

Systems of Care



The Intersect of Health Reform and Systems of Care for Children and Youth with Mental Health and Substance Use Disorders and Their Families

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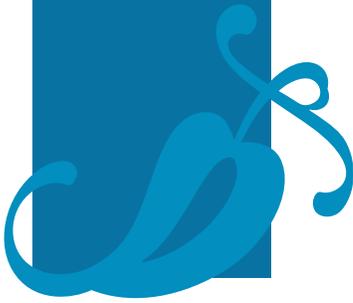


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Introduction and Purpose

This is a time of monumental change in health systems across the United States. With the passage of the Patient Protection and Affordable Care Act on March 23, 2010, referred to as the Affordable Care Act (ACA), an additional 41 million Americans will gain access to health care and the financing, organization, and delivery of health services, including mental health and substance use services, will be revolutionized. Activities are underway to implement provisions of the ACA in 47 states and the District of Columbia, as well as at the federal level. As states and federal agencies plan and implement the ACA, particular attention must focus on how mental health and substance use services (collectively referred to as “behavioral health” services in this Issue Brief) will be covered and provided and, in particular, how the needs of children with serious behavioral health challenges and their families will be met.

This Issue Brief is intended to provide an overview of the ACA and discuss the synergy of health reform with the system of care approach for serving children with behavioral health challenges and their families. Additionally, the Issue Brief will articulate how the system of care approach can provide both a conceptual framework and specific strategies for implementation of the ACA in ways that ensure that the behavioral health service needs of children, adolescents, young adults, and their families will be met effectively. This Issue Brief is part of an ongoing series that is intended to inform the field about the implementation of key aspects of the ACA and how issues related to children’s behavioral health can be addressed.

The system of care approach has been the major framework for improving delivery systems, services, and outcomes for children with mental health needs for the past 25 years, shaping

system reforms in many states, communities, tribes, and territories (Stroul, Blau, & Friedman, 2010; Stroul, Blau, & Sondheimer, 2008). Extensive research and evaluation have documented the effectiveness of this approach for improving the organization and delivery of children’s mental health services, and for improving clinical and functional outcomes for children and their families (Manteuffel, Stephens, Brashears, Krikelyova, & Fisher, 2008). Although the system of care approach continues to evolve to reflect advances in research and service delivery, the core values of community-based, family-driven, youth-guided, and culturally and linguistically competent services are widely accepted. In fact, the guiding principles calling for a broad array of effective services, individualized care, and coordination across child-serving systems are extensively used as the standards of care throughout the nation.

The system of care approach offers tested models for implementing many provisions of the ACA in order to address the needs of children with or at risk for serious mental health and substance use challenges and their families. Applying the system of care approach to the implementation of health reform can assist states to build on 25 years of experience in system reform and, at the same time, meet the central goals of health reform—assisting Americans to obtain affordable, appropriate health insurance; improving the quality of care; increasing efficiency and reducing costs; and improving health outcomes. The ACA also provides an opportunity for states and communities to sustain and expand key elements of the system of care approach that are already a part of their service delivery systems.

Decisions on the shape of health reform will, for the most part, be made by states. The information and issues raised in this Issue Brief are intended to assist state policy makers to make health reform work for children with mental health and substance use service needs and their families. The



Issue Brief examines relevant provisions of the ACA and explores how the adoption of the system of care approach can be effective in implementing those provisions. Overviews of health reform and the system of care approach are followed by sections that describe specific provisions of the ACA. For each provision, the “intersect” with the system of care approach is discussed, and issues and questions that should be considered in implementing the ACA are delineated.

Health Reform

Expanding Access to Health, Mental Health, and Substance Use Services

There are currently over 50.7 million uninsured people in the United States, and it is estimated that the ACA will provide coverage for 41 million of them (Congressional Budget Office [CBO], 2011; Washington Post, 2010). Coverage will be provided by expanding Medicaid and the Children’s Health Insurance Program (CHIP), through the implementation of Health Insurance Exchanges that will offer an opportunity for individuals to purchase private health insurance policies at reduced rates, and through incentives for small businesses to provide health insurance to their employees.

Medicaid will be expanded to cover individuals with incomes up to 133% of the federal poverty level; the federal poverty is currently \$22,350 for a family of four (Federal Register, 2011). CHIP will cover approximately 6.5 million additional children. It is estimated that by 2019, the expansions in Medicaid and CHIP will increase enrollment in these programs by 33%, covering approximately 17 million additional individuals (CBO, 2011; Washington Post, 2010).

The creation of Health Insurance Exchanges will further expand access to coverage. It is estimated that exchanges will provide coverage to an

additional 24 million individuals with incomes up to 400% of the poverty level. The ACA also includes financial incentives for small businesses to offer insurance to their employees, penalties for large businesses that do not offer insurance, and a mandate for all individuals to obtain health care coverage beginning in 2014. An estimated 95 percent of U.S. citizens and other legal residents will have health insurance within six years (CBO, 2011; Washington Post, 2010).

Since behavioral health is an integral part of health, behavioral health benefits will be included in Medicaid, CHIP, and policies purchased through Health Insurance Exchanges. It is estimated that between 20% and 30% of the newly covered individuals (approximately 6 to 10 million) will be persons with mental health or substance use disorders who will require specialty services from behavioral health professionals (Substance Abuse and Mental Health Services Administration [SAMHSA], 2011a).

Another significant influence on access to behavioral health services has resulted from enactment of the Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008 that requires health insurance plans containing behavioral health benefits to allow consumers the same number of mental health visits as for other kinds of health care, at no greater cost, and not subject to any additional limitations. The law now will require all health plans sold through the state Health Insurance Exchanges to cover mental health and substance abuse services coverage at parity with physical health coverage (Mental Health Parity and Addiction Equity Act, 2008).

General Provisions

The ACA includes a number of general provisions that protect consumers’ rights to access health care (Patient Protection and Affordable Care Act [ACA], 2010). A significant provision prohibits practices such as denial of coverage due to pre-existing conditions, annual



and lifetime caps on coverage, and rescission of coverage due to health conditions. Adults denied insurance because of pre-existing conditions can now access insurance through high-risk insurance pools until 2014, when insurance companies will no longer be able to deny them coverage. However, this requirement is already in force for children under age 18, and, therefore, they can no longer be denied coverage due to pre-existing conditions. Another provision allows young adults to be covered under their parents' insurance plans until they reach the age of 26.

An ACA component of particular importance for children is the creation of a grant program to support Maternal, Infant, and Early Childhood Home Visiting Programs. These programs are now offered in 49 states and focus on improving the well-being of families with infants, toddlers, and preschool children. They provide nurses, social workers, or other professionals who meet with at-risk families in their homes, evaluate their needs, and connect them to services and supports that can make a positive difference in their child's health, development, and ability to learn (U.S. Department of Health and Human Services [DHHS], 2010).

The ACA also addresses the reality that racial and ethnic minority populations are disproportionately uninsured, often face systemic barriers to accessing health care services, and experience worse health outcomes. Accordingly, the act includes specific actions to address racial and ethnic health disparities and to promote cultural and linguistic competence in service delivery (ACA, 2010; SAMHSA, 2011a).

Other provisions of the ACA encourage states to coordinate and integrate primary care and specialty services for individuals with chronic problems through the use of health homes. States are encouraged to experiment with new models of integrated behavioral health and primary care in order to improve outcomes and reduce the costs of care. Health reform also seeks to

improve the quality of medical practices, improve health outcomes in measurable ways, reduce industry waste and duplication, prevent medical error, enhance patient safety, increase the use of technology, and perhaps most difficult, "bend the curve" of rising costs (ACA, 2010; Washington Post, 2010).

