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A PLAN FOR CHILDREN'S MENTAL HEALTH SERVICES

In Response to the 118th Session of the Maine State Legislature Joint Standing Committee on Health & Human Services

L.D. 1744, (1997 Resolve, Chapter 80) To Plan for Services for Children with Mental Health Needs

Submitted December 15, 1997 by:
The Department of Mental Health, Mental Retardation, Substance Abuse Services in consultation with: the Departments of Human Services, Education, Corrections and representatives of parent groups, providers and legislators

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For additional information or questions, contact Robyn Boustead at 287-4251.

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I. EXECUTIVE SUMMARY

This document, ***A Plan for Children's Mental Health Services***, represents the final report to the 118th Maine Legislature's Joint Standing Committee on Health and Human Services, as required by LD 1744, 1997 Resolve, Chapter 80. The plan culminates six months of intensive effort on the part of Maine's child serving state agencies, parents of children with emotional and behavioral needs, legislators, providers of children's mental health services, and many other interested people from all geographic areas across the State of Maine.

The Department of Mental Health, Mental Retardation and Substance Abuse Services was charged to take the lead role in designing a comprehensive, integrated system for managing the delivery of children's mental health services in the State of Maine. Accordingly, this plan does not focus solely on the mental health services funded by and provided through DMHMRSAS. Rather, all stakeholders acknowledge that the Departments of Human Services, Education and Corrections each play a meaningful part in the lives of these children and their families, and will continue to do so in the future.

The Plan for Children's Mental Health Services is unprecedented in its comprehensive scope, by the commitment of its participants, and in its contents. The plan's features include:

Current data, developed specifically for this report, and available to members of the Design Team, provides a foundation for planning. The data estimate that at least ***42,000 Maine children have behavioral or emotional service needs*** serious enough to warrant treatment , and that 27,500 are challenged by serious emotional and behavioral difficulties. Information about services provided across all four child serving agencies, counting both state and federal funds, show expenditures which impact children's mental health services estimated to be as much as $151 million in Fiscal Year 1996. Of the $68 million in Medicaid funds spent on behavioral health services for Maine's children, three out of four dollars were spent in the most costly and restrictive out-of-home treatment alternatives, reducing Maine's capacity to develop community services and limiting the number of children who can be served.

A values based foundation, endorsed by all participants promotes a system which is ***child and family centered*** . The strengths and needs of the child and family dictate the types of services to be provided through an individualized planning process, with families/guardians às equal and full participants. Services must be outcome based, with management and decision-making responsibility residing at the local level. Shared values require that services are delivered in the least restrictive and most clinically appropriate environment, with safety as the first priority. Stakeholders agreed that prevention and early intervention enhance the likelihood of positive outcomes and that transition to adult services, when needed, must be ensured and supported.

The structural centerpiece of this plan is the development of a system of care, rather than fragmented, piecemeal responses that characterize children's mental health across the child-serving agencies today. A system of care for children must have a single management authority, a single mission and a common set of values. The plan endorses an ***integrated system of care, led and managed by DMHMRSAS.*** In this system, entry may come from any point in the community and will occur when a mental health need is first identified.

Services will be provided through a ***Local Service Provider Network***, part of the systems infrastructure under development by the DMHMRSAS. The management structure for this system will be through the ***Network Manager***, an independent entity under contract to the department, that represents the single point of gatekeeping authority and accountability for the assessment of need and delivery of services in the local area.

On a day to day basis, the system of care will be managed by ***the Child and Family Team***, utilizing an individual planning process. The process envisions that whenever a child needs the services/supports of multiple systems, direct care workers from each of these systems will come together with the case manager, family and other individuals identified by the family to develop an individual service plan. The team will address issues across all domains to ensure consistency of approach, sanction the blending of resources across agency lines and coordinate services from multiple agencies into a unified plan of care. Multi-agency cases may also be supported through a ***Local Case Resolution Committee*** or the ***Regional Children's Cabinet***.

