



Fiscal Strategies that Support the Building Bridges Initiative Principles

**A paper developed by
The National Building Bridges Initiative
Fiscal/Policy Workgroup**



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Fiscal Strategies that Support the Building Bridges Initiative Principles

Overview

The Building Bridges Initiative (BBI) represents a concerted and committed effort by family members, youth, advocates, community and residential providers, and policy makers to guide practice for service delivery in both residential and community programs to ensure positive outcomes for youth and families.

Since the first National Summit in 2006, the BBI has worked to identify and share effective practices that have been used to successfully implement BBI principles in various communities across the United States. While early BBI discussions focused on BBI principles and ensuring full partnerships between residential and community providers, presently, the task is not philosophical but real. Whether a community-based system of care should include well-integrated residential care is no longer being debated. The challenge and opportunity is how can it be implemented effectively. As states, counties, local communities and providers work to implement the BBI framework, principles and practices, they are asking for information to help them address the fiscal challenges and barriers that are preventing true systems transformation. In response to this need the BBI Steering Committee created a project to focus on the fiscal challenges and the solutions that have been employed to address them. Despite the current economic challenges, there are many examples where states, counties/local communities and providers have developed creative fiscal solutions to implement all or aspects of the BBI framework.

This document contains information on several identified fiscal solutions developed to support operationalizing BBI principles into practice. It is important to note that the BBI Fiscal/Policy Workgroup, which authored this document, did not limit examples to those that are formally described as Building Bridges Initiatives; they also researched and included examples of transformative efforts that have implemented similar values and principles as BBI. In addition, there is no attempt to provide an exhaustive list of examples. The examples included within this document were selected from those that members of the BBI steering committee or other workgroups recommended for inclusion. Examples were chosen to illustrate the key strategies that are highlighted. They are provided, first, to demonstrate that innovative work integrating residential care within a community-based system of care is happening across the country and, second, to inform readers of successful strategies that may have application in their state/county/community/provider efforts to implement BBI principles.

The BBI Fiscal/Policy Workgroup chose to document a limited number of examples so as to respond as quickly possible to the field's request for information. The workgroup intends to continue to collect information on successful fiscal strategies and make that information available on the BBI website.¹ Readers are requested to share other examples of successful fiscal strategies by emailing Julie Collins, chair of the BBI Fiscal/Policy Workgroup:

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Background

The Building Bridges Initiative (BBI) provides a framework for achieving positive outcomes for youth and families served in residential and community programs. Founded on core principles, an emerging evidence base, and acknowledged best practices, the BBI emphasizes collaboration and coordination among residential and community service providers, families, youth, advocates, and policymakers to achieve its aims.

The Building Bridges Framework is built on the principles that services should be family driven, youth guided, individualized and strength based, collaborative and coordinated, culturally and linguistically competent, research based, evidence and practice informed, comprehensive, integrated, and flexible, and focused on achieving sustained positive outcomes.ⁱⁱ Sites identified in this document have chosen different methods and vehicles to put one or more of these principles into operation. While this paper focuses primarily on the fiscal strategies that have been used, it also contains a grid that highlights promising and best practices that are most often used to implement BBI principles. For more information on the Building Bridges Initiative, including tools and tip sheets readers are referred to the BBI website:

<http://www.buildingbridges4youth.org/>.

Highlights of the Barriers and Challenges

The challenges and barriers experienced by states/counties, communities and providers when implementing BBI principles have been varied depending on geographic location, existing legislation, regulation, policies, and practices at the specific level (state, county, community or provider) that the BBI is being implemented. Some of the more common themes that have emerged are:

- Greater challenges experienced for all levels (state/county, provider, family, youth) if all child serving systems do not share the same values and principles;
- Lack of flexibility of traditional funding source(s) and/or 'siloes' funding impeded implementation for all three levels (i.e. state, county, provider).
- Funding sources do not provide differential support for addressing racial and ethnic disparity or disproportionality issues.
- Providers had a particularly difficult time trying to lead a transformation effort and implement the BBI framework when:
 - Funding sources did not embrace best practice values and principles;
 - Funding sources did not support the transition to doing business differently;
 - Funding for family and youth advocate positions that are critical to fully operationalizing family driven and youth guided approaches could not be identified;
 - Different funding sources had different definitions of services that can be paid for; and
 - Finding ways to fund critical best practices, such as the child and family teams, were not available because most funding sources do not pay for even the provider to attend the team meeting.

While many fiscal challenges and barriers have been encountered, states, counties, local communities and providers have successfully addressed many of them. The next section highlights several creative strategies used to address a myriad of challenges and barriers.

Creative Strategies for Addressing Fiscal Challenges and Barriers

Building Bridges Initiatives come in all shapes and sizes. The approaches employed cover an entire spectrum - from one that is statewide and comprehensive to much smaller incremental practice change. They all share a common element with other successful transformative/reform efforts— they have found a way to finance the changes they are making. Some financing is newly developed based upon a recent legislation, some based upon a creative reconsideration and reallocation of existing financing, while some is a cobbling together of financing from multiple sources. As is to be expected, the stability of the financing has enormous impact on both the scope and success of the various efforts.

This section provides examples of the most common fiscal strategies identified as part of this project that have been used in various places across the United States with some positive impact. These are organized into the following five categories:

Medicaid Waivers and Expanded use of Medicaid

Context and Known Limitations: A number of states and municipalities have pursued a Medicaid Waiver such as 1115 Research and Demonstration Projectsⁱⁱⁱ, Home and Community Based Waiver 1915(c)^{iv}, 1915(b) Managed Care/Freedom of Choice Waiver^{vii}, or a combination of 1915(b)(c). Others have expanded the use of Medicaid by increasing eligibility for individuals and families as well as a complete range of services. This has allowed states to tap into federal monies in ways that had not been previously available. These approaches have allowed some sites to increase the size of an existing program or to develop a new and creative model. Unfortunately, as a result of the current fiscal crisis, a recent trend to reduce or cut back Medicaid programs/funding for services has emerged. Rules and use of Medicaid are becoming more restrictive with less flexibility.

