Connecticut Community KidCare: A Plan to Reform the Delivery and Financing of Children's Behavioral Health Services

A Report to the General Assembly

Pursuant to June Special Session Public Act 00-2, Section 5

From the Connecticut Department of Children and Families and Department of Social Services

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PREFACE

This report was prepared by the Children's Behavioral Health Implementation Team, an interdepartmental work group formed by the Departments of Social Services and Children and Families working in close collaboration with the Office of Policy and Management and the Child Health and Development Institute of Connecticut, Inc.[1] The Institute retained F. Carl Valentine and Associates and Holt, Wexler & Farnam, LLP to assist in the preparation of the analyses and the report. The report was informed by discussions with the Children's Behavioral Health Advisory Committee[2] and reflects comments on the August 2000 Request for Information. Special thanks are extended to the Connecticut Health Foundation and the Children's Fund of Connecticut, both of which contributed funding to support system planning and preparation of this report. Thanks are also extended to Morgan Meltz, parent, Karl Kemper, DCF Regional Administrator, and Karen Snyder, DMHAS Assistant Commissioner for their thoughtful review and design contributions.

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[1] The Institute is a not-for-profit organization established by the Children's Fund of Connecticut to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut. The Institute creates, supports, and facilitates innovative primary and preventive strategies for children, and works to maximize the effectiveness of the institutions and systems that contribute to their well being.

[2] The Children's Behavioral Health Advisory Committee was established in 1999 to provide input into the February 2000 report to the legislature and subsequent work on design of the reforms recommended therein.

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Executive Summary

Introduction

The Department of Children and Families (DCF) and Department of Social Services (DSS) are preparing to embark on a sweeping reform of the public child behavioral health service system. The new Connecticut Community KidCare initiative is designed to eliminate the major system gaps and barriers that have plagued child behavioral health in recent years. The proposed initiative will allow children with behavioral health problems to grow and develop within nurturing family environments, increasing their ability to succeed in their homes, schools and communities. The new system will be family driven and family focused, giving families choice and helping families to care for children who have behavioral health challenges. The new system will emphasize the strengths of individual families and children and be culturally responsive.

The Governor and the Commissioners of these Departments have defined this vision for reform. For this vision to succeed, a partnership is required among families, providers, community members, and other State agencies. Building this new system is an evolutionary process that will require time for planning, training and capacity building, and a gradual phase-in of fully working systems. It will also require changes in structure, organization, management, financing, practice, and philosophy, affecting those involved at every level, from families to providers to State agencies.

Connecticut Community KidCare

Key Features

- Comprehensive behavioral health program with flexible benefit package including treatment and "wraparound" support services
- Full carve-out of HUSKY child behavioral health
- Community-based and culturally competent care planning and service delivery
- Greatly expanded community-based service capacity
- Families involved and supported in decision making role with strengthened family advocacy organizations
- Comprehensive training for all agency and system staff and parents
- Efficient balance of local control of care with statewide administrative support structure
- Integrated funding to support broad benefit package
- Reinvestment of increased Medicaid reimbursements
- Routine performance reports on key outcomes and quality measures

This is a tall order. With the commitment and investment of all concerned citizens in Connecticut, DCF and DSS firmly believe that this vision can be realized. The following report is divided into two sections. This executive summary provides an overview of the reform initiative and identifies the major concepts and structures. The full report that follows is more technical, and provides additional detail regarding the operation of the proposed system.

Background

The impetus for this reform came in June 1999 when, in response to growing concern about serious bottlenecks and quality issues in children's mental health services, the Legislature requested that the Department of Social Services (DSS) prepare a study of the financing and service delivery system for children's behavioral health. In February 2000, DSS, with assistance from the Department of Children and Families (DCF) and other State agencies, submitted a report to the General Assembly entitled, "Delivering and Financing Children's Behavioral Health Services in Connecticut," prepared by the Child Health and Development Institute of Connecticut. This report identified significant problems in the current way services are organized, financed, and delivered and pointed to five major needs of the service system:

1. Better mechanisms for coordination of care.
2. Enhanced community-based resources and treatment alternatives.
3. Integrated funding.
4. Family involvement in policy as well as service planning for their own children.
5. Redistribution of resources and refinancing of the service system.

The report recommended that Connecticut move to a *system of care* approach to children's mental health services, building on the emerging network of 22 Community Collaboratives (formerly referred to as Local Systems of Care, LSOCs or SOCs) around the state. The system of care approach will actively involve families in service planning and create the opportunity for flexibility in service planning so that children with a serious emotional disturbance are better able to live in their homes and communities.

The proposed reforms were supported by the June Special Session Public Act 00-2, Sections 3-5, in which the General Assembly endorsed the direction of the report and its call for the restructuring of children's behavioral health service delivery and financing. The Governor's Blue Ribbon Commission on Mental Health also expressed strong support for this initiative in its final report, which called for similar reforms in the adult public mental health system.

This plan is submitted in response to the requirements of June 2000 Special Session Public Act 00-2, Sections 3-5, in which the General Assembly charged the Commissioners with developing the elements of a plan to reform the current system. This report summarizes the planning and development activities that have taken place since the February 2000 report, and outlines the system's anticipated structure and organization. The framework outlined in this report is based on feedback obtained when DCF and DSS issued a Request for Information (RFI) in August of 2000. The RFI sought input about how to reform the children's behavioral health system, and as a result of this feedback, this report now reflects the input of families, providers, and other members of the community who participated on key advisory committees and responded to requests for public comment.

The plan represents a paradigm shift that introduces Lead Service Agencies (LSA) that have overall responsibility for managing behavioral health services for enrolled children within a designated catchment area. The Lead Services Agencies will work with local service providers and local Community Collaboratives to provide quality behavioral health and support services for all enrolled children. The LSAs will be assisted by a statewide Administrative Service Organization (ASO) with responsibility for managing integrated funding streams and for basic administrative services such as claims processing, contract management, data management and reporting. Children with complex behavioral health service needs will have unprecedented support made possible by integrated funding. Care coordinators will partner with families to create comprehensive, coordinated Individual Service Plans, so that these children are better able to live at home and go to school in their communities.

The Governor’s commitment to this program and a Medicaid revenue maximization effort to help finance the work has already been demonstrated by his direction to expand child behavioral health services and supports in the community. Within the next six months, DCF will procure and begin funding in-state specialized residential services and selected community-based services including short-term crisis stabilization, mobile emergency psychiatric services, care coordination services, outpatient psychiatric coverage, extended day treatment, intensive home-based services, and specialized mentoring. This sizable investment will facilitate the return of children from residential treatment facilities and HUSKY subacute programs, as well as the diversion of children who are being considered for residential care.

DSS, DCF and OPM have made great strides in designing the program’s organizational structure and financing. Aspects of this design will continue to evolve during the planning process based on input from families, providers, legislators, advocates, and other interested stakeholders. The State welcomes input from all interested readers of this report to help build a better program.

Overview of Reform

Connecticut Community KidCare (“KidCare”) is based on a system of care model in which service planning is driven by the needs and preferences of the child and family. The reform involves an expansion and redistribution of funds for children's behavioral health services that will place greater emphasis on preventing children's problems from escalating by providing a wider array of culturally competent services delivered in the home or in the community. The reform also will support the development and financing of an independent family-run organization to provide family-to-family support and encourage active family participation in treatment and system planning.

These reforms will result in a significant reduction in length of stay in psychiatric hospitals and residential treatment placements as well as a reduction in out-of-community and out-of-state placements.

Eligibility

The February 2000 Report recommended a partial carve-out of children's behavioral health services. Under this initial model, only those HUSKY enrolled children in the child welfare system and those with special behavioral health needs would be enrolled in KidCare. Nearly every respondent to the August 2000 RFI expressed a strong preference for a full carve-out model, in which all of the HUSKY child behavioral health services currently provided by the HUSKY plans would instead be provided as part of KidCare. The Departments have decided to move forward with a full carve-out. This decision is supported by a preliminary analysis of HUSKY encounter data, which indicated that children enrolled under a partial carve-out would account for more than 95% of child behavioral health expenditures; a pattern consistent with similar programs in other States. A partial carve out would leave few funds for the current HUSKY Managed Care Organizations (MCOs) to provide less intensive but necessary behavioral health services for the children who remained in their charge. The MCOs would have little incentive to prevent the deterioration of mild behavioral disorders or to invest in prevention and early intervention programs that might reduce the number of children with intensive needs. Thus, all children enrolled in the HUSKY A and B plans will be enrolled in KidCare for their behavioral health needs. The HUSKY plans will continue to be responsible only for *primary* behavioral health care[3] and behavioral health pharmacy services.

Children who are not HUSKY eligible may be able to enroll in KidCare through the DCF Voluntary Services Program. The Voluntary Services Program is not an entitlement and thus access to KidCare through Voluntary Services will be regulated by DCF based on resource availability. It is anticipated that the application process will be handled by the LSAs, and that the Administrative Services Organization will determine eligibility according to DCF policy. The Voluntary Services Program criteria are based primarily on a child's symptoms and functional status. These criteria will be reviewed and may be subject to change.

Benefit Package

The centerpiece of KidCare is a comprehensive benefit package made possible by the integrated management of DSS and DCF funding streams including Medicaid (Title XIX), State Children's Health Insurance Program (SCHIP or Title XXI), Title IV-E (board and care), and State general funds. The comprehensive benefit includes a full complement of *behavioral health treatment services* such as outpatient treatment, day program, home-based, and care coordination services, as well as out-of-home services such as residential center treatment, therapeutic foster care, and hospitalization. The benefit package also includes a range of *non-medical support services*, such as respite care and therapeutic recreation, which are often essential to allow children with behavioral health challenges to live in their homes and communities.

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[3] Primary behavioral health care includes all behavioral health services provided by primary care providers.

Family Involvement

Families will play an instrumental role in ensuring that each aspect of the system is accountable and responsive to the behavioral health needs of children and their families. DCF is supporting the development of a Family Support Organization to assure that children with serious behavioral health needs and their families have voice, access, and ownership in the development and implementation of their service plans. Families will have opportunities for involvement at multiple levels, from local family advocacy to input into policy and planning. Family involvement will help make Community KidCare responsive to families and accountable to communities. Childcare, transportation, and flexibility in meeting times, will help make it possible for families to participate. DCF and DSS are committed to financing this involvement, and ensuring that all aspects of culture are addressed as part of this initiative.

Organizational Structure

DCF and DSS will administer KidCare under an interagency agreement (also referred to as a memorandum of understanding). The agreement sets forth a pre-implementation process, so that both Departments are involved in building the management infrastructure and developing the policies, procedures, contracts, and standards necessary to support DCF's administration of the program. Post-implementation, DCF will have primary responsibility for management of the KidCare program. DSS will monitor program compliance with Medicaid and SCHIP requirements.

The new administrative structure will include an Administrative Service Organization (ASO), Lead Service Agencies (LSAs), and Community Collaboratives. DCF will procure and contract with an ASO to assume responsibility for claims payments, reporting, contracting, and other functions that are best conducted centrally.

The DCF regional offices will in turn contract with LSAs selected under a competitive procurement process. A minimum of five, but no more than twelve LSAs will be selected; the final number will be determined by a variety of factors including the number and qualifications of respondents to the RFP and financial analyses of service and administrative dollars available to finance the system. The LSAs will assume responsibility for managing the care of all enrolled children residing within their designated catchment areas. LSAs will have authority to manage service utilization and will have responsibility for local quality management and for overseeing the development of local community resources.

The LSAs will be responsible for ensuring that *all* enrolled children have access to quality behavioral health services, and they will have special responsibility for the care of children with complex behavioral health service needs. Children with *complex service needs* require the coordinated involvement of multiple state agencies (e.g., DCF, State Department of Education, Department of Mental Retardation, Court Services, and, for older children, Department of Mental Health and Addiction Services). In addition to specialized treatment and educational services, families of these children often require non-medical support services such as respite and mentoring and the support of friends, relatives, neighbors, churches, supports groups, and other community organizations.

The LSAs will employ *care coordinators* to work with families of children with complex service needs. The care coordinators will partner with families and children to design flexible, Individual Service Plans. Although LSAs are accountable for the care provided by care coordinators, most of the care coordinators will be based at provider agencies located throughout the LSA's catchment area. Thus, most of the care coordination will be carried out within local Community Collaboratives. A Community Collaborative is a local consortium of providers, parents and service agencies that have organized to develop coordinated, comprehensive community resources for children with complex service needs and their families. The Collaboratives may be small or large, encompassing from one to twenty cities and towns. Members of the Collaboratives have close working relationships and intimate knowledge of local needs and resources and thus are in the best position to work with families to create child and family specific teams and design Individual Service Plans.

Grievance and Appeals

DCF will assume responsibility for managing the KidCare grievance and administrative hearings procedures. All parents of children enrolled in KidCare will have the right to timely procedures for resolving complaints, concerns, and appeals, otherwise referred to as grievances. These procedures will meet all State and Federal grievance requirements (i.e., Federal Medicaid and Title IV-E requirements), and will be presented in writing and described to children and their parent/custodian at the time of enrollment. The grievance process will be available to resolve disagreements related to the denial, reduction, suspension, or termination of services, or the failure to respond in a timely way to a request for services.

Quality Management

DCF will assume overall responsibility for quality management, although quality management activities will take place at multiple levels within the KidCare program. Quality management will focus on sentinel event review (i.e., specific events that may cause concern) and system wide quality improvement. DCF will develop performance measures against which the State and LSAs can assess the effectiveness of the behavioral health care system. This will address widespread concerns about whether system investments result in positive outcomes for children. This system will also allow State agencies to meet program and fiscal reporting requirements to maintain and enhance federal funding.

Performance measures will be identified in the areas of finance, administration, clinical process, and outcome. These data will be collected on a statewide basis using uniform data elements, data definitions, data fields and timing in order to facilitate performance comparisons. The ASO will have primary responsibility for data collection and for assuring that key stakeholders (e.g., DSS, DCF, LSAs, Collaboratives, advisory committees, and members of the community) have timely, reliable, accurate, and informative reports that are useful for managing the system.

Training and Staff Development

No matter how innovative system reform efforts are, their effectiveness in improving outcomes for children and families is ultimately limited by the quality and competency of the managers and direct service delivery personnel who provide services on a daily basis. Changing practice will require ongoing mentoring, supervision, and support, and the periodic learning of new skills. To assist in creating a comprehensive approach to developing a system of training that supports the implementation of KidCare, DCF has contracted with the Child Health and Development Institute of Connecticut, Inc. (CHDI) to design a training plan and develop curriculum. CHDI is partnering with the Human Service Collaborative (HSC), of Washington, D.C. to assist in this effort. The partners of HSC bring a wealth of experience in the field of children's behavioral health and have provided training and technical assistance nationwide in the design, development, and implementation of systems of care for children with behavioral health problems. This consulting group is working with a core team in Connecticut that includes State and regional State agency staff, family advocates, community agency providers, and representatives from the Yale Child Study Center and the Department of Psychiatry at the University of Connecticut School of Medicine.

The purpose of the training will be to create and implement competency-based curricula to improve the knowledge, skills and attitudes of front-line, supervisory, and management staff from DCF, and staff in the service agencies with whom DCF contracts. The curricula will address the implementation requirements of KidCare and best service practices for the care of children with, or at risk of, serious emotional disturbances and their families. In addition, training opportunities will be developed for staff in other child-serving systems including schools and the judiciary, as well as family advocates.

Evaluation

An evaluation will be conducted to provide information about the services being delivered, how the services are being utilized and by whom, the extent to which services are effective, and the costs of the service system. The evaluation will also encourage accountability, cost consciousness, and responsiveness to those in need of and using services. DCF has contracted with CHDI to assist in the design and development of the evaluation. CHDI has secured matching grants from the Children's Fund of Connecticut and the Connecticut Health Foundation to help support the work during this fiscal year. DCF will seek additional State and private funds for the full-scale evaluation for future years. DCF, CHDI, and DSS have convened an evaluation workgroup responsible for the development of evaluation goals and methods and the procurement of an independent evaluator.

Financing

The integration of State and Federal funding streams will be necessary to support the proposed comprehensive benefit package. This will require changes in legislation and the re-appropriation of some dollars currently appropriated to DSS. It is anticipated that all or a portion of the following funding streams will be used to establish the integrated funding pool:

- The behavioral health portion of the capitation rate for the HUSKY Part A (Title XIX) and Part B (Title XXI) Managed Care Organizations,
- HUSKY Plus Behavioral funds,
- A portion of State funds currently used for reinsurance in Part A of the HUSKY program, redirected to community-based services,
- Title IV-E and State general fund dollars used for residential treatment, group care, and therapeutic foster care for children with behavioral health problems,
- Other DCF State and Federal funds spent on children's behavioral health services,
- Revenues derived from ASO billing of responsible third party payers.

Fee for service Medicaid funds for Medicaid-eligible children will not be included in the funding for Community KidCare.

The State anticipates that there will be additional federal Medicaid revenue from Medicaid revenue maximization strategies resulting from claims for residential and community-based treatment. A small working group consisting of a consultant under contract to CHDI and staff from DCF, DSS, and the Department of Administrative Services (DAS) have been working since the spring of 2000 to develop and implement a system for maximizing Medicaid reimbursement for DCF placements in residential facilities, and to enhance reimbursement for community-based care.

Implementation

The implementation of this reform is best conceptualized as an incremental process, one that requires the development of additional management and administrative capacity within the Departments as well as service infrastructure and human resource development at the local level. The Departments have established July 1, 2002 as the target date by which the new system will begin to be phased-in. The groundwork that needs to be laid for phase-in is considerable including financial analysis and budgeting, HUSKY B legislative changes, a new federal waiver or waiver amendment (section 1915b), and LSA/ASO procurement and contracting.

Pre-implementation (January 1, 2001-June 30, 2002). Preparation for phase-in will be conducted over the next 18 months. During this period DCF and DSS will be engaged in efforts to improve service delivery and address some of the system's most pressing problems. DCF will introduce a range of new and expanded services, including services that will be part of the comprehensive benefit available under Community KidCare. Special services such as care coordination, family advocacy, and emergency mobile psychiatric services will be greatly enhanced to better meet the needs of children with complex behavioral health service needs. Changes in practice will also be supported by the implementation of the Community KidCare training plan. The independent evaluation team will be selected and have the opportunity to design the evaluation and collect baseline data.

DSS will implement changes in the HUSKY A program that will improve MCO/DCF collaboration in the care of children with serious behavioral health disorders, and encourage support for comprehensive and coordinated outpatient service plans. These changes include modifying contract incentives to support increased community based care.

Implementation (July 1, 2002➔). Under the current proposal, the phase-in would begin with DCF procuring and contracting with an ASO to administer a full carve-out of the HUSKY child behavioral health benefit, beginning July 1, 2002. Shortly thereafter, LSAs would be brought on-line in two catchment areas. An *enhanced* benefit including non-medical support services (e.g., respite, mentoring) would be introduced in these catchment areas. The LSAs would assume responsibility for managing the full KidCare benefit package, which would include the HUSKY benefits and the enhanced benefits. Additional LSAs would be brought on in a sequential manner until the entire program is in operation statewide. It is expected that the phase-in will be complete in 1 to 2 years.

Concluding Comment

The Departments of Children and Families and Social Services have charted a course for unprecedented system reform and have committed to an enduring partnership. The plan outlined in this document provides a vision for the future—a vision in which children and families have access to behavioral health services and a choice of providers—a vision that celebrates family, community and culture—a vision that embraces prevention and early intervention—a vision that provides flexibility and responsiveness. Connecticut can improve the lives of children and families, and Community KidCare is the way.

Connecticut Community KidCare: A Plan to Reform the Delivery and Financing of Children's Behavioral Health Services

I. Background and Overview of the Reform

This report details efforts by the Commissioners of the Department of Children and Families (DCF) and the Department of Social Services (DSS) to develop a new system for delivering and financing children's behavioral health services in Connecticut. This plan is submitted in response to the requirements of June 2000 Special Session Public Act 00-2, Sections 3-5, in which the General Assembly charged the Commissioners with developing the elements of a plan to reform the current system. Although the focus of this report is an innovative partnership between these two agencies, this report provides the framework to improve services for children served by other State agencies and branches of government (for example, the State Department of Education and Juvenile Justice). The concept can also provide a working model for private insurance in Connecticut.

Background

In response to growing concern about serious bottlenecks and quality assurance issues in children's mental health services, the Legislature in 1999 requested that DSS prepare a study of the financing and service delivery system for children's behavioral health, specifically services for those enrolled in the state-sponsored health insurance programs for low-income families (HUSKY A and B).

In February 2000, DSS, in collaboration with DCF and other State agencies, submitted a report to the General Assembly entitled, "Delivering and Financing Children's Behavioral Health Services in Connecticut," prepared by the Child Health and Development Institute of Connecticut. This report provided a framework for reform of Connecticut's publicly funded behavioral health service system for children.

