Medicaid FFS. In the event a child needs a physical or behavioral health service, the lead agencies' case managers must locate a provider who accepts Medicaid and then bill Medicaid for the service. This is less problematic for a lead agency that is also a Medicaid provider and has in-house behavioral health services.

FCCS and other interviewees noted that in recent years the county has experienced increased demand for placements in group residential facilities due to the increasing complexity and acuity of need of children entering the system and the lack of non-group residential alternatives to foster home placements, particularly for teens ages 13 – 18 (one-half of the Franklin County children in out-of-home placements are in this age group). There has been a rise in referrals from juvenile courts that come with prescribed orders for residential placement (approximately 67 percent of FCCS children are involved in the juvenile justice system). FCCS has been working to increase the number of in-county residential treatment beds. An FCCS official reported to the authors in February 2003 that a new provider recently has opened a 30-bed secure residential treatment facility in Columbus and FCCS has begun making referrals to it, thus decreasing the number of children who would have otherwise been placed out-of-county.

Significant Findings

Several reasons were given by different interviewees for the termination of the ADAMH agreement. Most often cited was the concern raised by ADAMH (after signing) regarding the confidentiality of the medical records of parents of FCCS clients receiving services from them and billing FCCS for its share of the cost of the service. The concern was that access to these parents' records could open the door to allowing them to be subpoenaed for a court custody hearing. Other interviewees cited ongoing underfunding

of the ADAMH Board, lack of provider buy-in to treating children and families involved in the child welfare system, ADAMH orientation to adult rather than child services, and the arrival of a new ADAMH director who did not support the agreement. All interviewees who addressed this issue expressed disappointment that the agreement ended, since it had raised their expectations that access to, and coordination of, behavioral health services for children and families in the child welfare system would be significantly enhanced, particularly for children who need intensive services.

The contractor data tracked by FCCS, and confirmed by interviewees, demonstrate that the outcomes achieved by privatized placement services are the same as those achieved by FCCS for the children for whom it retains case management responsibility (although the hope in privatized child welfare initiatives is that private sector lead agencies can achieve better outcomes than the county agency). Various interviewees cited several factors for this:

- Some interviewees felt that their contracts were written in such a way as to encourage conducting placement and treatment activities in the same manner as FCCS and could thus hamper service delivery creativity. An FCCS official noted, however, that there are significant differences between OYAP and PFSN in the manner in which they conduct casework services from each other. PFSN does emulate FCCS but it does so at its own option. This official stated that FCCS has always welcomed creativity in the delivery of services, however as legal custodian of the children, it must ensure compliance with all state regulations, laws, and court orders. This does, however, still provide for much variation in how the services are provided.
- Performance measures in the contracts are based on point-to-point placement progress (there are no measures specifically related to the behavioral health services that contractors are expected to provide).
- The case rate mechanism includes risk corridors that provide for either gain or loss depending on the efficiency of the provider's delivery of services. Penalties are limited to failure to comply with the administrative requirements of the contracts, e.g., timely invoicing. Some interviewees noted that they would welcome the inclusion of more performance incentives that reward them for achieving better-than-expected outcomes, particularly in how behavioral health services are provided and coordinated.
- The contractors must attempt to arrange for behavioral health services in the same under-staffed and under-funded county behavioral health provider market as FCCS. Service delivery creativity, which relies largely on having access to an adequate range of traditional and non-traditional behavioral health providers and specialists, is difficult to achieve if the underlying supply of such providers is itself inadequate.

Specific physical and behavioral health services that interviewees mentioned were in short supply and/or difficult to access included:

- Child and adolescent psychiatrists.
- Residential treatment beds, especially those in secure settings.
- Aftercare services.
- Community-based wraparound services.
- Inpatient mental health hospital beds.
- Counseling appointments with ADAMH-contracted and individual Medicaid providers.
- Sex abuse and sex offender treatment services.
- Mental health assessments.
- Respite care for families.
- Substance abuse treatment for both children and adults.
- Primary care services (clients typically use the Children’s Hospital outpatient clinic for primary care, however there are long waiting lists for appointments).
- Dental services.
- Behavioral health case management.
- Therapeutic foster homes.
- School-based health services.
- Services for delinquent youths with severe emotional disturbances and youth with developmental disabilities.
- Culturally competent services for newly-arrived immigrant populations, particularly Somalis.

Specific recommendations from interviewees for other states and communities regarding activities to ensure successful collaboration and care coordination include the following:

- Adequately fund the public behavioral health sector and set Medicaid reimbursement rates at levels sufficient to attract providers with specialty practices in child and adolescent behavioral health.
- Anticipate and negotiate contract stipulations regarding medical record access (a pre-requisite to effective care management) prior to signing.
- Ensure that high-level collaborations between government agencies are promulgated throughout the system, particularly to line staff, and that problem-solving procedures are available up the line to higher level supervisors and administrators.
- Include contractual terms for lead agencies and providers that encourage and reward creative care planning, i.e. use “outside of the box” thinking rather than simply creating “a bigger box.”
- Provide process and outcomes measures to demonstrate how care coordination is occurring and hold contractors accountable for meeting and exceeding treatment goals.
- Work with juvenile justice systems to educate magistrates about the value of providing wraparound services in home-based settings to reduce the number of referrals coming into the system with pre-defined court-ordered residential treatment placements.

- Solicit and include lead agency and provider contractor input in the development of RFPs and contracts with the aim of enhancing care coordination requirements.

Site: Massachusetts (Boston), December 4 – 5, 2002

Background and Context

The Massachusetts Department of Social Services (DSS) has statewide responsibility for child welfare functions. It and its sister agencies, the Department of Mental Health (DMH), the Department of Public Health, the Department of Youth Services (DYS) and the Division of Medical Assistance (DMA) (Medicaid), are housed in the state Executive Office of Health and Human Services. There are no counties in Massachusetts, however the state is divided into six geographic regions for health and human service delivery purposes. Each region has a regional director. Children enrolled in Medicaid are served by the state’s managed care system, MassHealth, and its managed behavioral health organization, the Massachusetts Behavioral Health Partnership (MBHP) (whose contract is held by ValueOptions). Upon intake to the child welfare system, children receive physical health services from MassHealth on a fee-for-service basis and managed behavioral health services from MBHP.

In January 1997, the Commonworks program was launched. It is an initiative of DSS, DMA, the MBHP, and not-for-profit child placement lead agencies to serve the needs of children and adolescents age 12–18 in the state child welfare system whose needs require intensive service utilization.¹⁷ Its goals include the provision of a continuum of placement and treatment services to reduce the frequency of out-of-home placements for these children using focused treatment planning, to provide flexible funding to finance these services across multiple categorical funding sources, and to provide collection, analysis, and reporting of progress meeting these goals. ValueOptions, a for-profit managed behavioral health organization, was selected as Commonworks’ Administrative Services Organization to provide administrative services, financial management, and performance monitoring for the program. Commonworks has entered into contracts with not-for-profit lead agencies in all six state regions and currently serves about 1,200 children across the state. DSS regional offices refer children to Commonworks on a “no reject/no eject” basis. According to a Commonworks fact sheet:

“... The Lead Agency is responsible for determining the placement level of care necessary to meet the youth's needs. In conjunction with the DSS Social Worker, the Lead Agency determines when the youth no longer requires

¹⁷ As with the Missouri visit, the research team focused its efforts on the collaborative partnership and delivery systems of the Commonworks program for a specific child welfare population with high needs. The current DSS Commissioner has announced his intention to promulgate the implementation of a “systems of care” approach to expand utilization of community-based wraparound supports for larger numbers of child welfare clients who are not part of the Commonworks program. See *A Three Tiered Approach to Developing a Family-Centered Child Welfare Practice*. Available at http://www.state.ma.us/dss/Procurement/PR_Overview.htm. The site visit team also participated in a subcommittee meeting of a new Procurement Reform effort and provided attendees with information about other privatized child welfare and system of care efforts around the country.

placement services and may be transitioned with supportive aftercare services to a permanency placement or to living independently in the community. The Lead Agency is also responsible for: sub-contracting with an array of residential providers to provide placement services; working with providers to develop an individualized treatment plan for each youth; monitoring the youth's attainment of treatment plan goals; and ensuring that DSS is kept informed of the youth's progress."¹⁸

Lead agencies are required to develop a variety of placement and treatment providers, including enhanced residential care, behavioral treatment residences, group homes, specialized foster care, independent living programs, transitional care units, and aftercare services. They also are responsible for arranging through subcontracts or in-house resources the provision of all necessary ancillary health services as part of a unified treatment planning and case management effort. The agencies operate under a system of bonus payments that provide incentives for moving children to less restrictive care settings as quickly and safely as possible.

Significant Findings

The contractual language regarding care coordination in the Commonworks contracts, the MBHP contract, and the lead agency contracts is the most comprehensive and specific of all the four sites included in this study. This was borne out in interviews with these officials, all of whom cited the integration of coordinated behavioral and physical health care with placement activities as the hallmark of their efforts. For each child in the system, there are designated care coordinators and case managers at DSS (the legal guardian of the child), at MBHP, and at the lead agencies (which assume care coordination duties for Commonworks) and with some of their contracted providers. According to a couple of lead agency contractors, this multiplicity of care managers has resulted in some confusion as to the overlap of duties and responsibilities among these entities. Once a lead agency has developed a clinical and placement plan, it is not always clear what should be paid for by Commonworks and what should be paid for by MBHP. The contractors reported that Commonworks and MBHP have been willing partners throughout their tenure and are listening to their concerns and devising creative solutions to individual client needs. DSS has established clinical review teams that serve as arbitrators when lead agencies encounter a dispute over care. They also report that school-based systems have increased their participation in the provision of services as well.