All of these general provisions can positively impact access to treatment and the quality of care for children, youth, and young adults with behavioral health challenges, and their families. However, careful data collection and monitoring will be needed to ensure that these ACA provisions are implemented as required, and that appropriate and sufficient services are provided.

System of Care Approach

Rationale

An estimated 20% of children in United States has a diagnosable mental health condition, and about one in ten children suffers from a serious mental health disorder that causes substantial impairment in functioning at home, at school, or in the community (DHHS, 1999; Friedman, Katz-Leavy, Manderscheid, & Sondheimer, 1998; U.S. Public Health Service, 2000). The seriousness of mental health problems for children and youth has been well documented, confirming significant prevalence rates, persistence of these problems over time, difficulties experienced across many spheres of life, and high financial and social costs to families and to the nation (Friedman, Kutash, & Duschnowki, 1996; Greenbaum et al., 1998; Huang et al., 2005; Warner, 2009).

Most mental health disorders have their roots in childhood, with 50% of affected adults manifesting disorders by age 14 and 75% by age 24 (DHHS, 1999; Kessler, Chiu, Demier, & Walters, 2005, O'Connell, Boat, & Warner, 2009). These disorders affect children of all ages,



every socio-economic status, and every racial and ethnic background. Mental health disorders in children are typically complex, involving multiple problems, multiple diagnoses, and co-occurring disorders. These disorders impact children in different ways throughout their development, from infancy through school years and the transition to adulthood, and affect their functioning at home, in school, and in their communities. Further, these children are commonly served in more than one specialized system including mental health, substance abuse, primary health, education, child care, child welfare, juvenile justice, and developmental disabilities. Children and youth of various racial and ethnic groups are overrepresented in child welfare and juvenile justice systems. This involvement in multiple systems often results in fragmented and inadequate care and leaves families overwhelmed by having to work with multiple child-serving agencies.

Mental health problems can lead to devastating consequences including poor academic achievement, dropping out of school, substance abuse, involvement with the correctional system, lack of vocational success, inability to live independently, and suicide. Suicide is the third leading cause of death in the 15-24 year age group, and approximately one in five adolescents and young adults experience suicidal ideation every year (Huang et al., 2005).

Although these problems have been characterized as a public health crisis, approximately 65% to 80% of children with behavioral health disorders do not receive the specialty services and supports they need (President's New Freedom Commission on Mental Health, 2003; U.S. Public Health Service, 2000). To address inadequacies in service delivery and poor outcomes, the federal government developed the system of care approach in 1986 (Stroul & Friedman, 1986, 1996; Stroul, 2002; Stroul, Blau, & Friedman, 2010; Pires, 2002a, 2008, 2010). In 1992, the Substance Abuse and Mental Health Services

Administration (SAMHSA) began investing substantial federal resources to implement and evaluate the outcomes of systems of care in states and communities across the nation through the Comprehensive Community Mental Health for Children and their Families Program (also known as the Children's Mental Health Initiative or CMHI).

Framework, Philosophy, and Outcomes

The system of care approach provides an organizational framework and philosophy to better structure the delivery of mental health services and to improve the effectiveness of the interventions used to meet the complex and changing needs of children with serious mental health problems and their families. This approach has gained broad acceptance over the past 25 years as states and communities have recognized that traditional service delivery structures and practices are not successful, particularly for children and youth with serious and complex disorders who are involved with multiple child serving systems. The system of care approach involves collaboration across agencies, providers, and families to improve access and expand the array of high-quality services and supports that are home and community-based, individualized, coordinated, family-driven and youth-guided, and culturally and linguistically competent. The core values and principles comprising the system of care philosophy are shown on Table 1 (Stroul, Blau, & Friedman, 2010).

Research and evaluation results from the CMHI over the past 15 years have consistently found that the implementation of the system of care approach results in positive outcomes for children and their families, such as improvements in clinical and functional outcomes, increases in behavioral and emotional strengths, reduction in suicide attempts, improvement in school performance and attendance, fewer contacts with law enforcement, reductions in reliance on inpatient care, and more stable living situations. Data also show that caregivers of children served

**TABLE 1** SYSTEM OF CARE CONCEPT AND PHILOSOPHY**DEFINITION****A system of care is:**

A spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.

CORE VALUES**Systems of care are:**

1. Family driven and youth guided, with the strengths and needs of the child and family determining the types and mix of services and supports provided.
2. Community based, with the locus of services as well as system management resting within a supportive, adaptive infrastructure of structures, processes, and relationships at the community level.
3. Culturally and linguistically competent, with agencies, programs, and services that reflect the cultural, racial, ethnic, and linguistic differences of the populations they serve to facilitate access to and utilization of appropriate services and supports.

GUIDING PRINCIPLES**Systems of care are designed to:**

1. Ensure availability and access to a broad, flexible array of effective, evidence-informed, community-based services and supports for children and their families that address their physical, emotional, social, and educational needs, including traditional and nontraditional services as well as informal and natural supports.
2. Provide individualized services in accordance with the unique potential and needs of each child and family, guided by a strengths-based, wraparound service planning process and an individualized service plan developed in true partnership with the child and family.
3. Deliver services and supports within the least restrictive, most normative environments that are clinically appropriate.
4. Ensure that families, other caregivers, and youth are full partners in all aspects of the planning and delivery of their own services and in the policies and procedures that govern care for all children and youth in their community, state, territory, tribe, and nation.
5. Ensure cross-system collaboration, with linkages among child-serving systems and mechanisms for system-level management, coordination, and integrated management of service delivery and costs.
6. Provide care management or similar mechanisms to ensure that multiple services are delivered in a coordinated and therapeutic manner and that children and their families can move through the system of services in accordance with their changing needs.
7. Provide developmentally appropriate mental health services and supports that promote optimal social-emotional outcomes for young children and their families in their homes and community settings.
8. Provide developmentally appropriate services and supports to facilitate the transition of youth to adulthood and to the adult service system as needed.
9. Incorporate or link with mental health promotion, prevention, and early identification and intervention in order to improve long-term outcomes, including mechanisms to identify problems at an earlier stage and mental health promotion and prevention activities directed at all children and adolescents.
10. Incorporate continuous accountability mechanisms to track, monitor, and manage the achievement of system of care goals; fidelity to the system of care philosophy; and quality, effectiveness, and outcomes at the system level, practice level, and child and family level.
11. Protect the rights of children and families and promote effective advocacy efforts.
12. Provide services and supports without regard to race, religion, national origin, gender, gender expression, sexual orientation, physical disability, socio-economic status, geography, language, immigration status, or other characteristics, and services should be sensitive and responsive to these differences.



within systems of care experience reduced strain associated with caring for a child who has a serious mental health condition, more adequate resources, fewer missed days of work, and improvement in overall family functioning (Manteuffel et al., 2008).