The report concluded that although an impressive array of resources and capabilities in Connecticut are devoted to children's behavioral health, there are significant problems in the current way services are organized, financed, and delivered. The study pointed to five major problems:

1. There are insufficient mechanisms for effective coordination of care between levels of intensity and across service systems for children and their families.
2. Community-based resources and treatment alternatives are not sufficiently developed, contributing to the serious bottlenecks in the existing treatment system.
3. Funding is allocated by program and agency, each with its own requirements and incentive structure, causing fragmentation.

4. There are not adequate supports for families to be sufficiently involved in planning services for their own children or in system planning and policy.
5. A redistribution of resources and taking fuller advantage of Federal financing mechanisms that may be reinvested in services could go a long way toward supporting a more effective system of behavioral health services for children.

The report recommended that Connecticut move to a system of care approach to children's mental health services, building on the emerging network of 22 Community Collaboratives around the State. It further recommended that the State establish an Administrative Services Organization to handle selected centralized functions and Lead Service Agencies to provide local management authority.

In June Special Session Public Act 00-2, Sections 3-5, the General Assembly endorsed the direction of the report calling for the restructuring of children's behavioral health service delivery and financing. The General Assembly also approved the expenditure of $3.5 million within DCF's budget for development and implementation activities.

In addition, the final report of the Governor's Blue Ribbon Commission on Mental Health, delivered in July 2000, included recommendations that fully supported the direction reflected in the report and legislation.

On August 6, 2000, the Departments issued a joint Request for Information ("RFI") seeking comment on the structure of the proposed reform of the children's behavioral health system. The State received extensive comment at two three-hour public meetings and through written comment. The responses to the RFI informed the system design proposed in this report.

Overview of Reform

CT Community KidCare ("KidCare"), building on models already in place in Connecticut, will greatly reduce if not eliminate the major system gaps and barriers described in the February 2000 Report and the August 2000 Request for Information. Children with behavioral health problems will have the opportunity to experience healthy social, emotional, physical and cognitive development in the context of a nurturing family and community, increasing their ability to succeed in their families, schools and communities. Simply put, kids have said they don't want to be separated from all that is important to them—their friends, families, schools—in order to get the behavioral health services that they need. Their families feel the same way, but they often feel that they don't have a choice.

This system reform, designed to serve children and youth in HUSKY A and B, DCF's Voluntary Services Program, and eligible youth in the juvenile justice system, will ensure immediate access to local, community-based, traditional and non-traditional services. Children with unusually complex behavioral health service needs will have access to coordinated, integrated care based on individualized service plans. These service plans will combine traditional clinical services (e.g., outpatient therapy, partial hospitalization, medication) with non-traditional services (e.g., respite, mentoring, behavioral assistance, family-to-family support).

The reform is based on a local service delivery system driven by the needs and preferences of the child and family. Reform efforts involve an expansion and redistribution of funds for children's behavioral health services, with greater emphasis on preventing children's problems from escalating by providing a wider array of culturally competent services delivered in the home or in the child's community. The reform also will support the development and financing of an independent family-run organization to provide family-to-family support and foster active family participation in treatment and system planning.

This reform is expected to result in a significant reduction in length of stay in psychiatric hospitals and residential treatment placements as well as a reduction in out-of-community and out-of-state placements.

The proposed model represents a paradigm shift that introduces Lead Service Agencies (LSA) that have overall responsibility for managing behavioral health services for enrolled children. The Lead Services Agencies will work with local service providers and local Community Collaboratives to provide quality behavioral health and support services for all enrolled children.

Guiding Principles

The proposed KidCare initiative requires a fundamental reform in current philosophy, benefit design, organization, and financing of services in Connecticut. The change in philosophy is based on the findings presented in the February 2000 report, the considerable experience that DCF and DSS have gained in providing and managing behavioral health services for children, and national trends in behavioral health service system design and delivery. These philosophical changes are best summarized in the following principles:

- Prevention and early intervention
- Families and children as partners in service planning
- Cultural competence
- Informed choice
- Simplicity and ease of access
- Local decision making and care
- Comprehensive benefits including treatment and support services
- Community-based care
- Coordinated care for complex needs
- Consumer driven
- Accountability
- Evidence-based practice

- Quality improvement
- Cost-effectiveness

None of these values and concepts are new. Yet they are seldom brought together under a single umbrella to guide the design of a project of this scope.

A Personal View

KidCare will respond to the needs of different children in different ways, which cannot be captured in the story of any one child. The service system will work to make early intervention and prevention services more widely available, and by intervening early and intervening well, it is hoped that it will be possible to prevent many children from having to be placed in residential settings for treatment. For those children who are placed, it is expected that stays will be no longer than necessary, and that the available aftercare options will be more flexible, comprehensive, and accessible than has been true in the past.

With that said, much can be learned about the principles, practices and philosophy of the new system by considering the experience of a child with complex service needs and his family. In this example, the child was placed in residential treatment prior to the reform. On his return, he and his family had the benefit of a Care Coordinator and an LSA.[4]

Joshua was placed in a residential treatment center 6 months ago due to aggressive behavior towards other children and pets, unwillingness to go to school and temper tantrums at home. Joshua is 12 years old and somewhat small in stature. His parents are divorced. His mother has her own learning disabilities that were unrecognized when she was a child. Before Josh was placed in residential treatment, his mother worked hard to get him the treatment he needed so that she could continue caring for him at home. During this time, she had several confrontations with school personnel, each feeling the other was not doing enough to keep Josh's behavior under control. Josh's behavior was so aggressive that he was not able to belong to any school sports teams or engage in any school activities. After several suspensions, he was placed on home-based instruction, and two months later was placed in a residential treatment center.

After 4½ months of treatment, Josh no longer needed the structure of a residential treatment setting. However, he needed community services in place to support his safe return home. Fortunately, Joshua was now enrolled in KidCare and his local Lead Service Agency had identified a *care coordinator* to work with him and his family. The counselor at the residential center, along with Joshua's care coordinator, developed a plan for his return home.

The care coordinator met with Josh and his mother to find out what their goals were for Josh's return. The care coordinator worked with Josh and his mother as partners in designing Josh's Individual Service Plan. His mother appreciated that the process focused on Josh's strengths as well as needs and that it recognized the special challenge

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[4] This is a composite account, based on the actual experience of providers, children and families in similar service systems around the country.

of caring for a child with a psychiatric disability. The plan was designed to support her ability to provide the necessary care and structure as a single mother. The meetings with the care coordinator were free from allegations and blame, something she feared and expected from past experience. Consequently, she developed a sense of trust and a willingness to share her own conflicted feelings and fears about Josh's return.

Josh said that he wanted to return to school and be able to participate in school activities. He also said that he wanted to see his dad more often. Josh's mother talked with the coordinator about how anxious she was feeling about Josh's return home. She stated that she no longer wanted to have school personnel calling her everyday to tell her about Josh's behavior. She stated that it had been really hard to take care of Josh alone since the divorce, but hadn't felt that his father was willing to help with Josh. She wanted to make sure that if Josh came home, he would be able to stay home.

Together the care coordinator and the mother thought about whom to invite to be part of a team that would help Josh reintegrate into his community. They identified a therapist and psychiatrist who would work with Josh, personnel from the school, the leader of the youth group at the church, and his dad and his older siblings. The care coordinator said she would contact Josh's dad to see if he was willing to participate and Josh's mom agreed to talk with her other children. The care coordinator also gave Josh's mom the name of the family advocate in the area if she wished to talk with another person who could provide her with support.

The care coordinator gathered all the team members for a meeting about Josh. At this meeting, they discussed what Josh would need to come home successfully. The team agreed on the following plan:

- Josh will attend his neighborhood school with the help of a full time paraprofessional. Josh will be in regular classes except for resource room placement for reading help.
- Josh's therapist will see him weekly for individual psychotherapy and also provide weekly family therapy and/or parent guidance visits during the transition. The therapist will maintain contact with the child psychiatrist who will prescribe Josh's medications. The psychiatrist will join the team meeting once a month.
- Josh will attend his church youth group with the help of a behavioral assistant. The behavioral assistant will also work with Josh 3 days per week after school until bedtime. Josh's therapist will provide the behavioral health assistant with supervision as needed.
- Josh's brother will take care of Josh after school 2 days each week.
- Josh's sister will take care of Josh one day per weekend for 8 hours.
- In the event of an emergency the safety plan would be to contact Josh's care coordinator or use the emergency mobile psychiatric service.

As Josh progressed, services would be reduced and other social events, such as school dances, would be added. The care coordinator knew that the success of the Individual Service Plan depended as much on the quality of the relationship between team members, especially trust and communication, as it did the specific elements of the plan. Thus, although not an explicit goal, the care coordinator used the team process to begin to repair the relationship between the parents and the school.

Josh returned to his community within the next thirty days. During this time, the school hired a paraprofessional to help Josh with his schoolwork. The parents, together with the care coordinator, hired a behavioral assistant, a woman who was a part-time carpenter and someone that Josh already knew through a neighbor. The therapist agreed to provide the behavioral assistant with weekly supervision, with a plan to reduce supervision to a monthly schedule once Josh was stable. Plans were made with Josh's brother and sister for respite on weekdays and weekends. The parents also worked together to find ways for his father to be more involved in Josh's treatment and to spend more time with him.

Initially, the plan worked very well. Josh appeared to be "buying in" to being back in school and in the community. He made his appointments with the therapist and was adjusting well, with guidance, in school and at the youth group. Josh's siblings kept their commitments with Josh during the week and on weekends. Both of his parents were able to attend the weekly team meetings, because they were held at 8 a.m. before either of them had to be to work. Josh said that he liked his school aid and behavioral assistant, although he complained that the assistant at home was too strict. The team members, but primarily his care coordinator, reviewed with Josh the expectations of his behavior in the community, particularly regarding his aggressive behaviors.

One evening on the way to his youth group, Josh became very angry with his behavioral assistant when she told him that he needed to put on his seatbelt in the car. He was exceptionally defiant that evening, getting out of the car, throwing rocks at it, and finally breaking a window. The assistant was unable to calm him. As he became even more angry, he kicked and very much frightened her dog. At that point, Josh ran back into the house and refused to come out. His mom told the assistant that she would take care of Josh while the assistant took care of her dog. Josh's mom and his assistant debated about whether they needed to contact the emergency mobile psychiatric service, but when Josh agreed to go to bed, they decided to wait and contact the care coordinator in the morning.

Josh's mother called the therapist and the care coordinator first thing the next morning to let them know what had happened. Josh's therapist came to his home before school to talk with him about the incident, to help him understand why he had gotten so angry and to consider ways to avoid and manage his anger in the future. A team meeting was scheduled for the afternoon to talk over adjustments that might need to be made to the care plan and to talk with Josh about the incident the night before.

Josh talked about his feelings of anger at the assistant. He stated that he knew that throwing things at her car would make her angry. When she seemed less angry than Josh thought she would be, he broke the window and went after the dog. He regretted being so hurtful and destructive and felt badly about it. The team talked with him about his behaviors. He worked with his care coordinator to come up with a plan for apologizing to his assistant and for paying off the bill for the broken car window through community service. Josh was not the only one who needed professional support. The behavioral assistant took Josh's behavior personally and felt both betrayed and angry. She met with her supervisor to talk about her conflicted feelings about returning to work with Josh, to better understand the incident, and to review options for handling similar events in the future.

Josh and the assistant continued to work together. He was eventually able to get back on track with his care plan. Four months later, his behavior in school had improved. He earned special leadership responsibilities and was allowed to come to additional school functions. He also began spending more time with his dad. The team steadily reduced its meeting schedule, from weekly to biweekly to monthly. All team members agreed that Josh was doing well but knew there was still progress to be made.

Basic Values

This story illustrates a number of basic values and assumptions of the KidCare model. The first is that parents are partners in planning and that planning must first and foremost be based on child and family strengths. This partnership is a departure from traditional treatment planning processes in which the parent is a passive recipient of a prescribed treatment plan. Under this model, parents make informed choices that reflect their needs and preferences. They rely on professionals to help inform them of treatment and support options, to make a plan, and to help them carry out the plan. The parents direct the planning process and determine whether it meets their needs.

Josh's story also illustrates the basic importance of non-clinical support services, *supervised* supports (the carpenter) and supervised experiences (youth group), and traditional clinical intervention. A range of strategies is necessary to support families and children with complex service needs. These treatment and support strategies should be informed by knowledge of development, clinical experience, and common sense.

Relationships are central to this work. Without good working relationships among team members and participating institutions (schools, churches), the work will never last beyond the first crisis. In the case of Josh, repairing the relationship between parent and school was essential—setting the stage for an ongoing process of collaboration, mutual support, and problem solving. The same principle applies to individual supports and services. The quality of the relationship between a service provider (therapist, behavioral assistant) and the child and family is often as or more important than the type of service provided.

The KidCare service process is based on the notion that some children will present ongoing challenges as a result of their behavioral disorders. Like Josh, many children will continue to be vulnerable to lapses after a period of treatment progress. A lapse does not represent a treatment failure nor does it signal a full-fledged relapse. Instead lapses are to be expected—the natural course of a child with behavioral challenges who is being supported to live in the community. Moreover, every lapse presents the opportunity for understanding, growth, and change.

Related to this is the concept of “no eject, no reject.” As evident from Josh’s aggressive outburst, children who return from residential treatment or who are supported in the community as an alternative to residential treatment may engage in behavior that tests the will and commitment of key providers and supports. A major focus of the work under KidCare is to anticipate these challenges, and to focus on solutions and therapeutic responses rather than rejection by the service or members of the service team. Although children may at times need a different level of care or temporary treatment out of home, these decisions should not be incident driven and the team should remain responsible for the child’s care wherever he or she is served. No child will be ejected from a service team or from the KidCare program because of his or her behavior and needs.

Program Design

Full Carve-Out

One of the fundamental questions related to the design of this initiative is whether to include all children enrolled in HUSKY, Parts A and B (full carve-out) or only those children with special behavioral health needs (partial carve-out). Under a partial carve-out, only those HUSKY enrolled children in the child welfare system and those with special behavioral health needs would be enrolled in KidCare. In contrast, under a full carve-out, all of the HUSKY child behavioral health services currently provided by the HUSKY plans would be provided as part of KidCare. In essence, the child behavioral health portion of the HUSKY benefit would be “carved-out” to KidCare and all HUSKY children would automatically be enrolled in KidCare for their behavioral health benefits. The Departments have decided to implement a full carve-out design, based in part on responses to the August 2000 RFI, which strongly favored a full carve-out. A full carve-out design will reduce fragmentation and support the investment of resources in prevention and early intervention services, in order to reduce as much as possible the number of children who will eventually require more intensive intervention.

HUSKY A and B enrolled children will automatically be enrolled in the KidCare program through which they will receive the vast majority of their behavioral health services and supports. The HUSKY plans will continue to be responsible for behavioral health care provided in primary care settings and they will be responsible for pharmacy services. Parents of children with mild behavioral health disorders may decide to use primary care behavioral health services, however, they will be free at any time to use the behavioral health specialty services available in the KidCare program.

Non-HUSKY eligible children may be able to access KidCare through the Voluntary Services Program. The application process will be handled by the Lead Service Agencies and eligibility will be determined by the Administrative Services Organization according to DCF policy. Clinical and functional criteria that govern access will be reviewed and modified for this purpose.

Risk

Under a full-carve out design, more than $200 million will be budgeted for this program. While these resources should be sufficient to address the needs of all enrolled children, there will need to be protections in place to guard against excessive and unrestrained growth over the long term. This relates then to the second major design question, which is who should bear risk (State, ASO, or LSAs), and to what extent risk should be shared. Under the proposed design, the LSAs are not expected to bear financial risk during the initial phases of this reform. However, mechanisms will be required to ensure accountability for cost, quality, and the appropriate use of available resources.

Benefits

The centerpiece of KidCare is a comprehensive benefit package made possible by the integrated management of DSS and DCF funding streams including Medicaid (Title XIX), State Children's Health Insurance Program (Title XXI), Title IV-E (board and care), and State general funds. The comprehensive benefit includes a full complement of outpatient treatment, day program, home-based, and care coordination services, as well as out-of-home services such as residential center treatment, therapeutic foster care, and hospitalization. The benefit package also includes a range of non-medical support services, such as respite care and therapeutic recreation, which are often essential to allow children with behavioral health disabilities to live in their homes and communities.

Families

Families will play an instrumental role in ensuring that each aspect of the system is accountable and responsive to the needs of children with behavioral health disorders and their families. DCF is supporting the development of a family support organization to assure that children with behavioral health needs and their families have voice, access, and ownership in the development and implementation of their service plans. Families will have opportunities for involvement at multiple levels, from local family advocacy to input into policy and planning. Family involvement will help make KidCare responsive to families and accountable to communities. Efforts will be made to make childcare and transportation available, and meeting times will need to be set with special attention to family schedules. KidCare providers will respect the confidentiality of families enrolled in the program. The LSAs will practice in accordance with State and Federal confidentiality laws.

Service Delivery System

DCF and DSS will administer KidCare under an interagency agreement. The agreement sets forth a pre-implementation process, so that both Departments are involved in building the management infrastructure and developing the policies, procedures, contracts, and standards necessary to support DCF's administration of the program. Post-implementation, DCF will have responsibility for management of the KidCare program.

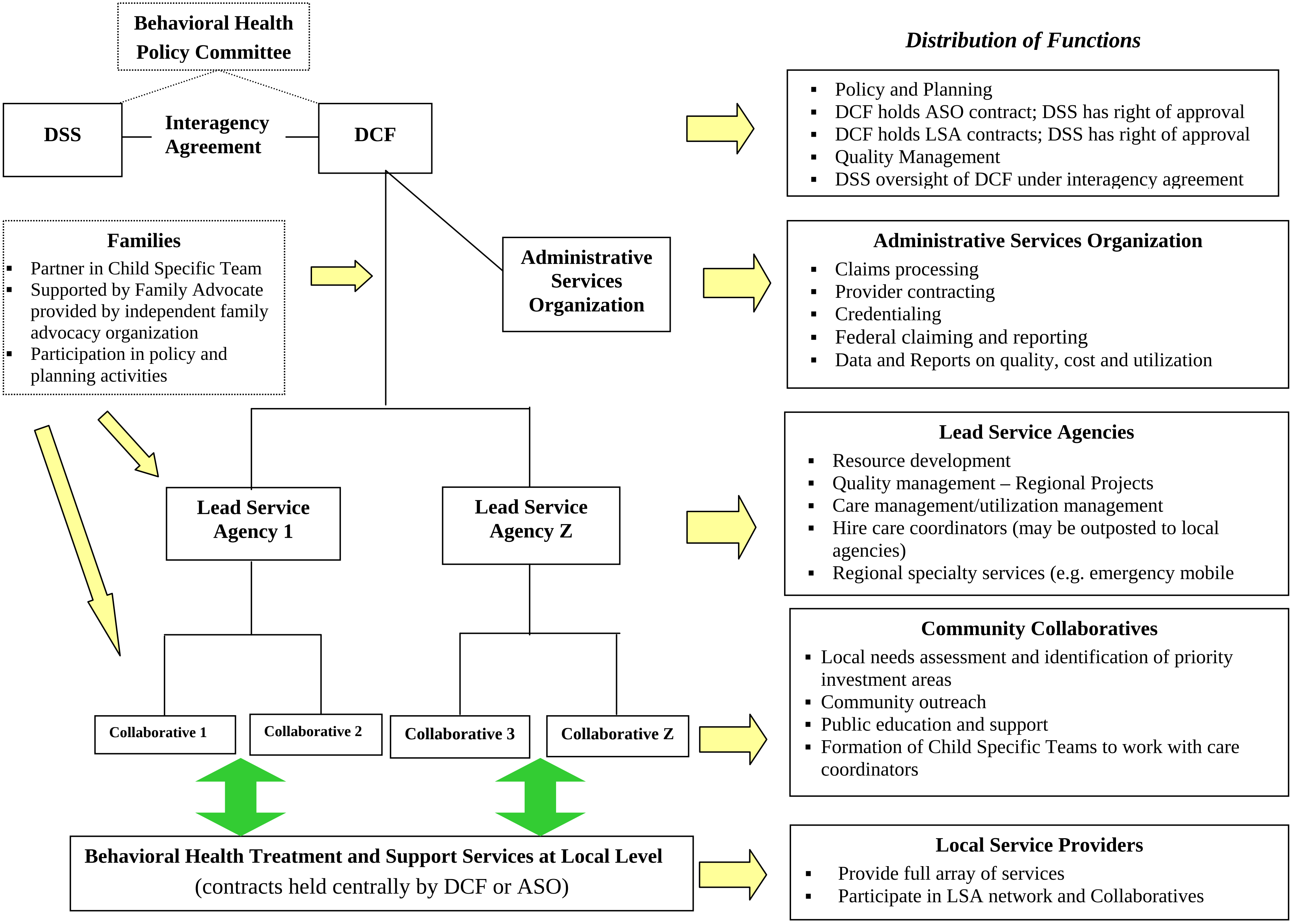
DSS will monitor program compliance with Medicaid and SCHIP requirements.