The plan establishes and defines ***Core Mental Health Service Components*** that are necessary to support the system of care. These service components include: prevention; crisis intervention; case management; family and child supports; clinical services; and residential treatment. The core service array is intended to provide a blueprint for developing service capacity in the seven local service areas of the state. Each of the child-serving state agencies currently provides or funds a number of these services within its own domain.

The Plan addresses ***state agency roles and responsibilities***, including new and proposed ***Interagency Memoranda of Understanding***. Participants recognize that the mental health needs of many children, youth and families served by DHS, DOC, DOE and schools are adequately met by those systems, and responsibility for delivering those services will remain within the existing agencies. However, in the proposed system of care, closer linkages between the systems will result in DMHMRSAS playing a major role in developing, providing and monitoring mental health services within the other child-serving agencies.

Financing strategies to support the development of this system include selective restructuring of Medicaid, redirection of funds from institutional settings to community-based services, expanded access to federal Title IVE dollars and flexible use of state and federal block grant funds. Mixing categorical and flexible resources in new ways will result in individualized services that meet a child's unique needs, as opposed to rigid funding that creates wasteful, "one size fits all" program slots. Through ***blended funding***, parts of each agency's resources can be used to fund a plan so that services and supports can be provided in a way that maximizes all revenue resources.

The plan addresses ***implementation strategies*** to begin the development of a comprehensive system of care for children and their families. A multi year ***service development sequence*** outlines the types of services that will be needed to support a complete system of care. These service needs were derived from current ***service capacity*** data that show the current utilization of core mental health services, statewide. The capacity study then estimates future need for discrete services. The results indicate which services will require additional capacity and which services show excess capacity. ***The data show priority needs to develop crisis services, case management, in-home behavioral health and outpatient services***, among others. Excess capacity is shown for acute inpatient and group homes/residential services. The plan concludes with a detailed ***First Year Implementation/Work Plan*** focusing on administrative, policy and regulatory priorities to be addressed through January, 1999.

II. INTRODUCTION

HISTORY OF LD 1744

During the first session of the 118th Legislature, members of the Joint Standing Committee on Health & Human Services (H&HS) passed a Resolve "To Plan for Services for Children with Mental Health Needs," which became Chapter 80 of the laws of 1997.

The impetus for the Resolve was a series of events and issues relating to children's mental health that came to the committee's attention during the course of the session. Because these issues touched all of the child-serving state agencies, the committee shaped the Resolve to address problems in the system from a comprehensive perspective.

The Governor's Office and the Joint Committee demonstrated their commitment to a meaningful, permanent solution to the problems facing Maine's families by designing the Resolve as a vehicle for structural systems change. LD 1744 calls for the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS, or the Department) to take the lead role, in consultation with the Department of Human Services (DHS), the Department of Education (DOE) and the Department of Corrections (DOC), in designing a comprehensive, integrated system for managing the delivery of children's mental health services in the State of Maine.

THE PLANNING PROCESS

Immediately following passage of Chapter 80, the Department created a steering committee to guide the mental health system design planning process, with membership representing all major stakeholder groups. The steering committee included policy level representatives from each of the child-serving state agencies, three members of the H&HS Committee, and representatives from the mental health service providers' organization and the statewide parent organization. The Commissioner of DMHMRSAS served in an ex-officio capacity.

The steering committee assumed responsibility for managing the overall planning process. Tasks included organizing a division of labor, defining manageable workgroup responsibilities, establishing a workplan to address the tasks required by LD 1744, maintaining communication among stakeholders, and sanctioning changes in direction or timetables when necessary.