In addition, evaluation of the CMHI has shown that the system of care approach has a positive impact on the structure, organization, and availability of services and that it is a cost-effective way of investing resources, redirecting resources from deep-end services (inpatient and residential treatment) to home and community-based services and supports (Gruttadaro, Markey, & Duckworth, 2009; Maine Department of Health and Human Services, 2011; Manteuffel et al., 2008; Maryland Child & Adolescent Innovations Institute, 2008). Care management entities have been created in many states and communities as the locus of accountability for managing care and costs for youth with the most serious and complex needs, and intensive care managers coordinate services across multiple providers and child-serving systems (Pires, 2010; Stroul et al., 2009). As a result of the positive outcomes measured and reported, the system of care approach has been widely adopted by mental health systems as well as by child welfare, juvenile justice, education, and substance abuse systems; early childhood programs; systems designed to serve youth in transition to adulthood; and even by many adult-serving systems. In addition, SAMHSA has launched a new effort to further this progress by providing funds to states, territories, and tribes to develop comprehensive strategic plans for widespread expansion of the system of care approach so that more children and families can benefit (SAMHSA, 2011b).

These documented outcomes of systems of care at the system and service delivery levels are closely aligned with the goals of health reform—improving access; improving the organization, management, and delivery of services; managing costs and better investing resources; and

improving care coordination and outcomes for service recipients. The system of care approach and health reform also share two additional goals. One of the central purposes of health reform is to increase health promotion, prevention, and early identification efforts in order to mitigate more serious health problems and associated costs in the future. Similarly, the system of care philosophy entails incorporating or linking with behavioral health promotion, prevention, and early identification and intervention activities in order to improve long-term outcomes. Particularly important is the linkage between primary health care services and behavioral health care and the consequent opportunity to identify behavioral health problems earlier in primary care settings. The increased access to health care resulting from health reform offers new potential for screening to detect behavioral health issues at earlier ages and at earlier stages, and for obtaining appropriate treatment in an integrated approach.

In addition, both systems of care and health reform are characterized by a commitment to high-quality care, data-informed service delivery, and continuous quality improvement to ensure that health care resources fund “what works.” The use of evidence-informed practices to improve outcomes is embraced in the system of care approach and is an explicit goal of health reform.

Given its alignment with the goals of health reform and its positive outcomes, the system of care approach provides an effective framework and approach for implementation of the major components of the ACA. The components of the ACA that have direct relevance to the system of care approach include:

1. Essential benefits packages in Medicaid, CHIP, Health Insurance Exchanges, and other insurance plans
2. Medicaid and CHIP expansion
3. Health homes
4. 1915(i) State Medicaid Plan Amendments



5. Money Follows the Person
6. Accountable Care Organizations

Each of these components is discussed in detail below, along with a discussion of the relevance and relationship of the system of care approach, and implementation issues to consider as they relate to children's behavioral health.

Essential Benefits Packages

The ACA requires the development of essential benefits packages for Medicaid, for policies offered through Health Insurance Exchanges, and for policies offered through individual and small group markets outside of the exchanges.

Description—Essential Benefits in Medicaid:

Work is currently underway to define a benefit plan that will be a “benchmark benefit package” for newly eligible Medicaid populations enrolled under the ACA. All new Medicaid enrollees will be entitled to this benchmark benefit package, and states can choose to offer benefits that exceed the benchmark package. DHHS, including SAMHSA, is undertaking activities to delineate an “essential benefits package” for behavioral health services to recommend for inclusion as part of the benchmark plan in Medicaid.

Description—Essential Benefits in Health Insurance Exchanges and Other Insurance

Plans: A Health Insurance Exchange is a governmental agency or nonprofit entity established by a state to offer an array of qualified health insurance plans for purchase by individuals with incomes from 133% to 400% of the federal poverty index and for small businesses. States must have their exchanges in place by January 1, 2014, or the federal government will develop an exchange for the state. States have wide discretion in setting the standards, requirements, and rates for plans

offered in their Health Insurance Exchanges. States will determine the benefits that must be offered by the plans and will create rules to ensure that plans are transparent regarding both the benefits provided and their costs. Nearly all states have already received federal funds to assist in covering the costs of planning and implementing their exchanges.

In addition to the benefit package under development for Medicaid, an essential health benefits package is being developed by the Department of Health and Human Services (DHHS) that will apply to all insurance plans offered through Health Insurance Exchanges, as well as to individual and small group health insurance markets outside of the exchanges. The Institute of Medicine (IOM) is charged with submitting recommendations to the Secretary of DHHS, and it is anticipated that rules regarding the essential health benefits package for insurance plans will be proposed by DHHS in 2011.

The ACA requires that the essential benefits package be the same as a typical employer-sponsored health insurance plan. The ACA also requires the Secretary of DHHS to ensure that this benefit package is appropriate for vulnerable populations, which includes children with behavioral health treatment needs. The statute lists general categories that must be covered, such as mental health and substance use disorder services, rehabilitative and habilitative services, and preventive and wellness services. Further, the ACA specifies four possible tiers of benefits. The silver and gold tiers are required, and as an option, states may enrich benefits by creating bronze and platinum plans. However, no details are specified under the categories of services or for specific benefits within each tier, leaving states with decisions to make regarding the services to include.

Intersect with Systems of Care: By definition, systems of care include a comprehensive array of services to meet the multiple and changing needs



of children with behavioral health challenges and their families, including many services and supports that have not historically been included in insurance benefit packages. The system of care approach also emphasizes an individualized approach to service delivery and the incorporation of evidence-informed practices to improve the effectiveness of services. The array of services and supports typically included in the system of care approach are shown in Table 2, with the addition of some especially relevant services and supports that are included in the recently developed for a model “Good and Modern Addictions and Mental Health Service System” (O’Brien, 2011). For many of these services, evidence-informed interventions, as well as interventions created or adapted for particular cultural groups, can be applied.

Many state Medicaid plans have already incorporated coverage for several of these services, offering a rich array of children’s behavioral health services and supports. In many cases, incentives are incorporated to reduce the utilization of high-cost inpatient and residential services and to increase the use of home and community-based services that have proven to be

effective. In this way, the system of care approach has resulted in the redirection of scarce resources. Employer-based insurance plans, however, typically include only a very basic behavioral health benefit, often limited to traditional outpatient and inpatient services rather than the wider range of services that is optimal for children’s behavioral health. As a result, children with serious and complex behavioral health disorders do not receive intensive services and supports, and are often placed in costly residential and inpatient settings due to the lack of coverage for community-based alternatives.

The comprehensive service array that is inherent in the system of care approach provides a model for the essential benefits packages under development for Medicaid, Health Insurance Exchanges, and other insurance policies. Adoption of this broader service array, in whole or in part, would ensure that children with serious and complex disorders receive the services and supports they need in a cost-effective manner. In addition, the system of care philosophy of family-driven, youth-guided, individualized, coordinated, and culturally and

TABLE 2 ARRAY OF SERVICES AND SUPPORTS IN THE SYSTEM OF CARE APPROACH

Non-Residential Services

- Assessment and evaluation
- Individualized “wraparound” service planning
- Intensive care management
- Outpatient therapy—individual, family, group
- Medication management
- Intensive home-based services
- School-based behavioral health services
- Substance abuse intensive outpatient services
- Day treatment
- Crisis services
- Mobile crisis response
- Therapeutic behavioral aide services
- Behavior management skills training
- Therapeutic nursery/preschool

(Specific evidence-informed interventions and culture-specific interventions can be included in each type of service)

Supportive Services

- Peer youth support
- Peer family support
- Youth and family education
- Respite services
- Therapeutic mentoring
- Mental health consultation
- Supported education and employment
- Supported housing
- Transportation

Residential Services

- Therapeutic foster care
- Therapeutic group home care
- Residential treatment center services
- Inpatient hospital services
- Inpatient medical detoxification
- Crisis stabilization services



linguistically competent services provides a template to help both states and insurance companies offer state-of-the-art children's behavioral health services that build on these now widely accepted standards of care.