An MBHP interviewee reported that Commonworks has done well in a variety of areas, however it is time to re-focus efforts to engage in preventive placement interventions and to embrace family-centered practices. Several interviewees noted that the most difficult clients to treat are those who have been designated "cases awaiting resolution and disposition" (CARD), colloquially known as "stuck kids." These are teens and adolescents with complex behavioral health conditions who have experienced multiple

¹⁸ Commonworks Fact Sheet. Available at <http://www.commonworks.org/Pages/CWFactSheet.htm>.

long-term group residential care placements with inordinately long lengths of stay. In January 2003, DSS launched a new demonstration program called “Comprehensive Family-Focused Care” (CFFC) to serve 350 children with SED (including CARD kids) in six sites with the goal of keeping them in community-based care. It is jointly funded by DSS, DYS, Medicaid, and the Department of Education, with additional funds from the Center for Health Care Strategies.

Early on in the Commonworks program, it was sometimes problematic for children to obtain physical examinations and EPSDT services. MBHP has worked to increase its provider network to improve access, however more work still needs to be done in this area. For children with co-occurring mental health and substance abuse conditions, their treatment regimens are split between two agencies: DMH for mental health and DPH for substance abuse. According to some interviewees, this can exacerbate the potential for communication disconnects in treatment planning and delivery for co-morbid conditions. There also is increasing concern regarding the lack of adequate treatment supports for children with developmental disabilities due to insufficient funding of the state MRDD agency.

Birth, foster, and adoptive families are actively involved throughout the Commonworks and MBHP programs. Not only are they engaged in regular team treatment planning meetings for their children, they also are involved in system-level design issues, e.g., their input was used in the new CFFC demonstration program. Parents also view the lead agencies and Commonworks as advocates on their behalf to whom they can turn when it is necessary to devise new treatment strategies or to resolve problems with providers.

Specific physical and behavioral health services that interviewees mentioned were in short supply and/or difficult to access included:

- Substance abuse treatment designed specifically for teens – programs often are modeled on the 12-step approach which may not be appropriate or effective for this age group.
- MBHP limits on weekly sessions often forces a choice between a mental health visit or a substance abuse visit.
- Adult substance abuse treatment for families of children in the child welfare system.
- Financing for aftercare services.
- Continuity of primary care services, particularly for children whose placements result in geographic relocations.
- Treatment for children with co-occurring cognitive impairments and mental illness.
- Step-down treatment for sex offenders.
- Medication management.
- Psychiatrists who specialize in child and adolescent treatment.
- EPSDT visits for children in residential treatment facility placements.

- Culturally appropriate behavioral health services for racial and ethnic minorities.

Specific recommendations from interviewees for other states and communities regarding activities to ensure successful collaboration and care coordination include the following:

- Case and care management duties and responsibilities should be clearly drawn when there is a multitude of people involved in a child's care, otherwise there is a risk of duplication of and/or gaps in services.
- Stress the importance of personal and professional relationships among officials and line staff that cross organizational boundaries to facilitate hands-on problem-solving.
- Take the time to develop trust and to estimate and build in reimbursements that reflect not only the cost of care but also the administrative overhead associated with care coordination efforts.
- One interviewee felt that true care coordination was still not happening since fragmentation of resources and different program eligibility criteria were creating treatment silos among DSS, DYS, and DMH.
- For lead agencies, give them more responsibility and authority to develop innovative service arrays – assumption of financial risk entails the need to transfer more control for individual treatment decision-making.
- Finally, most interviewees noted that Massachusetts has had several fine examples of small-scale programs such as Commonworks that have demonstrated good outcomes in addition to cost-savings and that it is now time to expand these efforts to larger populations in need.

Common Themes – Challenges and Promising Approaches to Collaboration and Care Coordination

Findings from the four sites reveal several cross-cutting themes common to the tasks of interagency collaboration and coordination of behavioral health care services for children and families in child welfare systems that use privatized managed care techniques. Although each site is unique by virtue of its governmental structure, the population focus of its efforts, local historical practice patterns, and provider availability, interviewees in all four sites most often made the following observations:

Challenges for Collaboration and Coordination of Care

- The success of interagency collaborations depends largely on key leadership having the authority, and taking the responsibility, for development and implementation of programs and systems that stress a coordinated approach to holistic care that integrates health, behavioral health, and permanency issues.
- The long-term success of interagency collaborations is often conditioned on their institutional ability to survive the departure of the key leaders responsible for their creation and implementation.

- Multiple categorical funding and reimbursement streams can create treatment “silos” that can hamper care coordination when children are perceived as “belonging” to one funding stream or another.
- Contracted child placement agencies that arrange for coordinated behavioral health services for the children in their systems should be subject to performance measures that adequately demonstrate their activities in this regard and rewarded for exceeding performance thresholds (i.e., incentives are more useful than disincentives or penalties).
- Even well-written contracts cannot overcome shortages of providers with child and adolescent treatment expertise that result from low reimbursement rates and/or under-funding and under-staffing of public and private child welfare and behavioral health systems. Effective monitoring and feedback systems must be instituted to continuously ascertain whether contract implementation is being hindered by factors beyond the control of contractual provisions.

Promising Approaches for Collaboration and Coordination of Care

- Interagency collaborations should involve as many child- and family-serving agencies as possible, (e.g., health, mental health, substance abuse, public assistance, schools, juvenile justice, and family courts).
- Agencies need to work collaboratively with juvenile justice and family court magistrates to enhance their understanding of the importance to include wraparound and other non-traditional services.
- Wraparound and ancillary support services are both cost-effective and “health-effective” alternatives to expensive care provided in clinical settings when appropriately utilized and monitored.
- The timeline from initial intake to permanent placement of children is shortened when integrated care management is conducted by a care manager who is able to access a variety of services for clients in need.
- Case and care management duties and responsibilities should be clearly drawn when there is a multitude of people involved in a child’s care, otherwise there is a risk of duplication of and/or gaps in services.
- Care managers are more successful when caseloads are kept at manageable levels and they are given the flexibility to devise individualized care plans by tapping into an extensive array of customizable services.
- The involvement of family members and other caregivers in both system planning and care management is critical to having a more complete understanding of a child’s physical, mental, and social service needs and how they need to be coordinated.

Implications for Policy and Practice

Perhaps the most significant finding in this study is that agencies and contractors are indeed encountering difficulties fulfilling their contractual care coordination obligations, largely due to external factors such as the inadequate supply of specialized treatment providers and insufficient case rates and Medicaid reimbursements. This is not to suggest, however, that agencies should lower their expectations and calibrate service requirements solely on these factors. Such actions would run counter to current professional thinking about necessary standards of care for children with complex needs, would likely lead to unforeseen decreases in quality of care and access across both child welfare and behavioral health systems, and lead to cost increases in “deep end,” restrictive levels of care. While contracts can affect provider supply by virtue of incorporating high or low reimbursement rates, the value of interagency collaborations is that they bring together decision-makers who can formally and informally apprise their colleagues of the intended and unintended effects of their mutual and individual actions on their own programs.

While the vast majority of children in the child welfare system ultimately achieve successful and stable placements, continuing highly publicized child welfare tragedies around the country serve as warning signals that state and county child welfare and behavioral health systems are under stress. At the same time that state economies are weakening and legislators and governors are making difficult budget decisions, increasing joblessness and the resultant loss of private sector health insurance are placing growing pressures on public sector and charitable community safety net providers as their caseloads increase. As agency directors cope with reduced staff and leaner budgets, it may be difficult to continue to invest in the types of creative and flexible integrated care management techniques used by our study sites. Unfortunately, care coordination activities and wraparound and ancillary support services that enhance clinical care and permanency efforts may prove to be easy targets for budget-cutting unless advocates can demonstrate the value-added contribution they make to child and family safety, well-being, and successful permanency. Devising appropriate performance indicators that adequately measure the effectiveness of integrated care coordination in this regard is essential.

This study was not designed to draw direct statistical correlations between care coordination methods and successful permanency or to assess the relative advantages and disadvantages of privatized child welfare initiatives or Medicaid managed care. Based on our review of the contracts as well as the insights provided by interviewees, it is clear that there have been varying degrees of success in integrated care/placement coordination efforts during implementation. Both Missouri and Franklin County, Ohio, which are coping with changes in partner involvement in the interagency agreements that formed the basis for their programs, are continuing to see improvements in child and family outcomes. Officials there, however, believe that these outcomes could be even more greatly enhanced if high-level state and county agency collaborations were to be reinstated. All sites, including El Paso County, Colorado and Massachusetts, which

are still operating with viable interagency agreements and also achieving positive outcomes, are facing the budgetary and staffing challenges described above, yet officials remain committed to providing the best possible care and services for the children and families in their systems despite these political and economic uncertainties.

Changing practice patterns and encouraging interagency and cross-system collaboration require contract language and visions that support system flexibility and agility as well as the willingness of agency heads, supervisors, direct line workers, providers, courts, schools, and families to adapt to both changing ways of managing agencies and of conducting care management that embraces both permanency and behavioral health treatment issues and priorities. Based on a synthesis of this study's findings, we offer a list of pitfalls to avoid, creative problem-solving approaches, and successes to capitalize on:

<i>Pitfalls to Avoid and Creative Approaches to Problem-Solving</i>	<i>Successes to Capitalize On</i>
<ul style="list-style-type: none">▪ Ensure adequate lead time for planning and include a wide variety of stakeholders' perspectives.▪ Case rates and reimbursement levels need to adequately reflect the overhead administrative costs incurred by coordinating care across systems.▪ Avoid contract language that is overly general or restrictively specific and explain in the contract the intent of the contract specifications.▪ Implement both regular and ad hoc team meetings to address problems before they arise or quickly after they emerge.▪ Anticipate and negotiate critical contractual issues as completely as possible before "signing on the dotted line."▪ Vaguely or poorly defined care management duties across systems can lead to confusion and service redundancy and/or gaps.	<ul style="list-style-type: none">▪ Promulgate an environment of trust and open communications from agency heads all the way through to front-line case managers.▪ Measure and reward successful care coordination efforts.▪ Actively include family members and other system case managers in care and treatment planning.▪ Pooled flexible funding helps to overcome agency-defined treatment silos.▪ Invest in preventive efforts such as family preservation to avert increases in caseloads and improve family and community well-being.▪ Ensure that contracted child placement agencies are given both responsibility and accountability for care coordination.▪ Cross-training child welfare case managers and behavioral health case managers enhances common understanding of the goals of child- and family-serving systems and efficient coordination of care.

