

**REPORT ON BEHAVIORAL HEALTH SPENDING FOR  
CHILDREN AND ADOLESCENTS IN GEORGIA  
ACROSS CHILD-SERVING SYSTEMS**

*Executive Summary*

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# REPORT ON BEHAVIORAL HEALTH SPENDING FOR CHILDREN AND ADOLESCENTS IN GEORGIA ACROSS CHILD-SERVING SYSTEMS

## EXECUTIVE SUMMARY

**Purpose of Analysis:** The Division of Mental Health, Developmental Disabilities and Addictive Diseases (MHDDAD) in the Georgia Department of Human Resources (DHR) contracted with the Human Service Collaborative (HSC) to analyze State spending on behavioral health (i.e., mental health and substance abuse) services for Georgia children and adolescents and their families across funding streams and child-serving systems. The project explores: which State agencies are spending dollars on behavioral health services for children and their families; how much is being spent; what types of funds are being utilized; what types of services and supports are being financed; how many and which children (e.g. by demographics, severity of disorder) are using services; what issues are raised by expenditures and utilization; and, what the current changes are in Georgia that have major implications for agency spending (risk) going forward.

The Department is interested in taking this systematic look at behavioral health funding for children and their families for several reasons:

- To more fully understand what is a complex picture of multiple funding streams to better inform policy decision making
- To get a better sense of areas of strength, as well as areas of duplication, inefficiency, and gaps
- To examine spending and service utilization within a system of care approach, that is, one that utilizes dollars more efficiently and effectively across systems, to reduce duplication and fragmentation and support better outcomes for children and families and that promotes a practice model, across State systems, that is strengths-based, culturally competent, individualized, partners with families and youth, and draws on natural helpers (such as faith-based organizations) to augment clinical services.

The report considers utilization and spending within the context of several environmental changes occurring in Georgia. These environmental changes include:

- Changes in Level of Care (LOC), also known as Therapeutic Residential Intervention Services (TRIS), or MATCH
- Adoption of the Psych Under 21 Option in Medicaid to cover Psychiatric Residential Treatment Facilities (PRTFs) and MHDDAD's receiving one of ten Federal demonstration grants awarded in late 2006 to allow for a 1915c waiver to provide home and community based alternatives to PRTFs
- Implementation of managed care organizations (known as Care Management Organizations) in Medicaid
- Conversion from Grant-in-Aid to Fee-for-Service funding of community-based behavioral health providers, including Georgia's Community Service Boards

- Federal challenges to and State changes in Targeted Case Management in the Division of Family and Child Services (DFCS) and in the Department of Juvenile Justice (DJJ).

These changes have a major impact on re-distribution of financial risk for child and adolescent behavioral health services among State agencies.

This project is not an analysis of the entire service delivery system for child/adolescent behavioral health services in Georgia. There are many other variables that affect service delivery that were not examined in this project, such as: rates paid to providers for services; provider capacity, skills, knowledge and attitudes; availability of services; the role and investment of families and youth in service delivery and system policymaking; the strength of clinical knowledge and leadership; staff recruitment and retention issues; the role of natural helpers and indigenous support structures in augmenting clinical capacity; contracting incentives and disincentives; billing and reporting structures; utilization management arrangements and the like.

**Challenges to Analysis:** There are many challenges to analyzing public sector spending on behavioral health services for children. There are multiple funding sources involved, which are controlled by multiple Federal, state and local systems, each of which has its own regulations and requirements. Many key funding sources, such as Medicaid, have Federal, state and, sometimes, county-level parameters. Different funding streams may support different providers, or, alternatively, support the same providers but with different contracting and reporting schemes. Most significantly for the purposes of this project, data are collected across these funding streams in different formats and for different purposes and may not even disaggregate into a category called, “child/adolescent mental health or substance abuse spending and utilization”. Because of the many challenges involved, analysis of public sector spending on behavioral health services for children is as much art as science. For this project, the State made considerable efforts to provide data for the analysis, yet, as discussed below, there are significant data gaps.

**Methodology:** HSC developed basic parameters for an analysis plan. An in-state consultant with many years of experience working within Georgia’s child-serving systems took the lead for gathering documentation and data for the analysis. HSC provided general direction and clarification for the data gathering process. In addition to obtaining spending and utilization data, HSC reviewed numerous State and national reports and web sites relevant to behavioral health services for children and adolescents. It also should be noted that HSC was involved in a child and adolescent behavioral health quality initiative in Georgia in the year prior to this study, which yielded considerable information about children’s systems in Georgia at State and local levels.

## Findings

### *Total Amount Spent and Number of Youth Served Across State Agencies*

Excluding the schools, the four agencies that spent the most on behavioral health services were, in order: DFCS, MHDDAD, DCH, and DJJ. Together, these four agencies alone spent an estimated \$590.8m in FY 06. There also appeared to be a 5% increase in expenditures across these four agencies from FY 05 to FY 06, and a 3% increase in the number of youth served. The majority of expenditures for behavioral health services across the four agencies were comprised of State general revenue (or TANF), followed by Federal Medicaid financing. Federal Title IV-E and Federal block grant and formula grant funding also play a critical role.