In crafting proposed behavioral health benefit packages, SAMHSA has considered stakeholder input advocating the inclusion of specific services in the benefit packages as part of the broad array of services and supports, such as intensive home-based services, crisis response and stabilization services, respite care, professionalized therapeutic mentoring, mental health consultation (for example, consultation in early childhood settings or psychiatric consultation with primary care physicians), parent and caregiver support partners who provide peer-to-peer support and assist families in navigating complex service systems, therapeutic recreation, increased use of technology such as e-therapy and e-support, and others. This provides concrete guidance to both state policy makers and insurance providers about how they should craft their benefit packages.

Implementation Issues to Consider: The addition of this comprehensive service array will be new for many insurance plans and, in some cases, for state Medicaid entities. An overriding concern is the need to be cost-conscious in developing benefit plans so as not to increase costs. Under Medicaid, both the Psychiatric Residential Treatment Facility (PRTF) Waiver Demonstration and the Money Follows the Person (MFP) initiatives are showing that the use of this broader array of services and supports can successfully maintain children with serious disorders in their homes, schools, and communities, and that this approach is more cost effective than expensive long-term residential treatment. On the prevention side, some states that provide early childhood mental health consultation in early child care and education settings are realizing cost savings by intervening early to address potential problems before they develop into more serious problems requiring intensive and costly

interventions at a later stage. The CMHI has amassed considerable knowledge and experience about how to develop capacity for the entire array of community-based service and support options. This experience can inform the crafting of essential benefits packages for Medicaid, Health Insurance Exchanges, and other insurance companies. If this array of services and supports is not fully included in the essential benefits packages, states should identify other funding sources to ensure that missing services and supports are available to supplement the benefits offered.

Key questions to consider include:

1. What is the definition of “essential benefits” for children’s behavioral health? How do these compare with what is included in typical employer-based plans?
2. What array of services and supports, inclusive of culture-specific and culturally adapted services and supports, should be covered under benchmark plans for Medicaid, Health Insurance Exchanges, and other insurance plans to meet the service needs of children, particularly for those with serious and complex disorders?
3. What incentives can be incorporated to shift care from costly residential settings to home and community-based services and supports?
4. Should states offer Health Insurance Exchange plans with varying levels of comprehensiveness for children’s behavioral health benefits?
5. What changes are needed in behavioral health coverage under CHIP, taking into consideration both parity legislation and the introduction of the new Health Insurance Exchanges?
6. What are the estimated costs associated with various benefit options for children’s behavioral health benefits?
7. How should these services be managed? What cost control mechanisms can be put into place?



8. How can information regarding the evidence base for services and supports be factored into the decisions to be made by states regarding benefits?
9. What types of culturally and linguistically appropriate services and supports should be offered?
10. What kinds of user-friendly materials should be developed about children's behavioral health benefits under the various types of insurance options to assist families to make informed choices among plans?
11. What other financing sources can be used to provide any essential services and supports that are not included in the benefit packages for Medicaid, CHIP, Health Insurance Exchanges, and other insurance plans?

It is critical that state mental health, substance abuse, and health policy makers understand and address these issues in crafting behavioral health benefit packages under the ACA, as well as regulations under parity legislation, so that families have access to the full array of home and community-based services and supports necessary for effective treatment.

Eligibility and Enrollment Issues to Consider:

A major issue for states to address is how Medicaid, CHIP, the plans offered in Health Insurance Exchanges, and employer-based insurance policies will fit together, how benefit plans might differ among them, and how families will navigate these different plans based on changes in their employment and income status. Individuals, especially those with disabilities (including behavioral health disorders), will require assistance in determining which options best address their service needs. Further, many individuals eligible for Medicaid and CHIP are not aware that they qualify for, or know how to enroll in, these public insurance programs, and many will move from Medicaid and CHIP to the Health Insurance Exchanges to employer insurance policies as their incomes and employment situations change.

States are required to develop “Express Lane Eligibility” processes that allow individuals to apply for and enroll in Medicaid, CHIP, or Health Insurance Exchange plans through websites administered by states using a simple two-page form. States must also provide navigators to assist individuals, including members of vulnerable and diverse populations, to complete this application and to counsel them in selecting the correct insurance plan or public program.

The implementation of the system of care approach in many states and communities already includes some form of peer navigators, who frequently are parent support partners. The National Federation of Families for Children's Mental has developed materials and a certification process for parent support partners. This approach can provide effective models for designing “Express Lane” eligibility processes and navigator systems for Medicaid, CHIP, and Health Insurance Exchange plans. In many states, family organizations for children's mental health have expertise in providing peer navigators, and contracts with these organizations offer a viable approach for delivering this service. Thus, system of care models currently operating in states offer guidance and resources to draw upon in providing peer navigation and family support, as well as in outreach to diverse populations in need.

Key questions to consider include:

1. What culturally and linguistically appropriate, user-friendly materials about children's behavioral health benefits are needed assist individuals and families to choose the correct plan?
2. What strategies can be implemented to assist individuals and families to move among Medicaid, CHIP, Health Insurance Exchange plans, and employer-based policies as their income and employment situations change, so that they can retain needed behavioral health benefits and service continuity?



3. How can “peer navigators” be incorporated into the essential benefits packages to assist individuals across all cultural groups, particularly those with disabilities, to determine the insurance option that will best meet their own behavioral health service needs and those of their children?
4. How can the experience of systems of care in utilizing peer navigators and peer support providers inform the development of peer navigator services under Medicaid, CHIP, and Health Insurance Exchanges?
5. What types of community outreach and marketing strategies are needed to enroll eligible children in general and culturally diverse children in particular in Medicaid and CHIP, and how will this be measured?

Medicaid and Children’s Health Insurance Program (CHIP) Expansion

Description: Medicaid and CHIP expansions provide a vehicle for delivering needed behavioral health services to many more children. It is estimated that the expansions in Medicaid and CHIP programs will increase their enrollment by 33% by 2019. Another benefit of Medicaid expansion under the ACA is that young adults exiting foster care will, starting in 2014, be automatically enrolled in Medicaid through age 25. Those young adults will have access to all necessary health and behavioral health services covered under the state plan.

Intersect with Systems of Care: The system of care approach can be used as the foundation and framework to ensure that the additional children served by Medicaid and CHIP receive necessary and appropriate behavioral health care. Many states and communities have already

implemented the system of care approach widely, or are in the process of doing so. As a result of Medicaid and CHIP expansions, their systems of care will be able to expand access to services to more children who are currently uninsured or under-insured and will be able to receive reimbursement for these services. This additional federal funding through Medicaid and CHIP will likely assist states to sustain and expand the services currently offered in community systems of care that are now supported with federal grant dollars or scarce state resources.

Systems of care will also be impacted by the addition of a new group of individuals that will now be eligible for Medicaid, primarily adults with incomes between 100% and 133% of the poverty level. Many of these adults have not had access to health and behavioral health services for some period of time, and a significant number of them may be parents of children with behavioral health needs. Existing systems of care may already be serving some of these children under Medicaid. The change in Medicaid eligibility will allow their parents to receive their own health and mental health coverage, enabling systems of care to meet the behavioral health needs of the entire family with a comprehensive and coordinated approach. In addition, based on the ACA, system administrators will have the ability to expand their system of care eligibility criteria to include young adults up to age 26 who are exiting foster care and who still require behavioral health services.