Performance-based/Incentive Contracting

Context and Known Limitations: Performance Based contracting is a strategy that has been more commonly used in managed care but is increasingly being used by state child welfare agencies. Performance based contracting allows public agencies to contract for results rather than contract for services. Incentive contracting associates incentives (both positive and negative) with achieving specific outcomes. Some providers are paid for performing well while others might be penalized for not performing well/failing to meet their targets. Both approaches can be very effective in driving performance related to particular outcomes but they can also have unintended consequences. They require careful consideration, development, and monitoring.^{vii}

Reallocation of Existing Funds

Context and Known Limitations: There has been an increase in creative use of existing funding in response to funding reductions. Some examples are a reconsideration of use for particular

funding, others reflect new partnering between agencies and/or government agencies. Some of the more common strategies for existing funds are:

- *Blended/pooled* - Context and Known Limitations: States, counties or communities take existing funds from a number of different systems/programs and put them together for use for a particular program/approach. This is called blending or pooling. Often states/communities will use this methodology to create a case rate for the provider(s) of the services or to use with a managing entity that is responsible for administering the dollars/programs. When they do this, the pooled dollars become almost indistinguishable to the contracting provider. Blending/pooling may require some adjusting or relaxing of regulations guiding the relevant state and/or federal funding streams by policy makers at the federal, state or local level in order to permit the provider/program flexibility to change the way services are set up and delivered.
- *Braided* - Context and Known Limitations: Others will “braid” funds from different sources, which remain in their separate pots but are used to support a combined initiative in as flexible but integrated a way as possible. Unlike blended/pooled funds that are invisible to the contractor, “braided” funds remain visible or in separate strands administratively but are used together to produce a wider array and a coordinated package of services and supports. They allow for greater tracking of their use for reporting to state and federal administrators but do require more resources to ensure accountability to the funders.
- *Case Rates* - Context and Known Limitations: This type of funding strategy usually uses blended funding sources and establishes a set amount of money per child/family per day/month/year based upon prior experiences and costs of similar populations. The use of a case rate provides flexibility to the provider. They have a predictable pool of money to work with over a defined period of time. They can front load services or develop a service that is unavailable in the community. This allows them to develop a truly unique service plan, one that can be individualized in direct response to a family’s strengths and needs. Most case rate contracts include some protections for the parties. Some have a cap of some sort to cover the situation where the costs associated with a large number of the children who are placed might substantially exceed the case rate/funds the provider is receiving. Sometimes there is risk sharing between the provider and the funder. An example is a defined “risk corridor” where the provider’s actual expenditures beyond some percentage above the case rate are protected and any savings from under spending beyond some percentage are returned to the funder. Developing and implementing a case rate approach is fairly complicated and a significant workload, however, a growing number of states have either developed or are in the process of developing case rates that cross systems, age and disabilities.

Private Funds

Context and Known Limitations: Private agencies have an established history of fundraising and using private dollars to help maintain financial stability. As governmental funding has become less available and more restrictions and limitations are placed on them, agencies have

sometimes been forced to be even more creative in their fund raising approaches and more strategic in how they use private dollars.

Reinvestment Strategies

Context and Known Limitations: Reinvestment strategies allow savings from a reduction in use of high cost services to be spent on lower cost alternatives that are responsive to needs. A reinvestment strategy is spending neutral while allowing providers the flexibility to provide services earlier, in greater intensity or at a lower intensity for a longer period of time. The flexibility allows providers to better individualize services and care in response to individual needs. Reinvestment strategies can be associated with individual cases (case rate) or they can be tied to system wide spending (e.g. a government entity agrees to take all of the foster care savings from a reduction in use of residential care and spend it on community based services that wrap around families in need thereby reducing the need for placement or supporting successful transition within the community following discharge from foster care).

In some instances, a community participation process is required to determine how the reinvestment dollars are to be used. This approach addresses concerns raised around public dollars going as “profit” and not back into the system. Reinvestment strategies require new accountability systems and are often time limited. In addition, they can be significantly influenced by changes in government administrations.

Fiscal Strategies

The following section provides specific examples and summary descriptions of how different fiscal strategies have been employed by various states, counties and agencies to implement the principles of the Building Bridges Initiative. They reflect an entire spectrum of initiatives from the most comprehensive which tend to be both system and state wide, to initiatives driven by individual agencies, and sometimes workers, that demonstrate that anyone anywhere can take actions, however incremental, to participate in this transformation towards ensuring positive outcomes for youth and families.

Readers will also find contact information as part of each summary in order to selectively pursue additional detail on a specific effort.

It is important to note that each site is unique so solutions that may be effective in one site may not easily transfer to another.

The information for each example was obtained from telephonic interviews with key staff at different sites, and review of site specific materials. Site staff verified the individual write-ups as accurate as of July/August 2011. With the rapidly changing fiscal environment in some States, some information may have changed between verification and publication of this document.

<u>Fiscal strategy</u>	<u>Site</u>
Medicaid/Medicaid Waiver	Arizona EMQ FamiliesFirst Wraparound Milwaukee (1915a) Kids Oneida
Performance-based/Incentive Contracting	Erie Illinois LA County Tennessee
Private Funds	Children's Village
Reallocation of Existing Funds	Arizona Children's Village Erie County (braided) EMQ FamiliesFirst (blended) Indiana Kids Oneida (blended and case rate) LA County (blended and case rate) Magellan Lehigh Valley RTF Virginia (pooled) Westchester County Wraparound Milwaukee (blended and case rate)
Reinvestment Strategies	Erie County EMQ FamiliesFirst Kids Oneida Tennessee Wraparound Milwaukee Westchester

Table 1: Fiscal strategies and sites that employed each

Practices

Table 2 provides the reader with a better understanding of the specific BBI types of practices being employed by each state, municipality or agency. Due to space constraints the practice labels are abbreviated. Please see the glossary at the end of the document for more complete descriptions of each BBI promising or best practice.

	Use of BBI Principles	Tracking and applying relevant outcomes	Shorter LOS in residential care with intensive community based services F/U	Child & Family Team/Wraparound implemented w/fidelity	Significant Role for Family Advocates	Significant Role for Youth Advocates	Residential Staff frequently work in family home, neighborhood and	Flexible funding for supports to family/youth in the community	Unique strategies for Family engagement	Unique strategies for Youth engagement	Family Search and Engage	Effective collaborations of Residential and Community provider	Reducing Racial Disparity and Disproportionality	Other
Arizona	X	X		X	X			X	X			X		
Children's Village	X	X	X	X	X	X	X		X	X	X	X	X	X
Erie	X	X	X	X	X				X			X	X	X
EMQ	X	X	X	X	X	X	X	X	X	X	X	X	X	X
Illinois		X	X									X		
Indiana	X	X	X	X	X		X	X	X	X		X		X
Kids Oneida	X	X	X	X	X				X	X		X		
Los Angeles County	X	X	X	X			X	X			X			
Magellan Lehigh Valley RTF	X	X	X	X			X					X		X
Tennessee	X	X	X					X					X	X
Virginia	X	X	X	X										
Westchester County	X	X	X	X	X	X			X		X	X	X	
Wraparound Milwaukee	X	X	X	X					X			X	X	X

Table 2: Most commonly identified BBI practices

Examples

Examples are organized by the categories of state, county/community and provider and presented in alphabetical order within these categories below.

State

This section includes examples of initiatives from individual states.

Arizona

Fiscal Strategy: Medicaid research and demonstration waiver (1115), multiple Medicaid options - clinic option, Rehabilitation option, Psych-under 21 inpatient benefits, EPSDT and Family of One, Reallocation of Existing Funds

The “Arizona Vision,” for children was developed in response to the Jason K lawsuit.^{viii} The vision was built on twelve principles based upon systems of care values.^{ix} It emphasizes individualized, culturally sensitive services, designed and developed in collaboration with the child, family and others. The Vision has significantly influenced the way services are delivered requiring the use of the Child and Family Team Practice for shared decision making with the family. A strong family advocacy effort influenced the inclusion of Parent-to-Parent Partners as a Medicaid billable service. (All Parent Partners have had personal experiences with the mental health system.)