- Although expenditures across the four agencies appear substantial, available national data on State Mental Health Authority and State Medicaid spending suggest that **Georgia spends less than national norms through these two key funding sources for child and adolescent behavioral health services.**

### *Number of Children Served/Low Utilization Suggested*

Utilization data suggest that over 300,000 children and youth received behavioral health services across the four key State agencies (again, not including the schools).

- While this appears to be a substantial number of children served, **child and adolescent utilization of behavioral health services in Georgia appears to be somewhat lower than national averages based on national data that allow for comparisons of children served through State Mental Health Authorities and Medicaid.** It also should be noted that utilization in every State falls well below prevalence estimates of the need for behavioral health services.

### *Racial, Ethnic and Gender Disproportionality*

- **The demographic data that were available suggest racial and ethnic disproportionality in service use.** Black/African American youth are over-represented in all agencies; White youth tend to be under-represented; Latino/Hispanic youth are under-represented, except in PeachCare and Head Start; Asian/Pacific Islander youth are under-represented except in PeachCare; and American Indian/Native American youth are under-represented except in Vocational Rehabilitation.
- **Males outnumber females in every agency that provided gender data.** These data are consistent with national data indicating similar racial/ethnic and gender disproportionality in service use.

### *Under-Representation of Young Children and Transition-Age Youth*

- **There appears to be an under-representation, overall, of service use by very young children (ages birth-5), as well as by older youth (18-24),** again consistent with national findings. Most children receiving behavioral health services are between the ages of 6-18, based on available data.
- **Georgia's VR Program serves very few youth with behavioral health challenges. Those served receive few services from VR other than assessment and counseling, and their outcomes are poorer than for youth with other types of disabilities.** For example, they are more likely to have lower

employment status and be more dependent on family and public support than youth with other types of disabilities. Again, these findings are generally consistent with national data.

*Relatively Low Substance Abuse Expenditures and Utilization*

- **Relatively little appears to be spent on substance abuse treatment services for youth, and most of the dollars seem to be spent on substance abuse day treatment.**
- **There is little indication that dollars are supporting a wide array of substance abuse services for youth.**
- **Medicaid is used to a far lesser extent to finance substance abuse services than it is for mental health services.**

*Types of Services Utilized: Disproportionate Use of Restrictive Levels of Care and of Assessment Services*

- **55% of expenditures across the four major State spending agencies (not including education) is being spent on restrictive levels of care for about 6% of the total population of youth receiving behavioral health services.**
- **National education data on Georgia's special education expenditures also suggest that the State may be over-relying on restrictive special education placements relative to many other States.**
- **While DFCS and DJJ were able to reduce average LOC lengths of stay overall, as well as average costs per youth served, between FY 05 and 06, the numbers of youth in LOC placements increased significantly, as did total LOC spending.**

*Cost-Shifting Concerns*

MHDDAD significantly reduced State general revenue spending on State hospitalization from FY 05 to 06 by closing beds and reducing utilization. While inpatient spending was reduced by nearly \$9m., MHDDAD community-based spending increased by only a little more than \$7m. Spending over the same time period increased for LOC placements paid for by the Division of Family and Child Service (DCFS) (a nearly \$28m. increase between FY 05 and 06). While MHDDAD experienced a reduction in spending on high cost services, DCFS experienced an increase during the same time period.

- **While this increase in DCFS LOC spending may not be entirely driven by MHDDAD's closing of State beds, it is clear that without an adequate community-based system in place, a State is unlikely to achieve savings in inpatient and other "deep-end" services across its child-serving systems.**

*High Use of Assessments, Relatively Low Expenditures and Utilization for Key Home and Community-Based Services*

- **The data suggest that the services youth are most likely to receive through Medicaid Rehab Option and MHDDAD grant dollars are diagnostic assessments, physician assessment/care, and nursing assessment/care.**
- **The low utilization of and amount spent on home and community-based services raise questions as to whether these assessments are leading to**

- strengths-based, individualized plans of care.** In total, probably less than a third of spending across State agencies is for home and community based services.
- **In particular, key home and community-based services, such as crisis services, respite, peer support, family support and education are among the services least likely to be used by children and their families.**
  - **The services children are most likely to receive through DCH's CMOs and through PeachCare are physician services, and the amount spent per child on these services suggests that physicians primarily are providing medication management (rather than evaluation and treatment services).**

*Lack of Information on Financing for Evidence-Based and Effective Practices*

- **There was no indication that the State is specifically financing development and support of evidence-based and effective practices such as Multisystemic Therapy, Multidimensional Treatment Foster Care, Functional Family Therapy, Parent-Child Interaction Therapy, Abuse-Focused Cognitive Behavioral Therapy, etc.**
- **There was no indication that the State is specifically financing family and youth-run organizations to support the growth of family and youth voice.**
- **The data suggest the use of practices whose effectiveness have been questioned in the research – for example, most youth in DJJ facilities who receive behavioral health services receive group counseling.** Researchers have raised concerns about the effectiveness of group counseling.
- **Family counseling would appear to be provided to very few of the families whose children are involved in public systems, yet virtually every evidence-based practice for children and youth with serious behavioral health challenges (e.g., MST, FFT, MDTF, PCIT) recognizes the critical importance of engaging the family to improve outcomes.**

*Variation in Amount Spent Per Youth By Similar Service Type Across Agencies*

There is considerable variation in the amounts spent per youth served by same service type across or within agencies, for example, between Medicaid Rehabilitation Option (MRO) and Grant-in-Aid expenditures. MRO, for example, tends to have higher expenditures per youth served for substance abuse treatment services of the same type, while Grant-in-Aid has higher expenditures per youth served for mental health services of the same type.