Implementation Issues to Consider: Some states currently use only state general fund dollars to pay for health care for adults between 100% and 133% of poverty. These states can realize significant savings immediately when they begin to claim 100% federal revenue for these individuals under the ACA. In addition to savings based on this change in Medicaid eligibility, states will also receive a 23% savings in their CHIP plans beginning in 2013, when



federal financial participation (FFP) will be increased. Savings that states realize could be reinvested to serve more children and families with behavioral health needs. Information and data are needed for policy makers to demonstrate the need for redirecting savings from Medicaid and CHIP to expand investments in systems of care.

States may also experience an increased demand for primary health, mental health, and substance abuse services as this new group of individuals becomes insured. As a result, states will likely need to increase their provider networks to serve the expanded covered population. A model for states is provided by systems of care that have incorporated parents and paraprofessionals in their provider networks to provide supports such as mentoring, peer support, and respite care (Annapolis Coalition, 2007). Adopting this approach would assist states to meet the increased demand for services.

Key questions to consider include:

1. How can savings in state funds from increased federal participation in Medicaid and CHIP be reinvested in order to expand the array of home and community-based services provided with the system of care approach and to serve more children and families?
2. What strategies are needed to meet the expected increase in demand for behavioral health services among newly covered children and families?
3. What strategies can be implemented to ensure that newly covered parents receive the behavioral health services they need in addition to services related to their children's needs?
4. How can provider networks be expanded to meet the increased demand for behavioral health services? How should this workforce be developed and trained in the system of care approach (that is, community-based, family-driven, youth-guided, individualized,

evidence-informed, culturally and linguistically competent interventions and supports)?

5. How can parents and paraprofessionals be incorporated into provider networks to provide services and supports to contribute to meeting increased demand?

Health Homes

Description: Health homes are a Medicaid option available for states to design programs to better serve persons with chronic illnesses, serious mental health conditions, and/or addiction disorders. Health homes must provide for an individual's primary care and disability-specific service needs in one location, and must provide care management and coordination for all of the services needed by each person. The major goal is to provide more comprehensive, coordinated, and cost-effective care for individuals with disabilities than is generally provided when services are fragmented across multiple health providers and organizations. A letter from the Centers for Medicare and Medicaid Services to state Medicaid Directors states that: "The health home provision authorized by the ACA provides an opportunity to build a person-centered *system of care* [emphasis added] that achieves improved outcomes for beneficiaries and better services and value for state Medicaid programs" (Centers for Medicare and Medicaid Services [CMS], 2010). The federal government will provide 90% Federal Medical Assistance Percentages (FMAP) for two years for certain services including comprehensive care management, care coordination, health promotion, comprehensive transitional care from inpatient to other settings including appropriate follow-up care, individual and family support, referral to community and support services, and the use of health information technology to link services, as feasible and appropriate. A second goal is for states to experiment with innovative



reimbursement methodologies for services, including case rates, inclusive salaries, and other mechanisms to save on the costs of care.

The ACA also delineates examples of providers that may qualify as health homes, such as physicians (including pediatricians, gynecologists, and obstetricians), clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, or any other entity or provider that is determined appropriate by the state and approved by the Secretary of DHHS. Given the license to include other types of entities, states may want to designate additional providers, subject to CMS approval, such as agencies that offer behavioral health services. Designated providers must have systems in place to provide health home services and must satisfy certain qualification standards.

Health homes are designed to operate under a “whole-person approach” to care that addresses all of the health-related needs of the person and uses a “person-centered” planning process to identify and provide needed services and supports. Teams of health care professionals are also expected to coordinate care. Teams can be comprised of medical professionals, social workers, and mental health and substance use prevention and treatment providers.

Intersect with Systems of Care: The health home concept is closely aligned with the system of care approach, sharing many of the same values and operational principles. First, the ACA specifies that health homes provide a broad array of services and supports which are all core services integral to the system of care approach. In the creation of health homes that serve children with serious behavioral health conditions, the coordination, individualization, and array of services and supports that comprise systems of care provide an effective model to build into the health home approach. Existing system of care structures, such as care

management entities, may be uniquely qualified to be designated as health homes for children with behavioral health disorders under the ACA. In addition, the creation of health homes for children and youth with serious behavioral health disorders provides a vehicle for expanding the system of care approach across localities within a state, the goal of SAMHSA’s current system of care expansion initiative.

Additionally, health homes use an approach to care that addresses all of the person’s needs and does not compartmentalize the person’s health or well-being. A person-centered team approach is used to plan and deliver services that are customized to meet each person’s needs. Health homes then provide care and linkages to other services and supports that address both the clinical and nonclinical needs of an individual. Individualized service planning and delivery is also a cornerstone of the system of care approach and the primary way that it is implemented at the service delivery level. Referred to as “wraparound,” a child and family team (including relevant service providers and professionals along with the family and youth) is convened to identify needed services and supports; create an individualized, culturally and linguistically appropriate service plan; provide services; and link the child and family to other needed services and supports. Considerable work by the National Wraparound Initiative has resulted in the specification of principles and processes that characterize the wraparound approach, and numerous tools to support and assess implementation. Thus, the experience, expertise, and resources developed for serving children with mental health challenges with the system of care approach offers much to guide the implementation of health homes.

Implementation Issues to Consider: Health homes offer a significant opportunity for children with serious behavioral health problems and their families to receive care that is aligned with the system of care concept and philosophy.



In addition, the system of care approach itself offers exemplars, prototypes, and models that can serve as the basis for the implementation of health homes—not only for children with behavioral health disorders, but for other health care populations as well.

Key questions to consider include:

1. How can the system of care approach be used to inform the design, development, and operation of health homes under the ACA?
2. How can care management entities that specialize in managing services for children with serious behavioral health disorders serve as health homes under the ACA?
3. What new financing strategies are needed to support the initial start-up and development of health homes that have special expertise in children’s behavioral health?
4. What types of providers are qualified to be designated as health homes for children with behavioral health disorders?
5. How can the broad array of services and supports inherent in the system of care approach be used as a model for the services and supports to be provided by health homes?
6. How can the individualized, culturally and linguistically competent wraparound approach to service planning and delivery be applied to the service delivery approach used by health homes, particularly those serving children with serious and complex behavioral health challenges and their families? What resources and tools might be valuable in this process?
7. What quality measures should be used for health homes in relation to children’s behavioral health?
8. What innovative financial reimbursement mechanisms for health homes can offer the best services most economically?
9. How can key child-serving systems be linked to health homes?

1915(i) State Medicaid Plan Amendments

Description: New 1915(i) State Medicaid Plan Amendments (SPAs) allow states a means to change their Medicaid plans to offer Home and Community-Based Services (HCBS) as an option for serving more individuals. Individuals with incomes up to 150% of the federal poverty level, and individuals with disabilities receiving up to 300% of the maximum Supplemental Security Income (SSI) payment (for 2010, 300% of SSI is equal to \$2,022 per month) will qualify for services under this option. States may include several different populations under a single 1915(i) SPA. Examples of populations that can be served include: 1) adults with severe mental illness, 2) seniors at risk of placement in nursing homes, and 3) children with a serious emotional disturbance.