The Arizona Department of Health Services (DHS) Division of Behavioral Health Services (DBHS) manages the statewide public behavioral health system through contracts with Tribal and Regional Behavioral Health Authorities (T/RBHAs). The T/RBHAs administer the delivery of services through a network of service providers to deliver a full range of behavioral health services. The T/RBHAs receive a capitated rate for Medicaid and State Children’s Health Insurance (SCHIP) covered services. They also receive state general revenue dollars and federal mental health and substance abuse block grant monies to provide services to non-Medicaid/SCHIP populations and to pay for non-Medicaid-covered services.

The largest percent of dollars for children and youth is spent on “support services” such as case management, therapeutic foster care, respite care, family support, transportation, personal assistance, flex funds services, peer support, housing support services and interpreter services.

The T/RBHAs use home care training to home care client homes (i.e., therapeutic foster homes) licensed by the Department of Economic Security, Office of Licensing, Certification and Regulation (DES/OLCR). Federal Title IV-E funds are utilized for room and board costs for eligible children. The 1115 waiver is used to develop home and community-based services. There are DBHS Practice Protocols related to the use of out-of-home services, including residential treatment centers and therapeutic foster care.^x

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Illinois

Fiscal Strategy: Performance-based Contracting

The State of Illinois implemented a performance based contracting approach in order to improve outcomes for children and youth who receive residential care in Illinois. This effort is one of three sites that was supported by The National Quality Improvement Center on the Privatization of Child Welfare Services (NQICPCW).^{xi} Support includes a formal evaluation.

Illinois had reduced their overall number of children and youth in residential care but, like many states, the greater proportion of children who remained in-group care demonstrated serious psychiatric and behavioral problems.

Illinois set goals (e.g. improve stability, reduce symptoms, improve outcomes at and following discharge). They also developed a series of indicators that were demonstrated to be related to the goals and tied fiscal incentives to the indicators. Early results are promising. While all agencies did not meet all of their benchmarks, almost all agencies exceeded their most significant benchmark – achieving sustained favorable discharge rate and fiscal incentives were awarded. More information on the Illinois effort can be found on the NQICPCW website.^{xii}

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Indiana

Fiscal Strategy: Reallocation of Existing Funds (flexible funding to support and facilitate provider practice change)

In July of 2010 the Indiana Department of Child Services (DCS), dissatisfied with both the outcomes and high cost of residential care, launched the new Integrated Services Pilot (now

referred to as IS). The pilot was based upon the lessons learned from a five-year demonstration lead by Damar Services, Inc. Integrated Services (IS) is a practice reform initiative that directly impacts clinical and financial outcomes for youth typically referred for residential placement. When a youth is referred to Integrated Services, residential treatment is used as an intervention, rather than a destination. DCS has given residential providers more flexibility to meet the needs of families – the right service, at the right time, at the right cost. Integrated Services providers can now deploy their agency/institutional-based resources to a youth’s home and community – rather than being restricted to only institutional-based interventions. Residential providers are required to have a full continuum of care and fluid extension of services to the community as one component of a best practice methodology.

The funding approach allows the residential provider to focus on the needs of the youth and family rather than only focusing on the services that the agency can provide. The provider can utilize any State approved service to meet the needs of the family rather than having to bid for a contract for a specific service and be limited to only those awarded. Payments are not tied to a placement (i.e. different rate for foster care, group home, residential placement, etc.) but rather provided as a service rate regardless of where the child may live. Payments are not based on a “head-in-a-bed” approach but rather a service needs approach. Payments are the same whether the youth is in residential placement or in his/her home. Payments are based on long term needs of families (up to 24 months). Payments start as an enhanced bundled daily rate that provides flexibility and allows front loading of services and moves to a payment for service units after 12 months.

The Lead Agency oversees fidelity to the best practice model and assists all providers in the network to meet the clinical and financial outcomes associated with the model. The provider guarantees the outcomes. If a youth needs residential care after 12 months of service, it is provided at no cost to the State/taxpayer. Recidivism is not funded during the course of the service/program/model.

Indiana set goals to reduce the number of children in placements and to increase the number of services provided to children in their own homes and communities. Integrated Services has demonstrated promising results. The cost of the service saves the State approximately \$110.00/day per child/family referred and the total cost savings since July of 2010 is estimated to be nearing \$ 1 million. More than half of the children referred for services have never entered residential placement. Of those that do need stabilization in a residential center, not one child has remained in a placement for more than 3-months.

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Tennessee

Fiscal Strategy: Performance-based Contracting, Reinvestment Strategies

The State of Tennessee (TN), Department of Children Services (DCS) implemented a performance based contracting (PBC) approach as a result of the Brian A. lawsuit. The settlement intends to achieve better outcomes for the children served in out-of-home care by DCS' privately contracted providers. The PBC model in TN uses an innovative approach that stresses permanency outcomes for children and utilizes a payment structure that reinforces provider agencies' efforts to offer culturally competent services that improve those outcomes. The provider contracts include a requirement to provide culturally competent services. They are paid based on the level of need of the child for the entire time the child is in out-of-home care and moving towards permanency. This gives the provider the flexibility to have funding for a full continuum of services and supports so the child can move towards permanency quickly with services wrapped around him. Residential care is an intervention that is used to stabilize and plan/prepare for next step in the permanency process. The permanency outcomes measured include: improved timeliness and likelihood of permanency (reunification, adoption, or guardianship), reduced placement moves and reduced instances of re-entries into care. It is funded through Title IV E and state dollars. Like Illinois, this effort was supported by the National Quality Improvement Center on the Privatization of Child Welfare Services.^{xiii}

The Department committed to a collaborative effort as part of the initial design and took concrete steps to establish a collaborative partnership with the providers. They held/paid for a number of provider conferences (2004-2005) and engaged a private consultant of the provider's choice (Chapin Hall) and the providers had access to Chapin Hall through DCS. They enhanced the rate for the PBC providers, and the first year providers were risk free and were paid the "earned" reinvestment dollars. These dollars are fully funded with state dollars and there are no restrictions on how a provider uses these. In addition, they established an appeals process relating to placement decisions and maintained open and frank discussions.

The TN collaborative approach to PBC has resulted in the number of children in custody being reduced from 10,000 to 7,000; permanent exits increased significantly over a 3 year period, placement is now based on the unique needs of the child, focus is on family placements, and there has been an improvement in permanency outcomes/reduction in reentry rates. There have also been significant dollar savings to the state. In the first three years of implementation alone there was a \$10 million dollar savings in state allocated funding.

In terms of savings for the agencies, in most cases they generated modest to significant reinvestment dollars and very few were assessed penalties. They were able to transition to this new model and learn as they go without having to realize financial penalties, as they were held harmless in the first year. In a number of instances agencies that underperformed during the first year were able to reverse their performance in the second year. Providers have reported that they had greater sense of worker satisfaction with fewer turnovers as staff felt like they are making a difference.