- **This raises questions as to the nature, intensity, consistency, and type of service provided, as well as rates paid for services across systems.**

*Variation in Spending per Youth Served Across Agencies*

- DFCS, DJJ, and MHDDAD (compared to DCH) spend more per youth served, and serve youth with more serious behavioral health challenges and/or provide a greater intensity of services – largely in out-of-home placements.
- Excluding TRIS, TCM, and MRO which are included above, DCH is providing a lower intensity of service and/or may be serving youth with less serious disorders.

- **National data suggest that Medicaid Rehab Option expenditures in Georgia are lower than national averages.**
- **Both CMOs and MHDDAD should expect to see costs per youth increase within MRO spending as MRO assumes greater responsibility for youth historically served in residential care (i.e. through LOC) and youth involved in child welfare and juvenile justice systems (who have a high prevalence for serious behavioral health challenges).**

*The Importance of Medicaid for Financing Home and Community-Based Services*

- **FY 05 and 06 data suggest that Georgia has relied less on Medicaid than many States to finance home and community alternatives to more restrictive levels of care, while, at the same time, using Medicaid to finance a large share of LOC (i.e., out-of-home) placements.** To illustrate --over 60% of MHDDAD's spending in FY 06 was comprised of State dollars, primarily supporting community-based services (though not a broad array -- primarily assessments and Community Support Services). In contrast, 55% of DFCS' behavioral health spending was comprised of Federal dollars, primarily for out-of-home services.
- **A major challenge for the State is to increase use of Medicaid for home and community-based services and reduce reliance on out-of-home placements.**

*High Costs, Few Options for Children in Parental Custody*

- **Children in parental custody in LOC placements have costs that are three times higher than those of children in DFCS custody as children in parental custody primarily use the highest Levels of Care (Levels 5 and 6).** This is not surprising, given that children in parental custody are able to access restrictive levels of care -- but *only* restrictive levels of care -- through Georgia's use of "Family of One" in Medicaid (which allows the State to waive parental income and deem a child Medicaid-eligible if he/she is expected to be in an institutional level of care for 30 days or more). Federal rules prohibit use of "Family of One" for home and community-based services.
- **The State's receipt of one of ten Federal "PRTF Demonstration Grants" provides an avenue to home and community-based alternatives for children in parental custody (as well as for Medicaid-eligible youth).**

*Changes in Targeted Case Management Provision*

As a result of questions raised by the Federal Center for Medicaid Services about Georgia's use of Targeted Case Management (TCM)<sup>1</sup>, policy changes are being implemented to apply stricter medical criteria to provision of TCM and to give DCH's managed care organizations (CMOs) greater responsibility for managing TCM. DFCS and DJJ face substantial service and revenue loss as a result.

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<sup>1</sup> It should be noted that the Federal Medicaid agency has been questioning a number of States about their use of TCM, not just Georgia, raising the concern that States may be cost-shifting case management responsibilities from child welfare and juvenile justice systems to Medicaid.

*Changes in Responsibility (and Risk) for Financing Behavioral Health Services*

In FY 06, DFCS and DJJ played a major role in financing behavioral health services for children and youth and their families through three avenues: LOC expenditures, which were considerable at \$296.5m.; Targeted Case Management (TCM), which totaled \$48.3m; and Other Behavioral Health Services, such as assessments, crisis intervention, and counseling., which totaled \$17.4m. Between them, DFCS and DJJ accounted for 64% of FY 06 behavioral health spending for children, primarily through Level of Care spending. The role of DFCS and DJJ is changing in the current environment in Georgia. They will rely more on MHDDAD and the Department of Community Health's (DCH) managed care organizations (CMOs) to pay for behavioral health services for children and their families and are transferring dollars to MHDDAD/DCH as a result. MHDDAD and DCH, in turn, must rely more on Medicaid, particularly MRO, to finance behavioral health services.

In the past, responsibility for financing behavioral health services for children was allocated among State agencies based primarily (although not exclusively) on type of service, rather than by type of population or eligibility category. Currently, there is a major re-structuring of responsibility among these State agencies for financing behavioral health services for children. Based on the information provided for this analysis, it would appear that the current re-assignments of risk are based primarily on eligibility category (i.e. type of population), rather than service type as in the past.

