

other sources (e.g., Supplemental Security Income, Title IV-E, and payments from parents). Moreover, the Medicaid funding is only for Medicaid-eligible children placed in Medicaid-eligible facilities.

In the course of its existence, the MATCH program has experienced major changes in the program's budgets, unit costs, and children served. The program experienced a large measure of growth during the early 1990s, but has had a stagnant budget for the last three years. The rapid rate of growth in MATCH clients from 272 in 1991 to over 700 in 1996 was due to the availability of new Medicaid funding and the need to accept children who were discharged from state hospitals due to court orders under the J.L./J.R. lawsuit. These orders require routine assessments and the release of children from state psychiatric hospitals who do not require a high level of restrictiveness in their treatment.

Management and Program Design. Because of the factors mentioned in the preceding paragraphs as well as additional factors (e.g., the nonpredictable changes in Medicaid certification of new costs), managing the cost of the MATCH program within an established budget is a daunting task.

Data Systems. Currently, data about MATCH children, their Medicaid status, and the budgets and expenditures in support of the service are held in three different data systems—not one of which is programmed to accurately project expenditures. Given the extraordinary complexity and difficulty involved in managing the MATCH budget, the lack of an integrated data system programmed to build cost projections and scenarios is an issue.

Outcomes and Cost-Effectiveness. While the MATCH program is missing some important management information system capabilities, it is relatively rich with respect to other information system capabilities. In particular, the MATCH outcomes project, when fully developed, will enable state-of-the-art tracking of children's progress through individual treatment plans and provider-specific services.

Children. The number of children in the MATCH program has grown. (See Figure 6.) While MATCH youth are still predominately male, the trend since the program's inception has been toward an increased usage of the MATCH program to serve female SED youth. Also, over the past 10 years, there has been a steady increase in the proportion of MATCH youth of African American descent and the proportion who enter MATCH at a younger age.

Division of Mental Health, Mental Retardation, Substance Abuse (MH/MR/SA). The Division of MH/MR/SA contracts for the delivery of service through the Regional Boards to the Community Service Boards and directly supports state psychiatric hospitals.

Community Mental Health

Program. Based on the C&A Capacity Building Plan developed in the late 1980s, the Division of MH/MR/SA has attempted to build the capacity in the community for providing a continuum of care for children and adolescents who are seriously emotionally disturbed. (See

Figure 7.) The plan lays out service delivery targets based on the most current studies of emotional and behavioral disorder prevalence among children. At the time that the plan was created, the lack of a true continuum of care forced parents of SED children to choose among three options: to keep their children in inadequate outpatient services, to admit their child to a state hospital, or to apply for a place in a long-term residential treatment facility through MATCH.

Figure 6. MATCH Placements

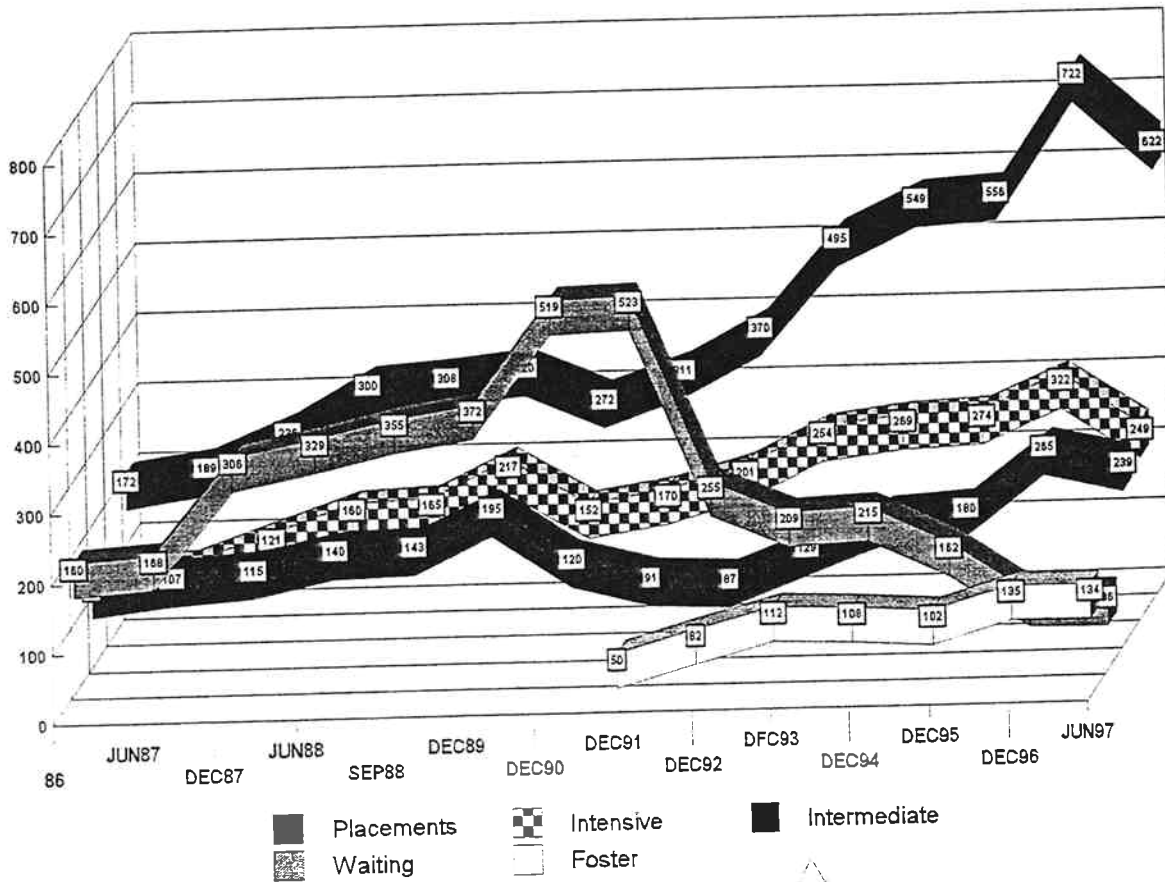
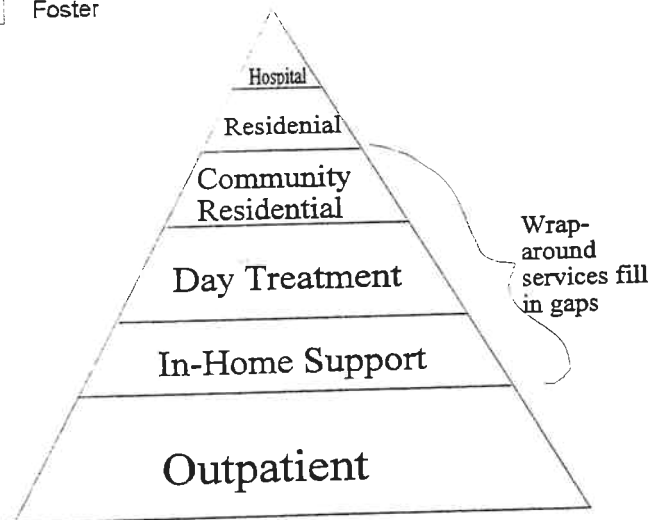