Contracting agencies may wish to consult a group of online sample purchasing specifications developed by the GWU Center for Health Services Research and Policy.¹⁹ These specifications, developed through an extensive professional consensus process, cover children in child welfare systems and children and adults with behavioral health conditions, and include suggestions for contractual language regarding interagency

¹⁹ Available at <http://www.gwhealthpolicy.org>.

collaboration and care coordination, including medication management (a particular weakness in the contracts reviewed for this study). The sample purchasing specifications are intended to serve as examples that purchasing agencies can modify and adapt to suit their own needs and local circumstances.

This study serves as a caution to state and local purchasers that contract specifications, while critical, are only an essential first step to ensure effective care coordination for children with behavioral health needs and their families. Ongoing attention must be paid to implementation issues, how contract requirements are playing out in actuality, and to the factors that impede adherence to contract specifications.

It is our hope that the findings from this study contribute to a growing body of knowledge of how public and private sector collaboration and care coordination can bring hope and stability to children and families in the child welfare system.

Appendix A. – Excerpts of Contractual Language Pertaining to Coordination of Behavioral Health Care Services

El Paso County, Colorado

Domain	County Child Welfare Language	State Medicaid Managed Care Language
Interagency collaboration	<p>“The Department will arrange, through the State Department of Human Services and the State Department of Health Care Policy and Finance, to transfer a portion of its Child Welfare capped allocation to the L.L.C. serving El Paso County. The agreement will allow a portion of these child welfare funds to be used by the state to match federal Medicaid funds through the 1915 B Waiver. These funds will become part of the L.L.C.’s capitated funding.” Page 1.</p>	
Enrollment and eligibility terms	<p>“COMMUNITY HEALTH CENTER: ...Beginning August 1, 1998 the Department’s Placement Services will fax a registration form and a Medical Authorization form for each child going into CPA level placement in El Paso County to the CHC. The CPA foster home will then call the CHC for an appointment for the initial medical and dental examinations. The CHC will provide needed care for the foster children enrolled. The CHC will enroll the children in CHIP and pay the \$25 annual fee.” Page 32.</p> <p>c. Both the COUNTY and the CONTRACTOR shall ensure that the child is enrolled in the Early and Periodic Screening Diagnostic and Treatment Program.” Page 21.</p>	<p>II. ELIGIBILITY AND ENROLLMENT ...</p> <p>C. Disenrollment</p> <p>I. The following are acceptable reasons for Disenrollment:</p> <p>g. Child welfare eligibility status (e.g., foster care) or receipt of Medicare benefits...</p> <p>XIV. SERVICE DELIVERY...</p> <p>3. Coordination with the EPSDT Program...</p> <p>a. The following requirements relate to the provision of EPSDT services and must be incorporated into the Contractor’s preventive health services:</p> <p>1. The Contractors shall notify all Members about EPSDT benefits...” Colorado Contract, page 52.</p> <ul style="list-style-type: none"> • Referral; Clients must be referred to appropriate service providers for further assessment and treatment of conditions found in the screening examination • Case Management; maintenance of a coordinated system to follow the Client through the entire range of screening and treatment” Exhibit A, pages 16-17.
Care coordination/ case management/ case work	<p>“Concurrent planning and service delivery must be a normal part of case management of all cases because of the shortened timeliness for permanency. Concurrent planning must consider kinship placement as well as potential adoption by the foster family.” page 30.</p> <p>“Post adoption services will be coordinated and managed by Pikes Peak Options L.L.C. through the use of their capitated Medicaid funds. All children placed with an adoption</p>	<p>EXHIBIT A</p> <p>COVERED SERVICES...</p> <p>A. 16 Mental Health and Substance Abuse Services...Persons who are enrolled in a Mental Health Capitation Program (MHCP) shall receive psychiatric</p>

<p>subsidy will now be eligible for Medicaid. Grant funds will be used to supplement the Medicaid post-adoption services.” page 37.</p> <p>“Under both Option A and Option B, the L.L.C. will purchase case management services from all participating CPA’s at a negotiated rate to be specified in the facility agreements.” page 3.</p> <p>“The CONTRACTOR will coordinate and assure access to the services described in the family services plan: therapeutic services, education, socialization, recreation, and remedial therapies such as speech therapy, occupational therapy, and the like.” page 35.</p> <p>The CONTRACTOR shall provide or have access to a wide array of services for children and families and shall assist families to obtain and coordinate such services. These services shall include but are not limited to family preservation, economic support, housing assistance, health care, mental health, substance abuse, domestic violence, adoption and post adoption services.” page 31.</p> <p>“The L.L.C. will develop a mental health treatment plan for each child with the CPA and other appropriate parties involved.” page 2.</p> <p>“Utilization management will incorporate a standard assessment performed jointly by the L.L.C. and the Department.” page 3.</p> <p>“The Department will maintain staff skilled in child welfare services who will monitor the CONTRACTS and cases assigned to the various Contractors. The case monitor will meet formally with the CONTRACTOR at least monthly to resolve any issues between them. Every case will be reviewed quarterly. The monitor will secure required Department approvals within 5 working days of the request.” page 38.</p> <p>“The Department and Contractor will work collaboratively on the overall process, but the Contractor will assume primary responsibility for coordinating functions and for informing the Department in a timely manner as to whether data is being adequately received for processing. Data Presentation will occur not less than at 6-month intervals.” Appendix C, page 18.</p> <p>“The CONTRACTOR will contact the child’s school district and incorporate into the family service plan the educational plan for the child...The child’s medical and dental records will be maintained in the child’s file. All required medical and dental services will be acquired for the child and documented in the child’s health passport.” page 30.</p>	<p>services including but not limited to... Case management services from the MHCP contractor and the HMO shall not be required to provide such services...” Exhibit A, pages 31-32.</p> <p>XIV. SERVICE DELIVERY...</p> <p>3. Case Management: In addition to efforts made as part of the Contractor’s internal Quality Assurance Program, the Contractor shall have an effective case management system that includes but is not limited to:</p> <ul style="list-style-type: none"> a. Procedures and the capacity to implement the provision of individual needs assessment after Enrollment and any other necessary time, including the screening for Special Health Care Needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers); the development of an individual treatment plan as necessary based on the needs assessment; the establishment of treatment objectives, treatment follow-up, the monitoring of outcomes, and a process to insure that treatment plans are revised as necessary. These procedures must be designed to accommodate the specific cultural and linguistic needs of the Contractor’s Members. b. Procedures designed to address those Members, including children with Special Health Care Needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services, and Members who require ancillary services, including social services and other community resources. c. A strategy to ensure that all Members and/or authorized family members or guardians are involved in treatment planning and consent to the medical treatment. d. Procedures and criteria for making referrals and coordinating care by specialist and subspecialist that will promote continuity as well as cost-effectiveness of care. e. Procedures to provide continuity of care for newly Enrolled Members to prevent disruption in the provision of necessary services that include but are not limited to: appropriate case management staff trained to evaluate and handle individual case transition and care planning; assessment for appropriate
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		<p>technology and equipment; procedures for evaluating adequacy of Provider Networks...” Pages 46, 48.</p> <p>Children with Special Health Care Needs</p> <p>XIV. SERVICE DELIVERY...</p> <p>3. Case Management: In addition to efforts made as part of the Contractor’s internal Quality Assurance Program, the Contractor shall have an effective case management system that includes but is not limited to:</p> <p>a. Procedures and the capacity to implement the provision of individual needs assessment after Enrollement and at any other necessary time, including the screening for Special Health Care Needs (e.g., mental health, high risk health problems, functional problems, language or comprehension barriers)...</p> <p>b. Procedures designed to address those Members, including children with Special Health Care Needs, who may require services from multiple providers, facilities and agencies and require complex coordination of benefits and services, and Members who require ancillary services, including social services and other community resources...” Colorado Contract, pages 46, 48-49.</p> <p>IV. COVERED SERVICES...</p> <p>C. Fee for Service Benefits</p> <p>1. [...]The Contractor shall communicate to its Members and Subcontractors, including Physicians and all ancillary providers, information about Medicaid benefits which are not Covered Services under this Contract but are available to Members. These benefits include, but are not limited to, benefits available only through the EPSDT and mental health capitation programs. pages 18-19.</p>
Interagency collaboration	<p><u>Administrative Management of Principal Contracts</u></p> <p>A. <u>Department of Social Services</u></p> <p>The Department shall designate the Director of Residential and Adolescent Services and</p>	<p>“2.06.07 Agreements with State Agencies</p> <p>The Contractor shall:...</p> <p>b. Develop and submit to the Division for prior review and approval within the first six months of the Contract, a plan to</p>

the Associate Director of Residential Services to act as contract managers and liaisons for the Department with the Lead Agencies and *ValueOptions/Commonworks* during the continuation of the Principal Contracts. The Department reserves the right to change its representatives at its sole discretion, and shall provide the Lead Agencies and *ValueOptions/Commonworks* with written notice of any such change. The Department representatives shall be responsible for:

1. Representing the Department on all matters pertaining to the Principal Contracts. The representative shall be authorized and empowered to represent the Department regarding all aspects of the Contracts;
2. Monitoring compliance with the terms of the Principal Contracts as further defined by mutually agreeable plans specified and submitted as deliverables;
3. Receiving and responding to all programmatic and operational inquiries and requests made by the Lead Agency or *ValueOptions/Commonworks*, in accordance with the terms and within the timeframes specified within the Principal Contracts;
4. Reviewing, approving and signing all required work products;
5. Providing reasonable access to appropriate staff, data, records, manual and automated information held by the Department or its providers as required by the Lead Agency or *ValueOptions/Commonworks* to perform their work in a timely manner;
6. Working collaboratively with the Lead Agencies and *ValueOptions/Commonworks* in the further development and refinement of the Commonworks system;
7. Meeting with the representatives of the Lead Agency and *ValueOption/Commonworks* on a periodic or as-needed basis and resolving issues which arise;
8. Monitoring the provision of adequate staff by the Lead Agency and *ValueOptions/Commonworks* with expertise in the following areas: administration, operations, finance, management information systems, clinical service provision, quality management, utilization reporting and education;
9. Informing the Lead Agency and *ValueOptions/Commonworks* of any discretionary action taken by the Department pursuant to the provisions of it's respective Principal Contract.