- DFCS and DJJ will continue to have financial responsibility for financing Targeted Case Management (TCM) for some DFCS/DJJ populations but not all. DFCS/DJJ will no longer have the financial responsibility for financing behavioral health services in LOC placements, including not having the responsibility for the State share of Medicaid for these treatment services.
- MHDDAD will have financial risk for Rehab Option for children in foster care and children receiving Adoption Assistance, as well as children eligible for Supplemental Security Income (SSI). MHDDAD also will be responsible for financing services for non-Medicaid and non-PeachCare eligible children through what had been its Grant-In-Aid program, using largely State dollars. MHDDAD is converting its Grant-in-Aid funds to fee-for-service funding. In addition, MHDDAD will be responsible for financing the State share of PRTF services to the above populations of children.
- DCH will have the responsibility to finance the State Medicaid share for all behavioral health service types (not just Hospital/Physician/Psychologist Services but Rehab Option and PRTF services as well) for Low Income (i.e. TANF) and Right from the Start Medicaid-eligible children and PeachCare-eligible children. This includes many children and youth involved with DFCS and DJJ who are not in foster care or a DJJ facility. DCH also will be responsible for financing Targeted Case Management for certain DFCS- and DJJ-involved youth. DCH is assigning the risk for managing these services to three managed care organizations (called "Care Management Organizations"). These CMOs are managing both physical and behavioral health care under Medicaid and PeachCare.

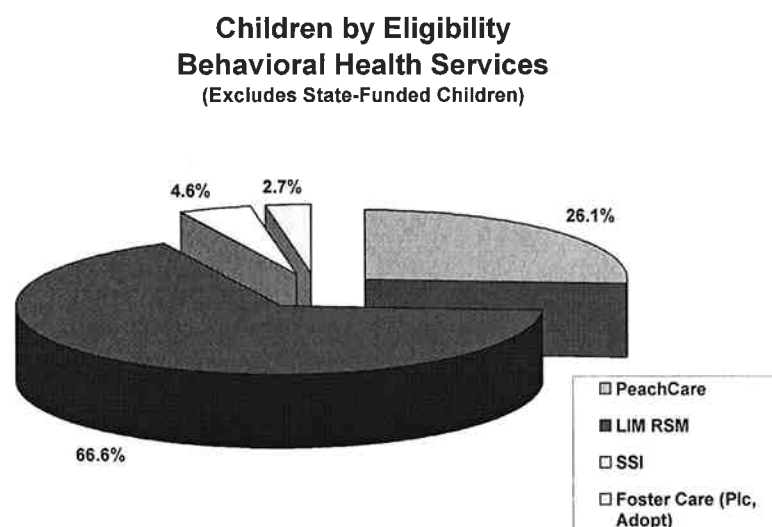
- **National research has found that when physical and behavioral health care Medicaid financing are combined in an integrated physical/behavioral health care managed care arrangement, insufficient attention is paid to behavioral health services for children, most particularly, for children with serious behavioral health challenges.**

**Diagram A** (attached) summarizes this shift in financial responsibilities (and risk) among State agencies for financing behavioral health services for children and youth, including responsibility for financing the State share of Medicaid.

*Assignment of Children from the Perspective of the Children and Families Served*

**Diagram B** (attached) summarizes the assignment of children among State agencies for accessing behavioral health services.

- Children in parental custody historically served by LOC and children involved with DFCS through child protective services, for example, will be served in the future through DCH's CMOs if they are Low Income or Right from the Start Medicaid-eligible or eligible for PeachCare, or through MHDDAD if they are eligible for Medicaid through SSI or if they are not Medicaid-eligible.
- Children involved in DFCS or DJJ who are in foster care or receiving Adoption Assistance or are SSI-eligible will be served through MHDDAD.



MHDDAD will assume responsibility for about 7% of the Medicaid population, and DCH's managed care organizations will assume responsibility for about 93%.

- **The Medicaid populations for which MHDDAD will be responsible are *all* high-need, high-utilizing, high-cost populations** (i.e., SSI, foster care).
- **DCH, with 93% of the Medicaid population, can spread its risk over a larger group of children.** However, within DCH's population, there also are subsets of

children with very high service needs, including many children involved in child welfare, for example, who are not in foster care.

- Many children move on and off of Medicaid and PeachCare eligibility and in and out of State custody so that their “status”, driving which agency is responsible for financing services, could change.

#### *Conversion to Fee-For-Service*

Among the changes occurring in Georgia is MHDDAD’s conversion from Grant-in-Aid funding for community providers (including Community Service Boards) to fee-for-service financing to strengthen accountability and ensure that dollars allocated for child/adolescent services are actually spent to purchase those services (and not get diverted to other uses). Conversion to a cost reimbursable, fee-for-service structure requires providers to have the capacity to navigate service authorization and billing and claims processing systems and establish good service documentation; this can be challenging for providers that have been used to operating in a grant environment. Conversion also can be a challenge for the State purchaser (in this case, MHDDAD), which has to implement efficient billing and claims processing systems, good quality monitoring, and rates that encourage provision of effective services.

#### *Medicaid Managed Care*

With the changes, DCH’s CMOs will share responsibility with MHDDAD for providing, the range of community-based services covered under the Rehab Option (i.e., under MRO).