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Virginia

Fiscal Strategy: Reallocation of Existing Funds (pooled)

Virginia has been able to sustain a clear focus on child welfare reform over two recent and different administrations. This attention has yielded significant statewide changes including: reductions in use of foster care, reductions in both use and length of stay of residential care along with increases in the rate of permanency achievement. Between December 2007 and September 2010, the foster care caseload has been reduced from 7557 to 5876; the number of children in group care has similarly been reduced from 1922 to 903. The percentage of children/youth in group care compared to total of all foster care has also been reduced from total 25.43 % to 15.37 %. More importantly the percentage of children over the same time period achieving a permanent discharge has also increased from 64.29 % to 70.90%.

Critical to Virginia's reform efforts has been the Virginia Comprehensive Service Act that was passed in 1993. The purpose of the act is to provide high quality, child centered, family focused, cost effective, community-based services to high-risk youth and their families. It provides for the pooling of eight different funding streams. Funds come from the Department of Social Services, the Department of Juvenile Justice, the Department of Education and the Department of Mental Health, Mental Retardation and Substance Abuse Services. The funds are pooled and provided to localities for services for high-risk youth and their families.

Localities must meet a required state/ local match and they must establish two interagency teams to manage and to implement the funds. The Community Policy and Management Team

(CPMT) has administrative and fiscal responsibility for the local funds pool, for developing local policies and procedures and appointing members of the Family Assessment and Planning Team. The Family Assessment and Planning Team (FAPT) are comprised of the supervisory level staff from the same agencies as the CPMT as well as the parent and often a private provider. These teams work with the families to develop the Individual Family Services Plan (IFSP).

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County/Community

This section includes examples of initiatives from individual counties and communities.

Erie County, New York (Buffalo Area)

Fiscal Strategy: Reinvestment Strategies; Reallocation of Existing Funds (braided); Incentive Contracting

Erie County's system-wide reform effort employs a care coordination model using Family Team and Wraparound with a strong emphasis on family voice, peer support and using data to monitor both process and outcome measures. The system wide reform was originally financed through a SAMHSA System of Care (SOC) grant. (A report issued in 2009 entitled Family Voices Network of Erie County: One community's story of implementing system reform can be downloaded and provides details on early implementation efforts.^{xiv}) Services are now financed through reinvestments as well as Mandated Preventive funding, a state child welfare fund for intervention with families with children at risk of out of home placement. This funding requires a local match.

In 2005 the county executive made a commitment to reinvest savings from reductions in hospitalizations, secure and non secure detention and residential care back into the system and since that time the agreement has held (although some of the savings are now being shared with the general fund).

That agreement is still holding through a transition to a new county executive. The new executive embraces the agreement; at least in part due to the emphasis on a sophisticated use of information the collaboration has had from the beginning. Decisions are fact based and data driven at all levels and they have reliable data and can track the changes they have been able to achieve.

Since 2005, they have saved approximately 5 million dollars per year in out of home costs. The number of children in residential care at any one point in time has been reduced from 228 to 112. Use of hospital beds for adolescents has been reduced by 60% with average length of stays dropping from 28/29 days to 10 days per stay. The county has a relatively new 64 bed secure detention facility but during 2010, their utilization averaged less than 20 youth from Erie County. The county has a contract for non-secure detention for 60 beds but their utilization has never been over 16 youth at any one time with an average stay of 2 days.

They have a separate entity called Community Connections^{xv} (CC) that manages data development and use for the network of providers. CC supports the use of data at multiple levels. At the systems level it monitors performance and supports strategic planning while at the organizational level it provides supports for monitoring the performance of the many different agencies that are now part of the system of care. At the worker and supervisory level it supports individual worker supervision by generating individual worker level reports. A report card is shared with individual workers on the families in their workload that includes the scoring on each of the fourteen domains that CAFAS includes. Workers use this for planning with their families. Supervisors use it in working with the individual staff.

The data are used to frame a series of questions that are used by workers to self assess and, in consultation with their supervisor, review patterns of decisions. Current efforts include looking at the disparity and over representation of minorities in out-of-home care. They have used the data in a quality improvement process to increase self-awareness, to promote self-examination and to move individual workers and supervisors to informed action. They began by looking at basic measures of responsiveness by race and comparing how long it took for a worker to complete certain processes such as making a referral, having the initial face to face meeting with the client, developing a crisis plan and completing the initial assessment. (E.g. across the systems initial assessments took 2 to 3 days to complete if the consumer was white, 15 if the consumer was Hispanic, and 28 if the consumer was Black or bi-racial.)

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Kids Oneida (KO)

Fiscal Strategy: Reallocation of Existing Funds (blended and case rates), Enhanced Use of Medicaid, Reinvestment Strategies

Kids Oneida (KO) is a not-for-profit organization, originally developed as a demonstration project of the New York State Office of Mental Health that provides individualized and non-

traditional services to the highest risk youth with social, emotional, and behavioral challenges and their families to avoid out-of-home placement and improve functioning within the family and community. KO has implemented a value-based, integrated community-based system of care for children and families using a comprehensive team approach to provide the child and family with individualized treatment and services to help them meet their goals.

KO employs a wraparound philosophy that empowers the family. KO relies on a capable, knowledgeable, and reliable provider network that includes private/individual providers, as well as not-for-profit agencies that provide individualized, flexible and creative services to children and families to best meet their needs. Through the Wraparound model, providers can be creative in developing and implementing plans which would not be possible in a more traditional setting. Because of this, acceptance of KO within the community has been very strong and, over time, the service network has evolved to become more mobile, flexible, and responsive. Presently there are approximately 50 contracts for services with Kids Oneida, constituting over 150 contracted workers. Seventy percent of the services provided can be described as non-traditional with over 80% of care and services provided either in the home or the community.

KO employs parent partners who through their own personal experiences know mental illness as well as the service system. They play a critical role in engaging the family and community. The focus on engagement begins with the family but extends to all community resources including schools, family court, and probation and allows for a successful and coherent practice model within a system of care.

KO also provides transitional services and after care for children discharged from residential care. Children can receive one of two levels of service depending upon need. The regular KO program serves children with higher level or they can be served in a step down program. Children with the highest level needs generally receive services for 12 months following return home before they are disenrolled. KO does a status check at six months after they have been dis-enrolled from KO, 95% of the youth are found to be at home at this point.

Since January 2008 KO has managed residential placements for Oneida County DSS's return home early project. Baseline measures had 140 children in residential placement at the beginning of the effort. By December 2009 the average daily population in residential care dropped to 91. As of June 2011, the program has reunited over 100 children early from the most restrictive levels of out of home placement. The project has demonstrated a cost avoidance of 3.6 million dollars in residential care costs through 2010 and at the same time achieving a recidivism rate of 15%. The same intervention was applied to Herkimer County, a smaller neighboring county, in June 2008. Through 2010, 25 children have been returned to their families early resulting in a cost avoidance of over \$920,000. For each dollar invested by Herkimer County, \$3.30 was saved. These monies are then available to be reinvested in earlier intervention to divert unnecessary placements and better serve children and families within their community.