The new organizational structure (see Figure 1) will include an Administrative Service Organization (ASO), Lead Service Agencies (LSAs), and Community Collaboratives. This structure is described in detail in Section IV. DCF will procure and contract with an ASO to assume responsibility for claims payments, reporting, data management, contracting and other functions that are best conducted centrally. The DCF regional offices will in turn contract with LSAs selected under a competitive procurement. No fewer than five, but no more than twelve LSAs will be selected; the final number will be determined by a variety of factors including the number and qualifications of respondents to the RFP, and financial analyses of service and administrative dollars available to finance the system. The LSAs will assume responsibility for managing the care of all enrolled children residing within their designated catchment areas. LSAs will have authority to manage service utilization and will have responsibility for local quality management and for overseeing the development of local community resources.

The Lead Service Agencies will be responsible for ensuring that *all* enrolled children have access to quality behavioral health services, and they will have special responsibility for the care of children with complex behavioral health service needs. Children with *complex service needs* require the coordinated involvement of multiple State agencies (e.g., DCF, State Department of Education, Department of Mental Retardation, Court Services, and, for older children, Department of Mental Health and Addiction Services). In addition to specialized treatment and educational services, families of these children often require non-medical support services such as respite and mentoring and the voluntary support of friends, relatives, neighbors, churches, support groups, and other community organizations.

The LSAs will employ *care coordinators* to work with families of children with complex service needs. The care coordinators will partner with families and children to design flexible, Individual Service Plans. Although Lead Service Agencies are accountable for the care provided by care coordinators, most of the care coordinators will be based at provider agencies located throughout the LSA's catchment area. Thus, most of the care coordination will be carried out within local Community Collaboratives. A Community Collaborative is a local consortium of providers, parents and service agencies that have organized to develop coordinated, comprehensive community resources for children with complex service needs and their families. Formerly referred to as Local Systems of Care (LSOC or SOC), the Collaboratives may be small or large, encompassing from one to twenty cities and towns. Members of the Collaboratives have close working relationships and intimate knowledge of local needs and resources and thus are in the best position to work with families to create child and family specific teams and design Individual Service Plans.

Figure 1: Organizational Framework for Connecticut Community KidCare



Distribution of Functions

- Policy and Planning
- DCF holds ASO contract; DSS has right of approval
- DCF holds LSA contracts; DSS has right of approval
- Quality Management
- DSS oversight of DCF under interagency agreement

Administrative Services Organization

- Claims processing
- Provider contracting
- Credentialing
- Federal claiming and reporting
- Data and Reports on quality, cost and utilization

Lead Service Agencies

- Resource development
- Quality management – Regional Projects
- Care management/utilization management
- Hire care coordinators (may be outposted to local agencies)
- Regional specialty services (e.g. emergency mobile

Community Collaboratives

- Local needs assessment and identification of priority investment areas
- Community outreach
- Public education and support
- Formation of Child Specific Teams to work with care coordinators

Local Service Providers

- Provide full array of services
- Participate in LSA network and Collaboratives

Implementation

The implementation of this reform is best conceptualized as an incremental process, one that requires the development of additional management and administrative capacity within the Departments as well as service infrastructure and human resource development at levels. The Departments have established July 1, 2002 as the target date by which the new integrated funding system will begin to be phased-in. Significant work needs to be done before full roll out such as financial analysis and budgeting, design and execution of an interagency agreement, HUSKY B legislative changes, a new 1915B Medicaid waiver and waiver amendment, and LSA/ASO procurement and contracting.

Pre-implementation (January 1, 2001-June 30, 2002). The most important piece of groundwork is community readiness—including community members, schools, providers, families, and advocates. Preparation for phase-in will be conducted over the next 18 months. During this period DCF and DSS will be engaged in efforts to improve service delivery and address some of the systems most pressing problems. DCF will be introducing a range of new and expanded services, including services that will be part of the comprehensive benefit available under KidCare. Special services such as care coordination, family advocacy, and emergency mobile psychiatric services will be greatly enhanced to better respond to children with special behavioral health needs. The reinvestment of dollars obtained through Federal revenue (i.e., Medicaid) maximization will help offset the cost of this enhancement in services. Changes in practice will also be supported by the implementation of the KidCare training plan.

During the interim, DSS is considering changes to the HUSKY A program that would improve collaboration between DCF and the HUSKY managed care organizations (MCOs) in the care of children with special behavioral health needs and support comprehensive and coordinated outpatient service plans. The program changes would involve the introduction of a new risk sharing arrangement for outpatient care, along with a modification of the existing reinsurance schedule for inpatient psychiatric care. These modifications will help keep plans involved in the care of children with extended inpatient stays and will provide the plans with an incentive to support comprehensive community-based aftercare.

Financial analysis to support the proposed KidCare model has been hampered by incomplete HUSKY encounter data. The proposed HUSKY risk sharing arrangements should help to remedy this problem. DSS's reimbursement of the plans will be based on claims paid. This will create a powerful incentive for the HUSKY plans to improve the completeness of the encounter data. DSS's ability to determine actual behavioral health expenditures and to make future projections should be greatly enhanced as a result.

Implementation (July 1, 2002➔). Under the current phase-in model, DCF would procure and contract with an ASO to administer a full carve-out of the HUSKY child behavioral health benefit, beginning July 1, 2002. Shortly thereafter, LSAs would be brought on-line in two catchment areas. An *enhanced benefit* including non-medical support services (e.g., respite, mentoring) would be introduced in these catchment areas. The LSA would assume responsibility for managing the full KidCare benefit package, which would include the HUSKY benefits and the enhanced benefits. Additional LSAs would be added in a sequential manner until the entire program is in operation statewide. The phase-in is expected to be complete in 1 to 2 years.

The sections that follow provide a more detailed description of the proposed plan including policies, administrative functions, lines of authority, accountability, and family involvement. This proposal represents a work in progress. Design changes and refinements are likely in response to input from the General Assembly and the citizens and stakeholders who will be directly affected by these changes.

II. Eligibility

KidCare will enroll children under the age of 19 years from the following categories:

- HUSKY A eligible children including all children in DCF child protective services or juvenile justice,
- HUSKY B eligible children including children in income bands 1 and 2, and
- Children who apply and qualify for the DCF Voluntary Services Program.

DSS will retain authority for determining eligibility for HUSKY A and HUSKY B as outlined in the Title XIX and Title XXI State plans. In the case of HUSKY B, DSS has delegated this responsibility to Benova, the HUSKY enrollment broker. No change in the HUSKY eligibility criteria will be required, although the State plans will need to be amended and approved by the Federal Health Care Financing Administration (HCFA) in order to allow enrollment in KidCare. Parents who apply to HUSKY in order to gain access to KidCare will have the same due process rights as any other HUSKY applicant. DSS is currently examining mechanisms to permit children in HUSKY B, band 3 (i.e., band in which parents pay full premium) to participate in KidCare, involving either a limited benefit or additional options for cost sharing.

The DCF Voluntary Services Program is designed to serve children with special behavioral health needs and their families. Children who qualify for the Voluntary Services Program receive DCF funded services without families having to give up custody of their children. Children who do not qualify for KidCare through HUSKY A or B, may be able to access KidCare through the Voluntary Services Program. The Voluntary Services Program is not an entitlement and thus access to KidCare through Voluntary Services will be regulated by DCF based on resource availability.

DCF will continue to manage access to this program directly during the initial phase of implementation. Once the LSAs have been established, it is anticipated that DCF will delegate management of the application process to the LSAs. The Administrative Services Organization will be responsible for determining eligibility and will do so in accordance with DCF policy. The Voluntary Services Program criteria are based primarily on a child’s symptoms and functional status. These criteria will be reviewed and may be subject to change.

LSA management of the Voluntary Services application process will offer the advantage of local access to a community agency, which parents prefer to access through the State system. The LSAs will provide a less threatening, less stigmatizing, and more family friendly point of access. Parents of uninsured children will be encouraged to apply for coverage through HUSKY and will be offered assistance with the application process. Cost sharing requirements for parents of children who are enrolled through the Voluntary Services Program will continue, but alternative means for administering the cost sharing requirements (currently conducted by the Department of Administrative Services) will be explored.

III. Benefit Design

KidCare will provide a comprehensive benefit package that includes a range of *behavioral health treatment services* and *non-medical support services*. KidCare will also encourage reliance on *natural community supports*, which are essential to a child's long-term success in the community. Each of these service types is described below along with a list of examples.

Behavioral Health Treatment and Related Services

Behavioral health treatment services include those services that are necessary to correct or diminish the adverse effects of a mental health or substance abuse disorder. Most of these services qualify, in whole or in part, for reimbursement under Medicaid or SCHIP. These services include, but are not limited to the following:

- Individual psychotherapy (home-based and outpatient)
- Family therapy (home-based and outpatient)
- Group therapy
- Psychiatric and substance abuse diagnostic evaluation
- Psychological testing
- Intensive outpatient program (mental health/substance abuse/dual diagnosis)
- Extended day treatment program
- Partial hospitalization program (mental health/substance abuse/dual diagnosis)
- Inpatient hospitalization (mental health/substance abuse/dual diagnosis)
- Inpatient detoxification
- Mobile crisis/emergency services
- Out-of-home therapeutic stabilization
- Consultation
- Professional parenting
- Treatment home/therapeutic foster care
- Group home care
- Residential treatment center care (mental health/substance abuse/dual diagnosis)
- Medical transportation
- Care coordination

It is anticipated that Connecticut's mental health parity law will apply to the above behavioral health treatment and related services. Accordingly, there will be **no arbitrary day, visit, or dollar limits**. However, coverage for these services will only be provided when medically necessary. The DSS definition of medical necessity will apply. The current definition is as follows:

> Health care provided to correct or diminish the adverse effects of a medical condition or mental illness, to assist an individual in attaining or maintaining an optimal level of health, to diagnose a condition or prevent a medical condition from occurring.

KidCare will not cover hospital-based emergency services, pharmacy, and behavioral health services provided by primary care providers. For children enrolled in HUSKY A and B, coverage for these services will be the responsibility of the HUSKY Managed Care Organizations (MCOs). For all other children, payment for these services will be the responsibility of the current insurance provider or parents.

Non-Medical Support Services

KidCare benefit package also includes *non-medical support services*. These services are used to help a child to function safely and independently in the community and to help support a family's ability to care for a child with special behavioral health needs. Non-medical support services available in the KidCare benefit package include:

- Behavioral assistance (home-based or community aide support)
- Outreach/information/referral
- Family-to-family support
- Out-of-home crisis respite
- Therapeutic respite care
- Supported recreation
- Supervision of natural community supports (see below)
- Non-Medical Transportation

Non-medical support services will not be subject to a medical necessity standard and are not expected to be subject to mental health parity. However, these services will be subject to care management by the LSA and/or ASO (see Section IV). Other limitations may also apply.

Non-Paid Natural Community Supports

In order for children with behavioral health service needs to be successful in their communities over the long term, these youth and their families will need to rely on informal, voluntary relationships and supports, apart from KidCare covered services. KidCare funded care coordinators are responsible for helping families involve or develop these natural community supports.

For example, parents occasionally need a respite from caregiving in order to have some time for recreation, errands, or to attend to other children in the family. In the case of a child with special needs, these sorts of breaks can be difficult to arrange because the child presents unique challenges. The child may require uninterrupted supervision or adult attention in order to prevent impulsive aggression or self-injurious behavior. A parent may be able to arrange for a neighbor to watch her son or daughter so that she can go bowling once a week in the evening. The neighbor may be willing to help out. The care coordinator and parent could provide some training to the neighbor and arrange for back-up support so the neighbor has someone to call in the event of a crisis.

The development of a healthy relationship between a volunteer and a child and family cannot be left to chance. These relationships often require careful planning and supervision to help prevent a volunteer from being overwhelmed or confused by a child's behavior and to ensure that the volunteer responds in an appropriate manner. Although natural community supports are volunteers, supervision of these supports is reimbursable when it is part of the Individual Service Plan. This includes, for example, time that a clinician spends with a scoutmaster providing guidance on how best to include and support a child's participation in mainstream scouting activities.

The list of potential sources of support and ways to use these supports is endless, limited only by the imagination and ingenuity of the parent and the local community. A few examples are as follows:

- Relatives, neighbors, and friends
- Mentoring programs
- Faith communities
- Recreational groups or programs
- Sports clubs
- Social and recreational clubs (e.g., Boys and Girls Club)
- Business and civic groups (e.g., Rotary Club, Lions Club)
- Private employers
- Support groups

While KidCare will not pay directly for these supports, the plan may provide assistance to allow a child to begin involvement with, for example, a sports group or business. A care coordinator or behavioral assistant could be helpful in teaching the adults (e.g., coach or employer) about a child's special needs and how those needs could be accommodated in a way that would be beneficial to everyone. This assistance could increase the likelihood that a group or business would get involved with a child with special needs, reduce the risk of adverse incidents, and help take advantage of the potential therapeutic value of the activity. The assistant could be present as an on-site support during the initial phase of a new activity, and then reduce involvement over time.

IV. Administrative Structure

KidCare will require a new set of organizational structures under the direction of DCF. These organizational structures will support the effective and efficient management of a reform that involves new services, new methods of financing and contracting, and new functions for organizing and coordinating care. The proposed structure represents a significant evolution of the HUSKY A and B service models as well as the Connecticut system of care model established under Public Act 97-272. The new approach is designed to accommodate a dramatically increased local role in service delivery and care coordination. It will maintain and enhance the community supports and communication processes, which the current systems of care groups have begun developing on a voluntary basis without significant resources. The responsibilities of the Regional Advisory Committees will be expanded to ensure that KidCare remains responsive to the needs of children, families, and communities.

The new organizational components presented in Figure 1 and described below include the following:

- A single statewide **Administrative Service Organization (ASO)** will be responsible for the administration of KidCare funding and will provide other statewide administrative functions including claims processing, network development, provider contract processing and management, credentialing, provider relations, member services, eligibility determination for children entering under the Voluntary Services Program, data reporting, and Federal financial claiming and reporting. Because of the considerable technical expertise required to create and maintain a care management department and the disproportionately high administrative costs associated with small scale care management operations (duplicated across LSAs), the LSAs will not be expected to build their own care management departments. Instead, the ASO will provide a care management infrastructure for use by the LSAs and it will be responsible for providing care management services in any region without an LSA during the transition period. The ASO will establish a care management <u>outpost</u> in each LSA. The outpost will consist of remote computer terminals with access to the ASO's management information system (MIS) and care managers trained and salaried by the ASO.
- A **Lead Service Agency (LSA)** will be established in each non-overlapping geographic catchment area. No fewer than five and no more than twelve catchment areas and corresponding LSAs will be established statewide. Each LSA will be responsible for managing the delivery of behavioral health services for all children enrolled in its service region. The LSA will be responsible for care management decisions (relying on ASO care management infrastructure), local quality management, resource development, emergency mobile psychiatric services, and Voluntary Services application processing. The LSAs will also employ care coordinators who partner with families to create and implement Individual Service

Plans for children with complex service needs. The care coordinators will be hired in partnership with members of the Community Collaboratives and the majority will be outposted among the Collaboratives' providers.

- Each LSA catchment area will have one or more **Community Collaboratives** (formerly referred to as local systems of care, LSOCs or SOCs). Community Collaboratives are composed of local providers, families and service agencies that have organized to develop coordinated community resources for children with complex service needs and their families. The Community Collaboratives will participate in DCF Regional Advisory Councils, provide outreach to draw in community resources, coordinate behavioral health services and supports, conduct community needs assessment to identify service gaps and priority investment areas for the State and LSAs, and provide public education and support.
- A statewide **Family Support Network** will be developed with local chapters to help build capacity for family involvement at all levels, from individual children to statewide policy development and oversight.
- The DCF **Regional Advisory Councils (RAC)** will serve in an advisory capacity for KidCare, focusing on LSAs within their respective service regions. RAC membership will be reviewed to ensure inclusion of families, providers, Collaborative representatives, and other persons responsible for services to children.
- The **Children's Behavioral Health Advisory Committee** to the State Advisory Council on Children and Families (PA 00-188), with representation from consumer families, providers and other significant persons will provide an opportunity for input from a broad cross-section of interested parties.

The development of these structures will be overseen by a **State Agency Consultation Group,** which will provide strategic planning and support for the development and implementation of the expanded system of care, with representation from DSS, DCF, the State Department of Education (SDE), the Department of Mental Retardation (DMR), the Department of Mental Health and Addiction Services (DMHAS), the Department of Public Health (DPH), Court Support Services, the Judicial Branch/Court Support Services Division, and OPM.

Administrative Service Organization

An Administrative Service Organization (ASO) will provide a range of administrative services and supports. It is expected that one ASO will be able to provide all of the functions outlined below. However, the State may elect to contract with more than one entity to provide ASO functions if this is determined to be in the best interest of the initiative.

The ASO is intended to serve as a shared <u>administrative back office</u> for all LSAs. By centralizing selected administrative functions, it is possible to achieve efficiencies and economies of scale that would not otherwise be possible. Beyond the start-up phase, responsibility for care management will be delegated to the LSAs. Once the system is fully functioning statewide, the ASO will not be involved in determining when, how, by whom, and for how long care is provided, except as a backup to the LSAs. The ASO will be subject to a performance-based contract employing both rewards and sanctions tied to performance on each of its essential functions. The ASO functions are as follows:

Claims processing

The ASO will be responsible for processing all claims for behavioral health treatment services and non-medical support services. Fast, reliable claims payment has been a problem for the HUSKY plans and their behavioral health subcontractors. Moreover, timely payment of service claims has been the Achilles Heel of several similar reform initiatives across the country. Among the goals of KidCare is to effect a dramatic improvement in the reliability of claims processing for child behavioral health services in Connecticut. This requires eliminating the economic benefit that accrues to an entity that delays or administratively denies payment. Performance measures will include the timely payment of clean claims and the percentage of claims that are clean on first submission. This latter measure will provide an incentive to the ASO to offer technical support to providers who encounter problems with claims submission.

Information Management and Reporting

The development of useful management information, essential to effective and efficient management at the LSAs, as well as for State level planning and oversight, often takes several years. The ASO will be required to develop and maintain a central database for financial, utilization, management, and outcome reporting. They will be required to produce monthly, quarterly, and annual reports for various audiences. These reports will need to include the full range of performance measures in addition to information that will enable the LSAs to track service use, quality, and cost. Special reports will be required for monitoring services provided under Individual Service Plans, the costs for all of the services defined in the Individual Service Plans, and performance measures specific to children served under these plans.

The ASO will be required to track service costs that can be claimed under applicable Federal funding streams including Title XXI, Title XIX, and Title IV-E. It will be required to work with the DSS and DCF designated Federal claiming and reporting vendors to ensure that DSS and DCF meet all Federal reporting requirements associated with these funding streams.

The ASO management information system will be of central importance to the administration of KidCare. The ASO contract will include provisions to ensure that the management information capacity is not lost or significantly compromised in the event that the ASO contract is terminated. For example, in this circumstance the contract may require that the State has the right to continue use of the system or that the ASO assumes responsibility for the transfer of management information data and functions to a new vendor or system.

Contract Processing and Credentialing

The ASO will be responsible for contract processing and credentialing any willing provider of behavioral health treatment services or non-medical support services that meets minimum credentialing standards. Although the ASO will assume responsibility for all aspects of contract processing and management, it will do so according to the needs of DCF and the LSAs. As LSAs and their Collaboratives develop new service options within their catchment areas, the LSA can refer these service providers to the ASO for contracting. To the degree that this new provider is interested in providing services outside the service region, the ASO will be required to ensure that this provider's services are available to interested LSAs and Collaboratives in other areas. Credentialing policies and procedures will reflect DCF requirements for demonstrating cultural competence.

The contracts will specify that the LSA responsible for any given enrollee will have final authority over authorization decisions. Contract rates will be negotiated by DCF and will be subject to the approval of DSS. DCF will sign all provider contracts in order to allow retention of the network in the event that the ASO contract is terminated.

Assigning responsibility for contract processing to the ASO has several advantages. ASOs typically integrate contracting and credentialing functions so that they can be certain that no contract is finalized until credentialing is complete. In addition, their contract management infrastructure allows them to investigate and/or suspend any provider based on malpractice and fraud reports from the national practitioner database. ASOs also rely on software specially designed for the management of provider networks. This software makes it easy to determine whether provider volume is sufficient for enrollment in any given region and that providers are within a certain geographic radius of every member. Also, it can allow this determination to be made for different levels of service or service types. The ASO will be responsible for making this information available and easily accessible to the LSAs to support their network development efforts.