B. Lead Agencies

The Lead Agency shall designate a representative to act as liaison with the Department of Social Services and *ValueOptions/Commonworks*. The representative shall be responsible

ensure that its Network Management staff communicate on an ongoing basis, and no less than monthly, with DSS designated staff, DPH/BSAS designated staff, DMH area directors and other appropriate state agencies' designated staff to address Enrollees' service planning, admissions, discharge plans, utilization, and coordination of DMH Continuing Care Services." Appendix B, pages 22-23.

Agreements with State Agencies
The Contractor shall:

- a. Enter into written service agreements with Massachusetts state agencies to implement mechanisms to address the special mental health and substance abuse needs of Enrollees who receive services from, or are eligible to receive services from these agencies, and to ensure that MH/SAP services are well coordinated and linked with these service agreements to the Division for prior review and approval. Subject to such review and approval, service agreements with the following agencies shall be executed by the end of the ninth month of the Contract...
 2. Department of Youth Services..." Appendix B, pages 19,22.

"2.0 PROVIDER NETWORK DEVELOPMENT, ADMINISTRATION, AND MANAGEMENT

2.01 Network Development

The Contractor shall:...

2.01.08 Agree to enter into non-financial affiliation agreements for the first and second Contract Years with qualified DMH designated state-operated community mental health centers (SOCMHCs) for the provision of Inpatient Mental Health Services and mental health Emergency Services to Enrollees, provided that the SOCMHCs meet the quality and performance standards established for Network Providers.

2.01.09 By no later than the first day of the third Contract Year, the Contractor shall enter into Provider Agreements with SOCMHCs for the provision of Inpatient Mental Health Services and mental health Emergency Services, subject to

<p>for:</p> <ol style="list-style-type: none">11. Representing the Lead Agency on all matters pertaining to the Lead Agency Principal Contract and this Agreement. The representative shall be authorized and empowered to represent the Lead Agency regarding all aspects of the Principal Contract.12. Monitoring the Lead Agency's compliance with the terms of the Lead Agency Principal Contract;13. Receiving and responding to all inquiries and requests made by the Department or <i>ValueOptions/Commonworks</i> in the timeframes and format specified by them per applicable contract requirements, or in the case of ad hoc requests, within a reasonable timeframe;14. Meeting with representative of the Department and <i>ValueOptions/Commonworks</i> on a periodic or as-needed basis to resolve issues which may arise;15. Working collaboratively with the Department and <i>ValueOptions/Commonworks</i> in further development and refinement of the Commonworks system;16. Coordinating requests from the Department and <i>ValueOptions/Commonworks</i> to assure that Lead Agency staff with the required expertise are available to participate in Department and <i>ValueOptions/Commonworks</i> activities and respond to reasonable requests by the Department and <i>ValueOptions/Commonworks</i> which may include, but not be limited to, requests to participate in training as well as requests to meet with the state agency representative or other parties;17. Making best efforts to resolve any issues identified by the Lead Agency, the Department or <i>ValueOptions/Commonworks</i> that may arise in connection with the Lead Agency Principal Contract;18. Meeting with the Department at the time and place requested by the Department, if the Department determines that the Lead Agency is not in compliance with the requirements of the Principal Contract;19. Ensuring that all reports, contracts, subcontracts, agreements and any other documents subject to the Department's prior review and approval are provided to the Department no less than 10 business days prior to execution or implementation, as applicable;20. Unless otherwise provided in the Contract or by the agreement of the Department, the Lead Agency shall submit to the Department any and all documents, reports, and other materials requested by the Department that fall within the scope of the Lead Agency Principal Contract within 10 business days of any such requests.	<p>prior review and approval by the Division, and provided that the SOCMHCs meet the credentialing, quality, and performance standards established for Network Providers. If Provider Agreements are not executed with the SOCHMCs, then non-affiliation agreements shall remain in effect until the Division directs otherwise." Appendix B, pages 5-7.</p>
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C. ValueOptions/Commonworks

ValueOptions/Commonworks shall designate a representative to act as liaison with the Department and the Lead Agencies. The representative shall be responsible for:

1. Representing *ValueOptions/Commonworks* on all matters pertaining to the SMO Principal Contract and this Addendum. The representative shall be authorized and empowered to represent *ValueOptions/Commonworks* regarding all aspects of the Principal Contract and Agreements;
2. Monitoring *ValueOptions/Commonworks* compliance with the terms of the SMO Principal Contract;
3. Receiving and responding to all inquiries and requests made by the Department in the timeframes and format specified by the Department;
4. Meeting with representative of the Department and Lead Agencies on a periodic or as-needed basis to resolve issues which may arise;
5. Working collaboratively with the Department and Lead Agencies in the further development and refinement of the Commonworks system;
6. coordinating requests from the Department and Lead Agencies to *ValueOptions/Commonworks* to ensure that staff with the required expertise are available to participate in activities and respond to reasonable requests by the Department and Lead Agencies which may include, but not be limited to, requests to participate in training as well as requests to meet with the state agency representatives or other parties;
7. Making best efforts to resolve any issues identified by *ValueOptions/Commonworks*, the Department or the Lead Agencies that may arise in connection with the SMO Principal Contract or this Agreement;
8. Meeting with the Department at the time and place requested by the Department, if the Department determines that *ValueOptions/Commonworks* is not compliance with the requirements of the SMO Principal Contract;
9. Ensuring that all reports, contracts, subcontracts, agreements and any other document subject to the Department's prior review and approval within the scope of the SMO principal Contract are provided to the Department no less than 10 business days prior to the execution or implementation, as applicable;
10. Unless otherwise provided in the SMO Principal Contract or by the Agreement of the Department, *ValueOptions/Commonworks* shall be required to submit to the Department any and all documents, reports, and other materials requested by the Department that fall within the scope of the SMO Principal Contract within 10 business days of any such requests. (Commonworks Service Program, FY 2002 Addendum).

	<p><u>Financial Management</u></p> <ol style="list-style-type: none"> 1. The financial management of Commonworks' Program resources is a shared responsibility among the Department, the Lead Agencies and <i>ValueOptions/Commonworks</i>. 2. As the purchasing agent, the Department is responsible for ensuring that public sector resources are used effectively and efficiently to serve the clients in its care. 3. The assumption of a portion of the financial risk for Commonworks necessitates sound management of those resources by the Lead Agency. 4. <i>ValueOptions/Commonworks</i> is responsible for ensuring that appropriate infrastructures exist to process claims payments, as well as support the Department and the Lead Agency in their management of the financial resources. (Commonworks Service Program, FY 2002 Addendum). <ol style="list-style-type: none"> 1. <i>ValueOptions/Commonworks</i> will work with the Department and a Massachusetts college or university to explore the establishment of training and resource center for residential staff, including an organizational structure and operations supported through co-funding, federal and private grants. 2. <i>ValueOptions/Commonworks</i> will support Department and Lead Agencies' efforts to collaboratively develop programs that are jointly funded with The Partnership by providing technical assistance and consultation in the design, management, and monitoring of those initiatives. 3. <i>ValueOptions/Commonworks</i> will assist the Department, Division of Medical assistance and The Partnership in further evaluation of the Enhanced Residential Care Program. 4. <i>ValueOptions/Commonworks</i> will assist the Department, as requested, in convening forums to provide opportunities for DSS staff and residential providers to share ideas on the future development of a residential care continuum within the Commonwealth. (Commonworks Service Program, FY 2002 Addendum.) 	
<p>Enrollment and eligibility terms</p>	<p><u>Client Referrals.</u> This Subcontract does not guarantee the Subcontractor of any level of referrals. However, subject to the availability of space in light of the limits of capacity specified in Exhibit A, the Subcontractor shall accept for service all Referred Clients. (Commonworks Standard Terms and Conditions for Subcontractors Amended and Restated as of July 1, 2002)</p> <p>A. Referral of Clients to the Commonworks Program</p> <ol style="list-style-type: none"> 1. The Department will ensure that appropriate referrals are forwarded to the Lead 	<p>"5) Expanded MassHealth Benefit Advocacy: DMH Consumers</p> <p>The Contractor shall provide outreach to DMH Acute Care Consumers not already determined MassHealth eligible by sending MassHealth application material to and following-up with the consumer or his/her DMH case manager. For consumers who are eligible for DMH services as of July 1, 1997 ('Known Consumers'), the Contractor shall target to complete such outreach activities within 90 days of the inception of MassHealth Expansion. For all new DMH</p>