Kids Oneida is funded through a blend of Medicaid and Department of Social Services Prevention dollars. A set case rate is provided for those children enrolled in Medicaid that meet certain eligibility requirements.

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Los Angeles County

Fiscal Strategy: Reallocation of Existing Funds (blended and case rates), Performance-based and Incentive Contracting

In 2007, California State legislation (AB 1453 Soto) authorized selection of four counties or consortia of counties, with private partners, to implement alternative program and funding models. The framework document that defines and describes California's Residentially Based Services Reform (RBS) initiative^{xvi} is consistent with SOC and BBI principles. It includes specific required elements such as Family Teams and Peer support. Los Angeles County was chosen following a competitive process and is one of four sites across the State of California (San Francisco, San Bernardino and Sacramento) that is implementing the RBS initiative. Each site is different in their approach to fiscal and program design. Each of the demonstrations will operate for two years (they may be authorized to be continued longer). The lessons learned from these projects will be reported to the legislature and will inform planning for statewide implementation of RBS reform.

LA's plan is to infuse residential care with Wraparound principles (active family voice and choice, facilitated planning process, care coordination, family finding), and transform the traditional residential milieu to a therapeutic community without walls.

Key program features are:

- One Child and Family Team Across all Environments
- Care Planning Unifies Residential and Community Treatment
- Family Search, Engagement, Preparation and Support from Day 1
- Building Life Long Connections and Natural Supports from Day 1
- Concurrent Community Work While in Residential
- 24/7 Mobile Crisis Support When in Community Phase
- Crisis Stabilization Without Replacement (14 days)
- Respite in the Community

A conscious component of the authorizing legislation is testing various models of financing. In LA County, providers will be paid an enhanced case rate for ten months. For the following ten months they will be paid a reduced rate that is about 40% of the enhanced rate regardless of where the child resides. The enhanced rate for the first ten months covers costs associated with Child and Family Team, concurrent family finding and engagement, preparation and support, respite, crisis stabilization, and intensive parallel community-based interventions including the development of connections. It intends to encourage providers to bring a heightened sense of urgency to youth and families and to front load services. The rate that applies for the second ten months intends to provide an *incentive* to providers to reconnect children with their families and communities and return them quickly to home based settings.

The LA demonstration has been operating since 2010 with promising early results. For more information on the LA demonstration as well as the RBS reform see the websites below.

<http://rbsreform.org/>

<http://www.childsworld.ca.gov/PG2119.htm>

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Westchester County

Fiscal Strategy: Reallocation of Existing Funds, Reinvestment Strategies

Westchester County services for children and families operates as a System of Care (SOC) and is built on collaboration and coordination across systems, communities, agencies, families and youth that promotes the physical, emotional, intellectual and social wellness of children and youth across the lifespan. In partnership with youth and families, Westchester’s System of Care consists of a coordinated network of services and supports that are characterized by multi-system sharing of resources and responsibilities. Within Westchester County’s SOC, systems, service providers, and natural supports join with families and youth to develop an integrated and individualized plan to address identified needs under the concept of “one family, one plan.” The effort to develop a SOC began in the 1990s and continues to develop today. A recent report published by the University of South Florida provides details on the Westchester SOC.^{xvii}

Child and Family Teams are employed throughout the entire family and child serving system and are supported through a true community-organization model. All of the major child-serving systems (child welfare, juvenile justice, mental health, youth bureau, education,

recreation programs, faith-based organizations, community-based organizations, peer/family support) meet together on a monthly basis in 12 communities throughout Westchester. All agencies and organizations participate voluntarily in this process and commit their staff and other resources of their offices to this process. Families are invited to participate in the Child and Family Team process by a “Family Ties” representative (advocacy agency) who discusses with the “referral source” and family who they would like to have at their Child and Family Team meeting. This can include both formal and informal supports.

The advocacy agency, Family Ties of Westchester, is a discrete organization separate from any of the county agencies. It is funded by the Department of Social Services (DSS) with state Mandated Preventive dollars and supported by the Office of Mental Health. It also receives grants from other government agencies (e.g. Early Childhood grants, Office of Aging to work with grandparents raising their children) and from foundations. The Peer Youth organization, Youth Forum, is funded primarily by DSS funding to sustain the program/initiative. Funding helps to support youth who are transitioning out of residential care or psychiatric hospital care and returning to the community; providing weekly peer-run support groups; weekly socialization activities; and provide training and awareness to the broader service system.

In 2008, Westchester established a formal Building Bridges Leadership Committee. Led by the county child-welfare agency and including representatives of key county child-serving system department leadership, the committee has worked to transform Westchester County’s use of residential care. Their objectives include reducing the number of children placed in institutional care by meeting their needs safely within the community, empowering communities to support and strengthen families, engaging residential providers in system of care work as partners, achieving permanency for children in the shortest time possible, and reducing racial disparity and disproportionality.

A number of significant initiatives have been developed as a result including the development of a vision for a new model for out-of-home care that uses a needs-driven approach emphasizes the safe use of less restrictive levels of care. This model promotes immediate and intensive family engagement and partnership and use of racially and culturally driven practices. Lengths of stay should be determined by the child and family needs and progress made (not prescribed length of time). Residential care is viewed as a service to meet a specific need within a system of care and is not a “stand alone service”. The new out of home models use wraparound and Child and Family Teams as foundation for work.

Additionally, Westchester has developed an aftercare program that provides in-home services and supports as well as community linkages and advocacy for children being discharged from foster care and transitioning home to parent or relative. This helps to prevent children from needing to return to care. A recent development includes a “data dashboard” that provides data on residential transformation and use of out-of-home services. The objective is to utilize a “data driven” approach for decision-making and program evaluation/analysis.

Westchester County has seen a significant decrease in residential placements and increase in use of lower levels of care in closer proximity to the youth’s home community. In 2004,

Westchester County experienced a 24% recidivism rate. Since implementing these changes, the county has witnessed a dramatic reduction in the rate of recidivism, down to 3-4% currently. In addition, between 2008-2010, the total in-care population has decreased by 11%; institutional care has been reduced by 34%; and PINS/JD admissions are down by 32%.

During the past 12-months Westchester County has made reducing racial disproportionality a major area of focus and attention. Westchester County Department of Social Services, with the support of Casey Family Foundation and the New York State Office of Children and Families scheduled 7 Undoing Racism Workshops in 2011. The workshops target child welfare staff, community providers and parents and youth. Westchester will have over 400 service providers and family members participate in the Undoing Racism workshops by the end of 2011.

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Wraparound Milwaukee

Fiscal Strategy: Reallocation of Existing Funds (blended and case rates), Reinvestment Strategies, Medicaid – 1915(a) agreement^{xviii} allows developing a private managed care system - agreement between the state and Milwaukee must be approved by CMS

Wraparound Milwaukee (WM) is a unique type of managed care program operated by the Milwaukee County Behavioral Health Division since 1995. It is designed to provide comprehensive, individualized and cost effective care to children with complex mental health and emotional needs. It is a publicly operated HMO approved by the Center for Medicaid and Medicare Services (CMS) under a 1915(a) contractual agreement with the State that manages, on behalf of the county, a single system of care for any child who has serious emotional or mental health needs, is referred through the Child Welfare or Juvenile Justice System and is at immediate risk of placement in a residential treatment center, juvenile correctional facility or psychiatric hospital.