There are other advantages to ASO contracting as well. LSAs would need to develop formidable, costly, and duplicative contracting infrastructures at a time when they should be focusing on forging collaborative relationships, developing resources, and promoting new care practices. ASO contract processing prevents unnecessary contract duplication (e.g., with major hospitals and residential treatment centers having to have contracts with all or nearly all LSAs) and associated administrative costs and burdens to LSAs and providers. It also avoids the need to maintain multiple fee schedules for every provider who has a contract with more than one LSA and in turn reduces the complexity of claims payment. Finally, an ASO will be in the best position to execute quickly the extensive array of provider contracts that this initiative is likely to require, thus diminishing the time necessary for start-up.

Provider Relations

The ASO will be responsible for developing a uniform, statewide provider manual and provider directory. The provider manual will describe in full all of the policies and procedures of KidCare. The provider directory will provide a comprehensive list of service providers cross-referenced to LSA catchment areas, with restrictions when these apply. The ASO may be required to create and maintain a WEB accessible guide to contracted services and service providers to facilitate care coordination. This would allow care coordinators to access the WEB database and search by type of service to identify providers in their service region.

Care Management Infrastructure and Transitional Support

There are many different, sometimes contradictory definitions of care management in circulation throughout the United States. For the purpose of KidCare, care management is defined as a systematic process for reviewing treatment plans and treatment authorization requests for both *quality management* and *utilization management* purposes. Care management may involve prospective or retrospective review and usually involves prior authorization and retroactive authorization procedures.

Care managers are the front-line personnel who review requests for authorization. They evaluate authorization requests for medical necessity and medical appropriateness using written guidelines or criteria. If a child does not meet criteria for admission or continued care, the authorization request is referred to a doctoral level reviewer. Doctoral level review is required before any service can be denied, reduced, suspended, or terminated. The care manager or doctoral level reviewer may recommend that the clinician consider alternatives to the requested service. Care managers do not have sole authority to deny a service.

The ASO will provide centralized care management of Medicaid and SCHIP covered services in any region *without an LSA* during the transitional or phase-in period. As LSAs are phased-in, the ASO will relocate or *outpost* its care managers on-site at the LSAs. It will in turn delegate authority for care management decisions to the LSAs. The ASO will remain responsible for maintaining the care management infrastructure. It will be responsible for timeliness of utilization review procedures and notifications, care manager training, operational efficiency, and reviewer reliability.

While it might seem that the ASO would still be in control of local decisions, this is not the case. The LSA administration will provide the doctoral level reviewers who co-review all decisions to deny, reduce, suspend, or terminate a service. These reviewers may be LSA staff, independent contractors, or staff from affiliated agencies. If necessary, the ASO may be required to contract with these reviewers in order to provide the LSA or independent reviewers with liability protection. Under this model, the LSA's doctoral level co-reviewers will make the final care management decisions.

Care managers will enter authorization data directly into the ASO's management information system (MIS) through remote terminals located on-site at the LSA. The use of a common (or shared) management information system offers clear advantages to independently operated management information systems. It avoids the considerable expense associated with developing multiple LSA MIS infrastructures, it eliminates the need to transfer authorization data to the ASO, and it ensures that authorization reporting is complete and consistent across LSAs. It also makes it possible for the ASO central office to provide back-up coverage when an LSA's care managers or doctoral level reviewers are unavailable.

Even after full LSA phase-in, the ASO will be required to provide 24-hour access for emergency inpatient admissions as a back up to the LSAs. The ASO will be held to strict ease of access standards. Providers must not be expected to wait for hours in a clinic or hospital emergency department for an authorization decision.

The ASO will be required to have a utilization review license from the Connecticut Department of Insurance. In addition, the ASO will be expected to operate the care management infrastructure in accordance with National Committee for Quality Assurance standards (NCQA). These standards require, for example, that the care management department undergoes an annual evaluation by senior management or a quality improvement committee, applies written level of care/medical necessity criteria, establishes inter-rater reliability of care managers, employs licensed doctoral level reviewers in all denial decisions, and meets review timeliness criteria. DCF will provide the medical necessity and level of care guidelines for use in care management reviews.

Member Services

The ASO will be responsible for producing a member handbook that clearly describes the health plan benefits including behavioral health treatment services and non-medical support services and definitions. The handbook will also describe the coordination and care-planning services available for children with complex service needs, member rights and responsibilities, and grievance and appeals procedures. The handbook will identify each of the LSAs, contact information, geographic catchment areas, and Community Collaboratives. These handbooks will be included in all of the welcoming packets for HUSKY A and B enrolled children and Voluntary Service Program enrollees, and will also be available upon request.

When members or their parents have questions about accessing behavioral health services, it is important that there be a single, central toll-free number that they can call for program information or referrals. The ASO will establish a toll-free number for this purpose. For children who are not already receiving services, the ASO will provide parents with the names and phone numbers of local providers and their

LSA. Parents of children who have more intensive or complex needs will be transferred directly to the LSA for assistance.

The ASO will also be required to maintain a 24-hour toll-free warm-line service for parents with urgent questions or a child in crisis. Responsibility for handling these calls can be worked out individually between the ASO and each LSA. Some LSAs may request to have all calls transferred to their own call centers or mobile emergency psychiatric services. Others may wish to handle only those calls that require a mobile emergency psychiatric response.

Lead Service Agencies

The Lead Service Agencies (LSAs) will be responsible for ensuring access to KidCare covered services and for the quality of those services for all enrolled children who reside in their respective catchment areas. They will have responsibility for service resource development, care management, local quality management, care coordination, family involvement, and training, under a contract with their DCF regional office. The LSA catchment area boundaries are not intended in any way to restrict access to providers. Parents and the LSAs will be free to use any provider in the ASO's contracted network.

There were many responses to the August 2000 Request for Information related to whether an LSA should be a current provider of children's behavioral health services, an organization providing a similar role for adult mental health services, or an organization that exclusively coordinates and manages the delivery of children's behavioral health services and resources. Although concerns were expressed about allowing a provider agency to serve as an LSA, the advantages appear to outweigh the disadvantages. The provider applying for the LSA role in a catchment area may be the dominant provider of children's behavioral health services as well as the organization best equipped to perform the LSA role. Requiring an organization to choose between the roles of service provider and LSA could result in the loss of an important service provider. Furthermore, there was no support for having managed care organizations assume these roles. Alternatively, although it is possible to develop new regional organizations that exclusively coordinate and manage the delivery of children's behavioral health services and resources, this would add considerable time to the start-up process and it would add significant administrative overhead.

The primary concern with having provider agencies play the role of LSA is that they might use their dual role to competitive advantage, for example by excluding other providers from the network, by providing themselves with lower authorization thresholds, by paying themselves higher rates, or by steering referrals to their own agency or affiliates. The proposed design, therefore, offers safeguards against some of these problems. Others will need to be developed based on continued input from families and providers and the experience of other States. Some anticipated safeguards are as follows:

- The ASO will be responsible for contract processing for any willing provider that meets credentialing standards;

- DCF will be responsible for rate setting (subject to approval by DSS);
- Families will have a provider directory that lists all network providers statewide;
- Families who receive care coordination services will be provided with a list of network providers from which to choose, once their Individual Service Plan has been developed;
- A provider report card will be developed and published on a regular basis containing consumer satisfaction and outcome measures to guide families in their choice of network providers;
- Satisfaction surveys will be conducted by a family organization to learn the extent to which families believe they had freedom to choose from among a panel of service providers, and were not inappropriately influenced by the care coordinator; and
- Referral and authorization practices will be reviewed by DCF to ensure that these practices are not biased in favor of the LSA. Changes in LSA service volume will be monitored and service expansions may be capped as has been done in other system of care initiatives.

The LSAs will be held accountable under performance-based contracts with the DCF regional offices. DCF will set performance targets in a range of areas, including quality and cost. An incentive pool will be created and distributed among the LSAs based on their performance on quality and cost targets and adjusted for LSA enrollment. The LSAs will be required to reinvest these dollars in the service system.

The LSAs will have two ways to achieve cost targets. They can 1) use the ASO’s care management infrastructure to manage utilization and 2) develop more cost-effective approaches for providing clinical care. Care management is a critical, but challenging aspect of health services administration. It is often adversarial and thus can serve to polarize relationships within an LSA (e.g., between care management and clinical service providers) and between the LSA and its network providers. However, care management can be an effective tool for controlling costs and arguably should be among the LSA’s functions.

The second strategy, developing more cost-effective approaches for providing clinical care, is actually an array of options that include early intervention services, community-based approaches, evidence-based practice, and other enhancements in the service delivery process. An LSA’s quality management team could work with individual providers and Collaboratives to introduce more effective care practices. The LSAs will have virtually unlimited options for improving care, some of which could be supported by incentive dollars. For example, an LSA could focus on care coordinator training, new procedures for hospital diversion, teleconferencing of child specific team meetings, introduction of evidence-based practices, early intervention with young children at risk (e.g., aggressive 3-5 year olds in day care), creation of new network resources (e.g., therapeutic horseback riding), or partnerships with primary care. With respect to the latter, they might work with primary care providers to assume responsibility for prescribing for children in psychotherapy who have mild to moderate and less complex disorders. Primary care providers could assume prescribing responsibility for more complicated children for whom medication type and dose are well established. This would improve access to child and adolescent psychiatrists, reducing service costs (PCPs are less expensive and paid by HUSKY plans) without sacrificing quality.

The proposed arrangement allows the LSAs to focus on clinical care and quality without having to occupy themselves with non-clinical administrative and operational matters. The ASO is a back office available to all LSAs to help them accomplish their quality and cost objectives. The LSAs will depend on the ASO for reliable claims payment, fast and efficient contracting, and the development of clear provider and member-oriented materials. Most important, they will rely on the ASO for providing them with timely, accurate, and organized reports about how their region is performing on quality, cost, management, and outcome targets. The ASO will be subject to DCF contract incentives and sanctions based on how effective they are in serving the LSAs.

When fully implemented, KidCare will have no fewer than five and no more than twelve LSAs with responsibility for members in designated catchment areas. The LSA catchment area boundaries will be consistent with DCF regional boundaries. Any given region may contain one or more LSA service areas. To be most effective in meeting the needs of children in crisis, the LSAs will need to provide emergency mobile psychiatric services (EMPS). The LSAs may operate their EMPS programs themselves or through subcontracts. Any given LSA may operate or subcontract with one or more EMPS programs.

DCF has begun preparing an RFP for LSAs. Greater weight will be given to applicants that propose to cover more than one area within a DCF region. Selected respondents will earn the right to enter into contract negotiations with DCF. DCF will reserve the right to negotiate service area boundaries and to determine the final number of LSAs based on a variety of factors including the qualifications of respondents and financial analyses of dollars available to administer the system. Proposals may be rejected at any point in the procurement and negotiation process. DCF may choose to conduct a joint EMPS/LSA procurement within a single RFP.

The following list summarizes the functions for which the LSAs will be responsible:

Network Development

The LSAs will be responsible for developing a service network sufficient to meet the needs of KidCare members in its catchment area. LSAs will refer new services to the ASO for contract processing and DCF signature. This may require a new contract (for new providers) or an amendment to an existing contract for providers who are offering a new service. The LSA may use incentive dollars, as available, to develop the infrastructure for new services and to pay for these services until the model has been established and a fee-for-service contract is in place with DCF. The service network will be expected to encompass and embrace the ethnic and cultural characteristics of the communities they serve. Each LSA will be required to demonstrate that it has assembled a comprehensive network of providers with representation at each level of the service continuum and meeting minimum geographic access standards for any enrollee regardless of town of residence.

Care Management

Each LSA will have authority over care management decisions for children enrolled in its catchment area. DCF will provide medical necessity and level of care guidelines for use in care management reviews. The LSA may be permitted to modify these guidelines to better-fit regional resources and management objectives and to reflect the input of families, community members, and providers. These modifications would be subject to the review and approval of DCF.

Depending on the care management model, prior authorization can be required for *all* decisions to initiate or continue a treatment or it can be *selective*, focusing only on decisions that have important quality or cost implications. For example, prior authorization could be required for admission to an intensive service (i.e., inpatient hospitalization, residential treatment, or partial hospitalization), continued stay in an intensive service, or continuation of a non-intensive service that exceeds frequency or duration thresholds (e.g., 3 times/week psychotherapy or more than one year of psychotherapy).

LSAs will be expected to use a selective care management approach. The LSAs may be permitted to adjust the thresholds that trigger a care management review. It is expected that most LSAs will allow 15-25 outpatient treatment sessions without prior authorization. Assuming sufficient trust has developed between an LSA and an intensive ambulatory service provider, the LSA might also permit, for example, admission to an intensive ambulatory service for up to 3 weeks at the discretion of the program and the referring clinician, again without prior authorization. It is likely that the LSAs will manage inpatient hospital, residential, and other institutional stays more closely.

Care managers will also manage access to care coordination services for children with complex service needs. The care managers will review all new requests for care coordination services to determine whether the child meets criteria. These reviews will be subject to doctoral level co-review if the request does not appear to meet criteria. Once care coordination services have been authorized, the care coordinator will form a Child Specific Team involving the family and other persons of the **family's choosing**. The Child Specific Team will be responsible for developing an Individual Service Plan, which will outline necessary behavioral health treatment and non-medical support services. This plan would be automatically authorized unless it exceeds the usual range of service units. In that case, the LSA's care manager would be required to review and approve.

Emergency Mobile Psychiatric Services

Emergency mobile psychiatric services are the only clinical services that are not expected to operate under a fee-for-service contract managed by the ASO. Instead, the LSAs will be responsible for providing emergency mobile psychiatric services directly or by subcontract. The service model will require that teams of professionals are available to children in their homes, in emergency rooms, in schools, and in community settings. The teams will conduct immediate mental health assessments and arrange for the best available interventions including hospitalization, crisis stabilization, or immediate support services. A specialized mental health care coordinator will be assigned to provide additional support to the child and family. The care coordinator will also be responsible for referring cases to appropriate community resources and if necessary, Community Collaboratives for more intensive coordination of treatment.

Emergency mobile psychiatric services must be available 24 hours a day for immediate assessment and crisis intervention. Following initial phone screening, it is anticipated that teams of professionals will be available to children and youth that are in need of immediate face-to-face assessment. With access to psychiatric consultation whenever necessary, these teams will be responsible for admitting or diverting **all** children from psychiatric hospitalization, and for developing an immediate crisis intervention plan.

The Lead Service Agency will be responsible for oversight of this service and for ensuring that clinical teams are available and responsive to the needs of children and youth within their respective catchment areas. In addition, the LSA must ensure that appropriate crisis intervention plans are developed and implemented. For those children requiring hospitalization or crisis stabilization placement, the LSA is responsible for ensuring that appropriate discharge planning teams are convened with input from parents and that the youth is discharged to an alternative community-based step-down program as soon as medical clearance is obtained, or the non-medical facility indicates discharge is appropriate.

Care Coordination

The LSAs will be responsible for providing care coordination services to families who have children with complex service needs. The LSAs may provide care coordination services either directly or through subcontracts. Care coordinators will partner with families and be responsible for convening *child specific teams*, the development of Individual Service Plans, and monitoring the effectiveness of those plans. The child specific team will have the authority to approve an Individual Service Plan within certain limits established by the LSA's care management department.

The care coordinator will also gather and organize information from all access points within the region and establish an individual file for each child and family in a centralized database. The assessment and service planning protocol will be uniform across all care coordination agencies statewide. Care coordinators will be responsible for approximately **twelve** families. The coordinator will:

- Identify, organize and coordinate assessments based on a common protocol;
- Coordinate involvement of family advocates in treatment planning;
- Design service packages with the family and the child specific team, based on assessment results;
- Manage information and monitor service progress; and
- Assist in problem solving as identified by the family.

Whether the care coordinators are hired directly or obtained through subcontract, the majority of the care coordinators will be outposted with provider agencies throughout the service region. Every Collaborative will be expected to have care coordinators placed with one or more of the participating agencies. This arrangement will facilitate access to care coordinators by ensuring that they work within the communities that they serve. Care coordinators will be trained and supervised by the LSAs, which are ultimately responsible for the quality of their services.

In the response to the Request for Information, providers were equally divided on whether care coordinators should be hired by the LSAs. Centralizing care coordination services at the LSA provides several advantages. It supports consistency of training and supervision and it facilitates the development of a team of care coordination experts who can share knowledge and experience as they carry out these major reforms in practice. It will also ensure that there is a single point of authority, responsibility, and liability, which is especially important in the formative stages of this reform. Finally, the LSA will be better able to support care coordination decisions through the authorization process if the coordinators are part of the LSA. For example, as an employee of the LSA, the Individual Service Plan could be approved immediately by the child specific team instead of having to seek additional authorization from the LSA.

Quality Management

One of the primary roles of the LSAs will be to assure and improve quality of care in their catchment areas. They will be expected to develop internal quality management policies and procedures and to implement continuous quality improvement projects related to the adequacy, effectiveness, and appropriateness of child and family service resources. It is expected that these quality management activities will address care coordination processes, treatment and support services, cultural and linguistic appropriateness, and ongoing assessment of local resource needs.

The LSAs will work closely with DCF, their system partners, family members and the ASO to monitor and participate in quality improvement processes regarding client access and service delivery, fidelity to the Individual Service Plan/Child

Specific Team model for children requiring service coordination, and identified performance measures for both the LSA and the larger system indicators.

Staff Development

The LSAs will coordinate and conduct education and staff development for staff and network providers in collaboration with DCF and local universities and colleges (see Section X).

Family Involvement

The LSAs will work with representatives of a local family support organization to develop and support the use of family advocates for children and their families. The LSA and family support organization will work together to assure that the children and families have voice, access, and ownership in the development and implementation of their Individual Service Plans. The LSA will engage a family support organization directly in the Individual Service Plan process when a family so requests, and will also involve them in training and evaluation functions.

Community Collaboratives

A Community Collaborative is a vehicle through which local communities can provide coordinated, comprehensive services. It represents a partnership of families, providers, local and State agencies, and community members. Members of these consortia will participate in Child Specific Teams as necessary and assist children and families in their geographical area (usually one or more adjacent towns). In the past five years, DCF has supported the development of 22 Community Collaboratives throughout the State. These Collaboratives were formerly referred to as Local Systems of Care. The number of Community Collaboratives or their service areas are expected to expand until every community within the State is served by a Collaborative. Each LSA catchment area is expected to encompass one or more Community Collaboratives.

Membership

Membership on the Collaborative will include behavioral health service providers, families of children who are active participants in the system, providers of other services and supports for this population, and community members not providing system of care services (e.g., representatives from the faith based community, business, civic groups, local education agencies, and juvenile court; other professional and non-professional community members). The Collaboratives will be encouraged to adopt by-laws establishing the governance structure of the Collaborative and identify or establish a fiscal agent willing and able to receive and manage grant or incentive funds on behalf of the Collaborative.

<u>Responsibilities</u>

The responsibilities of each Community Collaborative will include:

- Participation in the Regional Advisory Council, which oversees the performance of the LSA,
- Formation of child specific teams for children with complex service needs,
- Assessment of local resource needs and service barriers,
- Assessment of the suitability of services to meet the needs of a diverse population,
- Recommending priority services and supports for LSA or State agency investment,
- Community outreach to draw in diverse community resources, and
- Public education and support.

The DCF regional offices will provide the Collaboratives with staff support to help manage these activities.

Providers

Providers of behavioral health treatment services and non-medical support services will have the opportunity to join the KidCare behavioral health service network. They will submit application materials directly to the ASO, which will manage the contracting and credentialing process.

Providers will have the opportunity to expand existing services or enter new service markets such as care coordination, therapeutic recreation, or out-of-home crisis care. Providers will also have the opportunity to expand their capacity for services delivered in the home and at other off-site locations or develop new lines of business in collaboration with community partners.

Contracted providers should anticipate that they will need to do the following to function as part of an integrated system:

- Use uniform screening and assessment protocols for children with complex service needs;
- Register new patients with the LSA or ASO for an initial episode of traditional outpatient therapy (e.g., 15-20 visits);
- Obtain prior authorization from the LSA or ASO for continued care (e.g., more than 15-20 visits) and for more complex or intensive service plans (e.g., partial hospitalization);
- Provide residential care in concert with community-based family support services;

- Become Medicaid providers as appropriate for all services including new out-of-home and community-based services;
- Participate in their local Collaborative's child specific team process;
- Incorporate the role of family-run organizations and family-to-family support into agency practice; and
- Incorporate overall performance measures for children and families into agency practice.

These changes will be supported to the degree possible through changes in the Medicaid program including the use of the rehabilitation option and targeted case management. Providers will be encouraged to become Medicaid providers for a new set of out-of-home services that will be financed under Medicaid and for an array of behavioral health treatment and non-medical support services (see Section III). The introduction of a Private Non-Medical Institutions (PNMI) option is designed to allow Medicaid participation for the treatment portion of residential treatment facility and group home admissions.