	<p>Agency within one (1) week of notification that a vacancy is anticipated, or does exist, within an Agency's network.</p> <p>2. The Department will provide information and training opportunities for the Department's management and social work staff to enhance their understanding of the goals, policies and procedures of the Commonworks system. <i>ValueOptions/Commonworks</i> will assist the Department in this effort.</p> <p>3. In compliance with RFP specification and in recognition of the importance to the Lead Agencies' successful management of their network, the Department will ensure that:</p> <p>a) Youth referred for placement within Commonworks meet the general demographic, social and behavioral characteristics outlined in the Lead Agency Principal Contract;</p> <p>b) Prior to the Client's referral for placement in Commonworks, the DSS Referral for Residential Placement packet is thoroughly completed and includes:</p> <ul style="list-style-type: none"> • Supporting documentation of the youth's diagnostic and service needs • Assessment of the youth's educational status, including all documentation referred to in Section 6.1 of the RFP • Medical records • Social Security Number • Medicaid Number <p>c) Requests for TEAM evaluations are completed prior to referral for placement in Commonworks if it has been determined as part of the assessment that the youth is in need of special education services.</p> <p>d) Request that an Educational Surrogate Parent be appointed by DOE are completed prior to referral for placement in Commonworks.</p> <p>e) Work with the appropriate Local Education Agencies to obtain appropriate educational prototype for the youth must be initiated prior to referral for placement in Commonworks. The status of those efforts must be documented as part of the referral packet sent to the Lead Agency.</p> <p>4. The Lead Agency will place a youth within two (2) weeks of receipt of appropriate referral and/or appropriate referral packet.</p> <p>5. The Lead Agency may appeal the appropriateness of a referral by written notification to the Department's appropriate Regional Office. If that appeal is not successful, the Lead Agency may appeal to the Department's Director of Residential and Adolescent Services indicating that the referral, in their opinion, does not meet the criteria set forth in the Lead Agency Principal Contract. The decision of the Department's Director of Residential and Adolescent Services (or designee) will be binding.</p>	<p>acute care consumers ('New Consumers'), the contractor shall target to complete such outreach activities within 45 days of the Contractor's receipt of the consumer' DMH eligibility information...</p> <p>"4.0 ACCESS AND AVAILABILITY The Contractor shall:...4.01.08 Develop a report to monitor by Provider the number of Enrollees who transfer their care from one Provider to another Provider, evaluate the reasons for the transfer, take corrective action if required, and submit a quarterly report to the Division which shall include, the number of transfers by Enrollee and Provider, the reasons for the transfers, and corrective action Plans implemented or to be implemented." Appendix B, pages 26, 27.</p>
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B. Enrollment of Clients into Commonworks

1. The Lead Agency will complete Commonworks Enrollment and Change in Location Form and fax the completed form to *ValueOptions/Commonworks* within one (1) business day of a client being placed in Commonworks.
2. *ValueOptions/Commonworks* will enter the client Enrollment system within one (1) business day of receipt of information from the Lead Agency.
3. The Department will provide daily transfer of files from Family Net to *ValueOptions/Commonworks* in accordance with agreed upon protocols to ensure that the Department and *ValueOptions/Commonworks* have consistent information regarding clients authorized by the Department for placement in Commonworks.

C. Change in Client Location

The Department is interested in assuring that current information on the placement address for all Commonworks clients is available in Family Net. The following procedures have been established to ensure that a client's placement address is readily available on Family Net to Department staff.

1. The Lead Agency will complete a *Commonworks Enrollment and Change of Client Location Form* and fax the completed form by close of the business day to *ValueOptions/Commonworks* whenever:
 - a) a client has moved from one placement address to another.
 - b) a client has been discharged from placement.
 - c) a client is AWOL for more than one day.
 - d) a client has been hospitalized for medical or psychiatric treatment.

ValueOptions/Commonworks will enter the information provided by the Lead Agency on the change in client location into Family Net by the close of business on the day the information was received. (Commonworks Service Program, FY 2002 Addendum).

<p>Care coordination/ case management/ case work</p>	<p><u>Commonworks Policies, Procedures and Protocols Relative to Treatment Planning and Progress Review.</u> The Subcontractor will ensure that all staff are trained and implement all relevant policies procedures and protocols. The Subcontractor will submit to the Lead Agency copies of all Commonworks Treatment Plans, Treatment Plan Detail, Treatment Progress Review and Discharge Forms in a timely manner and in compliance with the procedures established by the Services Management Organization and the Lead Agency for such submissions to the Lead Agency. (Commonworks Standard Terms and Conditions for Subcontractors (Amended and Restated as of July 1, 2002)</p> <p><u>Submission of Information, Data and Claims.</u> The Subcontractor shall submit all claims, service utilization management, clinical case management and quality improvement information and data requested by the Lead Agency, the Services Management Organization or the Department in accordance with the schedules specified by the requesting organization. (Commonworks Standard Terms and Conditions for Subcontractors (Amended and Restated as of July 1, 2002)</p> <p><u>Attendance at Meetings.</u> The Subcontractor shall send appropriate representatives to all meetings and training sessions established by the Lead Agency, the Services Management Organization or the Department that are deemed reasonable and necessary to the administration of the Commonworks Program and to the case management of Referred Clients. This may include but not be limited to client specific meetings, Regional Network meetings and statewide meetings and training. (Commonworks Standard Terms and Conditions for Subcontractors (Amended and Restated as of July 1, 2002)</p> <p><u>Performance Specifications</u> The Subcontractor shall submit to the Lead Agency within two (2) weeks of the established schedule, a Commonworks Treatment Plan Summary and Treatment Progress Review for all referred clients.</p> <p>The Subcontractor shall submit to the Lead agency a Commonworks Service Delivery Report – Part 2 (SDR2) accurately documenting service utilization and critical incidents for each referred client on a weekly basis.</p> <p>The Subcontractor shall demonstrate compliance with the Commonworks Complaint, Grievance and Critical Incident Policy by submitting required documentation within specified timeframes on ninety (90%) percent of occurrences.</p> <p>The Subcontractor shall submit in accordance with procedures outlined in the “Commonworks Financial Management Manual” all Service Delivery Reports – Part 1</p>	<p>“SECTION 2: DEFINITIONS The following terms shall have the meaning stated, as they appear hereunder, unless the context clearly indicates otherwise...</p> <p>DMH case management services of Care Management Services – shall mean mental health Case Management conducted by DMH or its agents, and available to DMH continuing Care consumers, including those Recipients who are also DMH continuing Care Consumers. Core elements of DMH case Management Service functions include assessment, treatment planning, service linkage, monitoring, and client advocacy...” Appendix A, pages 6, 8.</p> <p>“Intensive Clinical Management (ICM) – shall mean the administration and provision of a set of clinical management services delivered to High Demand Cases.” Appendix A, page 11.</p> <p>“3.2 Delivery and Coordination of Services The Contractor shall:...</p> <p>J. manage certain inpatient mental health beds for uninsured children that DMH currently manages pursuant to a Memorandum of Understanding between DMH and those private psychiatric hospitals (‘Private Psychiatric Hospitals’) identified in Appendix Y to this Contract. Management shall include referral and screening of clinically appropriate, uninsured children, utilization review services and discharge planning.” Appendix A, pages 21-22.</p> <p>“5.01 Department Structure and Staffing The Contractor shall: 5.01.01 Develop a Utilization Management Department that shall be operational on the Full Service Start Date and shall be responsible for the following:...</p> <p style="padding-left: 40px;">f. Intensive case management...” Appendix B, page 29.</p> <p>“5.01.04 Design and submit to the Division for prior review and approval, a plan to be implemented within the first month of the Contract, which shall ensure that clinicians in the Utilization Management Department who are coordinating services and making service authorization decisions have training and experience in the specific area of service for which they are coordinating and authorizing</p>
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(Claims) for any services rendered to Referred Clients by the tenth (10th) of the month following each service delivery month. (Commonworks Standard Terms and Conditions for Subcontractors (Amended and Restated as of July 1, 2002)

D. Authorization of Services

Authorization of services for Commonworks' clients is the responsibility of the Lead Agency.

The determination of the level of placement service to meet a client' needs is an important component of care management and is determined through the Commonworks level of care and treatment planning processes.

Authorization for service is also fundamental to the effective financial management of Commonworks. The rigorous maintenance of the authorization system is critical to timely payment of claims and accurate projections of financial liability. The following responsibilities have been established to ensure that the Department, Lead Agencies, and ValueOptions/Commonworks have timely and accurate information on service authorizations.

The Lead Agency is responsible for maintaining up to date and accurate authorization information on all clients in the Options MHS system. Retroactive changes in authorizations potentially result in the need to reverse claims previously paid against that authorization. Therefore, authorizations for service should be entered in compliance with the protocols outlined in the FY'02 Commonworks Financial Management Manual to reflect all changes in client placement and status. As specified in the protocols, the Lead Agency is responsible for monitoring and making necessary corrections to authorizations within the MHS system once each week.

ValueOptions/Commonworks is responsible for providing reports to support the Lead Agencies' maintenance of timely and accurate authorizations within the MHS system. These reports include, but may not be limited to, *Total Authorizations vs. Total Claims* and *Pre-posting Report*. An extract of the claims and authorization files will be refreshed and made available to the Lead Agencies on a daily basis.

ValueOptions/Commonworks is responsible for providing training and technical assistance to the Lead Agencies on an as needed basis to ensure that the authorization system is maintained.

services. The Contractor shall ensure the following:

- a. that the clinician coordinating and authorizing adult mental health services shall be a clinician with experience and training in adult mental health services;
- b. that the clinician coordinating and authorizing child and adolescent mental health services shall be a clinician with experience and training in child and adolescent mental health services;
- c. that the clinician coordinating and authorizing adult substance abuse services shall be a clinician with experience and training in adult substance abuse services.
- d. that the clinician coordinating and authorizing child and adolescent substance abuse services shall be a clinician with experience and training in child and adolescent substance abuse services.
- e. that the clinician coordinating and authorizing Dual Diagnosis services shall be a clinician with experience and training in Dual Diagnosis services; and
- f. that the clinician coordinating or authorizing services for an Enrollee with a coexisting medical and mental health or substance diagnosis shall be a Registered Nurse or Psychiatrist with experience and training in services with a coexisting medical and mental health and substance abuse diagnosis..." Appendix B, page 32.

“5.05 Intensive Clinical Management

The Contractor shall:

5.05.03 Operate an ICM Program that shall include:

- a. assessment
- b. treatment planning;
- c. case monitoring;
- d. coordination and authorization of services;
- e. collaboration with the DMH Care Manager, who shall have responsibility for the management of Enrollees who are enrolled in the ICM Program and who shall be receiving DMH Continuing Care Services;
- f. service linkage; and
- g. client advocacy.

Lead Agencies and *ValueOptions/Commonworks* will review any problems related to the maintenance of the authorization system during Quarterly Quality Improvement Planning meetings with the Lead Agencies. Recommended changes in workflow processes will be incorporated into the Action Plan.