- CMO responsibilities will include provision of these services to subsets of children with serious behavioral health challenges, such as children in child welfare who are not in state custody, who will require more than assessments, medication management and short-term care. To the extent that adequate MRO and other behavioral health services are not provided, in-patient hospital costs – the most expensive service - will only increase more.
- Additionally, depending on how risk is allocated between DCH or CMOs and MHDDAD with regard to PRTF services, there is a concern for cost-shifting.
- Research has shown that when Medicaid physical and behavioral health care financing are integrated – as in Georgia – less attention is paid to behavioral health care than is the case in a managed behavioral health carve out. Integrated physical/behavioral managed care designs tend to be especially problematic for children with serious behavioral health challenges, who require more than acute, short-term services, a more “customized” approach than is generally found in integrated arrangements, and much more extensive coordination across multiple child-serving systems.
- If the CMOs are unable to adequately serve these subsets of children, there is a danger that families whose children are supposed to be served through the CMOs will be faced with custody relinquishment in order to access more extended care through MHDDAD. The only other possibility for these families would be to try to have their children determined to be SSI-eligible, but it is very difficult for children with behavioral health challenges to meet the disability requirements

under SSI. This is another reason why many children with serious behavioral health challenges are found within the TANF (i.e. Low Income) population.

*Potential for "Double Jeopardy" for DFCS and DJJ*

With the changes described above, DFCS and DJJ will likely transfer dollars they had been spending on behavioral health services to MHDDAD and DCH. If children and youth involved in DFCS and DJJ cannot access an appropriate array or intensity of services, DFCS and DJJ could find themselves having to provide needed services (particularly with respect to court-involved children and youth, where DFCS and DJJ could be court-ordered to provide certain services). This could put DFCS and DJJ in the position of having to "pay twice" for behavioral health services.

**Summary:** It is in the interest of all of these agencies to come together to better understand historic behavioral health utilization and expenditures, how responsibility is to be co-shared in the future, and, **most importantly, how to implement a more individualized, strengths-based, outcomes-oriented approach to care.** This is especially critical to implement for the populations of children who historically have used LOC services. **In the absence of a collaborative approach to the changes that are underway in Georgia, cost-shifting is bound to occur across these agencies, creating unintended consequences both for the agencies and for the populations of children and families that rely on them for services and supports.**

## RECOMMENDATIONS

*Recommendation #1: Use the Financing Analysis to Support Cross-Agency Policymaking in Partnership with Families and Youth and Regional and Local Stakeholders*

A series of briefings should be conducted with State agencies and the Governor's Office and with key stakeholder groups, i.e., families and youth, managed care organizations (CMOs), providers, regional and local administrators, etc. to review findings and consider recommendations.

*Recommendation #2: Expand Use of Georgia's Medicaid Rehabilitation Services Option to Finance Home and Community Based Services, Including Evidence-Based and Effective Practices*

Georgia's Medicaid Rehab Option (MRO) seems to cover many of the home and community-based services needed by children and their families. The data strongly suggest a need to understand more clearly why such services as intensive family intervention, crisis stabilization, behavioral aides, family education and support, peer support, respite and supported independent living are not being more widely utilized so that targeted improvement strategies can be developed. These are particularly important services for youth involved in child welfare and juvenile justice systems and as alternatives for youth historically served in residential treatment. Part of this analysis should consider Georgia's rate structure for home and community-based services (which was beyond the scope of this analysis). Consideration might be given to differential (higher) rates for clinicians to provide services out of their offices, in

homes, schools, etc., and other incentives to move away from office-bound and out-of-home care, as Arizona has done. MHDDAD and DCH also should collaborate on development of consistent, “child-friendly” service definitions and guidance for community providers. Service definitions and rates also should encourage use of evidence-based and effective practices. Many outpatient models, such as Functional Family Therapy, in home models, such as Multisystemic Therapy, and out-of-home approaches, such as Multidimensional Treatment Foster Care can be covered in whole or part through Medicaid. Non-Medicaid resources can be used to help finance training and fidelity monitoring.

*Recommendation #3: Develop Provider Capacity through Training and Technical Support*

Providers may not have the technical expertise to develop and provide the full array of home and community-based services and supports needed in a system of care and, seemingly, covered by MRO, for the most part. There may be a need for a systemic approach (i.e. statewide or regionally) for the development of new home and community-based service capacity. There may be a need to train CSBs and other community providers, as well as families and other child serving systems, such as child welfare, on effective practices for children and adolescents and their families. In the new fee-for-service environment, additional factors may aggravate provider capacity to provide home and community-based services. For example: if it is difficult for providers to get services authorized – in a timely manner and in a sufficient number of units to be able to adequately serve a child in the community; if rates paid for services do not distinguish between office-based clinic services and clinicians going out into the community for service provision<sup>2</sup>; if rates paid for services are not adequate or if billing and claims processes are under-developed or difficult for providers to navigate or if reimbursement timeframes are lengthy; or, if the services authorized do not provide the type or level of intensity of services needed to serve children in the community. These are factors that need to be specifically examined to ensure that they do not thwart appropriate service provision, and training and technical support should be provided to community providers to build their capacity to operate effectively in the current environment.

*Recommendation #4: Orient DCH’s Managed Care Organizations to Child/Adolescent Behavioral Health Issues, Including Systems Issues*

If the anticipated re-distribution of risks/responsibilities is to remain in place, there is a critical need for orientation of the CMOs to behavioral health service issues within the child/adolescent population, and, in particular, orientation regarding the service needs of children with serious behavioral health challenges, as well issues unique to children and youth involved in DFCS and DJJ, including systems issues, such as the role of the court or the fact that both birth and foster families may be involved with a given child at the same time and need to both be engaged in services.

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<sup>2</sup> For example, the Arizona behavioral health system pays higher rates for clinicians to leave their offices to provide services in community settings, such as in a child’s home or school, than it pays for office-based services.