States may not waive the requirement to provide services statewide, nor can they limit the number of participants in that state who may receive the services if they meet the population definition. In order to limit costs, however, states may identify a very specific population in an SPA request. A state could, for example, focus an SPA only on children with serious emotional disorders who have had two or more psychiatric hospitalizations, rather than include all children with serious emotional disorders, thereby limiting the number of eligible individuals and the associated cost impact on the state. The SPA may also be phased in over a five-year period, allowing states time for providers to develop new, flexible, home and community-based services, and time to secure the financing necessary to implement the SPA. One benefit of 1915(i) SPAs is that children with incomes up to 150% of the poverty level no longer must meet the criteria for institutional care to receive “waiver-type” services like respite or wraparound facilitation (an intensive service



planning and case management process). States using the 1915(i) SPA vehicle will neither bear the burden of renewing a short-term waiver application and will not be required to demonstrate “cost neutrality.” 1915(i) SPAs will be approved by CMS for a five-year period and may be renewed.

Intersect with Systems of Care: Systems of care have led the way in developing new intensive, home and community-based services for many children with serious mental health disorders in most states. As noted, many states have already developed and financed a broad array of treatment services and supports including intensive home-based services, respite care, family support, therapeutic behavioral aides, mentors, wraparound facilitation, intensive care management, evidence-based practices, culture-specific interventions, and many others. Some of these services that comprise the system of care approach have been financed through multiple Medicaid options and waivers. Other federal, state, and local funds have, however, been used to cover these services when they are not covered under the Medicaid Clinic Services or Rehabilitation Options or under waivers. The 1915(i) SPA now makes it possible to cover these services through a single mechanism, so long as they are offered statewide for the defined population.

This option also offers an opportunity for states to combine some or all of the services they currently offer using the system of care approach that are covered under the Rehabilitation Option and incorporate them under a 1915(i) SPA. This would allow them to offer waiver-like services without the requirement of meeting the definition of rehabilitation services (Public Health, 2010). For example, infant mental health services may be provided without the need to demonstrate that the infant is being “rehabilitated,” which currently is a requirement under the Rehabilitation Option. Infants are not likely to have a condition to rehabilitate, thus making

them ineligible for such services through their Medicaid coverage. In addition, some services such as respite care, parent support partners, intensive in-home services, and therapeutic behavioral aides provide critical supports to maintain children in their homes and communities, but may not meet the strict definition of rehabilitation. Moving these types of services from the Rehabilitation Option to a 1915(i) SPA allows these services and supports to be provided without having to meet the criteria for what constitutes rehabilitation.

The system of care approach offers a framework for crafting 1915(i) SPAs, assisting states to determine what services and supports should be provided to qualifying children. States and communities using the system of care approach will also benefit from this option, as it will allow them to provide the more intensive, flexible services and supports that are both highly valued by families, and essential for serving children with complex needs in the community rather than in more costly residential settings. States should be encouraged to submit applications for 1915(i) SPAs for children with serious emotional disorders and their families in order to expand the availability of the services typically offered through systems of care that have demonstrated positive outcomes.

Implementation Issues to Consider: 1915(i) SPAs offer states an incentive to maximize federal Medicaid funds for services that are less costly than residential care. However, a concern for states might be the potential costs associated with 1915(i) SPAs, primarily because the services must be available statewide. Data are needed to determine the estimated costs of making these services available statewide and to determine what resources are already being used to finance these services. This information can then be used to determine whether or not it would be cost-efficient to make these services Medicaid billable. For example, a state may be spending \$2 million on respite care using 100% state dollars. If all



children receiving respite care were included in the SPA, by making this service Medicaid billable, the state could expand available resources to \$4 million, provided that their state match is 50% and that the population currently receiving the service is Medicaid eligible. If the state match is 25%, total available resources could potentially expand to \$5.5 million, and the state could then cover many more children who require this service, enabling the benefits to accrue statewide with no additional costs to the state. This same model could be used for other services such as family support or wraparound facilitation. It is critical for the children's behavioral health community to collect information assessing the advantages of pursuing this option, and to inform high-level policy makers and decision makers.

In other instances, a state may move services currently covered under the Clinic and Rehabilitation Options into a 1915(i) SPA. Depending on the desired service array, a state could make the case that it will be able to keep more children out of psychiatric hospitals or residential treatment facilities by making intensive home and community-based services available and by managing placements more effectively. States could also build a case for redirecting funds to intensive community-based services from more restrictive and costly care such as residential treatment or psychiatric hospitalization. For example, if a state included wraparound facilitation, respite, therapeutic mentoring, parent support partners, intensive in-home services, and other intensive community-based services for children in addition to outpatient clinic services, then these services could be provided in lieu of high-cost placements. In this example, a state could build a business case for using the 1915(i) SPA, because the intensive community-based services could help reduce out-of-home placement costs. This is just one of many options that states could consider regarding the use of 1915(i) SPAs. States and communities will need to work in partnership to use this option effectively.

Key questions to consider include:

1. Should the state apply for a 1915(i) SPA for a defined population or sub-population of children with serious behavioral health disorders?
2. Which of the expanded array of service and supports that comprise the system of care approach should be incorporated into a 1915(i) SPA, including services that are currently funded under the other Medicaid options or waivers?
3. What data are needed to determine the cost-efficiency of including specific services and supports under the SPA, and how will that data be collected?
4. Are the services and supports included in the 1915(i) SPA likely to result in reduced utilization of inpatient and residential treatment services and redirection of resources to more effective home and community-based approaches?

Money Follows the Person

Description: Enacted as part of the Deficit Reduction Act (DRA) of 2005, the Money Follows the Person (MFP) Rebalancing Demonstration is part of a comprehensive strategy within Medicaid to assist states, in collaboration with key stakeholders, to make widespread changes to their long-term care support systems. This initiative was included in the ACA and encourages states to reduce their reliance on institutional care while developing community-based, long-term care alternatives. The target population for this initiative includes children and youth with serious emotional disorders who have been in psychiatric hospitals or Psychiatric Residential Treatment Facilities (PRTFs).

Congress initially authorized up to \$1.75 billion in federal funds for the MFP Demonstration program through 2011 to increase the use of



home and community-based services and reduce the use of institutionally-based services. The funds are also intended to strengthen the ability of state Medicaid programs to ensure ongoing, high-quality home and community-based care to individuals transitioning from institutions.

The ACA provides an opportunity for more states to participate in MFP in addition to those states that are already participating in the demonstration, and will help states continue to build and strengthen their demonstration programs. The ACA extended the MFP Demonstration Program through September 30, 2016, with an additional \$2.25 billion appropriated over four years. Any unused portion of a state grant award made in 2016 would be available to the state until 2020. The ACA also expanded the definition of the eligible population for the demonstration to include individuals who reside in an institution for more than 90 consecutive days (down from 180 days in the original MFP demonstration). This change makes it possible for many children and youth who receive treatment in PRTFs to transition to the community with needed services and supports that otherwise are typically covered only in a Medicaid waiver (such as wraparound facilitation, respite, therapeutic mentoring, intensive in-home services, parent support partners, and others), with the added benefit of enhanced federal Medicaid match. A formula is used to determine the match that involves dividing the current FMAP in half and then adding that number to the current FMAP. A state currently at 50% would receive an enhanced match of 25%, which would take the entire match to 75% FMAP, with an upper limit of 90% FMAP. The enhanced federal match is available for 365 days after each individual's discharge from the institution.