E. Treatment Planning and Service Provision

Active and focused treatment planning assists the client in achieving his/her permanent goal as quickly as possible. Treatment planning and review of client progress is a primary responsibility of the Lead Agency in collaboration with their network providers. The case coordination and treatment planning process developed for Commonworks is the result of significant collaborative effort by *ValueOptions/Commonworks*, the Lead Agencies, network providers, and the Department. The following expectations supplement those outlined in the Commonworks Adolescent Services Program RFP forming a part of the Lead Agency Principal Contract, providing greater detail on responsibilities for Commonworks treatment planning and service provision.

Department

The Department is responsible for providing information to the Lead Agencies at the time of the client's referral to Commonworks on the client outcomes identified in the Department's Service Plan.

The Department is responsible for participating in ongoing Treatment Planning case conferences and working with Lead Agencies and providers to ensure that the needs of the client are being addressed and that there is continued progress toward achievement of treatment planning goals.

The Department is responsible for notifying Lead Agencies in a timely manner of any changes in the client's service plan goal, or significant changes in the client's family that would effect treatment planning or case coordination.

Lead Agencies

The Lead Agency is responsible for compliance with all Commonworks policies and procedures related to case management and treatment planning specified in the *Commonworks Clinical Protocols Manual*.

The Lead Agency, with the assistance of *ValueOptions/Commonworks* is responsible for

	<p>ensuring that all providers with which it subcontracts are trained on applicable policies and procedures related to treatment planning, case management and service provision within Commonworks, and kept apprised of any changes therein.</p> <p>The Lead Agency is responsible for participating in all required case conferences as delineated in the Commonworks Treatment Planning Manuals for Placement and Aftercare.</p> <p>The Lead Agency is responsible for updating the Department on the treatment plans and progress toward achievement of treatment goals for each client within their Network.</p> <p>The Lead Agency is responsible for ensuring that all Commonworks Service Delivery Reports and Treatment Planning are completed by subcontractors in a timely manner.</p> <p>The Lead Agency is responsible for ensuring that appropriate Treatment Planning forms are provided to subcontractors during times of transition. This includes the Initial Referral Plan completed by the Lead Agency in new Commonworks referrals as well as the Discharge Plan Summary completed by the client's last Commonworks placement subcontractor and forwarded by the Lead Agency to the next placement subcontractor or aftercare subcontractor.</p> <p>The Lead Agency is responsible for reviewing client Treatment Plans and Quarterly Progress Reviews to ensure that the needs of the client are being addressed and that continued progress toward treatment planning goals is achieved. Lead Agency review of client treatment plans and progress is documented on the <i>Lead Agency Review Form</i>.</p> <p>The Lead Agency is responsible for implementing the Commonworks Level of Care criteria as set forth in the implementation plan, and for ensuring that subcontractors comply with their responsibilities therein.</p> <p>The Lead Agency is responsible for ensuring that all services outlined in the client's Treatment Plan are available to the client.</p> <p>The Lead Agency is responsible for coordination of appropriate educational placements in the least restrictive environment to meet the client's needs.</p> <p>The Lead Agency is responsible for ensuring that Case Management Forms (<i>including all Initial Referral Plan, Treatment Plan Summaries, Treatment Progress Reviews, Discharge Plans, Lead Agency Review Forms and Service Delivery Report - Part 2</i>) are entered into the</p>	
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<p>Commonworks Client Information System during both placement and aftercare in a timely manner.</p> <p>The Lead Agency, with the assistance of <i>ValueOptions/Commonworks</i> are responsible for ensuring that their data entry staff are trained on Commonworks policies and procedures and on entering client data into the Commonworks Client Information System, and for providing ongoing supervision on the same.</p> <p><u>ValueOptions/Commonworks</u></p> <p><i>ValueOptions/Commonworks</i> is responsible for assisting Lead Agencies in training new provider staff on the Commonworks Case Management and Treatment Planning policies and procedures.</p> <p><i>ValueOptions/Commonworks</i> will make available to all Commonworks providers a <u>Commonworks Provider Manual</u>, a <u>Commonworks Treatment Planning and SDR2 Manual for Placement</u>, a <u>Treatment Planning Manual for Aftercare</u>, and a <u>Commonworks Clinical Protocol Manual</u> that include information on their responsibilities related to treatment planning and service provision</p> <p><i>ValueOptions/Commonworks</i> is responsible for providing technical assistance to support Lead Agencies' training of their data entry staff on procedures related to entering data into the Commonworks Client Information System.</p> <p><i>ValueOptions/Commonworks</i> is responsible for providing weekly extracts to the Lead Agencies on service utilization and case management data the Lead Agencies have entered into the Commonworks Client information System.</p> <p><i>ValueOptions/Commonworks</i> is responsible for reviewing service utilization and treatment planning as components of provider site reviews, case record reviews and Lead Agency Quarterly Quality Improvement Planning meetings.</p> <p><u>F. Care Coordination and Utilization Management</u></p> <p>Coordinated care and effective management of utilization support timely achievement of client outcomes and efficient use of Commonworks' resources. Working in collaboration with the Department's Area and Regional Offices, the Lead Agency has primary responsibility for ensuring that Commonworks' resources are used creatively and flexibly to enhance the services received by clients and to maximize the number of clients who</p>	
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	<p>may be served.</p> <p>The Lead Agency is responsible for making decisions on level of care to meet the educational, behavioral and social needs of clients in the least restrictive setting.</p> <p>The Lead Agency is responsible for ensuring the continuity of client care to facilitate smooth transitions between levels of placement and into Aftercare services.</p> <p>DSS Regional Clinical Review Teams will be the final arbiters should disagreements between the Lead Agency and the Department's Area Office occur in regard to decisions on level of placement services or discharge from placement services.</p> <p><i>ValueOptions/Commonworks</i> is responsible for reviewing utilization management with the Lead Agencies as a component of the Quarterly Quality Improvement Planning meetings.</p> <p><i>ValueOptions/Commonworks</i> is responsible for providing training opportunities for providers and Lead Agencies on effective utilization management.</p> <p><i>ValueOptions/Commonworks</i> is responsible for analyzing and reporting on service utilization data to support enhanced utilization management by the Lead Agencies. (Commonworks Service Program, FY 2002 Addendum).</p> <p><u>Care Coordination.</u></p> <p>Resources for Care Coordination are included in the administrative line of the Lead Agency contract. Care Coordinators are funded in FY'03 for an annual salary of \$xx,xxx. Care Coordination is based on 50 pro-rated consumers in placement to 1 Care Coordinator. The Lead Agency will receive a check based on the PV line amount for Care Coordination from the SMO after DSS deposits funds into the DSRA.</p> <p><u>Education Coordination.</u></p> <p>Resources for Education Coordination are included in the administrative line of the Lead Agency contract. Care Coordinators are funded in FY'03 for an annual salary of \$xx,xxx. Education Coordination is based on 90 pro-rated consumers in placement to 1 Education Coordinator. The Lead Agency will receive a check based on the PV line amount for Care Coordination from the SMO after DSS deposits funds into the DSRA. (Fiscal Year 2003 Financial Management Manual, July 2002).</p>	
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Missouri

Domain	Child Welfare Language	State Medicaid Managed Care Language
Interagency collaboration	<p>"Documented working agreements with courts and other referents for children in traditional pathways for the Divisions of Family Services, Youth Services, Psychiatric Services, Mental Retardation and Developmental Disabilities, and Alcohol and Drug Abuse." page 15.</p> <p>"Include a detailed description of how coordination with the MC+ Health Plans, Medicaid fee-for-service providers, and/or other private insurers will be developed/fostered where appropriate. The Plan of Care must also include coordination with the local school." page 12.</p>	<p>"2.11 Coordination With Out-Of-Plan Services:...</p> <p>The major types of out-of-plan services with which it must coordinate are described below... When communities and school boards agree, schools may, and some do, operate school based clinics. This is particularly true when addressing the unmet needs of adolescents. The State supports the efforts of such communities; therefore, it must at a minimum, have a written process describing how school based clinic services will be coordinated with other services which are the responsibility of the plan to provide." page 57.</p>
Enrollment and eligibility terms	<p>"Upon admission to the CMO, the IT, at its discretion, may approve a child for participating for a period of six (6) continuous months or longer dependent upon the needs of the child and family. After the six-month period and if necessary, a three-month period may be authorized by the IT based upon clearly established goals in the Plan of Care. If necessary, further authorization in two-month increments may be made by the IT based on documented Plan of Care goals. The CMO must provide written requests for continued authorization as directed by the IPA." Page 11.</p> <p>"The CMO shall establish enrollment procedures that orient and register children and families assigned by the IT for care management. The enrollment procedures shall include education about the care management process and child and family rights, responsibilities, and roles within the care management process. In addition, services and providers that are available by type and location will be defined." Page 10.</p> <p>"Selection of eligible children and families will result from referrals from each participating child-serving decision at key decision points for long-term residential care, and at decision points for discharge from long-term residential care back to the community. Enrollment will be voluntary by children and their families and/or legal custodian." Page 5.</p> <p>"Division of Youth Services Residential Secure Care \$xxx per day. The Medicaid program provides certain benefits for Medicaid-eligible children. For all exams, and pharmacy benefits (when medically necessary) will be the responsibility of the Medicaid program. For category 4 Medicaid-eligible children (see below), all Medicaid covered behavioral health benefits have been incorporated into the case rate and are, therefore, the responsibility of the CMO, and Medicaid must not be billed separately for those services.</p>	<p>b. Eligibility of Other Medicaid Children: All children in the legal custody of the group Department of Social Services; all children placed in not-for-profit residential group home by a juvenile court...</p> <p>Health plans are financially responsible for providing medically necessary psychology and counseling services as specified in this RFP. A health plan is not responsible for behavioral health services for children who are in the care and custody of the State (Group 4 category of assistance)..." Attachment Five.</p> <p>c. Medicaid eligibles in the above specified eligibility groups who are:...</p> <p>4) receiving foster care or adoption assistance under part E of the Title IV of the Social Security Act;</p> <p>5) in foster care or otherwise in out-of-home placement..." Missouri RFP, page 15.</p> <p>"Group Eligibility Criteria... AFDC-Foster Care..." Attachment One.</p> <p>"1.4.4 Parent's Fair Share Under Title XIX</p> <p>a. Covered Groups</p> <p>Certain uninsured non-custodial parents actively participating in the Missouri's Parent's Fair Share program will be eligible for Medicaid under this waiver amendment...</p> <p>To be eligible for Parent's Fair Share the non-custodial parent must</p>