*Recommendation #5: Establish Communication Mechanisms and Liaisons for Troubleshooting*

If the anticipated re-distribution of risks/responsibilities is to remain in place, communication mechanisms need to be put in place between DCH and MHDDAD, as well as with DFCS and DJJ, to resolve issues as to which agency is responsible for financing treatment costs and to guard against children falling through the cracks if their eligibility status changes (rather than leaving this solely to providers to try to manage). It would be helpful to establish liaisons within DJJ and DFCS to focus on troubleshooting issues that arise with MHDDAD and the CMOs related to youth involved in these systems.

*Recommendation #6: Consider a Re-Design of the Behavioral Health System for Children*

Georgia might want to consider an intentional re-design of its managed care system for child/adolescent behavioral health services, given what appears to be the complexity and potential for fragmentation with the current changes. Possibilities for a more integrated approach are suggested by designs developed in other States. Several are illustrated below:

- In Delaware, integrated physical/behavioral health managed care organizations (similar to Georgia's CMOs) are responsible for managing only an acute care behavioral health benefit but for all Medicaid eligibility categories of children as well as the SCHIP population. The acute care benefit is defined as equivalent to the cost of 30 outpatient visits (and a wide range of services can be provided within this equivalent). Children needing more than acute, short-term services (as well as non-Medicaid, non-SCHIP children) are managed by the State Division of Child Mental Health Services (DCMHS), acting as a public MCO, which manages a broad array of services and supports financed by Medicaid, SCHIP, general revenue and block grant dollars. The commercial MCOs must include DCMHS outpatient providers in their networks to facilitate coordination, and DCMHS has specific criteria in place to govern service referrals from the MCOs to guard against cost-shifting. The Delaware design could be described as an integrated design with a partial behavioral health carve-out.<sup>3</sup>
- Another option is a full behavioral health carve out, as in Arizona, among many other States. Arizona's behavioral health carve out includes all children (Medicaid, SCHIP and non-eligible children) and combines Medicaid, SCHIP, general revenue and block grant funding. The benefit design includes a very broad array of services and supports, a new provider category, called "community service agencies", that allows non-traditional agencies (for example, family-run

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<sup>3</sup> Note that "carve out" as used in this report does not mean "left out". For definitional purposes, an *integrated physical/behavioral health care design* is when a State takes both its physical health care dollars and its behavioral health care dollars and combines them in a single managed care arrangement. A *behavioral health carve out design* is when a State takes its behavioral health care dollars and puts them into a managed care arrangement separate from physical health care. An *integrated design with a partial carve out* is when a State combines some physical and behavioral health dollars in a managed care arrangement and carves out other behavioral health dollars in a separate managed care arrangement.

organizations) to provide certain rehab services, such as respite and family peer support, without having to become a fully licensed behavioral health provider. In addition, the design incorporates a “child and family team”, or wraparound, approach to serving children and families.

- Another option is a non risk-based behavioral health carve out, as in New Jersey, which includes all child populations (Medicaid, SCHIP and non-eligible children) and utilizes a statewide Administrative Services Organization and locally based Care Management Entities (these are care coordination entities not managed care entities as in Georgia) to manage care for children with serious, complex issues who are involved with multiple systems. New Jersey also includes locally based Family Support Organizations (family-run organizations) in its design to partner with the care coordination entities. The State purchaser is the Department of Human Services, which houses Medicaid, child welfare and mental health, and the State has created a single payer system, through the State Medicaid agency, to support the system.

*Recommendation #7: Create a Locus of Accountability, Regionally or Locally, through Care Coordination Entities, for Children with Intensive Service Needs Who Cross Multiple Systems*

Whether Georgia retains its current situation or creates a new design, there is a need for a more coordinated care approach for children with serious behavioral challenges and their families, who are involved with multiple systems. This includes many children and youth involved in DFCS and DJJ, as well as children in parental custody. In particular, these children need access to dedicated care management that can function with authority across child-serving systems and work with families with low family-to-care coordinator ratios.

A number of States and localities have reformed their service delivery approaches for children and families, adopting a more individualized, “wraparound”, family-centered approach to move children out of restrictive levels of care. These are values-based initiatives, taking their values from a family-centered, system of care and effective practices base. They move away from a “placement” mentality to individualizing care and creating a sense of urgency when a child does have to be placed in an out-of-home setting so that the child does not remain in a restrictive setting for a long period of time.

These initiatives create *one locus of management accountability* across child-serving systems -- statewide or within counties or regions -- , which is charged with carrying out a number of key functions: implementing highly individualized child and family team approaches to planning and overseeing care, which operate across all systems involved in the life of a given child and family; managing utilization so that children do not remain “stuck” in inappropriate places; partnering with all types of families and youth to build on strengths; mobilizing natural helping networks to augment formal services; ensuring access to a broad range of services and supports, including mobile crisis and stabilization capacity, respite and education so that families and caregivers

are supported to better handle difficult behaviors in children; and, providing one accountable care coordinator (accountable across systems) with small caseloads (1 care coordinator to 8 families) and available 24 hours, 7 days a week for families. Many of these initiatives are using Medicaid to support a wide array of home and community alternatives and using managed care technologies to manage financial risk to the State and the Federal government.<sup>4</sup> This type of coordinated approach requires shared liability among the systems that share responsibility for these children, namely, DFCS, MHDDAD, DJJ, DCH, and DOE.