Intersect with Systems of Care: The system of care approach provides a framework and philosophy for serving children who qualify for MFP. Children and youth who qualify must meet

the requirement of having stayed in a PRTE, inpatient psychiatric unit, or state psychiatric hospital for at least 90 consecutive days. These children have the most serious functional impairments, and are typically served by multiple systems, including mental health, education, child welfare, juvenile justice, developmental disabilities, and/or substance abuse. Such youth have often experienced multiple episodes of hospitalization and residential treatment and have received many high-cost services from multiple child-serving systems without adequate coordination, individualization, family and youth involvement, or cultural competence.

Many states and communities have demonstrated how the system of care approach can be used effectively to divert youth from inpatient and residential treatment, as well as to successfully transition youth in residential settings back to their homes, schools, and communities (Kamradt, Gilbertson, & Jefferson, 2008; Maryland Child & Adolescent Innovations Institute, 2008). Typically, a highly individualized approach is used to develop a service plan that includes intensive services and supports coordinated by a skilled care manager. A care management entity is often the locus of accountability for this population, managing both services and costs (Pires, 2010). States crafting their MFP programs can benefit from this experience by using this approach to create an effective “package” of intensive, individualized services and supports that are managed as a cost-effective alternative to institutional treatment.

MFP can also assist states and communities build the capacity within their systems of care to implement evidence-informed interventions, promising practices, and culture-specific interventions. The additional funding from enhanced federal match could help states and communities assess their readiness to implement these practices (and potentially provide the fiscal support for start-up costs including training and coaching for providers), to ensure that children



and youth transitioning from residential settings will be served with the most effective treatment interventions.

Implementation Issues to Consider: Children and youth transitioning from restrictive residential settings often need an intensive, coordinated service delivery approach, with multiple child-serving agencies partnering to provide services and supports in the child’s home, school, and community. Experience has shown that traditional outpatient clinic services are not sufficient to successfully serve children with the most serious and complex disorders in the community. Rather, a full array of intensive home and community-based supports in accordance with the system of care philosophy and approach is needed as alternatives to treatment in institutional settings—intensive, individualized, coordinated across systems, family driven and youth guided, and culturally and linguistically competent, and with skilled care management at the child and family level.

Key questions to consider include:

1. How will a partnership across child-serving systems, providers, and family and youth organizations be developed to plan and implement an approach for transitioning youth from residential to community-based services? What ongoing structures and processes are needed?
2. What intensive services and supports are needed to successfully serve this population in the community?
3. What is needed to implement an individualized, wraparound approach to planning and delivering services to this high-need population?
4. What evidence-informed, promising, and culture-specific interventions should be incorporated to ensure effective treatment and support?
5. How will services and the system be managed?

Accountable Care Organizations

Description: Accountable Care Organizations (ACOs) are structures created by the ACA that are responsible for providing, managing, and coordinating the total care of a defined population of 5,000 or more individuals. ACOs will be created by linking a group of providers within a single entity with shared governance, and with clinical and financial incentives to provide high-quality health services at a reduced cost. They may serve as a “neighborhood” medical and behavioral health care network that consists of multiple primary care practices, health homes, and specialty providers such as family-run organizations, residential treatment services, and hospitals.

The ACA calls for demonstration pilots of ACOs for Medicare enrollees and at least one pilot of a pediatric ACO, but does not specify how behavioral health (or more specifically children’s behavioral health) should be incorporated. Current planning for ACOs appears to be primarily among large health care organizations and hospital systems. Many of these organizations are attempting to acquire specialty practices, such as nonprofit community mental health centers, to bring behavioral health expertise into their medical-surgical networks.

Most states are in the early stages of defining ACOs for their health systems and will have major decision-making authority about their design, business models, operational requirements, quality standards, and performance requirements. The National Committee for Quality Assurance (NCQA) will issue draft standards for ACOs, and CMS will issue regulations for ACOs, in part based on ongoing demonstrations.



Intersect with Systems of Care: ACOs will be required to develop plans specifying the services they will provide in their networks, how service delivery will be structured, how care management and other essential functions will be handled, and how services will be coordinated. Similar to the applicability of the system of care framework to health homes, the system of care approach can provide a value base, operational principles, a defined array of services and supports, and a collaborative cross-agency model for service planning and delivery that can serve as a guide for ACOs for the provision of behavioral health services to enrolled children and families.

Implementation Issues to Consider: A significant challenge in the creation of ACOs is to determine how behavioral health services will be organized, licensed, regulated, financed, and monitored within these structures. In addition, state leadership must determine if and how the system of care approach will be applied to the design and operation of these structures, and in particular how this approach will be applied to children's behavioral health services.

Although health reform is seen as an opportunity to better integrate physical health and behavioral health care, a concern is that research on managed care has found that when physical and behavioral health are integrated into one organization (perhaps like an ACO), behavioral health services lose focus, particularly when specific resources are not designated for those services. "Carving out" behavioral health has tended to result in greater expertise, resources, and better behavioral health outcomes, without necessarily sacrificing coordination with physical health services (Pires, 2002b). Care should be taken to consider lessons learned from previous experience to inform the development of the new clinical and financial structures called for under the ACA.

It is essential to consider mental health and substance use in planning ACOs and to carefully consider the types and the cultural diversity of

specialty providers that should be included in the ACO structure to address children's needs. In addition, consideration is needed to determine how care management entities within systems of care may serve as health homes incorporated within the ACOs.

Key questions to consider include:

1. Given the initial focus on Medicare, how will the needs of children and families be considered in future ACO efforts?
2. What will be the relationship between ACOs and health homes? Will ACOs be global structures that incorporate health homes?
3. How can behavioral health organizations become specialty health homes or specialized behavioral health service providers within ACOs?
4. How can care management entities using the system of care approach be incorporated into ACOs as health homes or as some other participating structure?
5. How will standards, licensing, and regulation of ACOs address behavioral health in general, and children's behavioral health needs in particular?
6. What quality measures should be assessed for ACOs in relation to children's behavioral health?
7. Will small groups and individual providers be included within ACO structures and, if so, how?
8. How will care managers, nontraditional providers, peer to peer providers, culture-specific and other providers be included in ACO networks?
9. What strategies can be used to ensure that families and consumers will have oversight and ombudsperson roles in ACOs?
10. Since multiple systems fund and provide behavioral health services for children, what systems should be included (health, mental health, substance abuse, child welfare, juvenile justice, education), and how will this network be structured?



Conclusion

Systems of care and health reform intersect in a number of important ways that have implications for the future implementation of both. The alignment of goals is clear in that both systems of care and health reform are designed to increase access to health care services, increase the array of available services and supports, improve the coordination of care, improve the quality and outcomes of care, improve the cost-effectiveness of services, and better invest resources. Systems of care have demonstrated that the availability of a broad range of treatment and support services for children's behavioral health is effective in preventing more serious problems and in mitigating overall health care system costs. Further, an individualized, wraparound approach to service planning and delivery has proven effective in many states and communities and has been the primary approach used to operationalize the system of care philosophy at the service delivery level, ensuring that children and their families receive optimal, appropriate, and cost-effective care. Care coordination and management at the individual and system levels have reduced fragmentation and resulted in better use of resources. Systems of care have demonstrated that there are, in fact, cost-reducing and cost-effective alternatives to serving children in hospitals, residential treatment centers, and other institutional settings, which is especially important during this time of fiscal challenges. These and other elements of the system of care approach may be new for insurance companies, but have been used effectively for many years by states and communities.