	<p>For other Medicaid eligible children (not Category 4), a limited array of behavioral health benefits.” Page 23A.</p>	<p>meet the following requirements:</p> <ol style="list-style-type: none"> 1) Must reside in the State of Missouri 2) Must have one child receiving TANF benefits, food stamps, or Title XIX benefits in the State of Missouri (child cannot reside with the non-custodial parent); 3) Must be the legal or presumed parent of the child (paternity cannot be in question); and 4) Must be unemployed or underemployed (working fewer than 40 hours a week at minimum wage or less)...” pages 13-14. <p>“14.5 Uninsured Custodial Parents Below 100 Percent Under Title XIX</p> <p style="padding-left: 40px;">a. Covered Groups</p> <p>Uninsured custodial parents with income up to 100 percent of the federal poverty level will be eligible for Medicaid.” page 14B.</p> <p>“2.14.8 Children in state custody or foster care placement will be allowed automatic and unlimited changes in health plan and provider choice as often as circumstance necessitate. Foster parents will normally have the decision making responsibility for which health plan will serve the foster children resident with them; however; there will be situations where the Social Service worker or the courts will select the health plan for a child in state custody or foster care placement.” page 75.</p> <p>“Services for children in the custody of the Jackson County office of the Missouri Division of Family Services:... Health plans shall be responsible for providing all services in paragraphs 2.11.13 (a) and (b) following the effective date of enrollment in a health plan. If the child is already enrolled in a health plan and enters custody, the health plan shall be responsible for providing all services in paragraphs 2.11.13 (a) and (b) from the time the child enters DFS custody...” page 64.</p> <p>“2.11.7 Mental Health Benefits:... b. Mental Health Out-of-Network Referrals: If the health plan believes that a child or youth may require residential care in order to receive appropriate care and treatment for a serious emotional disorder, the health plan may apply to the Missouri</p>
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<p>Care coordination/ case management/ case work</p>	<p>“II. Services requiring delivery by professional staff: Case management.” Attachment F, page 1.</p> <p>“Care Management Process: The CMO shall design and implement a comprehensive, individualized care management process. Under a 'No eject, no reject' policy, success for this initiative is highly dependent upon care management that assumes financial and operational control of a Plan of Care and actively works with all available resources to maintain household stability and anchors the child and family to the community. 'No reject' is defined to mean any child referred by the IT [Interagency Team] must be accepted for treatment. 'No eject' is defined to mean a child shall not be disenrolled from care until all Plan of Care objectives are met and the Interagency Team has approved disenrollment.” page 9.</p> <p>“Organization (CMO) assumes responsibility for b. Design and implementation of comprehensive, individualized care management processes, to support Family Support Teams under a 'No eject, no reject' policy.” page 8.</p> <p>“During the initial (60) sixty days of the contract, the CMO shall recruit and develop a comprehensive array of community-based providers and resources. Under a 'No eject, no reject' policy, success for this initiative is highly dependent upon care management that assumes financial and operational control of a Plan of Care and actively works with all available resources to maintain household stability and anchors the child and family to the community. 'No reject' is defined to mean any child referred by the IT must be accepted for treatment. 'No eject' is defined to mean a child shall not be disenrolled form care until all Plan of Care objectives are met and the Interagency Team has approved disenrollment.” page 9.</p> <p>“The CMO network shall integrate paid professionals, family members and friends, community resources or providers of services, participating child-serving divisions' staff, and community volunteers in coordinated efforts to implement individual Plans of Care.” page 6.</p> <p>CLIENT PLACEMENT/TREATMENT HISTORY/ASSESSMENT INFORMATION</p>	<p>“2.11.7 Mental Health Benefits:... d. Targeted case management services for mental health benefits shall be reimbursed to the state agency according to the terms and conditions of the Medicaid fee-for-service program.” page 62.</p> <p>“The DMH service coordinator and the MC+ health plan...primary care provider must collaborate on behalf of the client to insure coordinated care, access to care, and to avoid duplication of services...” page 66.</p> <p>e. Consent Decree Medical Case Management: Children in the custody of the Jackson County office of the Missouri Division of Family Services and residing in Jackson County also receive targeted medical case management services...The medical case management services provided by the Medical Case Management Agency include, but are not limited to:</p> <ol style="list-style-type: none"> 1) promoting the effective and efficient access to comprehensive medical services for the targeted children, 2) facilitating the coordination of medical services, 3) maintaining confidential centralized files for each child, 4) assisting in the education of Division of Family Services staff, caregivers, and health care providers regarding the child’s medical care, 5) providing information regarding the need for specialized health services, 6) coordinating and monitoring all primary and specialty care necessary for the child, and 7) ensuring that essential medical care received by the child complies with the Consent Decree, Part III...” page 65. <p>Targeted case management services for mental health benefits shall be reimbursed by the state agency according to the terms and conditions of the Medicaid fee-for-service program.” page 62.</p>

	<p>FROM THE AGENCY CLIENT FILES Client Placement History (type, frequency, duration, movements from current case file.) Other Client History (Machine-readable elements from historical file of significance in treatment planning, establishing outcomes, monitoring progress, for tracking clients and court actions required by a child placing authority/jurisdiction, if any.) ASSESSMENT AND TREATMENT PLANNING Automated Initial Assessment Data, and Date Assessment at Tx Plan Update, ad Date (included each time the Tx Plan is updated) Automated Treatment Planning Period Covered by the Treatment Plan Date Schedule for the Next Routine Update of the Plan (should be at least 10 days prior to the expiration of the period covered by the treatment plan).” pages 15-17.</p>	<p>“2.11.8 Comprehensive Substance Treatment Abuse and Rehabilitation (C-STAR) programs are carved out of the MC+ program. Services provided by a C-STAR Medicaid provider will be reimbursed fee-for-service by Medicaid...</p> <p>“2.11 Coordination With Out-Of-Plan Services:... The major types of out-of-plan services with which it must coordinate are described below... Individuals with Disabilities Education Act Part B and Part C: The health plan will not be financially liable for therapy services... developed under the First Steps Program...The First Steps program serves children from birth to age three (3) who are developmentally delayed or have diagnosed conditions associated with developmental disabilities...” page 57.</p> <p>“o. health plans shall subcontract with school based clinics as primary care clinics and reimburse at rates equivalent to the Medicaid fee schedule, unless otherwise negotiated, only if the following conditions are met by the school based clinic...” page 28.</p>
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Franklin County, Ohio

Domain	County Child Welfare Language	State Medicaid Managed Care Language
Interagency collaboration	<p>“CHILDREN SERVICES will provide up to \$x,xxx,xxx for Children Services funds annually to the pooled funds for the purpose of purchasing behavioral healthcare services...” Ohio (Franklin County), Contract with Franklin County Children Services, page 1.</p> <p>“CHILDREN SERVICES agrees to modify its agreement with the appropriate providers in order to accommodate MACSIS requirements so as to allow 100% reimbursement of billed behavioral health care services through the ADAMH Board identified in this section. In the event that the modification of provider agreements under this Section results in a negative impact on the reimbursement claim made to Title IV-E, by CHILDREN SERVICES, CHILDREN SERVICES and the ADAMH Board of Franklin County agree to share equally any such loss of Title IV-E revenues.” Ohio (Franklin County), Contract with Franklin County Children Services, page 1.</p> <p>“SECTION VIII. The ADAMH Board's portion of the pooled fund includes federal Medicaid FFP. Both ADAMH's and CHILDREN SERVICES' state and local portion of the pool used as Medicaid match.” Ohio (Franklin County), Contract with Franklin County Children Services, page 3.</p> <p>“SECTION X. Children Services will withhold appropriate child and adult Medicaid match from case rate payments made to the CHILDREN SERVICES Care Partnership Project providers. In order to assure proper payment adjustments, rate reductions will be made after actual match requirements are determined by the ADAMH Board. The ADAMH Board of Franklin County agrees to periodically invoice Children Services for these local public funds, including details by individual and a breakdown between child and adult, match requirements. Children Services agrees to make timely payments of such invoices for use as pooled funds for future Medicaid match.” Ohio (Franklin County), Contract with Franklin County Children Services, page 3.”</p> <p>SECTION XXI. CHILDREN SERVICES agrees to pay the ADAMH Board a quarter of the \$x,xxx,xxx on a quarterly basis beginning January 1, 1999 through an invoice process which will be based on the monthly cost and service utilization reports submitted by the ADAMH Board for both the Franklin County Behavioral</p>	<p>The substance abuse screening and referral requirement involves the participation and cooperation of the MCP; its prenatal care providers; ODADAS; Alcohol, Drug Addiction, and Mental Health/Alcohol and Drug Addiction Services Boards; and organizations selected by ODMH/ODADAS to provide or manage behavioral health services...” page 14.</p>