Workgroups comprised of representatives of all stakeholders were organized to address three topic areas: systems/access, services and supports, and finance. Beginning in June, the three workgroups met on the average of twice a month, and maintained coordination with one another by meeting as a large group once a month. For each topic area, workgroups came to agreement on overarching principles, identification of barriers to effective services for children, and strategies to overcome the identified barriers. The intense work over the summer built a collaborative atmosphere among the state departments, providers and parents. There is a strong commitment among all the stakeholders to the creation of a mental health system for children. More detailed discussion of the planning process and a list of all participants is included in Appendix A. Almost a hundred individuals participated as members of the overall "Design Team".

Section Two of LD 1744 required that DMHMRSAS and DHS review current Medicaid rules for children's mental health services, and adopt new rules consistent with the goal of providing a comprehensive network of children's mental health services in the least restrictive and most appropriate settings. In order to implement this section of the Resolve, staff from the two Departments met a number of times, and with the assistance of an expert consultant, conducted a review of Medicaid rules applicable to providing care and treatment for children (see section on Medicaid Rule Review and the report as Appendix B).

The planning process focused on designing a children's mental health system to assure easy, family-friendly access and a complete and comprehensive range of services and supports, financed through a creative blend of existing resources as well as reallocation and redistribution of existing dollars. The workgroups also analyzed recent utilization and cost data. The plan that follows is based on recommendations from the three workgroups.

WHO ARE THE CHILDREN?

Recent national epidemiological estimates from the Center for Mental Health Services project that between 14 percent and 20 percent of children and youth between the ages of 0 and 18 years of age have mental health problems serious enough to require treatment (6.8 to 9.8 million children nationally), and that 9 percent of children and youth experience serious emotional and behavioral disturbances (4.4 million children). Applying these prevalence rates to Maine, it is estimated that between 42,000 and 61,305 children experience behavioral and emotional problems, and approximately 27,500 are challenged by serious emotional and behavioral difficulties.[1]

The following statistics are based on a national evaluation of 22 community-based systems of care for children and families:[1]

Children Served in Community Systems of Care

- The children served are predominantly male (63% boys, 37% girls);
- Most children (74%) are between the ages of 6 and 15 years, with an average age of 14 years;
- 35% of the children have a history of physical abuse and 25% have experienced sexual abuse;
- A substantial percentage (42%) of the children live in single-parent homes;
- Over one quarter (29%) of the children have experienced one or more previous inpatient psychiatric hospitalizations;
- Two-thirds (67%) of families and 81% of single-parent families served are living below federal poverty level;
- Two-thirds of families served are challenged by mental illness, domestic violence, and/or substance abuse.

[1] Report from CMHS Strategic Planning Meeting, June 18-19, 1997, Washington, DC. The descriptive profile is based on data obtained on 11,497 children and youth involved in the Center for Mental Health Services National Evaluation of the Comprehensive Services Program for Children and Adolescents.

One of the twenty-two comprehensive service demonstration sites funded by the Center for Mental Health Services is located in four counties in northeastern Maine. Called the Wings Project, it has funded and evaluated a local approach to coordinated services for children with serious emotional disturbances for the past three years. The following chart compares children and families served in the Wings Project to the national profile

Comparison of Children and Families Served - Wings vs. CMHS National System of Care Profile