As planning and implementation activities for health reform gain momentum, it is essential to consider the implications for children, adolescents, and young adults with behavioral health challenges and their families and to determine how their needs will be addressed. The system of care approach has been embraced as the basis for a "paradigm shift" in the children's mental health field, as well as in other child-serving systems and even adult service systems. Given the close alignment of goals, the system of care approach provides a valuable framework and value base for health reform and defines critical elements of children's behavioral health services that should be incorporated into the implementation of the ACA. The ever-growing knowledge base and experience with systems of care can make a vital contribution to structuring ACA implementation to effectively provide children's behavioral health services in order to achieve shared goals. In turn, the ACA and health reform provide a strategic and important vehicle for sustaining and expanding systems of care and the gains made for children and youth with behavioral health challenges and their families in states, communities, tribes, and territories across the country.

As health reform continues to unfold, information will be needed to guide states and communities in addressing children's behavioral health services. This Issue Brief is intended to fulfill this function. Initial priorities for implementation include health homes, essential benefits packages, and Health Insurance Exchanges. Subsequent Issue Briefs in this series will provide timely information on these aspects of the ACA and how they intersect with systems of care.



Resources

Health Reform

The National Council of State Legislatures

State-by-state information about strategies, timelines and action plans for implementing the Affordable Care Act.

www.ncsl.org/?tabid=20231

The Kaiser Family Foundation

Descriptive information, timelines, and updates on implementation of the Affordable Care Act.

www.kff.org

The Commonwealth Fund

Information about health care reform, including state-specific information about ACA implementation.

www.commonwealthfund.org/Innovations/View-All.aspx?topic=State+Health+Policy

The State Reform

Discussions and related documents about each state's work on ACA.

www.statereform.org

Healthcare.gov

Information on provisions of the ACA:

www.healthcare.gov

Information specifically targeted at young adults:

www.healthcare.gov/for-you/young-adults

Clickable map that shows the funding states have for implementing the ACA:

www.healthcare.gov/center

Child Welfare Provisions in the ACA

www.napcwa.org/Legislative/admin_activities.asp

CLASS Act Provisions for Individuals with Developmental Disabilities and Co-occurring Disorders

http://healthreform.kff.org/~media/Files/KHS/docfinder/crs_1511CLASSAct.pdf

www.advanceclass.org/background/fact-sheet

The California Endowment

Strategies for Successful State Implementation of the Affordable Care Act.

www.communitycatalyst.org/doc_store/publications/Rubber_Meets_Road_Jan_2011.pdf

Grant Opportunities Under the ACA

http://nashp.org/sites/default/files/PPACA_Demos_and_Grant_Programs_final_July20_2010.pdf?q=files/PPACA_Demos_and_Grant_Programs_final_July20_2010.pdf

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Raymond, A., March 2011. Lessons from the Implementation of Massachusetts Health Reform. Boston, MA: Blue Cross Blue Shield of Massachusetts (BCBSMA) Foundation. <http://bluecrossfoundation.org/~media/Files/Health%20Reform/Lessons%20for%20National%20Reform%20from%20the%20Massachusetts%20Experience%20Lessons%20Learned.pdf>

Pre-Existing Condition High Risk Insurance Pools Website to access plans offered by DHHS or participating states:
www.pcip.gov/stateplans.html
www.pcip.gov/LearnMore.html

Essential Benefits Packages

Institute of Medicine

Work on essential health benefits
www.iom.edu/Activities/HealthServices/EssentialHealthBenefits/2011-JAN-12.aspx

Kaiser Family Foundation

Document with strategies, state examples, requirements and funding for electronic enrollment systems
www.kff.org/healthreform/upload/8108.pdf

Centers for Medicare and Medicaid Services

Resources for providers such as Children's Coverage Toolkit
www.insurekidsnow.gov

ACA and Co-Occurring Mental Health and Substance Abuse Services Options

Garfield, R., Lave, J., and Donohue, J., November 2010. "Health reform and the scope of benefits for mental health and substance use disorder services." *Psychiatric Services*. Vol. 61 No. 11, pages 1081-1086.

National Federation of Families for Children's Mental Health

Information and certification for parent support partners
<http://ffcmh.org/national-initiative-for-parent-support-providers>

Medicaid and CHIP Expansion

Kaiser Family Foundation Resources

Key Questions About Medicaid and its Role in State/Federal Budgets and Health Reform
www.kff.org/medicaid/upload/8139.pdf

Robert Wood Johnson Foundation Resources

Medicaid, CHIP, and Health Insurance Exchanges
www.rwjf.org/files/research/72126medicaidhealthexchange201104.pdf

Report on Opportunities for Utilizing Medicaid and CHIP under Health Care Reform—State of the States
www.rwjf.org/files/research/71835report.pdf



National Council of Community Behavioral Healthcare

Health Care Reform Implementation Timeline: Medicaid Provisions

www.thenationalcouncil.org/galleries/policy-file/Healthcare%20Implementation%20Timeline%20Medicaid%20Provisions.pdf

Centers for Medicare and Medicaid Services Guidance Letters

State Option to Provide Health Homes for Enrollees with Chronic Conditions

www.cms.gov/smdl/downloads/SMD10024.pdf

Improving Access to Home and Community-Based Services—CMS 1915(i)

www.cms.gov/smdl/downloads/SMD10015.pdf

Community First Choice Option

Summary of the provisions of the Medicaid CFC option, see Section 2401 of the Affordable Care Act (ACA) or go to

www.thearc.org/document.doc?id=2605%20

Health Homes

CMS Guidance Letter on Health Homes

www.cms.gov/smdl/downloads/SMD10024.pdf

American Academy of Pediatrics

Document on Collaborative Projects on Behavioral Health Problems

www.aap.org/mentalhealth

Commonwealth Fund Resources

www.commonwealthfund.org/Content/Newsletters/States-in-Action/2011/Jan/December-2010-January-2011/Feature/Feature.aspx

<http://healthreformgps.org/wp-content/uploads/Abrams-Realizing-Health-Reforms-Potential.pdf>

American Academy of Child and Adolescent Psychiatry

Paper on children's mental health and health homes and mental health toolkit for pediatricians

www.aacap.org

National Wraparound Initiative

Tools for wraparound approach

www.nwi.pdx.edu

1915(i) State Plan Amendments

Centers for Medicare and Medicaid Services

CMS letter to State Medicaid Directors, dated August 6, 2020, outlines requirements for states that are submitting Medicaid Plan amendments for 1915(i).

www.healthreformgps.org/wp-content/uploads/he08092010_waiver.pdf

Money Follows the Person

Centers for Medicare and Medicaid Services

CMS letter State Medicaid Directors, dated June 22, 2010, regarding extension of Money Follows the Person Rebalancing Demonstration Program.

www.cms.gov/smdl/downloads/SMD10012.pdf

Accountable Care Organizations

NCQA

Draft standards for ACOs

www.ncqa.org/portals/0/publiccomment/ACO/ACO%20Criteria_Public_Comment.pdf

National Council on Community Behavioral HealthCare

Descriptive document on ACOs

www.thenationalcouncil.org/galleries/default-file/Partnering%20With%20Health%20Homes%20and%20ACOs%20Full%20Paper.pdf

ACO Learning Network

Toolkits and other information on ACOs

www.acolearningnetwork.org

Brookings Institution Resources

www.brookings.edu/search.aspx?doQuery=1&q=Accountable%20Care



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