Providers will be paid fee-for-service for all or nearly all services including services that may currently be grant subsidized. During the first 1-3 years of implementation, mechanisms may be put into place to protect providers from the reduction or elimination of grant subsidies, to the extent that providers are unable to achieve necessary revenues from fee-for-service billing. In addition, the provider fee schedule will be reviewed and modified in order to introduce rates that are more advantageous to providers.

Regional Advisory Council

The **Regional Advisory Councils (RAC)** will be responsible for providing guidance and feedback to the LSAs. The RACs are comprised of participant families and representatives from DCF, DSS, schools, providers, and, representatives of Community Collaborative including members who represent the cultural and linguistic characteristics of the community, among others. Responsibilities will include:

- Review of LSA performance in comparison to standards (for quality and cost);
- Review of local service networks as compared to findings of needs assessment or other emerging issues identified throughout the catchment area; and
- Assistance in securing additional resources to increase the effectiveness of the local service network.

Department of Children and Families Regional Offices

The DCF Regional Offices will have the following responsibilities:

- Execute and oversee contracts with the LSA,
- Complete LSA readiness review prior to start-up,
- Assure appropriate involvement of breadth of systems in the design and delivery of care in the region,
- Address problems in system of services and supports at the local level,
- Provide technical assistance and support to LSAs and Community Collaboratives;
- Organize regional training,
- Coordinate regional service system development where appropriate (e.g., identify need for regional services vs. local), and
- Monitor LSA/service provider performance using agreed upon parameters.

LSA contract oversight will be a new responsibility for DCF Regional Offices. This difficult assignment will be particularly challenging in the early start-up phase when new roles and responsibilities are being worked out. Five newly appointed mental health program directors have been assigned to each DCF regional office. Among other responsibilities, they will be required participate in LSA contract management. Many provider contracts currently managed at the DCF Regional Office level will become the responsibility of the ASO to manage with DCF oversight. The child protective function and related service contracts will remain with the DCF regional offices.

V. Enhanced Role for Families

KidCare will provide families with new and expanded opportunities for involvement in the service delivery system. This involvement will occur at multiple levels, ranging from the development of Individual Service Plans to input into policy and planning. Family involvement will help make KidCare responsive to families and accountable to communities. To ensure this level of family involvement, DCF is committed to establishing a statewide family advocacy organization.

There are four areas in which the participation of families will be enhanced. These include:

- Families as partners in planning the care of their children with complex service needs,
- Families as advocates for families with children with complex service needs,
- Families as participants in regional policy and planning, and
- Families as participants in State-level policy and planning.

Families as Partners in Care Planning

KidCare is designed to bring about a fundamental shift in the care planning and service delivery process for children with complex service needs. Families of children with complex service needs will be provided with the services of a care coordinator. The family and care coordinator will become partners in service planning. Together, they will convene a child specific team composed of individuals that the family and coordinator feel are essential for service planning. This might include friends of the family or other family supports, the family advocate (see below), clergy, behavioral health and/or medical service providers, school personnel, and other members of the community who are interested and able to serve as resources or supports. The goal of the team is to develop a plan that the family feels will best support their child's health and development, and best support the family in caring for their child over the long term. This team approach will require a shift in therapeutic style for many professionals and paraprofessionals, and therefore, training and supervision will be necessary to promote the change in attitudes and skills required to support parent/professional partnerships.

Family Advocacy

Every family of a child authorized for care coordination services will be contacted by a family advocate at the point of intake. The family advocate will offer direct peer support and assistance, working to ensure that the child and family have voice, access, and ownership in the development and implementation of the Individual Service Plan. In addition to helping individual children and families with service planning, the family advocates will participate in a variety of activities designed to make KidCare more responsive and sensitive to families. They will:

- Develop local family support groups,
- Assist in training families and providers to act as partners in care planning and system design,
- Participate in the design and delivery of training curricula,
- Participate in all phases of system evaluation,
- Be represented in State, regional and local committees and Community Collaboratives (see below).

DCF will issue a Request for Proposal (RFP) to strengthen the family advocacy program throughout Connecticut. The number of full-time paid and volunteer family advocates will be increased. In addition, a system will be developed to support recruitment, training and management outside the DCF organizational structure using contracts for services.

As proposed, the family advocacy program will be responsible for the overall administration of the program as well as recruitment and training of family advocates. The family advocacy program that receives this contract will be expected to sub-contract with local and specialized family advocacy organizations that emerge or already exist in Connecticut. This will help ensure that the advocacy services are culturally competent. It is also anticipated that family advocacy "resource centers" will evolve as a result of this effort.

Regional Policy and Planning

Families will also play an important role in the development of local service systems in their own communities. There will be two vehicles for doing so. First, families will be represented on the DCF Regional Advisory Councils (RAC), which will review the performance of LSAs in their region. The RACs will review needs assessments conducted by the Community Collaboratives and they will review LSA performance data provided by the ASO. Second, families will have substantial representation in local Community Collaboratives and thus will have a voice in identifying resource needs and issues related to quality of care such as family involvement in care planning.

State-level Policy and Planning

In addition to local planning and resource development, it will be important for families to participate in statewide policy and planning. Since the inception of this initiative, families of children with behavioral health disorders have been represented on the Children's Behavioral Health Advisory Committee and have had ongoing input into the design of KidCare. In addition, families are represented on the DCF State Advisory Council (SAC) and the Children's Behavioral Health Advisory Committee to SAC, both of which advise and provide recommendations to KidCare.

Families will also be included in specialized committees established to manage the implementation and ongoing operations of KidCare. For example, families will be included on the KidCare Quality Management Committee (QMC).

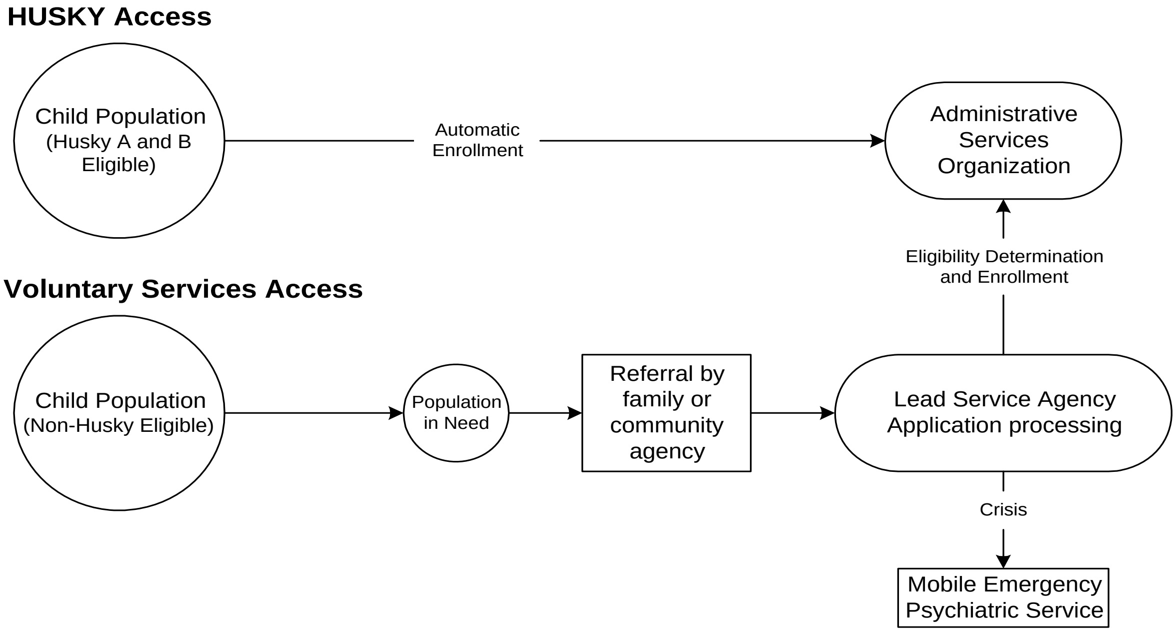
VI. Child and Family Enrollment and Service Process

Enrollment

KidCare will be available to all HUSKY A and B (bands 1 and 2) enrolled children including children under the care of DCF. Under this model, HUSKY enrolled children would automatically be enrolled in KidCare at the time their enrollment becomes effective with a HUSKY MCO. The ASO will send new KidCare enrollees a welcoming packet with a member handbook and provider directory. The handbook will describe the benefit package, the process for accessing KidCare treatment and support services, and member rights and responsibilities.

KidCare may also be available to children who qualify for services under the DCF Voluntary Services Program. Access will be regulated by DCF based on resource availability. Once the LSAs have been established, Voluntary Services referrals will be made directly to the Lead Service Agency. Children may be referred from one of the DCF child serving programs (mental health, juvenile services), the courts, schools, or through a direct request from the family/child. Parents may seek access through a provider, emergency psychiatric service or by telephone through their regional LSA or the ASO. The Lead Service Agency will be responsible for working with parents to complete the Voluntary Services application. Once the application is complete, the Lead Service Agency will forward it to the ASO for eligibility determination and assessment of cost-sharing requirements. If the child is determined eligible, enrollment will be retroactive to the first of the month on which the application was completed. The enrollment process is illustrated in Figure 2.

Figure 2: Enrollment Process



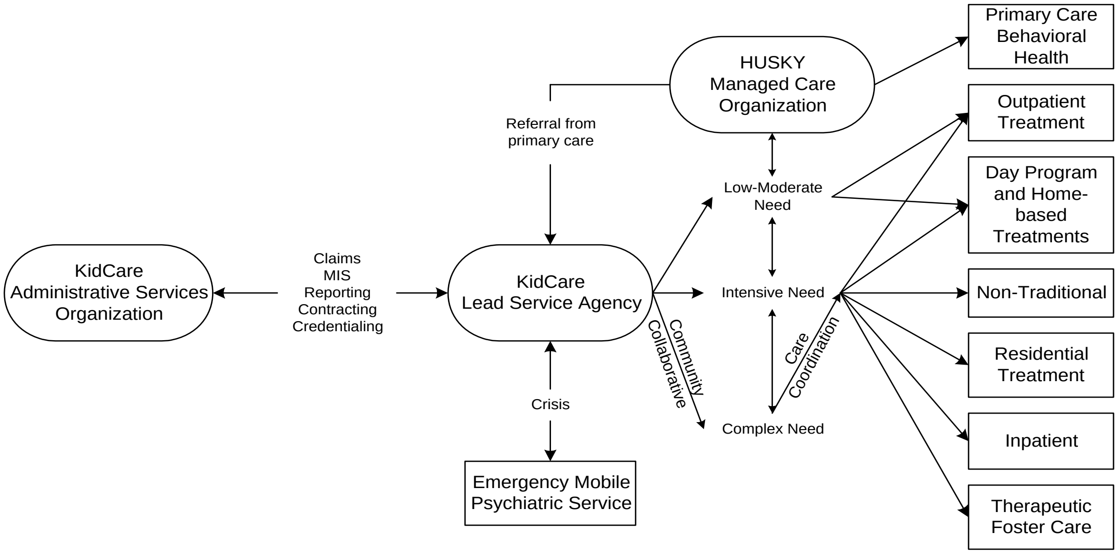
The Voluntary Services application and eligibility determination process is expected to take less than 30 days, a substantial improvement over the current 90-day average. In the case of a crisis, the LSA will expedite the application process and the ASO will be held to strict eligibility determination timelines. In the interim, the LSA will provide mobile emergency psychiatric services as necessary without charge to the family. Responsibility for the cost of care provided during the application process (e.g., outpatient therapy, partial hospitalization) will be borne by the parent or the applicable third party. If the child is determined eligible for KidCare and the parent meets cost-sharing requirements, these costs would be eligible for reimbursement. These costs will, however, be subject to third party liability requirements. KidCare is the payer of last resort. If the child is not determined eligible for KidCare or the parent does not meet cost-sharing requirements, the parent under his/her insurer will be responsible for the costs of care.

Service Process

For children with mild to moderate service needs, parents will access care in much the same way as they do now under the HUSKY program. They will be able to call KidCare Member Services for a referral or self-refer directly to an outpatient provider of their choice listed in the KidCare provider directory.

If the family and the provider believe that additional services are necessary, either more intensive or of another type, the provider can obtain authorization from the LSA, make the necessary referral, and coordinate with the new provider. The LSA will be available to assist the provider in arranging for additional services if necessary. Parents or children who are dissatisfied with their provider will be encouraged to express their concerns to the LSA or to file a formal grievance (see Section VIII). The service process is illustrated in Figure 3.

Figure 3: Service Process



Routine Screening by the LSA

Care managers will screen treatment authorization requests to assess level of clinical need. The LSA will coordinate referrals to appropriate levels of care including crisis management. Depending on level of risk and complexity of need, children and families may be offered:

- Urgent or emergency access to clinic or facility-based services,
- Emergency mobile psychiatric services,
- Family advocacy services for assistance in accessing and utilizing services, and
- Care coordination services to assist in planning and coordinating multiple services when the child and family's needs are complex.

Care Coordination Services for Children with Complex Service Needs

The new community-based services and supports available under KidCare will encourage home-based and community-based services consistent with a "wraparound" model. Wraparound involves matching intensive community-based services with natural supports to keep children with complex service needs at home, in school and out of trouble with the law. This will be accomplished through an Individual Service Plan process that "wraps" services and supports around the child/family and gives them access to the services they need within the communities where they live, work, and attend school. The Individual Service Plan process will put children and their families at the center of the planning process and service plans will be based on the needs they identify.

As is the case for any covered service, the LSAs will be responsible for determining whether a child has a complex service need that requires care coordination. The family of a child who meets authorization criteria will be offered care coordination and family advocacy services. The care coordinator will meet with the child and family to conduct an assessment and to develop an Individual Service Plan. Once the service planning process is complete, the family will have a choice of service providers in the KidCare network. Families will be given a list of qualified providers from which they can select their choice of provider.

VII. Accountability

The design of accountability measures and mechanisms is a critical component of this initiative. KidCare will rely on performance-based contracts that establish rewards and sanctions related to performance on measures of quality and cost. The ASO, LSA, and provider contracts will be performance-based. Performance on quality and cost measures will be subject to public accountability, made possible by dissemination of LSA and provider performance reports. DCF and DSS have established a workgroup to examine performance contracting options. The Departments welcome input into this important area.

Administrative Service Organization

The ASO will have a performance-based contract subject to rewards and sanctions. The ASO will be accountable for performance on a range of measures which may include the following:

- <u>Claims timeliness</u>: percentage of clean claims that meet timeliness thresholds.
- <u>First submission processing</u>: percentage of claims that are clean and payable on first submission.
- <u>Timeliness of provider network contract processing</u>: percentage of target behavioral health treatment and non-medical support services contracted in each LSA region at successive time thresholds during start-up.
- <u>Timeliness of new service credentialing and contracting</u>: Percentage of providers referred by LSA that are credentialed and contracted (or denied) within 45 days.
- <u>Accuracy and timeliness of quality management and financial data</u>: Based in part on assessment of key stakeholders including DSS, DCF, RACs, and LSAs.

Lead Service Agencies

As the entities responsible for overall performance of their regions, the LSAs will be evaluated based on both quality (e.g., good child and family outcomes) and cost performance measures. Performance targets will necessarily need to be adjusted for regional case-mix (e.g., proportion of DCF Voluntary Service and committed children). Mechanisms to support favorable LSA performance are as follows:

- *Public accountability*: A Connecticut Community KidCare report may be developed that summarizes overall performance of the entire initiative and the performance of individual LSAs on quality and cost measures. The report may be posted on the WEB, disseminated to family organizations, and made available to review and advisory entities such as the RAC, the Children's Behavioral Health

Advisory Committee to SAC, Collaboratives, and provider associations. The LSAs will be motivated to perform well in order to preserve a favorable public image.

- *Financial rewards*: A pool of resource investment dollars may be established for distribution among the LSAs based on relative performance on quality and cost targets. The LSAs would be required to reinvest these dollars in the service system. These investments could be used to "seed" or "start-up" new programs until they become part of the contracted network and eligible for fee-for-service reimbursement.

- *Contract sanctions*: No LSA will be indispensable because they will not hold provider contracts, they will not have their own management information systems and data, and it would be possible to establish a comparable administration in another agency. Consequently, failure to perform favorably could lead to contract sanctions, up to and including termination.

VIII. Grievance and Appeals

Eligibility Decisions

All children enrolled in HUSKY A or B (bands 1 and 2) will automatically be enrolled in KidCare. Children who are ineligible for HUSKY A or B may be able to access KidCare through the DCF Voluntary Services Program. Parents of children who are denied eligibility through the DCF Voluntary Services Program will follow DCF appeals procedures for this program.

Service Authorization Decisions

DCF will assume responsibility for managing the KidCare grievance and administrative hearings procedures related to service authorization and administrative decisions. Once a child is enrolled in KidCare, his or her parents will have the right to a timely procedure for resolving complaints, concerns, and appeals, otherwise referred to as grievances. This procedure will meet all State and Federal grievance requirements (i.e., Federal Medicaid and Title IV-E requirements), and will be presented in writing and described to children and their parent/custodian at the time of enrollment.

Parents will be encouraged and supported to express their grievances without fear that it will affect their child’s services. As much as possible, the LSAs will make an effort to handle grievances informally. When this is unsuccessful, parents can follow the LSA’s grievance process. When needed, translation services, including sign language interpretation, will be provided for the parents throughout the grievance process by the assigned center. Parents or caregivers pursuing a grievance will be offered the support of a family advocate. Although in most instances parents will act on behalf of their enrolled child, adolescents 16 years of age and older will be permitted to act on their own behalf.

The grievance process will be available to resolve disagreements related to the denial, reduction, suspension, or termination of services by an LSA, or the ASO in regions without an LSA during the transition period. It will also be available if the LSA/ASO fails to respond in a timely way for a request for services.

A summary of the grievance procedure, written in a manner easily understood by the general public, will be distributed to all families at the time of the child’s enrollment in KidCare. Copies will also be provided whenever requested, with all denials of requested services and whenever a parent expresses dissatisfaction with a decision eligible for administrative review.

To ensure a consumer friendly and legally appropriate grievance process, DSS and DCF have convened a grievance workgroup involving representation from the State’s Attorney General’s Office. This group is developing an integrated grievance process for all children, whether they enroll in KidCare through the HUSKY A, HUSKY B, or

Voluntary Services Programs. Although policies and procedures have not yet been finalized, the process will conform to the due process standards required under Title XIX and other applicable Federal requirements.

IX. Resource Development

In accordance with the recommendations provided in the February 2000 report, *Delivering and Financing Children's Behavioral Health Services in Connecticut*, the State of Connecticut has demonstrated a significant commitment to improving children's behavioral health. This commitment can be evidenced by the State's development and implementation of plans to enhance the infrastructure necessary to prepare for this unprecedented system change. Community-based services and intensive in-state residential services provide the foundation for future reform initiatives. Toward this end, the Department of Children and Families has issued a Community-Based Services Request for Proposal (RFP) and a Specialized Residential Services Request for Application (RFA).

During the RFI comment period, DCF and DSS received many comments from consumers and providers related to system design and administrative structure. Although comments were varied and diverse, a common concern raised by most respondents was the immediate need for service infrastructure enhancements on which to build the new system. These comments were consistent with the State planning efforts, and with the report issued by the Governor's Blue Ribbon Commission on Mental Health. The State-initiated resource development activities build on these recommendations to expand the children's mental health service delivery system.

The Community-Based Services Request for Proposal (RFP) was designed to obtain proposals from community providers willing to expand the availability of a variety of therapeutic and support services to assist children and youth with special behavioral health needs. These services include extended day treatment, intensive care coordination, home-based behavioral treatment and therapeutic respite care.