WM employs a strength-based and individualized approach to service delivery that is based on families identifying what support they need to care for their youth with complex needs in their home and community. Families are paired with Care Coordinators to assist them in identifying personal, community and professional resources to meet those needs and to “wrap” those services around the youth and family. WM is designed to increase parent choice in selecting



resources and service providers. WM promotes family independence by acknowledging families or caregivers know what is best for their youth and family. Care coordination and case management is done by WM; services are purchased from private providers.

While the Child Welfare and the Juvenile Justice departments contribute about the same amount spent in 1996 on similar populations (\$20 million each), WM has been able to add to that another \$25 Million dollars through Medicaid, with \$7 million specifically targeted for responding to crises. When savings from reductions in use of residential care and hospitals are combined with additional Medicaid funding, investment in community services has increased 10 fold to \$45 million per year.

Since 1995 significant system level outcomes have been achieved. The number of children in residential care at a point in time has been reduced from 375 to 80 youth. The number of days in psychiatric beds used by seriously emotionally disturbed youth has been reduced from over 5,000 days to 400 days per year. During this same time period there have been significant changes in the service system. Both the amount of community-based services as well as the number of community providers has increased dramatically. Additionally, the characteristics of service providers has changed to be much more reflective of the service population. In 1995 there were approximately 30 community-based service agencies. Currently there are over 200 community-based agencies and perhaps of even greater significance is that over 50 % of service agencies are minority operated and locally developed.

WM is also tracking outcome data on permanency plan achievement, school attendance and recidivism. School attendance has increased 40%, eighty-five percent of the children in child welfare are achieving their permanency plans at the time of discharge and a recent recidivism study of juveniles who had committed a delinquent offense shows only 11.9% of youth exhibited new, referred offenses after enrollment in WM.

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Provider

This section includes examples of initiatives from individual providers.

The Children's Village

Fiscal Strategy: Private Funds; Reallocation of Existing Funds

The Children's Village (CV) is a large innovative multi-program agency with a main campus located in Westchester County NY and programs in communities throughout the five boroughs of New York City (NYC) and Westchester County. Reforms have taken place at CV during the last 5 – 8 years beginning with an organizational commitment to pursuing positive long term outcomes for families and youth, using a “whatever it takes” approach that recognizes children and youth need to grow up in families within communities.

CV embraces SOC and BBI values and principles and emphasizes youth and parent voice and participation in services and planning as well as policy and program development. In response to suggestions or requests from family or youth, CV is predisposed to say yes first, and then explore/develop mechanisms for responding appropriately. CV raises private monies through foundations and private donations and uses these donations to selectively provide services that would otherwise be unavailable if government was the sole financier.

Four years ago, CV instituted a program to provide a minimum of one year of support to youth who leave their residential treatment center. This program has both shortened the length of stay for the youth and dramatically improved the outcomes for them. It is funded totally with private dollars. All families are offered aftercare for 12 months and between 75 to 95 percent of the families accept the service (varies from year to year). CV tracks the families who accept the service and after 12 months, 85% of the families are doing reasonably well. The service intensity changes over time with greater intensity and frequency of contact during the first 8 – 9 months with services reduced over time consistent with changes within the family.

To demonstrate its commitment to family participation, CV used private funding to purchase a van to make it easier for families to participate in meetings and to encourage community partners who may be able to provide resources to the family to participate. Based on the idea of a cottage manager, the “Family Team Conferencing Van” travels to families’ neighborhoods providing a convenient, comfortable place for everyone to meet. The van is a convenient tool and a symbol of CV’s commitment. Since the van has been put into use a significant improvement in the percentage of families who participate in Family Team Conferences has been seen. Recent data show over 90% participation of family in family team meetings.

CV also has a significant parent advocacy/leadership program. CV used a small grant to cover the initial costs of the parent advocate/parent leadership effort. After two years of expenditures CV has embedded the program costs into their base operating expense and so it is now reflected in the daily rate they are reimbursed for services. Parent advocates are full time staff who have experienced the system and have graduated from a certified training program

offered by CV. Parent Advocates have become members and full participants of the clinical teams. They also have direct access to the COO and the CEO. They have also become the bridge between CV and parents and the community at large. Through their efforts a significant number of parents from within the community have joined a parent leadership group at CV. Parent advocates and parent leaders have changed how staff see and think about the system. Parents are the number one force at work in all decisions being made. They are recognized and welcomed as a “disruptive force” in how the organization thinks and solves problems. Their job is, in effect, to require agency staff to consider every decision from the perspective of family and community before proceeding.

CV also created a program to more effectively engage fathers. The Fatherhood Initiative emerged from an idea proposed by staff in response to a recognition that a large proportion of the youth in the program were black and Hispanic and had been separated from their dads. It began simply with telephone calls to eighteen different fathers. The calls invited the fathers to attend a lunch saying simply “your son needs to know you.” No other request was made. The goal was to get Dads to say yes and to use the yes as an opportunity to begin an engagement process. The program has grown from this point and continues to ask questions and offer invitations where a yes answer is possible and perhaps likely. CV has found that about 30% of the fathers of youth in residential care will be engaged over time and eventually become a resource of some kind for their child (foster home rate is closer to 50%). Remarkably, these dads sometimes also become a resource for other children who are friends of their child. What CV found was simple. Fathers needed permission to be fathers and, once given, relished becoming a dad. Recently two of the fathers in the program became permanency resources for eight children, only two of the children were their birth children.

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EMQ FamiliesFirst^{xix}

Fiscal Strategy: Medicaid– EPSDT; Reallocation of Existing Funds (blended) and Reinvestment Strategies

EMQ FamiliesFirst is a leader in the field of residential transformation as a result of their efforts over the past 20 years. They provide individualized care using the system of care values and principles, wraparound with model fidelity and child and family teams. They provide family finding along with other evidence based programs and practices such as Trauma Focused Cognitive Behavioral Therapy, Positive Behavioral Intervention and Supports (PBIS) and Parent Child Interaction Therapy. They have well designed measurement feedback systems in place such as indicators and benchmarks, program evaluation and quality of care monitoring and

clinical process and outcomes. They are committed to do whatever it takes to help children, strengthen families, build community, and advocate for systems change that will ensure families to thrive. They have a strong belief in the importance of parent voice and demonstrate this through their recent merger with the parent run organization, FamiliesFirst. They have parent partners as a key component of their service delivery system.

When they initiated their reform efforts they realized there was no funding source for wraparound practices so they worked with the county to fund an initial pilot wraparound approach and were able to secure passage of legislation (AB2297) making the state's 40% share of the group home rate available to help fund their program. Wraparound was expanded statewide with the passage of (SB163) that "provides access to the state and foster care share of the group home rate for each wraparound slot".^{xx} With voter support of the Mental Health Services ACT Wraparound is now a required approach all across California.