Figure 7. Continuum of Care Service System

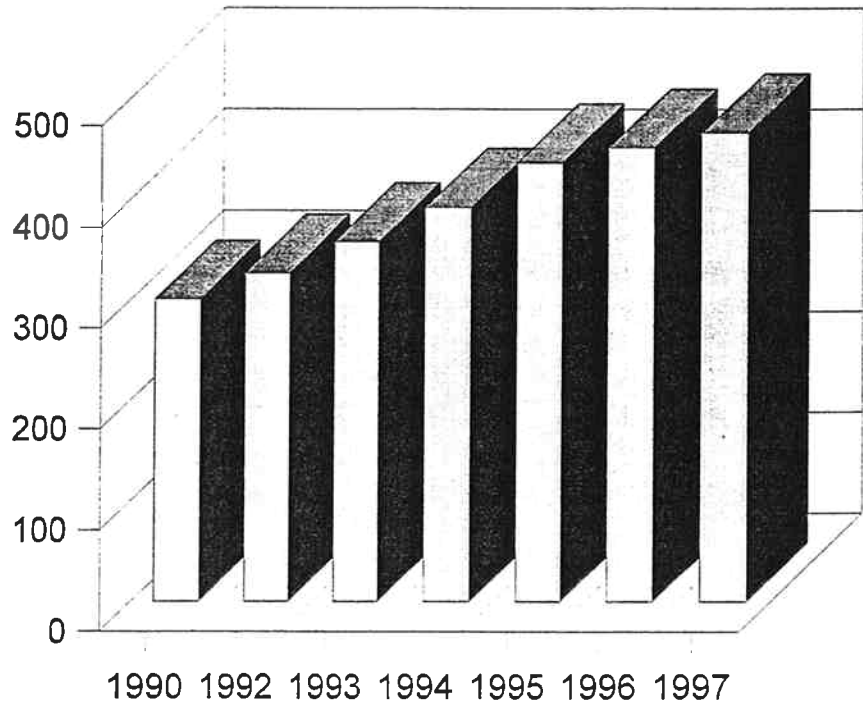


Levels of Service. The per capita rate at which community service boards and other providers have been seeing children for behavioral disturbances on an outpatient basis has steadily increased from 300 per 100,000 civilian noninstitutionalized population in 1990 to 459 per 100,000 in 1997, a 35 percent increase. (See Figure 8.)

Figure 8. Community Outpatient Services: Children Served per 100,000

Factors Affecting the Level of Service. The C&A Capacity Building Plan lays out a set of service delivery targets that, if funded, would move the state toward a balance of service delivery methods.

Funding Streams. When we total the FY98 Budget 200 allocation for C&A services to the regions (\$34,330,691) and the amount of Medicaid funding earned in the prior fiscal year (\$29,322,896 as a proxy for the expected earnings for FY98), we can estimate that the public providers of community mental health services should be able to expend \$63,653,587 on C&A services and associated administrative costs.