*Recommendation #8: Promote a Common Family-Centered Practice Model Across Systems Supported by Strengths-Based Decision-Support Tools for Service Planning*

A number of States (e.g., NC, KN, MD, AZ, VT, HI) are engaged in efforts across agencies to train clinical staff, child welfare workers, juvenile probation officers, contracted providers, families and youth in a common, family-centered practice model – not just for children with serious problems but for all children and families involved in public systems. This approach treats families and youth as partners in service planning, reinforces strengths, is culturally and linguistically competent, engages natural helping networks (such as faith-based organizations) and is individualized. Family-centered practice often is assisted by strengths-based, standardized service decision-making tools, such as the Child and Adolescent Needs and Strengths (CANS) tools.<sup>5</sup>

*Recommendation #9: Implement Utilization Management Mechanisms that Support Home and Community-Based Service Provision*

States and localities that are implementing family-centered practices also are putting in place utilization management mechanisms at a systems level that support home and community-based alternatives and are values-based and outcomes-focused. Outcomes include system-level outcomes, such as: reduction in use of out-of-home placements, improved school attendance, reduction in disrupted placement rates of children in child welfare, reduced recidivism rates in juvenile justice, and reduced costs per child served, as well as service-level outcomes, such as improved clinical and functional outcomes and improved capacity on the part of families and other caregivers to handle difficult behaviors in children.<sup>6</sup>

*Recommendation #10: Use the PRTF Demonstration Grant to Reform Service Delivery for Children Historically Served through Level of Care*

Georgia's receipt of a Federal Center for Medicare and Medicaid Services "PRTF Demonstration Grant" provides an excellent opportunity for the State to develop a reformed service delivery approach for the populations of youth now using LOC services, particularly those using Levels 4 through 6. States that received this grant, including Georgia, can implement 1915c waivers to demonstrate home and

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<sup>4</sup> See, for example, Arizona, Hawaii, New Jersey, Massachusetts, Central Nebraska, Milwaukee Wraparound, Marion County, Indiana.

<sup>5</sup> See: Lyons, J. and CANS website at: [www.buddjnpaedfoundation.org](http://www.buddjnpaedfoundation.org).

<sup>6</sup> See, for example, Milwaukee Wraparound, Dawn Project, Central Nebraska Integrated Care Coordination Project, Arizona, Hawaii, Vermont.

community-based alternatives to Psychiatric Residential Treatment Facility (PRTF) level of care, as well as to hospital level of care. (Historically, 1915 c waivers have been allowed only for alternatives to institutional levels of care, i.e. hospital level; the federal grant program expands the concept of “institution” to PRTFs.) Successful implementation of the grant program requires not only re-directing LOC dollars to home and community-based alternatives, but creating changes in the way children are assessed and referred for care and how they are managed (both at a service level in terms of care management and at a population level in terms of utilization management). Those states and communities that are employing a highly individualized, wraparound approach to service planning, supported by strengths-based standardized decision support tools for assessment and care planning, such as the CANS tools, seem to be producing strong results. This is a fundamentally different approach than using a standardized assessment tool to determine eligibility for placement in Levels of Care, as Georgia has done with its use of the Child and Adolescent Functional Assessment Scale (CAFAS) to determine Level of Care placements. Successful initiatives also employ mobile response teams and care managers with very small caseloads, who are accountable across systems, as well as values-based utilization management structures that are outcomes-focused. In addition, they partner with families and youth in decision-making and draw on natural helping networks (for example, faith-based organizations) to augment formal services.<sup>7</sup>

*Recommendation #11: Include Children in Parental Custody in the PRTF Demonstration*

Children in parental custody have a very high dependence on the most intensive Levels of Care. This population needs to be included in MHDDAD’s PRTF Demonstration Grant to ensure their access to alternative home and community-based services and supports and to create a viable alternative to “Family of One” access to out-of-home services. Otherwise, the State will have only two options for financing services to this population – either continuing to use “Family of One”, which will drive up Medicaid costs without necessarily producing good outcomes, or using State dollars only to finance care.

*Recommendation #12: Identify More Complete Historical LOC Expenditure and Utilization Data*

There is a critical need for a more comprehensive analysis, supported by more complete data, of LOC expenditures by type of program component, as well as by eligible child population, to ensure an equitable distribution of current LOC funds across the various agencies that are assuming responsibility for financing services and supports to children historically served by LOC and historically paid for by DFCS and DJJ.

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<sup>7</sup> See, for example, Wraparound Milwaukee, the Dawn Project, Central Nebraska Integrated Care Coordination, New Jersey, Arizona, Vermont, Hawaii.

*Recommendation #13: Analyze Regional Differences in Use of LOC Placements*

Analysis of regional differences can be useful for several reasons. Regions with high use of LOC placements may benefit from technical assistance, including from other regions with low LOC use. Regions with high use may be targeted as “first adopters” for a Care Management Entity approach to redirect expenditures to home and community care.