EMQ FamiliesFirst has shifted from 72% of their annual revenue coming from residential to about 9% currently and has significantly increased their annual revenue base from \$12M in 1996 to approximately \$116M in 2010. It took about 4 years of a very focused strategic process to implement their system change efforts. The current Wraparound practice has a blended funding stream from Child Welfare foster care Title IV-E (funds that would have been used to place children in high level residential treatment) and mental health Medicaid (Medi-Cal) primarily EPSDT funds. This blended funding allows them to maximize appropriate billing to EPSDT and that maximizes FFP, while maximizing savings for state/county funding for foster care that can be redirected to other services for foster children.

EMQ FamiliesFirst uses flex funding and has very clear guidelines about the use of these flexible dollars. They focus utilization of these dollars for one-time expenses otherwise it creates program dependence. They also work hard to expand the social support network of families with the philosophy of "working their staff out of a job".

EMQ FamiliesFirst uses the same service planning approach and philosophy in all of their programs; residential, wraparound, intensive in-home, outpatient, and early intervention. They use the vast majority of BBI Best Practices throughout their programs and agency and attribute this to why they get very positive outcomes and are able to keep children at home. They pay significant attention to the linguistic and cultural needs for the families served. The largest population they serve are identified as Latin American (36%) and appear to show the largest % improvement (62%) in CAFAS scores and % living in a community setting at discharge (89%) while the next largest population served is Caucasian and their scores are 60% and 87% respectively. The overall functioning of the young people served is improving as demonstrated by the following outcomes in FY 2010.^{xxi}

- Eighty seven percent of the young people served are in a community setting at discharge.
- Seventy four percent of the young people served discharged to permanency.
- Seventy five percent of the young people served are in school at discharge.
- Eighty four percent of the young people served are out of trouble at discharge.

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Magellan Lehigh Valley Care Management Center (CMC) Short-Term Residential Treatment Facility (RTF) Pilot Program

Fiscal Strategy: Reallocation of Existing Funds (managed care)

The Pilot Program is a short term Residential Treatment Facility (RTF) developed by the Lehigh Valley Care Management Center (CMC), in collaboration with Lehigh and Northampton counties of Pennsylvania and community providers that opened in 2009.

The program is designed to meet the needs of youth and community safely while simultaneously working with families and providing empirically supported treatment on an intensive level. The program was designed collaboratively using Magellan’s white paper, “Perspectives on Residential and Community-Based Treatment for Youth and Families,”^{xxii} as foundation. The model has four key components: small caseloads, family involvement, comprehensive discharge planning, and data collection.

In this model, a child or youth has a brief out-of-home placement that lasts between 30 to 120 days. During this time, intensive services are provided to the child and the family with most of the service provided within the family home. The child is then returned home. The clinical team from the residential placement, who has been working with the child and family, continues to work with them for the next six to eight months post discharge. The comprehensive discharge plan identifies community-based providers appropriate to the needs and strengths of the family and youth. These providers join the team prior to the discharge from RTF and remain with the family after the RTF clinical team disengages. In instances where a return to the birth family is not safe or clinically appropriate an alternate setting within the community (e.g. Therapeutic Foster Family Home) is found and supported with evidenced based programs such as Multisystemic Therapy (MST)^{xxiii}, Functional Family Therapy (FFT)^{xxiv}, and Multi-Dimensional Treatment Foster Care MTFC^{xxv}.

Data from the first year is promising. The average length of stay for children discharged from the short term RTF was 95 days. When compared with traditional RTF placements for the contract years of 2007-2010, this is 171 days shorter. Additionally, there were no readmissions to RTF following treatment in the Short-Term RTF program during the first 12 months post discharge compared to an average of six readmissions for traditional RTF programs for the 2007-2010 contract years. The full report is available and can be downloaded.^{xxvi} The second year report is expected in the fall of 2011.

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Editor's Note

As this paper is prepared for publication, the authors are aware of two important points. First, many creative examples that have been implemented successfully are not represented here and, second, new, even more creative and successful efforts are being developed and will continue to be developed over time. While it is remarkable that even in the current fiscal environment there has been noticeable success and progress in implementing significant changes, it is clear there will be much more in the future, as states, counties, communities and providers move forward with implementation of BBI principles.

New, creative, fiscal strategies are currently being tested (e.g. bonding as a method of financing services^{xxvii} that can be a critical component of a reinvestment strategy that allows the future savings to be anticipated and provides flexibility to front load services). New solutions are being developed and applied to critical areas that influence the success of implementation efforts (e.g. sophisticated use of data as foundation for continuous improvement efforts); and, a significant number of sites have initiated creative efforts to improve cultural and linguistic competencies (see examples TN, EMQ FamiliesFirst, WM, Children's Village, Westchester and Erie Counties) leading to reductions in disparity and disproportionality.

As these efforts progress and additional examples and successes are identified and shared, the BBI website will become a library of documented successes to promote sharing of different approaches and learning of what works. Readers are invited to contribute to the identified examples of successful initiatives by sending a description of the effort via email to Julie Collins, Chair BBI Fiscal/Policy Workgroup; JCollins@cwla.org. Please monitor the BBI website for new information. <http://www.buildingbridges4youth.org>

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We would like to thank each of the members of the Fiscal/Policy Workgroup that helped develop this document and, in numerous instances, also contributed content. The writing of this document could never have happened without the leadership of Julie Collins, the expert writing skills of William McLaughlin and the tireless support and wisdom of Betty Levy, Bill Przulucki and Beth Caldwell.

Finally, our sincere thanks to the families, youth, advocates, community members and providers who are engaged in the day-to-day process of bringing the principles of the Building Bridges Initiative to life within their communities. Their vision and hard work guide and inspire us.

Glossary

BBI Practices

- Use of BBI and/or System of Care Best Practice Principles (e.g., family-driven; youth-guided; cultural and linguistic competence; accessibility & community involvement; transition planning & services) as a framework for delivery.
- Tracking of recidivism at least one-year post discharge, and other relevant long-term outcomes related to sustained success of youth with family and community, and using this data to inform practice improvements.
- Significantly shorter lengths of stay in Residential Care (i.e. three to five months) with intensive community based services follow up.
- Child & Family Team/Wraparound implemented w/Fidelity (or similar best practice model).
- Hiring of multiple family advocates, who have meaningful and comprehensive roles in the organization or contracting with family-run organizations for full and/or part-time advocates assigned to the organization.
- Hiring of multiple youth advocates, who have meaningful and comprehensive roles in the organization.
- Residential staffs frequently work in family home, neighborhood and community.
- Defined and well-developed flexible funding streams to support family and youth in community.
- Unique strategies to support family engagement (e.g., use of family advocates to provide meaningful support for families touched by residential; all staff receive specific training in successfully engaging families; funding of community family support groups; mobile vans to meet family in convenient community locations at time convenient for the family; clinical staff expertise in family systems and engagement strategies; clinical supervisory staff noted for deep knowledge base and expertise in engaging a broad range of family members with multiple challenges).
- Unique strategies to support youth engagement (e.g., funding of community youth support groups; funding for mentors in the community; youth provided education and support to lead own team meetings; youth involved daily and/or multiple times weekly in normalizing community activities that match individual interests/skills/strengths).
- Family Search and Engage or other Family Finding Models.
- Strong, well-defined and well-developed collaborations between residential and community programs and supports that result in improved outcomes for individual children and families.
- Reducing racial disparity and disproportionality – targeted initiatives directed at enhancing cultural and linguistic competence and reducing disparity and disproportionality.
- Other