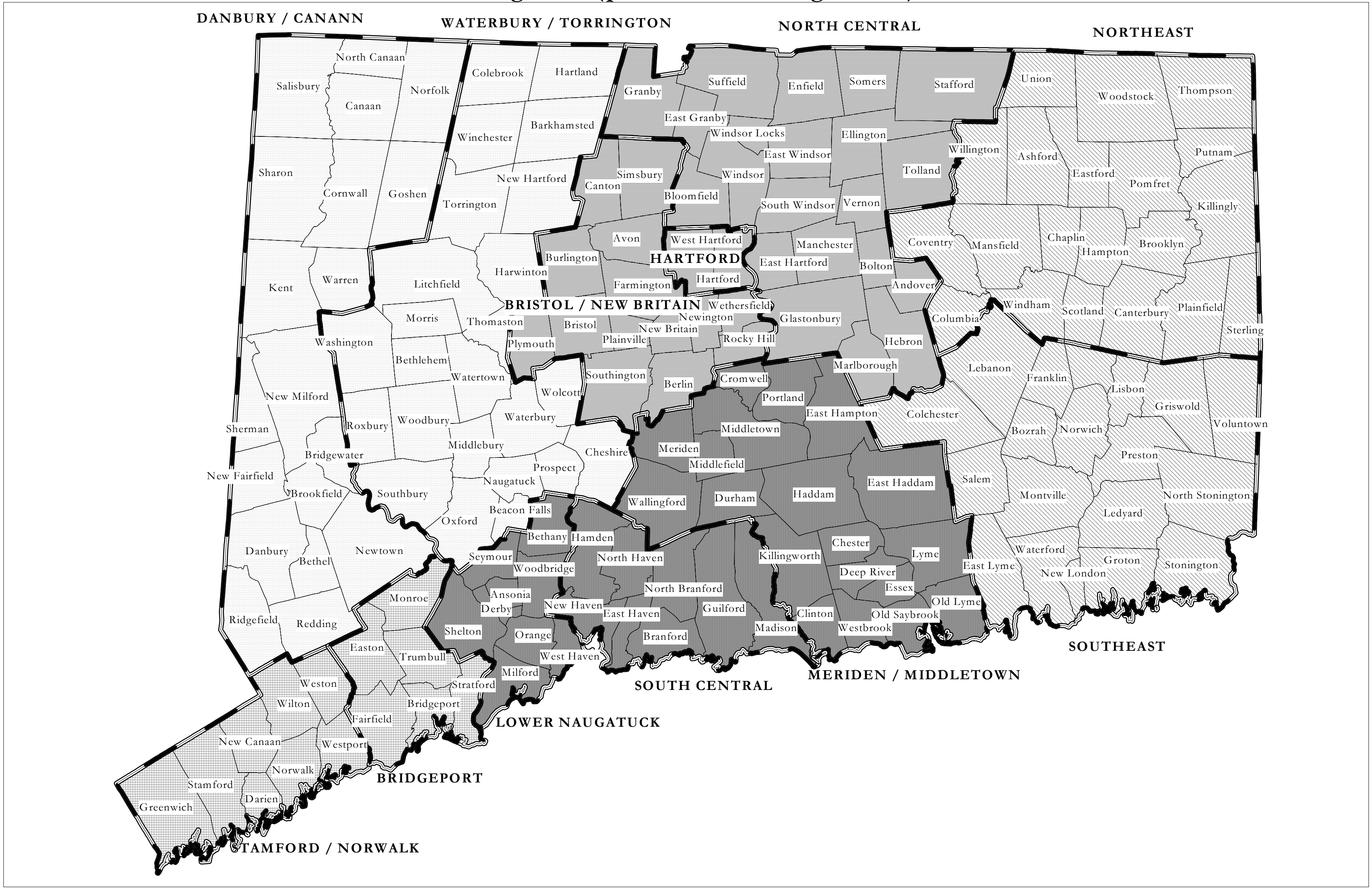
The Specialized Residential Services Request for Application (RFA) was designed to obtain proposals from residential providers willing to develop, expand or enhance their ability to provide services to youth with challenging behaviors. Such services are intended to reduce the length of hospital stays, minimize the use of hospital emergency rooms and offer alternatives to youth in detention facilities. These services will also minimize the over reliance on out-of-state residential placements.

Recognizing that emergency mobile psychiatric services (EMPS) are a key component of the children's behavioral health system, DCF is proposing a statewide enhancement of the existing structure to allow emergency mobile psychiatric teams to expand their scope of practice. The proposed model will allow for increased psychiatric coverage as well as the increased availability of mental health crisis teams who will be able to respond to a child experiencing a behavioral crisis irrespective of time of day and locality.

DCF is currently preparing to issue an RFP for EMPS programs. Figure 4 identifies the twelve areas in which the Department wishes to establish these programs. The Department is seeking to have EMPS programs operational statewide no later than July 1, 2001, well in advance of the LSA phase-in, which is scheduled to begin July 1, 2002. The EMPS programs will initially operate under a contract with DCF. As the LSAs are established, the emergency mobile psychiatric service programs will be required to be part of an LSA or to operate under subcontract to an LSA. Preference will be given to applicants that propose to cover more than one area within a DCF region, either through satellite offices or subcontract arrangements with other entities. In this case, there must be a lead applicant who will contract with DCF for coverage of the proposed service areas. DCF may choose to conduct a joint EMPS/LSA procurement under a single RFP.

The focus of these efforts is on the development of a broad array of high quality services that are sensitive to the cultural and linguistic demands of Connecticut's diverse populations and that allow youth and families to play a major role in developing treatment plans and choosing services and providers. The infusion of services along with the expanded role of families and training are viewed as the critical foundation from which the system reform will occur.

Figure 4: Proposed Emergency Mobile Psychiatric Service Areas (dashed boundary) over DSS/DCF Regions (patterned background)



X. Training and Staff Development

Background

No matter how innovative system reform efforts are, their effectiveness in improving outcomes for children and families is ultimately determined by the quality and competency of the managers and direct service delivery personnel who provide services on a daily basis. Findings of research on systems of care indicate that neither policy and administrative structural changes nor expansion in array of services will make sufficient difference if attention is not paid to what happens at the level of individual practice – in the interaction between staff and children and their families. Training, if well done, becomes the essential link that translates reforms into a different way of practice. This involves not only learning new knowledge about how a system of care approach operates, but also developing new skills, values, and attitudes relevant to understanding the developmental context of children. It also requires working with families to achieve their clinical goals, overcome barriers to change, and mobilize their available resources in a way that is family driven, community-based, and culturally competent.

Practice will not change as the result of staff just attending one-time workshops. It requires ongoing mentoring, supervision, and support, and the periodic learning of new skills. In addition, the effectiveness of training depends not only on the quality and content of the training itself, but also the environment in which the person receiving training works, and the standard setting or credentialing that confirms that competence has been attained or maintained. If the rules, regulations, organizational culture, reward system, and attitudes of supervisory staff do not support the use of the new skills and knowledge, the training will not be successful.

To assist in creating a comprehensive approach to developing a system of training that supports the implementation of KidCare, DCF has already contracted with the Child Health and Development Institute of Connecticut, Inc. (CHDI) to design a training plan and develop curriculum. CHDI is partnering with the Human Service Collaborative (HSC), of Washington, D.C. to assist in this effort. The partners of HSC bring a wealth of experience in the field of children's mental health and have provided training and technical assistance nationwide in the design, development, and implementation of systems of care for children with behavioral health problems.

Purpose of the Training

The purpose of the training will be to create and implement a competency-based curricula to improve the knowledge, skills and attitudes of front-line, supervisory, and management staff from DCF and staff in the service agencies with whom DCF contracts. The curricula will address the implementation requirements of KidCare and best service practice for the care of children with, or at risk of, serious emotional disturbances and their families. In addition, training opportunities will be developed for staff in other child-serving systems including schools and the judiciary, as well as family advocates.

The design and implementation of the training will build on the principles and practice that are the foundations of systems of care, including:

- The involvement of families in the design, implementation and evaluation of training;
- Interdisciplinary collaboration and delivery, to break down categorical and discipline specific silos;
- Cultural competence;
- Strengths-based assessment and intervention; and
- The use of natural informal supports and resources.

The training will attend to the importance of clinical and supervisory competence in a way that complements the education and experience unique to each discipline (e.g., social work, psychology, psychiatry, psychiatric nursing, special education).

Process for Designing the Training

CHDI is working with a core team in Connecticut that includes State and regional State agency staff, family advocates, community agency providers, and representatives from the Yale Child Study Center and the Department of Psychiatry at the University of Connecticut School of Medicine to design and develop the training, through the following steps:

1. Information will be gathered regarding job functions and expectations among the relevant DCF, DSS, and provider agency staff at the State, regional, and local levels.
2. Based on this information, in the context of national best practice guidelines, a set of job-related skills and competency expectations will be developed. A Competency Expectations document will guide identification of knowledge and skill areas (beyond discipline-based education and experience) appropriate for Connecticut’s front-line, supervisory and management staff.
3. A curricular outline that identifies relevant knowledge and skill content will be developed.
4. A set of complete curricula will be developed. The materials will cover basic System of Care knowledge and skills, including specialized services, drawing from existing relevant curricula developed and implemented in other States and communities (e.g., North Carolina, Pennsylvania, South Carolina, Vermont, Miami, and Santa Barbara), and adapted to the needs and requirements of Connecticut’s system. Additional elements and components will be created, to complete a set of competency-based curricula that follow basic adult learning principles. National and State experts, including family members, with

knowledge appropriate to those competency areas, will be involved throughout the project leading to products that reflect the best knowledge available.

5. The curricula will be field tested to fine-tune the materials using feedback from participants.
6. A Training Plan addressing how these curricula will be used to improve competence among front-line, supervisory, and management staff throughout Connecticut will be developed, allowing for the application of skills and knowledge in practice over time.

Training Approach

A train-the-trainers approach will be used. Initially, DCF regional management staff and resource group members will be trained. They in turn will train direct care staff. The process for training contract agency staff, staff in systems other than DCF, community collaborative members, and family members will be part of the training plan designed later this year. The initial LSAs will become learning centers, providing training for the next sites to come on board. Eventually every LSA will be expected to form partnerships with training institutions to provide ongoing training, mentoring, coaching, and supervisory support so that the training becomes a standard part of operations and is constantly being adapted to meet changing needs, with the input of staff in the field.

Examples of Competencies

The training will be targeted to a set of competencies pertinent to working in a system of care. As a starting point, these include the following:

1. Basic system of care knowledge and skills
    - Values and principles
    - Evidence-based and common practice
    - Child and family development
    - Cultural competence
    - Working with families as partners
    - The role of mental health in community care
    - Interagency and community partnerships
    - The use of natural helpers and resources
    - Wraparound philosophy and approach

  - Individual treatment planning
  - Team-based planning and management

2. Training in specific service areas, including
   - Care coordination
   - Family advocacy
   - Child and family mentoring
   - Respite care
   - Behavioral management skills training
   - Crisis interventions

XI. Quality Management

Overall responsibility for quality management will reside with DCF. DCF will establish a KidCare Quality Management Committee, which will include representation from DSS, senior management from the ASO and LSAs, and family members of children with a behavioral health disorder. The State Advisory Council's Subcommittee on Children's Mental Health will be given opportunities to review the Quality Management Committee's quality management plan and to make recommendations for revision. The ASO will be responsible for providing data and reports to support quality management.

Quality management functions fall broadly into two areas. *Clinical* quality management refers to those policies, procedures, and activities that relate to the quality of clinical care. These activities typically involve managing sentinel events (potential adverse or critical incidents), monitoring plan performance on clinical measures, and conducting continuous quality improvement. *Service* quality management pertains to those areas of administrative service that do not directly involve clinical care. These include such areas as member services (e.g., call abandonment rates), claims processing (e.g., timely payment of clean claims), and utilization management (e.g., authorization turnaround times).

Clinical Quality Management

Sentinel Event Review

A quality of care issue or *sentinel event* is defined as an event that raises the possibility that quality of care for a member was inadequate, inappropriate or otherwise compromised. Sentinel events may be identified through the complaint and grievance process, utilization management, medical record review, and member services activities. The sentinel event review and resolution process is designed to address events of all levels of seriousness including events that could place a member at risk for significant harm and/or which require immediate action to avoid an adverse effect to a member or to prevent additional occurrences.

DCF will be responsible for sentinel event identification, investigation and tracking. The ASO and LSAs will be required to apply standardized screens for sentinel events for all KidCare enrollees. DCF will provide training for ASO and LSA care managers and member services personnel in the identification of sentinel events. The Quality Management Committee will be responsible for identifying the standardized screens. Examples of screens include inpatient admission due to adverse results of outpatient care, hospital readmission within 30 days, or an incident involving child safety. Serious incidents with immediate implications for child well-being will be subject to expedited review.

When an LSA or ASO identifies a sentinel event, it will refer the event to DCF's quality management personnel for review. DCF may permit the LSA or ASO to participate in the investigation of sentinel events, but DCF will retain responsibility for overseeing and retaining documentation of this process and for presenting these events to the Quality Management Committee.

Quality Improvement

The Quality Management Committee will design and implement quality improvement activities that are statewide in focus. It will develop performance measures against which the State and Lead Service Agencies can assess the effectiveness of the behavioral health care system. This will address widespread concerns about whether system investments result in positive outcomes for children. The system will also allow State Agencies to meet program and fiscal reporting requirements to maintain and enhance Federal funding.

Data to support clinical quality improvement will be required in the areas of clinical process and outcome. These data will be collected on a statewide basis using uniform data elements, data definitions, data fields and timing in order to facilitate performance comparisons. The ASO will have primary responsibility for data collection and for assuring that key stakeholders (e.g., DSS, DCF, LSAs, Collaboratives, advisory committees, and members of the community) have timely, reliable, accurate, and informative reports that are useful for managing the system.

Service Quality Management. DCF will be responsible for monitoring and improving the quality of KidCare's administrative services. The Quality Management Committee will identify specific performance measures and standards for administrative service areas for inclusion in DCF's contracts with the ASO and LSAs. Such standards could include timeliness of claims payment, timeliness of eligibility determinations, speed and efficiency of contract processing, access to member services, reporting, reliability and ease of use of care management services, and stakeholder satisfaction.

XII. Evaluation

A high quality, systematic, comprehensive, and independent evaluation of the impact of KidCare at multiple levels is important if the State is to understand and assess the appropriateness and effectiveness of this major change. The evaluation will provide information about the services being delivered, how the services are being utilized and by whom, the extent to which services are effective, and the costs of the service system. In addition, evaluation encourages accountability, cost consciousness, and responsiveness to those in need of and using services.

It is important to select an evaluator as soon as possible so that a process and outcome evaluation can be designed and the team will be in place to collect information at the earliest point in the implementation of this reform. The evaluator will examine the process of design and development of the initiative and its implementation, and assess the outcomes, impact and cost-effectiveness. The purposes of the evaluation will be as follows:

- Measure and assess how the performance of the system influences changes in outcomes for individual children and families;
- Inform those responsible for policy, funding, and implementation to help in making decisions regarding need for policy adjustments, service planning and delivery, need for quality improvement, and training and technical assistance;
- Evaluate the effectiveness of the overall initiative in the early phases to guide future decision-making about expansion;
- Examine costs and savings associated with the initiative, as compared to costs if the initiative had not been implemented.

Integrating Service Delivery and Outcome Evaluation

Clinical assessment of children with complex service needs is an important step in the development of Individual Service Plans. When assessment data are collected over time and aggregated they become useful for evaluating effectiveness. To the degree possible, the evaluation of outcomes will be integrated into routine clinical intake and service delivery practices. Clinical and functional progress measures will be an aspect of the intake assessment process and in periodic progress assessments.

Developing clinical assessment and evaluation tools requires input from a variety of stakeholders and should target the priorities in the State where the systems operate. In May 2000, DCF developed an Assessment Advisory Committee, which is broadly representative of parents of children with behavioral health disorders, care coordinators, child guidance clinics and other providers, a psychology professor, and staff from OPM and DCF. The Committee has developed uniform client records (UCR) for referral summary, eligibility review, comprehensive assessment, service plan template, and case closing/disenrollment summary. DCF has been collecting information for one year from contracted care coordinators regarding caseload activity and individual client history of hospitalization and treatment, school attendance, and juvenile justice contacts. Now the Committee is examining the priority domains for use of standardized assessment tools, such as functioning in school, home and community; clinical status; caregiver strain; and risk, resiliency, resources and strengths. Committee members have interviewed parents and evaluators at exemplary evaluation sites around the country. The final task of the Committee will be to recommend assessment tools that correspond to the priority domains as part of a feasible strategy to be adopted statewide and incorporated into the evaluation.

Next Steps

An evaluation will be conducted to provide information about the services being delivered, how the services are being utilized and by whom, the extent to which services are effective, and the costs of the service system. The evaluation will also encourage accountability, cost consciousness, and responsiveness to those in need of and using services. DCF has contracted with CHDI to assist in the design and development of the evaluation. CHDI has secured matching grants from the Children’s Fund of Connecticut and the Connecticut Health Foundation to help support the work during this fiscal year. DCF will seek additional State and private funds for the full-scale evaluation for future years. DCF, CHDI, and DSS have convened an evaluation workgroup responsible for the development of evaluation goals and methods and the procurement of an independent evaluator.

XIII. Financing

A comprehensive and flexible benefit package is among the essential features of this initiative. It will be of value in care planning for all enrolled children, but will be especially indispensable for children with serious disorders under the care of a Child Specific Team. In order to support this comprehensive, integrated community-based service system, it will be necessary to design, develop, and implement an inter-agency blended funding model.

Full Carve-Out

DCF and DSS have decided to implement a full carve-out of the child behavioral health benefit from the HUSKY program. This means that all HUSKY enrolled children will be enrolled in Community KidCare, whether or not they have a need for behavioral health services. These children will continue to be enrolled in the HUSKY program, which will provide them with coverage for physical health problems as well as pharmacy and primary care behavioral health services. This decision is supported by a preliminary analysis of HUSKY encounter data, which indicated that children enrolled under a partial carve-out would account for more than 95% of child behavioral health expenditures; a pattern consistent with similar programs in other States. A partial carve out would leave few funds for the current HUSKY Managed Care Organizations (MCOs) to provide less intensive but necessary behavioral health services for the children not affected by the carve out. The small amount remaining for the MCOs would provide little incentive to provide adequate behavioral health services and supports that might prevent the deterioration of mild behavioral disorders. Similarly, this arrangement would discourage MCO investment in prevention and early intervention programs that might reduce the number of children with intensive needs. A partial carve out would give MCOs every incentive to shift costs and difficult cases to the LSA system, leading to disputes about responsibilities, and children falling through the cracks between the two systems. The full-carve out model will reduce fragmentation and provide much needed support for early intervention services.

Sources of Funds

The model will initially include Federal and State funds currently spent on children's behavioral health treatment services and non-medical support services through DSS and DCF. These include:

- Parts A and B of the HUSKY Program, these will be carved-out of capitation rates for existing HUSKY Part A and Part B Managed Care Organizations;
- HUSKY Plus Behavioral funds for eligible children;
- A portion of State funds currently used for reinsurance in Part A of HUSKY, redirected to community-based services;

- Title IV-E and State general fund dollars used for residential treatment, group care, and therapeutic foster care for children with behavioral health problems;

- Other DCF State and Federal funds spent on children's behavioral health services; and

- Revenues derived by billing responsible third party payers.

It is expected that fee for service Medicaid funds for Medicaid-eligible children will not be included in funding for KidCare. Children with special behavioral health needs, including those with more complex and intensive needs, are currently enrolled in HUSKY. Most of the existing fee-for-service child behavioral health expenditures are transitional, providing coverage until a child is enrolled in a HUSKY MCO. These transitional costs are considerable in part because the enrollment of a hospitalized child does not become effective until the first of the month after discharge. It is anticipated that the same policy will be adopted under KidCare. Consequently, these costs would remain under fee for service Medicaid. The costs associated with children enrolled in the Department of Mental Retardation's targeted case management program will also remain in fee for service.

During phase one of the implementation, the initiative will focus on children already participating in DCF and DSS programs. As community services are developed and more experience is gained through operation of this innovative funding mechanism, the two departments will broaden program participation within revenues to be derived from billing third parties and available appropriations. Expansion beyond DCF and DSS will also be considered in the future based on evolving discussions with the Department of Mental Retardation, the State Department of Education, and the Department of Public Health.

Case Rates and Membership Accounts

The ASO will be paid on a prospective monthly basis and will use these revenues to pay claims on services authorized by the LSAs. Under the current proposal, the State will cost settle with the ASO based on encounter data.

A Membership Account will be established for each LSA based on monthly enrollment. If case rates differ according to enrollment category, this will be reflected in the Membership Account. The Membership Account represents the total dollars available to an LSA for the provision of necessary behavioral health treatment and non-medical support services to its members. Distribution of incentive pool dollars will be based in part on the degree to which an LSA can provide all necessary services without exceeding dollars available in its account. The account will be adjusted at least monthly based on claims processed by the ASO.

Medicaid Maximization

A small working group consisting of a consultant under contract to CHDI and staff from DCF, DSS, and the Department of Administrative Services (DAS) have been working since the Spring of 2000 to develop and implement a system for maximizing Medicaid reimbursement for DCF placements in residential facilities. This project is known as PNMI, an acronym that stands for Private Non-Medical Institutions.

DCF is projected to spend an estimated $84.8 million on residential treatment in SFY 2001. A little over half the children placed in these facilities are Title IV-E eligible. Thus, much of the cost of care provided by these facilities can be reimbursed under Title IV-E. Estimated Title IV-E reimbursement for SFY 2001 amounts to $20.3 million. DCF has done an exemplary job in maximizing Title IV-E reimbursement, however, the percentage of children eligible for Title IV-E limits the amount of Title IV-E reimbursement.