*Recommendation #14: Develop Mobile Response and Stabilization Teams Statewide*

DCH, MHDDAD, DFCS, DJJ and DOE should help to co-finance the development of mobile response and stabilization capacity across the State, modeled after Milwaukee Wraparound’s Mobile Urgent Treatment Teams and New Jersey’s Mobile Response and Stabilization Teams. These models are getting excellent results in reducing use of hospitals, emergency rooms, and residential treatment, as well as reducing placement disruption rates in child welfare. This model should be covered within Georgia’s State Medicaid Plan (as it is in Wisconsin and New Jersey).

*Recommendation #15: Develop Cross-Agency Criteria to Define and Govern the Provision of Targeted Case Management*

Georgia’s experience with TCM suggests a need for the major child-serving systems involved in TCM decisions going forward – namely, DFCS, DJJ, MHDDAD, and DCH - to develop clinical and functional criteria to guide the provision of TCM, not only for children and youth involved in DFCS and DJJ but for all children and youth needing this intensity of case management services. As well, there would seem to be a need for these systems to articulate a definition for TCM and provider qualifications on which all systems can agree. It would be helpful for these systems to collaborate on a utilization study to determine what is a legitimate target number for utilization of TCM across child-serving systems, based on a combination of prior utilization, newly agreed-upon definitions of the population and service, the experience of other States, and prevalence data. The systems now responsible for providing TCM also need to determine a process for communication and coordination to ensure that children receiving TCM do not have to change care managers, or lose TCM, if their Medicaid or placement status changes.

*Recommendation #16: Expand Provision of Substance Abuse Treatment Services, Including Expanded Use of MRO*

The literature suggests that, to be effective, adolescent substance abuse treatment should be broad-based and diverse.<sup>8</sup> It is always a challenge for States to find the resources to adequately fund this broad array. However, Medicaid MRO does provide one route. Currently, it would appear that youth with substance abuse challenges primarily receive assessments and substance abuse day treatment, which is a relatively expensive service type. The State needs to undertake an analysis of why more substance abuse services are not being provided through MRO – e.g., whether this is due to the rate structure, lack of provider expertise, service definitions or coverage that are restrictive, etc.

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<sup>8</sup> See, for example, *Adolescent Substance Abuse: A Public Health Priority. 2002*. Physician Leadership on National Drug Policy. Center for Alcohol and Addiction Studies. Brown University. [www.plndp.org](http://www.plndp.org).

*Recommendation #17: Expand Access to Vocational Rehabilitation Services for Youth*

Stronger partnerships are needed between youth providers, particularly the schools, group homes and other community programs serving youth, and the VR Program both to identify youth in need of VR services and to provide youth with a wider array of VR services and supports, including supported employment services. Also, there is a need to reach out to more females and younger youth (age 14-17) for involvement in VR services.

*Recommendation #18: Establish Transition Supports for Youth in Department of Corrections*

The numbers of youth involved with DOC are small, but youth with identified mental health or substance abuse problems represent nearly 30% of the overall DOC youth population. Over 40% of the youth population in June 2006 was serving less than five years, suggesting that many of the youth now in custody will be re-entering society as very young adults with, presumably, a continuing need for behavioral health services.

*Recommendation #19: Analyze Reasons Behind and Implement Targeted Approaches to Reduce Racial/Ethnic and Gender Disproportionality*

The data provided for this analysis points to several areas where additional analysis could be conducted to determine reasons for disproportionalities and improvement strategies. For example, the State could engage African American leaders in mobilizing a systemic, community-based response to the over-representation of African American youth in restrictive levels of care. Strategies might include use of natural helpers to “wrap” supports around youth and families, work with those who refer youth to restrictive levels of care where racial or cultural biases may be involved, or incentives to providers to adopt culturally competent approaches.

*Recommendation #20: Support the Development of Family- and Youth-Run Organizations throughout the State*

It is in the State’s interest to have strong family and youth organizations throughout the State for many reasons. These organizations help to grow “family and youth voice” to ensure effective advocacy for appropriate and sufficient behavioral health financing. They help to recruit and train family and youth partners to provide peer support to other families/youth involved in public systems, which can help to reduce treatment costs. They help to ensure that the services being provided “make sense” and that the State is not wasting finite resources on high cost/poor outcome approaches. Georgia has the advantage of having a SIG grant that can help to finance family and youth organizations statewide, but all of the State agencies need to see this as a critical “cost of doing business” in an effective system of care. Resources need to be identified across systems to finance family and youth voice.<sup>9</sup>

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<sup>9</sup> New Jersey provides one example of a statewide approach to financing family organizations statewide, using Medicaid administrative case management dollars, state general revenue from child welfare and mental health, and block grant funds.

*Recommendation #21: Establish a State Locus of Policy and Management Accountability for Child and Adolescent Behavioral Health*

It was beyond the scope of this project to analyze whether there is sufficient “infrastructure”, that is, sufficient numbers of and appropriately trained staff, data systems, quality monitoring systems, provider network management systems, etc., to effectively manage an integrated behavioral health system for children and families – or, the extent to which there is such capacity but it is fragmented across or within numerous State agencies. Whether Georgia re-designs its current system or develops safeguards and communication and coordination mechanisms within the changes currently underway, it needs adequately financed infrastructure, which also is a cost of doing business.