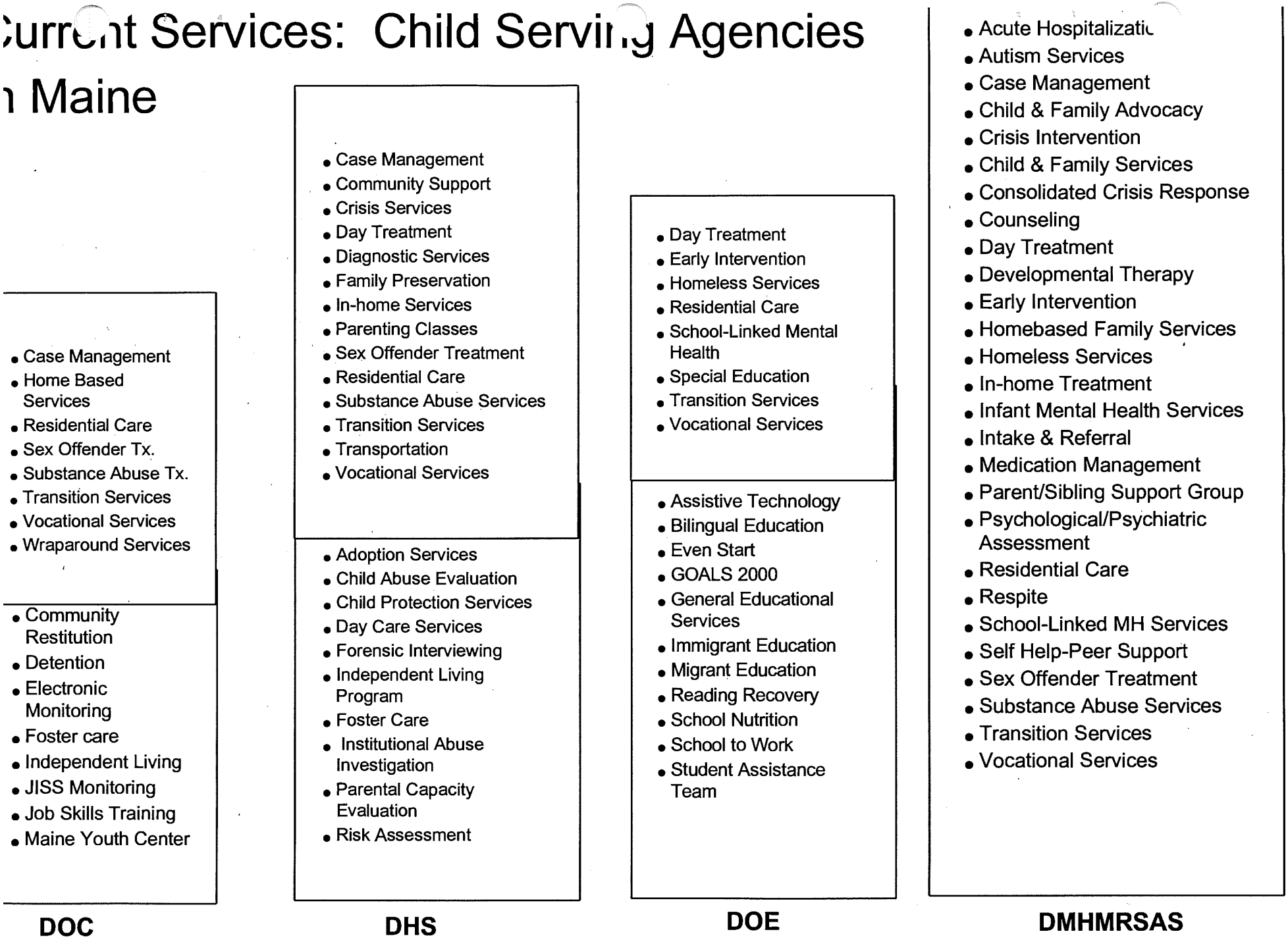
	Wings (n=275)	CMHS National Study (n=11,497)
Gender: Male	65%	64%
Female	35%	36%
Average Age	12 years	14 years
Single-parent Families	49%	42%
Families Living with Poverty	50%	67%
Previous Psychiatric Hospitalizations	54%	29%*
History of Physical Abuse	44%	35%*
History of Sexual Abuse	38%	25%*
Mental Health Problems in Family	60%	41%
Family Violence	62%	56%
Family History of Substance Abuse	63%	62%

These data show that in the four project site counties in Maine, children with serious emotional disturbance have a slightly higher incidence of physical and sexual abuse and a higher rate of mental health problems in the family than the national comparison group. Even more strikingly, children in the Maine project are hospitalized at almost twice the national rate. This finding reflects the lack of community-based services throughout the state, resulting in an over-utilization of inpatient services.