DSS's Medicaid State plan currently includes coverage for DCF PNMI, but Federal Medicaid reimbursement is not claimed. The proposed maximization strategy would remedy this problem by setting up a mechanism for Medicaid reimbursement of eligible stays. Maximization would work as follows: About 90% of children placed in residential facilities should be eligible for Medicaid (Title XIX). Through use of a random moment time study applied to facility staff that have direct contract with children, the work group hopes to be able to establish the share of facility costs that may be covered by Medicaid. Conservatively the group estimates that Medicaid could cover 60% of daily facility costs. Overall, Title XIX revenue would amount to $20.8 million on an annual basis. It is important to note, however, Title IV-E could no longer cover those facility costs defined as covered by Medicaid. Therefore, capturing Medicaid revenue would lead to a loss of $11.8 million in Title IV-E revenue, resulting in a net gain of $9 million dollars.

The PNMI work group believes that the documentation necessary to support a Medicaid claim generally exists because DCF's Central Placement Team authorizes the placement of youngsters into PNMI, and because PNMI staff are professionals who document their interactions with the residents. Based on this documentation and the results of a random moment time study planned for this fiscal year, claims for Medicaid may be able to begin as early as April 1, 2001. Promulgation of PNMI regulations through the process established by the Uniform Administrative Procedures Act will take until summer 2001; so claiming will not take place until July 1, 2001. However, a claim retroactive to April 1, 2001 for in-state facilities could begin producing net additional Medicaid revenue for services in the current fiscal year. The maximization revenues generated under PNMI will be reinvested in the community-based service enhancements described in Section IX.

Management of Funds

The statewide ASO will manage expenditure of this pool of existing funds and expanded Federal reimbursements based on charges for services and supports prescribed in Individual Service Plans authorized by regional LSAs. The ASO will also directly reimburse providers of behavioral health services to children with less intensive needs.

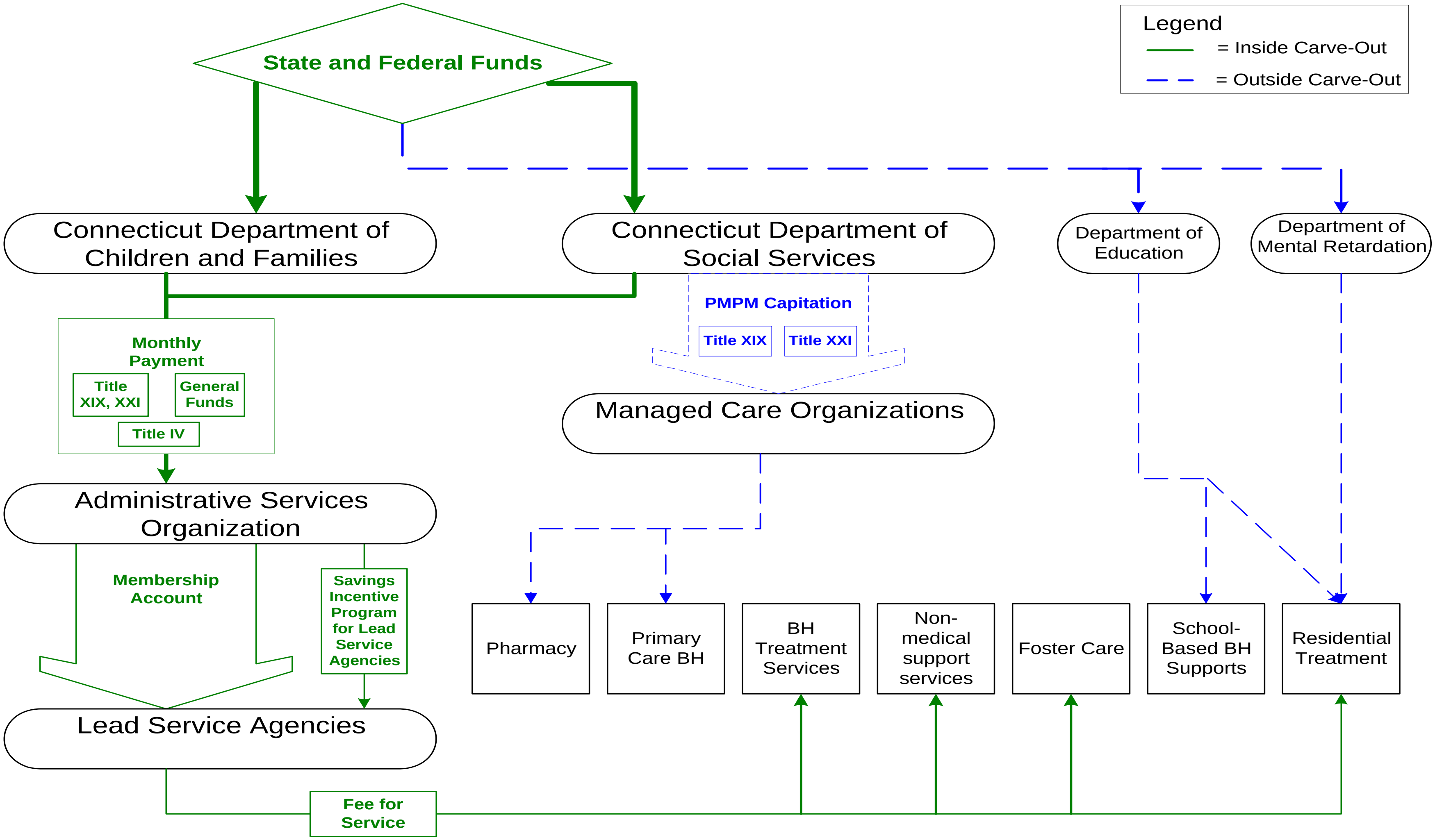
Behavioral health funds will “follow the child” rather than the categorical requirements of a particular program. For children with complex service needs, care coordinators will have access to flexible dollars for the purpose of designing Individual Service Plans that best meet the needs of children. The ASO will be responsible for tracking service expenditures and the funding source or sources from which expenditures derive. This function will be essential to ensure maximum qualification for Federal financial participation (e.g., IV-E, Medicaid, and SCHIP). Figure 5 illustrates the flow of funds.

Speed-Up

DCF and DSS recommend beginning implementation of KidCare on July 1, 2002. In doing so, the State recognizes that the real transition will not happen with the flip of a switch at midnight on June 30, 2002. In financial terms, the real transition will take place over a period that begins sometime before June 30, 2002 and ends sometime after July 1, 2002. Those who make policy and establish budgets must explicitly recognize, account for, and fund the “speed up” of funding that will occur during this transition. Before July 1, 2002, HUSKY MCOs will be responsible to provide and pay for all of the behavioral health services needed by children who are their members. At the same time the ASO will be incurring administrative expenses in the course of setting up and testing networks and systems for operations of KidCare. As of July 1, 2002 when the ASO has begun to operate KidCare and the HUSKY MCOs have ceased to be responsible for children’s behavioral health services, higher spending will occur as obligations from the previous period are discharged at the same time the new system has begun to assume its obligations.

The extent of speed-up spending and the time period over which it will be incurred depends on the implementation model. The leading phase-in strategy would have HUSKY children enrolled in the ASO all at once under the standard HUSKY A and B benefit packages. Then LSAs would be phased-in along with additional funding to support the enhanced benefit package. Under this model, there would be no HUSKY B speed-up and 30-days of Medicaid speed-up (July, 2002). DCF speed-up for SFY 2003 would be limited to those catchment areas that have been phased-in. Regional implementation would also provide an opportunity to further assess the costs associated with the new model, including costs associated with increased enrollment and utilization due to system improvements. The KidCare Budget and Finance Team is currently working on specific implementation models and budget estimates.

Figure 5: Flow of Funds



XIV. Implementation

Phase-in of KidCare is scheduled to begin on July 1, 2002. During the 18 months leading up to implementation, DCF and DSS will engage in a range of collaborative activities to prepare the community service system and the administrative infrastructure. Families, providers, and other community members will continue to play an instrumental role as planning and transitional activities gain momentum.

January 1, 2001-June 30, 2002

During the remainder of SFY 2001, DCF and DSS will prepare for a transition year in which the community-based service infrastructure will be developed and the HUSKY plan contracts will be amended to support community-based alternatives to institutional care.

Within the next six months, DCF will procure and begin funding in-state specialized residential services and selected community-based services including short-term crisis stabilization, mobile emergency psychiatric services, care coordination services, outpatient psychiatric coverage, extended day treatment, intensive home-based services, and specialized mentoring. This sizable investment in funding, supported in part by Federal revenue maximization dollars, will facilitate the return of children from residential treatment facilities and HUSKY subacute programs, as well as the diversion of children who are being considered for residential care.

In January, DSS will begin negotiating the terms of HUSKY contract extensions, which will take effect on July 1, 2001. DSS will introduce special arrangements for the management of child behavioral health services during the extension. These arrangements will be designed to encourage the MCOs to increase their reliance on community-based alternatives to institutional care. The MCOs will be expected to increase their use of community-based services and to coordinate closely with DCF caseworkers and DCF funded service providers to create comprehensive “wraparound” care plans for children with complex behavioral health service needs.

July 1, 2002 ➔

Extensive preparation will be required to lay the groundwork for implementation on July 1, 2002. During the next 18 months, DSS and DCF will be working together closely in joint policy and management teams, headed by a DCF/DSS/DMHAS Behavioral Health Policy Committee. The Policy Committee will oversee the activities of the Implementation Team, the Budget and Finance Team, and the Quality Management Team. Workgroups have been established to address the following list of deliverables:

Deliverable

Overall System Development

1. Interagency Agreement - (DSS/DCF)

Finance

2. Robert Wood Johnson Foundation grant ($100,000) to support refinancing
3. Financing/Case Rates & Benchmarking
4. 1915B Waiver and Amendment
5. HUSKY B Statutory Change

Systems Operations

6. Family Advocacy RFP Finalized / issued by DCF
7. Emergency Mobile Psychiatric RFP Finalized/ issued by DCF
8. Benefits Package
9. Voluntary Services Eligibility Criteria and Process
10. Unified/coordinated Grievance and Administrative Hearing
11. Unified Notice of Action
12. Performance based contracting and accountability structure
13. Performance measurement and reporting
14. Training and Technical Assistance Plan
    - Training and technical assistance to families
    - Training and technical assistance to providers
    - Training and technical assistance to schools
    - Training and technical assistance to State agency staff
15. LOC Local Planning and Development Process

Evaluation

16. Evaluation RFP
17. Evaluation Funding (including Robert Wood Johnson Foundation application)

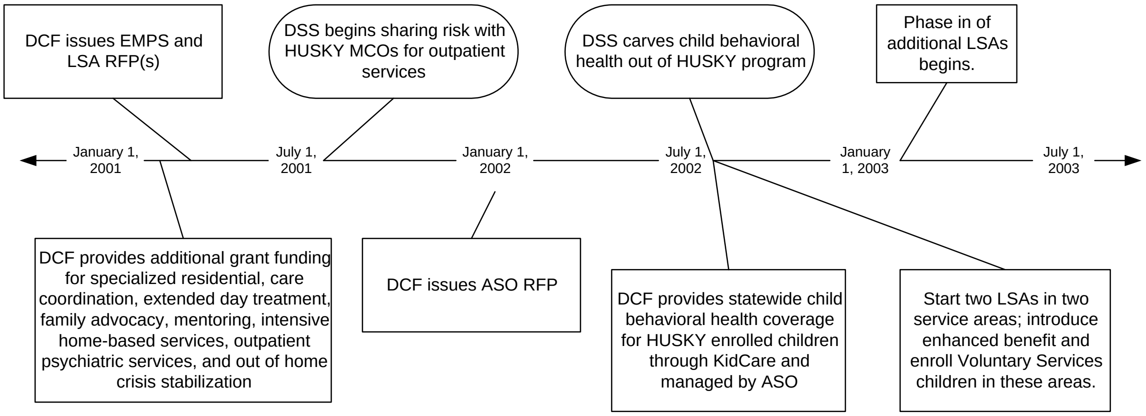
Deliverable

Administrative Structure

18. ASO Request for Proposals
19. LSA Request for Proposals
20. LSA Contract
21. ASO Contract

It is anticipated that an ASO will be procured and that enrollment will begin by July 1, 2002. Under the most likely rollout scenario, enrollment will occur at a single point in time statewide with the ASO having transitional management responsibility in any region without an LSA. Depending on progress during the next 18 months, LSAs may be introduced all at once or may be phased in during a one or two year implementation. For all other regions, the ASO will administer the HUSKY A and B child behavioral health benefits. The implementation timeline is illustrated in Figure 6.

Figure 6: Implementation Timeline



XV. Glossary

Administrative Hearing: A formal review process used by DSS and DCF. In the past, DSS has referred to this process as fair hearing. In KidCare, administrative hearing will be a DCF administered formal review process that occurs after the LSA and member have fail to find mutual satisfaction concerning treatment issues such as denials, reductions, suspensions, terminations or appropriate levels of care. It may also occur if a client is aggrieved about an administrative decision (e.g. eligibility decision).

Administrative Services Organization (ASO): An organization that provides centralized, statewide administrative services and supports for CT Community KidCare. Among the functions performed are claims processing, data reporting, contracting, credentialing, provider relations/network management, utilization management, member services and quality management. The ASO must have a utilization review license from the State of Connecticut Department of Insurance.

Adjudicated: A finding by the Superior Court for Juvenile Matters (SCJM) that a child is abused, neglected or delinquent. In Connecticut General Statutes 17a-7-8, it specifies that children found to be delinquent are committed to the custody of the DCF Commissioner.

Adverse incidents: An event of significant severity that indicates that a client's functioning is significantly compromised or deteriorating. Occurrence of an adverse incident should trigger scrutiny of the care needs of the client and the responsiveness of the system.

Appeals: A type of grievance in which a parent (or child over 16 years of age) or provider requests a formal review of a decision made regarding treatment, usually by an LSA or the ASO. The family or the provider has the right to appeal a denial, reduction, suspension or termination of treatment. Eligibility decisions can also be appealed. If a satisfactory resolution of the appeal is not achieved, the client may proceed to an Administrative Hearing.

Behavioral assistance: Behavioral assistance is designed to augment more traditional therapeutic modalities through the use of trained behavioral aides working directly with children and adolescents and their families in a home, school/work, or community setting to carry out elements of a treatment or service plan. Services generally are time limited, focused on specific goals and used to aid in the transition between levels of care or to facilitate adjustments to developmental tasks.

Behavioral health: Of, or relating to, mental health and substance abuse disorders.

Behavioral health treatment services: Those services that are necessary to diagnose, correct or diminish the adverse effects of a mental health and substance abuse disorder.

Benova: The State's contracted single point of entry service responsible for applicants and enrollees under HUSKY Parts A and B. Benova is responsible for making a preliminary determination of eligibility under HUSKY A and a final determination of eligibility under Husky B and enrolling eligible children under both Husky A and B into a managed care plan.

Call abandonment rate: The rate at which telephone calls to an organization are abandoned (discontinued) without satisfactory connection with the object of the call. It reflects failure of the organization to handle calls in a timely manner.

Care coordination: Services provided to children identified as having complex service needs. These include the appointment of a care coordinator, the formation of a Child Specific Team and the development of an Individual Service Plan, which may include both behavioral health treatments and non-medical support services.

Care coordinators: Bachelors level personnel with expertise in service planning and coordination. Care coordinators partner with parents and share responsibility for convening Child Specific Teams, the development of Individual Service Plans, and monitoring the effectiveness of those plans.

Care managers: Masters level clinical personnel who review requests for authorization of initial and ongoing services for medical necessity and medical appropriateness using written guidelines or criteria. Reviews are conducted for the purpose of quality management and utilization management.

Care management outpost: An ASO remote management site located in an LSA. Such outposts will consist of remote computer terminals with ASO management information system access and care managers trained and salaried by the ASO. Decisions to deny, reduce, suspend or terminate a review will be made by the LSA's doctoral level reviewers.

Case-mix: Categories of health plan members classified by disease, procedure, method of payment, or other characteristics usually measured or counted by aggregating groups of patients sharing one or more characteristics. Case-mix categories usually have implications for cost. Consequently, proportion of members in each category may be taken into accounting in the setting of capitation payments or case rates.

Catchment area: The geographical area that defines the extent of LSA responsibility for KidCare members. The LSA is responsible for providing behavioral health treatment services and non-medical support services to all KidCare members residing in its catchment area.

Child Health and Development Institute of Connecticut, Inc.: A not-for-profit organization established by the Children’s Fund of Connecticut to promote and maximize the healthy physical, behavioral, emotional, cognitive and social development of children throughout Connecticut.

Child specific teams: A team consisting of parents, other individuals of the parents choosing and a care coordinator that is responsible for developing an Individual Service Plan for individuals approved for care coordination services.

Children: For the purposes of this report children refers to individuals age 0-18 years.

Children with complex service needs: Children with a psychiatric or substance abuse disorder who need the most specialized, coordinated level of behavioral health services. Children with complex service needs require the coordinated involvement of multiple State agencies (e.g., DCF, SDE, DMR, Court Services, and, for older children, DMHAS). In addition to specialized treatment and educational services, families of these children often require non-medical support services such as respite and mentoring and the voluntary support of friends, relatives, neighbors, churches, supports groups, and other community organizations.

Children's Behavioral Health Advisory Committee: A committee established by legislative act to advise the State Advisory Council on Children and Families. Its purpose is to promote and enhance the provision of behavioral health services to all children in Connecticut. The Committee became active July 1, 2000. The Committee is composed of 31 members with representation from various State agencies, behavioral health service providers and family members of children with behavioral health needs. At least fifty percent of the members must be persons who are parents or relatives of a child who has or had a serious emotional disturbance or persons who had a serious emotional disturbance as a child.

Community-based care: Behavioral health treatment and support services provided on an outpatient basis within close proximity of the child's home with the intention of keeping the child functioning at maximal level in the home.

Community-Based Services RFP: A request for proposal issued in September 2000 by DCF seeking proposals from community providers to enhance the services available to children with special behavioral health needs. These services include extended day treatment, care coordination, intensive home-based behavioral treatment and therapeutic respite care.

Community Collaborative: A local consortium of providers, parents and service agencies who have organized to develop coordinated, comprehensive community resources for children with complex service needs and their families. They have responsibility for treatment planning for the children in their geographical area (usually one or more adjacent towns), community outreach and resource development, assessing community service needs, identifying services gaps and priority investment areas, and public education and support. These were formerly referred to as Local Systems of Care (LSOC or SOC).

Competency expectation document: A document delineating the skills, competencies, training and knowledge deemed necessary for frontline, supervisory and administrative staff to successfully operationalize the systems of care.

Complex service needs: See Children with Complex Service Needs.

Concurrent review: A formal evaluation of a service plan, authorization request, or medical chart while the service is being rendered (e.g., during hospitalization). The evaluation is used to determine whether continued services are medically reasonable, necessary and provided in the most appropriate setting.

Connecticut Community KidCare: The State organized initiative to reform the delivery and financing of behavioral health services for children in Connecticut. It is a statewide program designed with significant input from consumers of children's behavioral health services, providers of care, State agencies, health insurers and health care consultants. Key features include enhancement of local service delivery systems, incorporation of non-traditional services (e.g., respite, behavioral assistance) emphasis on family participation, accountability and cost-effectiveness.

Coordinated care: Care that takes into consideration all the required information on a child's condition and family's need to assure that medical and non-medical services are integrated in a manner that maximizes benefit in a cost-effective plan.

Credentialing: The process of making a determination as to the qualifications and ascribed privileges of a specific provider to render specific mental health and substance services.

Cultural competence: Behavioral health services that are responsive to the diverse racial, ethnic, gender, linguistic and cultural groups of the local community or service area. Cultural competency is demonstrated when congruent behaviors attitudes and policies come together in a service system, agency or among professionals enabling effective work in the context of the clients life experience, life style and culture. A culturally competent organization values diversity, identifies and builds on the strengths of its staff and client's ethnic and cultural tradition, manages the dynamics of difference, institutionalizes cultural knowledge and adapts services to fit the diverse norms of the community being serviced.

Day program: A class of outpatient treatment programs including extended day treatment, partial hospitalization and intensive outpatient programs.

DCF Custody: Children who are committed to the care of the DCF Commissioner due to findings in the Superior Court for Juvenile Matters (SCJM) of being abused, neglected or delinquent.

DCF Regional Office: The Department of Children and Families services are coordinated and delivered through five distinct geographic areas of the State. Each area has a regional office whose functions and responsibilities include: conducting investigations of suspected abuse and neglect; providing ongoing services to families on the DCF caseload; and planning, allocating and managing funds to community based programs that provide services to children and families.