SED, Medicaid, and Other Funding. Provision of state SED grant funds typically enable a CSB to generate other funding, primarily from Medicaid. The percentage of additional resources that can be generated for each state dollar spent will vary by the service provided. For example, day treatment services may be able to generate in the range of 31 percent additional resources, while regular outpatient services will typically generate only about 13 percent additional funds.

In FY97, the Department of Medical Assistance paid claims for 20,381 children who had a behavioral health disorder. A number of CSBs have made effective use of the amended Medicaid Clinic Option that allows for reimbursement for children's behavioral health services not delivered at the main clinic. However, the portion of the cost of therapeutic foster care and group home care that goes to basic residential support cannot be reimbursed by Medicaid. While we can broadly track the use of Medicaid funding for C&A/SED services, available data do not allow us

to identify with precision the degree to which the expanded SED services are supported by Medicaid.

Management and Program Design. Because of the decentralized delivery of C&A services, CSB program descriptions were reviewed and C&A program managers were surveyed regarding their programs and ideas for improvements. A review of these data suggests that a number of CSBs are working toward greater out-stationing of clinical staff in schools, juvenile courts, health clinics, and DFCS offices; more are outsourcing the delivery of certain services; and more are developing and refining in-home (wraparound) service delivery capabilities.

With regard to program design issues, survey results indicated

- a desire for more flexible funding (across programs, services, and diagnostic groups) and for an allocation of MATCH funding and C&A hospital savings back to the community for the purpose of preventing out-of-community placements.
- a shift in some service areas away from supporting group home services and toward in-home services and substance abuse services for adolescents.
- that CSBs are becoming more innovative in terms of contracting with private providers of in-home, day treatment, and residential care; working together with others in collaboratives such as the Family Connection and joint DFCS/MH family preservation efforts; placing services in out-of-clinic settings such as schools, RYDCs, DFCS, court services offices, etc.; building a culture and comprehensive/coordinated system of "whatever it takes"; developing parent support groups, joint purchasing agreements, and a single point of entry; and cross-training mental health and substance abuse staff.
- a need for better funding and planning for crisis stabilization and substance abuse services that can be delivered at an earlier point in the development of a child's problem, i.e., before needing inpatient services.
- a need to increase the availability of support to parents who are in danger of turning their children over to the state for care because of the lack of sufficient in-home support.
- a need to develop joint CSB, Juvenile Court, and School programs/services to prevent SED children from being expelled from school.

Adequacy of Management Information. In terms of keeping track of the children who receive C&A/SED services and the funding streams that support them, three weaknesses have been discovered: (1) inability to conduct cross-departmental/division tracking of SED children receiving therapeutic residential services; (2) inability of the Division of MH/MR/SA to identify whether a child is eligible for Medicaid (primarily because this field is not consistently used by intake workers); and (3) inability to track the nature and use of wraparound services being provided by the CSBs.

Referral Patterns. Although the current data system used by the Division of MH/MR/SA has a field in which intake workers are expected to record the referral source for the client, this field usually is not completed in a manner that provides information that could be useful in describing the multifaceted nature of children's relationships with human service agencies. For example, in 186,000 C&A client records, only a very small percentage of these youth were recorded as being referred by any agency outside of the mental health system itself. For example,

723 youth were reported as referred from acute care general hospitals, 127 from DFCS, 567 from nonpsychiatric physicians, 2,104 from courts or law enforcement, 200 from private community agencies, 111 from DJJ, 16 from school systems, and only 2 from Public Health.

Although these data obviously do not reflect the direction and strength of the informal referral network, the pattern of referrals does suggest particular weaknesses in the system. Assuming that the numbers reported here represent a fair picture of the proportion of referrals made by specific organizations, these data may suggest that public health, schools, DFCS, and DJJ may all be underutilizing the formal referral channel to public mental health services. Interviews with respondents from these agencies indicate that some persons may have failed to make referrals due to the belief that their client would not receive services. Overall, these data are instructive more by what they do not reveal than by what they do. That is, they do not reveal the existence of a healthy system of care or of an information system that allows for the tracking of a child through multiple care givers.

Children. Table 7 outlines the number of children served by the Division of MH/MR/SA in the community and in all facilities (which includes state hospitals) by primary disability.

Table 7: Children Served by the Division of MH/MR/SA by Primary Disability, FY97 Unduplicated

	Community	All Facilities
Totals	28,408	29,620
C&A	24,839	25,904
MR	1,645	1,840
Alcohol	263	266
Drugs	593	593
Early Intervention	946	949

Age and Primary Diagnoses. As children get older, the proportion of primary diagnoses of conduct-, drug-, and alcohol-related disorders tends to increase, while the proportion of developmental delay disorders and those related to hyperkinesis (e.g., Attention Deficit disorders and Attention Deficit Hyperactivity disorders) tends to decline.

Hospitals

Program. Care for psychiatric disorders can occur in both general acute care hospitals and in hospitals that specialize in psychiatric services. Within the latter group, a distinction is made between short-term psychiatric hospitals and intensive residential treatment centers (or long-term hospitals). In Georgia, Medicaid will only reimburse for services provided in the acute care