A need for mental health treatment and supports may originate from any single or combination of factors which may be neurobiological, genetic, environmental, or traumatic in nature. Any of these factors can decrease a child's well being or ability to function across any or all domains of his/her life (residential, education/work, interpersonal relations, physical/psychological, safety, legal, and spiritual/cultural). Mental health services are those clinical interventions and supports which help stabilize emotional and behavioral problems and teach children the self-management and social skills needed to improve their level of functioning. Clinical expertise from the mental

health system may be used to support children in the context of other service settings, for example, assisting the school in the reduction of the behaviors which are interfering with a child's ability to stay in school. Similarly, expertise from the school system may be invaluable for the clinician in establishing how a child learns so that behavioral plans are developed within a context that the child can understand. An integrated system of care brings each system's expertise together in order to address the needs of the "whole" child.

Current Services: Child Serving Agencies in Maine



: Shaded areas represent specialized services available to children with mental health needs.

LD 1744 - MH SERVICES BY FUNDING SOURCES AND DEPARTMENT

SERVICE CATEGORIES	DMHMRSAS	DHS	DOC	DOE
Case Management • Targeted Case Management	General Fund, Medicaid, PATH, Wings	General fund, Title IV-B, Family Pres.	General Fund, Medicaid, Federal OJJDP, County Corr.	General Fund, Medicaid, Part H
Outpatient • MH Day Treatment • Infant MH • Children Outpatient • Children Medication • MH Adult Outpatient • Interpreter Services • All Psychologists • Psych Examiners • Psych RN/MSW • Hospital Outpatient • Psych Hospital Outpatient • Physicians/Psychiatrists	General Fund, Medicaid, Block Grant	General Fund, Medicaid	General Fund, Federal Justice Assistance	
Residential • Residential Treatment Center • Group Care/ Residence • Therapeutic Foster Home • Out of State	General Fund, Medicaid, Private Non-Medical Institution (PNMI)	Medicaid, General Fund, Title IV-E	General Fund, Medicaid	General Fund, Local Educational Authority (LEA) (Educ. Cost for Res. Treat. Center)
Crisis • Crisis Response • Crisis Beds • Emergency Shelters	General Fund, Medicaid, Block Grant, OSA-Shelters	General Fund, Medicaid, Title IV-E, Family Pres., Social Service Block Grant		
Homebased Services • Homebased Community Services • Child/Family Community Suppt. • Family Mediation • Wraparound Flexible 1:1	General Fund, Medicaid, (Wraparound)	General Fund, Medicaid, Family Pres.	General Fund, Medicaid	
Family Support Services • Respite Services • Parent Support Groups • Parent Advocacy • Social/Recreation Services	General Fund, Fed. Wings	General Fund		

LD 1744 - MH SERVICES BY FUNDING SOURCES AND DEPARTMENT

SERVICE CATEGORIES	DMHMRSAS	DHS	DOC	DOE
Early Intervention • Birth thru School Age	General Fund	General Fund Medicaid, Preventive Health Prog.		Federal Part H
School Based Services • Day Treatment • School Psychologists, Counselors		Mental Health in Schools Project		General Fund, Medicaid, LEA
Substance Abuse Services • SA Outpatient • Residential (PNMI)	Medicaid Block Grant	General Fund		
Inpatient Hospital • Childrens Psychiatric • General Hospital/Psych Hospital • Out of State		General Fund, Medicaid		
Transportation • 0-17 • 18-21		General Fund, Medicaid, Title IV-E, Social Services Block Grant		

III. STATEMENT OF THE PROBLEM

The following section summarizes the major structural problems in the current service delivery system that were identified by the three workgroups. These issues, and the recommendations for the development of a system of care that follow, are in substantial agreement with recommendations made in a number of previous studies and reports, including the Maine Task Force for Mental Health: Findings and Recommendations Regarding Services for Children (September, 1996), The Commission on Children in Need of Supervision and Treatment (March, 1989), Interdepartmental Reports per Legislative Resolves (June, 1986), Special Commission on Governmental Restructuring (December, 1991), and the Task Force on Adolescent Suicide and Self-Destructive Behaviors (May, 1996).