Department of Administrative Services (DAS): The State of Connecticut Department of Administrative Services is the State agency responsible for various State functions including procurement/purchasing and human resource services. It issues bids, extends contracts, makes purchases, oversees job specifications, etc.

Department of Children and Families (DCF): The State of Connecticut Department of Children and Families is a comprehensive, consolidate State agency serving children and families. Its mandates include child protective and family services, juvenile justice services, mental health services, substance abuse related services, prevention and educational services. It is a direct provider of services, a provider of funds for private community-based services, and a licensor and monitor of private services.

Department of Mental Health and Addiction Services (DMHAS): The State of Connecticut Department of Mental Health and Addiction Services is the single State agency for providing comprehensive mental health and substance abuse services throughout Connecticut. It provides prevention services for all Connecticut citizens and treatment services to adults (over 18 years of age) with psychiatric or substance use disorders, or both, who lack the financial means to obtain such services.

Department of Social Services (DSS): The State of Connecticut Department of Social Services is designated as the State agency for the administration of the child care development block grant, the Connecticut energy assistance program, programs for the elderly, the state plan for vocational rehabilitation services, the refugee assistance program, the legalization impact assistance grant program, the temporary assistance for needy families program (TANF), the Medicaid program, the State Children's Health Insurance Program (SCHIP), the food stamp program, the State supplement to the Supplemental Security Income Program, the state social services plan for the implementation of the social services block grants and community services block grants, and Section 8 public housing.

Doctoral level: Providers or reviewers who have received a doctoral degree in either psychiatry or addiction medicine (MD or DO) or clinical psychology (Ph.D. or Psy.D.) and a Connecticut license in one of these areas.

Emergency mobile psychiatric services: Community based crisis services to prevent unnecessary placement of young people with emotional and behavioral disturbances. The service is available 7 days a week, 24 hours a day. Through this service, an emotional or behavioral crisis is stabilized.

Evidence-based practice: The conscientious, explicit and judicious use of current best evidence in making decisions about the care of individual patients. The practice of evidence-based medicine means integrating individual clinical expertise with the best available external clinical evidence from systematic research.

Family: A child or children and biological parent(s), legal guardian(s), adoptive parent(s), foster parent(s), or person acting in the place of a parent such as the person with whom the child or children legally resides and/or a person legally responsible for the child's welfare.

Family advocacy organization: An entity that provides support to families who are in need of services and/or information regarding meeting the needs of children with a serious emotional disturbance.

Family support organization: An independent organization offering family-to-family support that also collaborates with the LSAs to assure that the children and families have voice, access and ownership in the development and implementation of their Individual Service Plans.

Family-to-family support: Peer support for families of children with complex behavioral health service needs.

February 2000 report to the legislature: A report to the Connecticut General Assembly, pursuant to Public Act 99-279, Section 36, from the Department of Social Services. The report was entitled "Delivering and Financing Children's Behavioral Health Services in Connecticut" and is available through the Department of Social Services or the Department of Children and Families.

Federal financing mechanisms (Federal financial participation): Programs established by the United States Federal government for financing or subsidizing medical and non-medical services (e.g. Title IV-E, Title XIX and Title XXI). States use these mechanisms to obtain Federal reimbursement (i.e., matching funds) to help pay the cost of services and administration.

Fee-for-service Medicaid: Medicaid covered healthcare services that are not part of managed care. Many Connecticut Medicaid enrollees are enrolled in programs (HUSKY A and B, SCHIP) that utilize managed care companies to authorize and pay for their services and equipment. Some individuals with Connecticut Medicaid continue to have their services paid for in the traditional manner of having the provider of the goods or service bill for each specific good or service with payment specified by a fee schedule.

Full carve-out model: A model under which a State contracts with a specialty organization or organizations to provide behavioral health services separately from the physical health care program.

General fund: The General Fund of the State of Connecticut accounts for all receipts and disbursements not specifically included in other funds, including jointly financed State-Federal programs and certain restricted accounts. The General Fund finances the State's general operations under a budget authorized by the General Assembly in its annual Appropriations Act.

Governor's Blue Ribbon Commission on Mental Health: A Commission empanelled in January 2000 by Governor John G. Rowland to examine the mental health system in the State and to recommend how it might be improved. It issued a report in July 2000 complete with recommendations for service enhancements and needs.

Grievance: A grievance refers to any formally registered complaint or concern that is submitted in writing or that is orally communicated to DSS, DCF, or their subcontractors (e.g., HUSKY MCO, LSA). Grievances can concern clinical care or administrative decisions. An attempt is made to resolve grievances informally, but if one cannot be resolved within the timeframes established for complaint resolution, the client or family is entitled to pursue an administrative hearing.

Hardship exemption: An exemption to the eligibility requirement for enrollment into HUSKY B based on financial hardship experienced by a family as defined by an excessive expenditure for medical insurance premiums.

Health Care Financing Administration: The Federal agency that administers the Medicare, Medicaid and SCHIP programs.

Home-based services: Services provided in the home for children with special medical or behavioral health needs. They encompass a wide range of care and support services designed to enhance functioning in the home.

Human Services Collaborative (HSC): A Washington, D.C. consulting company who will partner with the Child Health and Development Institute of Connecticut, Inc. to develop training materials.

HUSKY Plan, Part A and Part B: The acronym HUSKY stands for Healthcare for UninSured Kids and Youth. It denotes State supported or subsidized health insurance coverage for children in Connecticut. HUSKY Part A refers to Medicaid covered for children under age 19 years of age and families enrolled in Medicaid Managed Care. Children whose family income is below 185% of the Federal Poverty Level qualify for Medicaid. Husky Part B provides health insurance coverage for children whose family income does not qualify for HUSKY A (the family income is over 185% of the Federal Poverty Level).

HUSKY B income bands 1, 2 and 3: The size of the State subsidy for HUSKY B depends on the family's income level. Income band 1 refers to families whose income falls between 185-235% of the Federal Poverty Level (FPL). The State pays the full premium for these families. Income band 2 refers to families between 235-300% of the FPL. The State shares the cost of the premium with these families. Income band 3 is for families above 300% of the FPL. The family may buy in at State Premium rates.

Incentive pool: A reserve of money set aside that will be distributed annually among the LSAs on the basis of their performance on a set of quality and cost targets. The LSAs must reinvest the money awarded to them in their service system.

Individual Service Plan: Personalized plan of care for a child receiving care coordination services. The plan, developed by a Child Specific Team, outlines the necessary behavioral health treatments and non-medical support services.

Intensive services: Behavioral health services (generally required by children with complex service needs) that entail more interaction and intervention than routine outpatient treatment services. These include, e.g., partial hospitalization, extended day treatment, residential treatment, and inpatient hospitalization.

Integrated funding: An arrangement in which multiple funding sources flow to a service provider in a single, integrated (or unified) stream consolidated by the payer, in this case, the ASO.

Interagency agreement: A document between two organizations that outlines their agree-upon working relationship, including roles and responsibilities for specific tasks and activities.

KidCare: See Connecticut Community KidCare.

Lead Service Agency: An agency responsible for ensuring access to and delivery of CT Community KidCare covered services for all children enrolled in a unique geographic catchment area. LSAs are responsible for care management, quality management, training, family involvement, and emergency mobile psychiatric services. An LSA may be a direct service provider.

Least restrictive environment: A tenet of treatment philosophy that holds that clients should be provided care in the setting that is most appropriate for their treatment needs while being the least confining. The continuum of restriction extends from locked inpatient hospital care to outpatient services.

Levels of intensity/care/service: Levels of service continuum organized from most intensive/restrictive (e.g., inpatient hospital) to least intensive/restrictive (e.g., outpatient treatment).

Local systems of care: A comprehensive spectrum of mental health and other support services that are organized into a coordinated network to meet the multiple and changing needs of children and adolescents with complex service needs and their families. As part of this initiative they are referred to as Community Collaboratives.

Management information system (MIS): Computer-based methods of information collection, storage, management, analysis, and reporting to support the operation and management of an organization or system.

Medicaid: The joint Federal/State program of medical assistance established by Title XIX of the Social Security Act. In Connecticut it is administered by the Department of Social Services.

Medical appropriateness or medically appropriate: Health care that is provided in a timely manner and meets professionally recognized standards of acceptable medical care; is delivered in the appropriate setting; and is the least costly of multiple, equally-effective, alternative treatments or diagnostic modalities.

Medical necessity or medically necessary: Health care provided to correct or diminish the adverse effects of a medical condition or mental illness; to assist an individual in attaining or maintaining an optimal level of health; to diagnose a condition; or to prevent a medical condition from occurring.

Member (same as beneficiary, enrollee and subscriber): An individual or dependent who is enrolled in and covered by a health care plan.

Mentoring: Mentors are volunteers from the community who are willing to spend time to encourage and support youth. DCF's "One-on-One" mentoring program is for youth ages 12 to 21 who are in out-of-home care. They are matched with caring adult mentors who provide the youth with a broader view of their future.

Mobile crisis services: See emergency mobile psychiatric services (EMPS).

National Committee for Quality Assurance (NCQA): An independent, non-profit organization whose mission is to evaluate and report on the quality of the nation's managed care organizations.

Natural community supports: Non-professional, non-paid services which may occur spontaneously in the community and which promote more successful functioning within the community. Care coordinators may help a family develop these informal, voluntary, supportive relationships in an effort to enhance their success. The supervision of these supports is reimbursable when it is part of the Individual Service Plan.

Needs assessment: A needs assessment is the process of documenting the current health system's operations ('what is') and identifying the required changes in the system to improve its functioning and eliminate gaps in the system ('what could or should be'). It is a step in the planning process for system enhancement.

Non-medical support services: An array of services traditionally not covered as medical procedures, which are used to help a child (or family) function safely and more effectively in the community. The services are employed to prevent the need for more restrictive levels of care or divert placements out of home. Among the services included are behavioral assistance, family-to-family support, respite care, and supported recreation.

Office of Policy and Management: The staff agency to the Governor of Connecticut. Its mission is to provide information and analysis that the Governor uses to formulate public policy goals for the State of Connecticut and assist State agencies and municipalities in implementing policy decisions on behalf of the people of Connecticut.

Out-of-community: A child-caring facility such as a residential treatment facility that is outside the child's community, either in or out-of-state.

Out-of-home placements: Placement of a child, either temporary or permanent, outside of the family home. This may refer, for example, to hospitalization, foster care, residential treatment, therapeutic foster care, or group home treatment.

Out-of-state placements: Placement of a child in a residential facility or foster home outside of the State of Connecticut.

Outpatient treatment: Treatment provided to a client on an outpatient basis, i.e. the client is not receiving room and board and professional services on a continuous 24-hour-a-day basis.

Parent: For the purposes of this document a parent is broadly defined to include not only the child's biological parent, but also the legal adoptive parent or guardian, foster parent, step-parent or other person who is recognized by the child and provider as the primary caretaker of a child in treatment.

Partial carve-out model: A model under which a State integrates some behavioral health services into a physical health benefits program, but place other (and often expanded) behavioral health services or populations under a separate managed care program.

Performance measurement: Objective assessment of how well the behavioral health care system carries out specific functions or processes. Areas of special concern include financing, administration, clinical process and outcomes. The ASO will be responsible for collection of performance measurement data and reporting to key stakeholders such as State agencies, families, providers and advisory committees.

Placement disruption: A foster care arrangement that has broken down and is discontinued, temporarily or permanently.

Primary behavioral health care: Behavioral health care provided by primary care providers or allied health professionals in primary care settings. Primary behavioral health care may include screening, evaluation, referral, medication management and counseling services.

Primary care provider: Medical providers of primary health care services (e.g., Internists, Family Practitioners, Pediatricians, Gynecologists, Physician's Assistants, Advanced Practice Registered Nurses).

Prior authorization: Approval of a service before the provider actually provides the service.

Private non-medical institutions (PNMI): An optional Medicaid covered service. A PNMI is not a health care facility but rather a private (as opposed to public) residential institution that may provide some medical services.

Prospective review: A formal evaluation of a service plan or authorization request before the service is rendered. The evaluation is used to determine whether the proposed services are medically reasonable, necessary and provided in the most appropriate setting.

Provider: Any individual or group of individuals (such as physicians, hospitals, group practices, nurses, child guidance clinics, social workers, psychologists, family service agencies, or pharmacies) that provides a KidCare reimbursable service or support.

Public Act 97-272 (see system of care): State legislation passed in 1997 that adopted the national 'system of care' approach identifying a set of core values and guiding principles for Connecticut's services for children and adolescents with serious emotional disturbances.

Psychiatric hospital: An accredited or State licensed institution that is engaged in providing hospital level psychiatric services, under the supervision of a physician, for the diagnosis and treatment of mentally ill persons.

Quality assurance (QA): A formal set of activities to review and safeguard the quality of services provided. QA includes quality assessment and implementation of corrective actions to address any deficiencies identified in the quality of care and services provided to individuals or populations.

Quality improvement (QI): The effort to assess and improve the level of performance of key processes and outcomes within an organization. Opportunities to improve care and services are found primarily by examining the systems and processes by which care and services are provided.

Quality management (QM): A program of systematic and objective activities designed to continuously monitor, evaluate, and improve the processes of delivering mental health and substance abuse services to enrollees. Quality management targets both clinical care issues and administrative services performance. Quality management includes both quality assurance and quality Improvement functions.

Quality Management Committee (QMC): A joint DCF/DSS committee with overall responsibility for quality management for CT Community KidCare. Among its functions will be sentinel event tracking and reviews, quality improvement and establishment of uniform LSA grievance processes.

Regional Advisory Council: Advisory councils representing each of DCF's five regions of the State. Each council is made up of providers and consumers from that region. Along with the statewide Advisory Committee they participate in advising DCF on the development, implementation and management of needed services.

Rehabilitation option: An option available to State Medicaid programs to cover "services recommended by a physician or other licensed practitioner of the healing arts, within the scope of his (or her) practice under State law for maximum reduction of physical or mental disability and restoration of a recipient to his or her best possible functional level." Among other possibilities, this allows for coverage of residential treatment for behavioral health disorders to be included in the Medicaid benefit.

Request for Application (RFA): A document issued by a company or agency that is seeking applicants who qualify to perform specified functions or services. Individuals or entities that meet the criteria are under no contractual obligation to perform the function or service. For example, the Specialized Residential Services RFA will qualify applicants to provide the specialized services but will not obligate any of them.

Request for Information (RFI): A document used to solicit input from interested individuals on such issues as program design and network development and capacity, and to seek information on potential bidders.

Request for Proposals (RFP): A document issued by a company or agency calling for proposals from organizations to perform functions and responsibilities to specifications developed by that company or agency. It is the basis for a fair, open, and competitive procurement process. Based on the response, one or more organizations may be selected to receive a contract.

Residential treatment facilities (RTFs): The most intensive of the residential treatment services. RTFs provide integrated, longer-term treatment services for children and youth who are unable to function in their home, school and community. These facilities offer a 24-hour, seven day per week integrated treatment environment, including on-campus schools.

Residential treatment services: A therapeutic out-of-home living situation that includes an array of services that is less intensive than inpatient hospitalization but more intensive than shelters or group homes. Examples include: residential treatment facilities, (RTF's), therapeutic foster homes, *specialized* group homes, and supervised apartments.

Respite: Temporary supervision including crisis stabilization and temporary residential services, provided to individuals living with family members, family care providers or significant others, when short-term relief is needed. Respite care can be provided in or out of the home during the day, evening and/or overnight.

Retrospective review: A formal evaluation of a service plan, authorization request, or medical chart after the service is rendered. The evaluation is used to determine whether the services were medically reasonable, necessary and provided in the most appropriate setting.

Sentinel event: An event that raises the possibility that quality of care for a member was inadequate, inappropriate or otherwise compromised. They are reviewed as part of the ongoing clinical quality management activities.

Serious Emotional Disturbance (SED): A serious emotional disturbance is defined by the Federal Center for Mental Health Studies as a range of diagnosable mental, behavioral or emotional disorders of sufficient duration to meet diagnostic criteria specified within the official Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition (known as DSM-IV). By definition, these disorders result in functional impairment that substantially interferes with or limits the child's role or functioning in family, school, or community activities.

Service area: The geographical area for which a provider is contractually obligated to provide services.

Specialized Residential Services RFA: A request for applications issued in August 2000 by DCF for residential service providers. The RFA was designed to encourage the enhancement, expansion and development of various residential services available in the State of Connecticut for those children and youth needing this level of care. These services are intended to reduce the length of hospital stays, minimize the use of hospital emergency rooms and offer alternatives to youth in detention facilities. These services will also minimize the over reliance on out-of-state residential placements.

State Advisory Board: A subcommittee of the statutorily mandated DCF State Advisory Council.

State Advisory Committee (*Council on Children and Families*): A statewide consumer and provider body appointed by the Governor which, along with the Regional Advisory Committees, is one component of the Department of Children and Family's planning and advisory structure.

State Children's Health Insurance Program (SCHIP): The State Children's Health Insurance Program is a State administered, Federally subsidized health insurance program for targeted, low-income children as established by the Federal government under Title XXI. It is also sometimes referred to as CHIP.

State Department of Education (SDE): Connecticut's State Department of Education is the State agency responsible for certification of teachers, approval of private educational residential facilities, regulation of primary education, and other functions. By virtue of the schools' extensive role in children's lives, SDE is a partner in many initiatives designed to improve the welfare of Connecticut's children.

State Interagency Policy Committee: The State-level advisory committee responsible for overseeing the strategic planning and the development and implementation of the expanded systems of care for CT Community KidCare. The committee will have representation from families as well as DSS, DCF, the State Department of Education, the Department of Mental Health and Addiction Services, the Department of Public Health, Court Support Services and the Office of Policy and Management.

Subcontract: The act of delegating contractual obligations between two original parties through a second contract with a third party.

System of care: A system of care is a comprehensive approach to coordinating and delivering services from multiple agencies for children with complex behavioral health service needs and their families. The approach is designed to be community-based, coordinated, family-centered, culturally competent and individualized.

Targeted case management: Case management services that provide children with guidance in accessing services so that multiple services are delivered in a coordinated and therapeutic manner. This allows a child to move efficiently through a system of care in accordance with his/her changing needs. Under KidCare, targeted case management is referred to as care coordination.

Targets (quality, cost, performance, outcome): Performance goals that are set in the areas of quality, cost, and outcomes. Measurement of the LSA's ability to reach the targets will be one method of fostering quality and cost accountability.

Therapeutic foster home: Also known as treatment foster care is foster care for children with special needs. The treatment agents are foster parents in a family setting who have received special training, are highly skilled, and are provided with strong support services.

Title IV-E: The Federal program that provides board and care for children place out of home for child welfare purposes.

Title XIX: The current State Medicaid program.

Title XXI: The State Children's Health Insurance Program (SCHIP).

Training plan: CT Community KidCare plan to implement a competency-based curriculum to improve the knowledge, skills and attitudes of front-line, supervisory, and management staff from DCF and staff in the service agencies with whom DCF contracts. The ongoing training will provide understanding of the key values and concepts of CT Community KidCare and best service practice for the care of children with, or at risk of, serious emotional disturbances and their families.

Urgent service: A medical service is considered urgent if a delay in getting the service would lead to serious medical consequences within one (1) to ten (10) days.

Utilization management (UM): The process of evaluating and determining the appropriateness of the utilization of behavioral healthcare services, as well as providing any needed assistance to clinician or patient in cooperation with other parties, to ensure appropriate use of resources. Utilization management typically includes prior authorization, concurrent review, retrospective review, discharge planning, and case management.

Utilization review: A formal evaluation (prospective, concurrent or retrospective) of a service plan, authorization request, or medical chart using objective written criteria or guidelines. The evaluation is used to determine whether the services are medically reasonable, necessary and provided in the most appropriate setting.

Voluntary Services Program: A DCF sponsored program available to children with complex behavioral health service needs who are not in the care of DCF, do not qualify for HUSKY A or B, and who are otherwise uninsured or underinsured. The services can include residential services and all services available through local systems of care, including extended day treatment.

Withhold: An incentive mechanism to support a performance based contract.

Wraparound coverage: Ancillary social and rehabilitative support services for persons with behavioral health disorders. The appropriate mix of wraparound services would be individually determined as part of the person's treatment plan. The following services are commonly regarded as wraparound services: transportation; assistance with housing; vocational and employment-related services; educational support services; legal or financial counseling; domestic violence support services; nutrition education; parenting courses and training; and child/adolescent support services (including child care, after school programs, teen centers, mentoring programs, recreational, programs and cultural enhancement). A commitment to cover wraparound services as described in this document does not necessarily include all services mentioned above. In addition, other entities (e.g., State Department of Education, HUSKY MCOs) may be expected to cover all or a portion of the cost of some of the listed services.

Wraparound philosophy: A philosophy of care that includes a definable planning process involving the child and family that results in a unique set of community services and natural supports individualized for that child and family to achieve a positive set of outcomes.