	Health Care Partnership and the Children Services Care Partnership.” Ohio (Franklin County), Contract with Franklin County Children Services, page 4.	
Enrollment and eligibility terms	<p>“Persons eligible for services under this AGREEMENT are children and families with open cases, including Family Preservation cases, with CHILDREN SERVICES and assessed by the ADAMH system as in need of behavioral health care services. All persons enrolled in the ADAMH system through this process will be eligible to receive any of the behavioral health care services currently available and contracted for in the ADAMH system of care, and shall be given the same priority for provision of services as those persons ADAMH is statutorily mandated to serve.” page 1.</p> <p>SECTION XII. The ADAMH Board agrees to enroll and track all eligible children and families in its data system for both the Partnership and the Children Services Managed Care Project.” Ohio (Franklin County), Contract with Franklin County Children Services, page 3.</p> <p>“Service Population: Provider will serve children and their families referred on a random basis from Children Services’ Intake and Investigations Department - While Children Services investigation may have been initiated because of concern about only one child, the referral will be the “case,” as defined in Section 3.5, which is the entire family... Provider will serve children of all ages up to their 18th birthday or, if the child is enrolled and attending high school, graduation from high school, whichever is later, and until their 21st birthday if they are handicapped, and serve their families without restrictions during the same period.” Ohio (Franklin County), Contract with The Ohio Youth Advocate Program, Inc. (OHFC2), page 5.</p> <p>“SECTION V. In order to track the targeted population, a referral and enrollment process for referral into the Partnership project which emanate from providers other than NetCare will be jointly developed by CHILDREN SERVICES and ADAMH to ensure that all individuals referred are enrolled.” Ohio (Franklin County), Contract with Franklin County Children Services, page 2.</p> <p>“SECTION VI. All persons enrolled in the ADAMH system through this process will be eligible to receive any of the behavioral health care services currently available and contracted for in the ADAMH system of care, and shall be given the same priority of provision of services as those persons ADAMH is statutorily mandated to serve.” Ohio (Franklin County), Contract with Franklin County Children Services, page 2.</p>	<p>Children in foster care or out-of-home placement</p> <p>“B. Background Program History and Status... Currently, MCP-enrolled children whose custody has been legally transferred from legal parent or guardian to another entity, such as a public children service agency (PCSA) are automatically disenrolled from the plan following notification to ODHS. PCSAs have the option to enroll children in their custody in an MCP...” page 3.</p> <p>Plan disenrollment for loss of coverage or eligibility</p> <p>“5101:3-26-021 Managed care plan: Disenrollment... (B) The following applies to all automatic disenrollments in both voluntary and mandatory counties:... (2) Automatic disenrollment occurs for one of the following reasons: (e) An enrolled minor’s custody has been legally transferred from the legal parent or guardian to another entity...” Appendix E, OAC 5101:3-26-021, page 1.</p> <p>“Children with Special Health Care Needs The enrollment in managed care of children with special health needs presents unique challenges in service delivery, care coordination, and reporting. With the expansion of eligibility, ODHS is interested in approaches which assure and document that all Medicaid-covered children have access to appropriate, quality services. Managed care, with its emphasis on prevention, care management, and accountability, offers an opportunity to improve the services received by many children with special health needs. Additional program requirements have been developed designed to identify and assess children with designated special health needs (including those receiving SSI or services through the Children with Medical Handicaps program), monitor care management and service utilization, and assess consumer satisfaction and quality of care.” page 11.</p> <p>“3. Children with Special Health Care Needs The enrollment of children with special health care needs (CSHCN) raises additional issues for Medicaid managed care. Care coordination</p>

	<p>All children with Mental Health or Mental Retardation/Developmental Disabilities issues must be referred to those systems for evaluation of assignment to case managers from those systems.” Ohio (Franklin County), Contract with The Ohio Youth Advocate Program, Inc. (OHFC2), page 9.</p>	<p>becomes especially critical, as does timely identification and assessment. ODHS is therefore establishing specific provisions to assure the appropriate delivery of quality services to children identified as CSHCN.</p> <p>a. Identification ODHS, through its Enrollment Services Contractor (ESC), will conduct a preliminary screen as part of the enrollment process to identify children (those less than 21 years of age), that may potentially have a special health care need, including any child receiving services through the Ohio Department of Health (ODH), Bureau for Children with Medical Handicaps (BMHC), or known to be eligible for Supplemental Security Income (SSI). The screen will focus on chronicity and complexity of health condition(s)...</p> <p>For enrollees auto-assigned to an MCP, the MCP will be responsible for conducting the preliminary screen within 30 days of being notified of the auto assignment. ODHS will make available the screen used by the ESC for use by the MCPs.</p> <p>ODHS is exploring additional ways to identify children receiving services through BMHC and/or SSI. Contracting MCPs will be notified of any enrollees identified using such approaches for further assessment.” page 17.</p>
<p>Care coordination/case management/case work</p>	<p>“Case Management: Case management includes but is not limited to: activities related to a child and/or his/her family assessing risk to the child and the results of care or services; supporting the management of care or service referral to or arranging for care or services; planning or supervising care or services; supporting access to care of services; assessing results of care or services; placement of a child; preparation or and participation in judicial determinations; preparing custody petitions; assisting with voluntary placement agreements; and preparing for the safe return of a child to the family or for permanent placement of a child." Ohio (Franklin County), Contract with The Ohio Youth Advocate Program, Inc. (OHFC2), page 2.</p> <p>"Direct Services: Services received by children and their families and services received by foster parents, including, but not limited to: case management, individual, group or family counseling, mentoring, arrangement for and transportation to and from school and physical and medical treatment, recreational activities, day care, respite, foster parent support services, crisis stabilization, in and</p>	<p>“E. Service Delivery Specification... 2. Case Management The respondent will be required to meet all specification of OAC rule 5101:3-26-031 (see Appendix E) as well as establish and document a case management program to assure continuity of care and care coordination...” page 15.</p> <p>“13. Children with Special Health Care Needs... (c) Case Management The MCP must provide or arrange case management services to each CSHCN. A treatment care plan must be developed and retained by the MCP on each CSHCN. A PCP (which may be a specialist) and case manager must be identified and the coordination of services and providers clearly delineated in the care plan. The case manager may be the PCP, another physician, physician assistant, or registered nurse. Coordination of services</p>

<p>out of home care, and transportation." Ohio (Franklin County), Contract with The Ohio Youth Advocate Program, Inc. (OHFC2), page 3.</p> <p>"Case management, placement services and such other services as the Quality Assurance Director may approve shall remain in place for child(ren) granted PCC or LTFC status, though such services shall be paid outside the COS payment." Ohio (Franklin County), Contract with The Ohio Youth Advocate Program, Inc. (OHFC2), page 7.</p> <p>"Mental Health, Alcohol and Other Drug Services: Mental health and substance abuse services must be available for both parents and children but may be provided either directly by the Provider or network or through referral. All children with Mental Health or Mental Retardation/Developmental Disabilities issues must be referred to those systems for evaluation of assignment to case managers from those systems." Ohio (Franklin County), Contract with The Ohio Youth Advocate Program, Inc. (OHFC2), page 9.</p> <p>"SECTION V... Every attempt will be made to ensure that those persons with the most severe needs as determined by both the CHILDREN SERVICES triaging system and the ADAMH system's level of care determination are served as quickly as possible." Ohio (Franklin County), Contract with Franklin County Children Services, page 2.</p> <p>Case Management:... Activities related to voluntary or court ordered protective services or the placement of a child either voluntary by the parent(s) or under a court order of custody including: documentation of the need for court orders or placement as required by the O.A.C.; preparation for and participation in judicial determinations that court ordered protective services are required or that a placement is reasonable and in the best interest of the child; preparation for and participation in case reviews; preparation of motions for charges, renewals and termination of case plans, court orders and custody; and preparation of motions for and participation in court hearings for extensions of voluntary placement agreements." Ohio (Franklin County), Contract with The Ohio Youth Advocate Program, Inc. (OHFC2), pages 2-3.</p> <p>"Interface with Intake and Investigations:... Should placement be required, I & I staff will obtain the medical screen for the child(ren)." Ohio (Franklin County), Contract with The Ohio Youth Advocate Program, Inc. (OHFC2), page 7A.</p>	<p>must include, where appropriate, the involvement of social or public health agencies. The care plan must also define clear objectives related to quality of care and health outcomes.</p> <p>Care plans must be monitored and updated on a regular basis and made available upon request to ODHS or its designee." pages 17-18.</p> <p>"5101:3-26-031 Managed care plan: Availability and access to services... (E) Case management. (1) Each MCP must submit a written description of its case management program to ODHS for prior approval. The case management program description must:</p> <ul style="list-style-type: none"> (a) Provide and assure that each enrollee or the enrollee's caretaker selects a PCP to provide and coordinate care; (b) Establish and describe the criteria to be used to identify which enrollees require specialized case management due to catastrophic, acute, chronic or complex illness or injury; (c) Establish and describe the referral and service coordination mechanisms between the PCP and specialists, including documentation of a standardized referral system and/or forms; (d) Describe under what circumstances a specialist may act as a PCP; (e) Describe under what circumstances and how care plans are developed, implemented, and evaluated and which MCP staff are responsible and involved; (f) Establish and describe the procedures to be followed by the MCP and/or providers to follow-up with enrollees in the event of missed appointments; (g) Establish and describe a policy regarding the enrollees' responsibility for and participation in their care, including a description of how the policy is implemented and monitored with providers and enrollees; and (h) Establish and describe the procedures to be followed by the MCP in coordinating and documenting the provision of sign and language interpreter services for enrollees with LEP or hearing impairments, as well as to ensure the translation of member materials for the LEP or the vision impaired. Such procedures must include the designation of the staff person responsible for such coordination and documentation." Appendix E, OAC 5101:3-26-031, pages 1-2. <p>Substitute House Bill 167 of the 121st Ohio General Assembly mandated</p>
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		<p>that ODHS require Medicaid-serving MCPs in mandatory enrollment counties to screen pregnant enrollees for the possible abuse of alcohol and/or other drugs. If the screening identifies a pregnant enrollee as possibly abusing alcohol and/or other drugs, the MCP is to refer the individual to an alcohol and other drug addiction provider certified by the Ohio Department of Alcohol and Drug Addiction Services (ODADAS) for a clinical assessment and possible treatment.</p> <p>2. Substance Abuse Services MCPs are responsible for ensuring that enrollees receive any medically-necessary substance abuse services and for coordinating those services with all other medical and support services. MCPs are responsible for ensuring that enrollees receive medically necessary inpatient detoxification services, general hospital outpatient alcohol and other drug treatment services, physician/psychiatrist alcohol and other drug treatment services, psychology alcohol and other drug treatment services, and outpatient clinic alcohol and other drug treatment services.” page 13.</p>
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