Structural Problems

1. **Lack of a System of Care.**

Even though Maine spends millions of dollars on behavioral health services for children, there is no unified system for the provision of mental health services for children, either at the state or local level.

Explanation: The statute creating the former Bureau of Children with Special Needs within the DMHMRSAS limited DMHMRSAS' involvement to children not eligible for services from any other State agency. This forced each agency to develop mental health services for the children in their respective systems. Although state and local agencies serving children and youth strive to coordinate services, there is currently no single system responsible as the lead agency in coordinating a comprehensive system for children's mental health services. This lack of a systemic approach to managing mental health resources occurs both at the state level and at the local level, where there is no effective structure for the planning or management of integrated services. Even Medicaid, the state's largest resource for financing mental health services, does not support a system of care: Because there is no designated entity responsible for coordination, capacity development and gatekeeping across complex and overlapping services, the policies governing Medicaid-reimbursed mental health services inadvertently undermine the concept of a system of care (see Medicaid Rule Review in Appendix B). The result is that a myriad of services are paid for retrospectively by Medicaid without the benefit of a network of care that was prospectively designed to serve Maine's children in the best possible way.

The lack of a coordinated system of care has also resulted in conflicting definitions of the target population. Moreover, children with multiple problems (e.g., a severe emotional disturbance and mental retardation) have a particularly difficult time accessing appropriate services.

2. **Overutilization of High Cost Services.**

Current federal and some state funding rules result in the use of high cost institutional placements. As a result, Maine hospitalizes children at twice the national rate, and spends three-quarters of its child mental health dollars on the most restrictive settings.

Explanation: State Medicaid criteria are complex, with multiple steps required to gain access to low cost options, while criteria for higher cost services are less restrictive. For example, "non-traditional Preventive Health Program (PHP)," the least restrictive Medicaid reimbursable service, requires prior authorization, while in-state psychiatric hospitalization has no prior authorization criteria. Guidelines concerning length of care also tend to favor hospitalization: While length of care requirements exist for four of the least restrictive Medicaid reimbursable services, psychiatric in-patient length of care decisions are controlled by the admitting hospital. Additionally, current practice has state agencies responsible for managing Medicaid seed for community-based Medicaid reimbursable services, while psychiatric hospitalization is covered 100% by the Bureau of Medical Services (BMS), an arrangement that can encourage cost shifting as a way to protect limited agency resources.

Maine's use of the optional "Medicaid Psychiatric Facility Services" (which covers free-standing psychiatric hospitals) encourages high cost out-of-state hospitalization. The availability of this option, which covers 100% of costs, encourages the use of out-of-state placements for many children with severe mental health needs. Continuity of care is more difficult to maintain for children placed out of state, as connections with families and communities deteriorate and planning for their return is hampered by lack of current knowledge about the child.

Example #1: Emily has been diagnosed with a hearing impairment and significant development delays. In order to receive the specialized, in-home services she needs, Emily must first be shown to "fail" with traditional home health services, and receive prior authorization for "nontraditional PHP" from a home health provider. In contrast, if Emily's mother wanted to put her in a hospital, no prior authorization would be required.

Example #2: There is a thirteen-week limit on home-based services from DMHMRSAS. This service places clinical staff in the home when a child is in extreme emotional and behavioral crisis: mental health workers help to stabilize the situation, support other family members affected by the crisis, and help the family to develop the skills necessary to handle the child's behavior. In contrast there is no limit to the total days that a child in crisis may be hospitalized, and no external UR process to review the need for continued inpatient care.