End Notes

ⁱ <http://www.buildingbridges4youth.org/>

ⁱⁱ For detailed information on the Building Bridges Initiative, including tools and tips readers are referred to the BBI website. <http://www.buildingbridges4youth.org/>

ⁱⁱⁱ Section 1115 of the Social Security Act provides the Secretary of Health and Human Services broad authority to authorize experimental, pilot, or demonstration projects likely to assist in promoting the objectives of the Medicaid statute. Flexibility under Section 1115 is sufficiently broad to allow states to test substantially new ideas of policy merit. These projects are intended to demonstrate and evaluate a policy or approach has not been demonstrated on a widespread basis. Some states expand eligibility to individuals not otherwise eligible under the Medicaid program, provide services that are not typically covered, or use innovative service delivery systems.

http://www.cms.gov/MedicaidStWaivProgDemoPGI/03_Research&DemonstrationProjects-Section1115.asp

^{iv} States may offer a variety of services to consumers under an HCBS waiver program and the number of services that can be provided is not limited. These programs may provide a combination of both traditional medical services (i.e. dental services, skilled nursing services) as well as non-medical services (i.e. respite, case management, environmental modifications). Family members and friends may be providers of waiver services if they meet the specified provider qualifications. However, in general spouses and parents of minor children cannot be paid providers of waiver services. States have the flexibility to develop HCBS waiver programs designed to meet the specific needs of targeted populations. Federal requirements for states choosing to implement an HCBS waiver program include:

- Demonstrating that providing waiver services to a target population is no more costly than the cost of services these individuals would receive in an institution.
- Ensuring that measures will be taken to protect the health and welfare of consumers.
- Providing adequate and reasonable provider standards to meet the needs of the target population.
- Ensuring that services are provided in accordance with a plan of care

[http://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915\(c\).asp](http://www.cms.gov/MedicaidStWaivProgDemoPGI/05_HCBSWaivers-Section1915(c).asp)

^v Section 1915(b) Managed Care/Freedom of Choice Waivers: This section provides the Secretary authority to grant waivers that allow states to implement managed care delivery systems, or otherwise limit individuals' choice of provider under Medicaid.

http://www.cms.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp

^{vi} Section 1915(c) Home and Community-Based Services Waivers: This section provides the Secretary authority to waive Medicaid provisions in order to allow long-term care services to be delivered in community settings. This program is the Medicaid alternative to providing comprehensive long-term services in institutional settings. http://www.cms.gov/MedicaidStWaivProgDemoPGI/01_Overview.asp

^{vii} for more information on performance based contracting see – www.dshs.wa.gov/pdf/ca/CaseyFamilyPBCreview.pdf and

<http://www.uky.edu/SocialWork/qicpcw/documents/2009/Performance%20Based%20Contracts%20in%20Child%20Welfare.pdf>

^{viii} <http://www.azdhs.gov/bhs/children/jk.htm>

^{ix} <http://www.azdhs.gov/bhs/children/pdf/JK/principles.pdf>

^x <http://www.azdhs.gov/bhs/guidance/index.htm>

^{xi} <http://www.uky.edu/SocialWork/qicpcw/>

^{xii} <http://www.uky.edu/SocialWork/qicpcw/research.htm>

^{xiii} <http://www.uky.edu/SocialWork/qicpcw/resources/summit.htm#top>

^{xiv} Kernan, J., Pagkos, B., & Grieco, J. (2009). Family Voices Network of Erie County: One community's story of implementing system reform. In E. J. Bruns & J. S. Walker (Eds.), *The resource guide to wraparound*. Portland, OR: National Wraparound Initiative, [http://www.nwi.pdx.edu/NWI-book/Chapters/Kernan-5b.2-\(Erie%20County\).pdf](http://www.nwi.pdx.edu/NWI-book/Chapters/Kernan-5b.2-(Erie%20County).pdf)

^{xv} <http://www.comconnectionsny.org/>

^{xvi} http://www.rbsreform.org/materials/RBS_Framework.doc

^{xvii} <http://rtckids.fmhi.usf.edu/rtcpubs/study02/WestchesterSiteReport2008>

^{xviii} "Section 1915(a) permits the State to enter into a voluntary contract with an entity to provide State plan services. Section 1915(a) authority provides a vehicle for voluntary enrollment into capitated managed care otherwise unavailable to States providing on a fee-for-service basis. A State may design a contract that serves particular geographic regions of the State, or that provides a uniquely designed service package for particular populations without being in violation of state-wideness, comparability or freedom of choice requirements in section 1902. Under section 1915(a), the State may not limit the number of qualified providers who may serve as the contracting entity (PAHP, PIHP or MCO). In addition, section 1915(a) authority is entirely voluntary, meaning that the individuals must elect to receive services through this mechanism." Excerpted from www.cms.gov/CommunityServices/Downloads/ManagedLTSS.pdf - 2010-09-03, pages 5 and 6

^{xix} <http://www.emqfamiliesfirst.org/press/docs/SupportingWraparound5d6.pdf>

^{xx} Ibid

^{xxi} EMQ FamiliesFirst FY 2010 Agency Report Executive Summary revised

^{xxii} www.magellanhealth.com/.../CommunityResidentialTreatment_White_Paper.pdf

^{xxiii} <http://mstservices.com/>

^{xxiv} <http://fftinc.com/>

^{xxv} <http://mtfc.com/>

^{xxvi} www.magellanofpa.com/media/.../lehigh%20short%20term%20rtf_final.pdf

^{xxvii} <http://now.eloqua.com/es.asp?s=1222&e=236514&elq=7f1a5b3e3a5e4199aab860121971c452>

Other Resources

Effective financing strategies for systems of care: Examples from the field – A resource compendium for financing systems of care: Second edition (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub # 235-03).

Authors: Beth Stroul, Sheila Pires, Mary Armstrong, M.I., Jan McCarthy, Karabelle Pizzagati, Ginny Wood, Roxan McNeish, & Holly Echo-Hawk (2009). Tampa, FL: University of South Florida, Louis de la Parte, Florida Mental Health Institute (FMHI), Research and Training Center for children's Mental Health

<http://rtckids.fmhi.usf.edu/study03.cfm> or

<http://pubs.fmhi.edu> click Online Publications (By subject)

See also a series of papers in financing for systems of care.

<http://rtckids.fmhi.usf.edu/finance/default.cfm>