3. **No Single Point of Access -- No Clear Roles or Responsibilities.**

There is currently no single point of access to the state's full array of mental health services, and no clear definitions of roles and responsibilities, resulting in confusion for families about where to go for help.

Explanation: Eligibility criteria vary across systems due to varying federal and state requirements and mandates. Services and resources across agencies are fragmented, and there is no coordinated mechanism for creating a clear point of entry to a full array of services.

Moreover, since each child-serving agency provides some limited mental health services, there is continuing confusion about the roles of the different agencies. This situation has resulted in part from the limited mandate of the Bureau of Children with Special Needs, in part from the lack of resources and adequate specialized clinical expertise in the mental health system, and in part from the lack of capacity for the Department to deliver services on-site in the other child-serving systems.

Example: Wendy Kelly has agreed to provide temporary foster care services for Joe, an 18 year old boy with bipolar disorder and moderate mental retardation. Although Joe clearly requires supervision, he is currently his own guardian. Joe will continue to receive special education services until he reaches the age of 21, but needs intensive in-home supports in order to remain in the community. Wendy doesn't know whether the local school district, DHS, or DMHMRSAS should be responsible.

4. **Inequitable Distribution of Resources.**

Currently, the ability to access resources for mental health care depends to a large extent on where the child lives, as well as on parental custody arrangements.

Explanation: Federal funding resources which are tied to specific populations of children create barriers to equal access. In addition, because of the fragmentation of the system, children in the custody of DHS have access to a larger pool of resources than children residing in intact families. Many families face relinquishment of their custodial responsibility to DHS so that their children may receive services.

There is also an inequitable distribution of resources geographically. A review of service utilization by geographic area reflects large disparities in use of various service components across the state. For example, children residing in the Northeast, Kennebec-Somerset, and Western service areas are more likely to receive services in inpatient hospital and residential treatment settings than children residing in other areas of the state. Without further review of the data, it is not possible to cite specific reasons for this disparity.

Example: Ronnie is a 9 year old whose impulsive and often aggressive behavior places both of his two younger sisters and often his mother, in danger. His diagnosis of ADHD adds a very short attention span to his behavioral issues. The local education authority is able to educate the boy with 1:1 aides and a very structured, individualized program. At home and in the community, however, even with in-home supports, respite care, and a short crisis stabilization placement, his behavior is unmanageable. The mother is worn out, fears for the safety of her two younger girls, and has exhausted what have proven to be ineffective community-based services. Her child requires a residential treatment placement. The local PET feels, appropriately, they are able to educate him in the local school. There is no correctional involvement. The DMHMRSAS has provided numerous community-based resources, including a crisis placement, but is unable to provide the long-term residential treatment necessary as there are no funds for room and board. In desperation, the mother seeks DHS custody as the only method available to her to fund the necessary residential program.

5. **No Clear Point of Accountability.**

Accountability for effective management of care, and for good client outcomes is divided between several agencies.

Explanation: Although DMHMRSAS, DHS, and DOE have mechanisms in place for limited gatekeeping of the services within their systems, there is no coordinated gatekeeping procedure for the vast majority of Maine's mental health resources. Approximately 53% of children placed out of state have no documentation in the case record of an assigned case manager from any state agency.[1] Lacking a single point of accountability, many Maine children are inappropriately placed in institutional settings, with no agency or individual clearly responsible for monitoring their treatment or assuring a timely and coordinated return to their community. Fragmented accountability has also resulted in the state's inability to collect basic data regarding number of children served, how resources are utilized and whether the interventions provided are effective. Each agency maintains separate information systems and collects different information, making it difficult to make effective policy and program decisions.

Example: A DMHMRSAS mental health coordinator receives a call from Mrs. Jones. Her daughter, Jeanine is 16 years old and has been at Charter Brookside Psychiatric Hospital in Nashua, NH for 18 months. Charter Brookside wants to discharge Jeanine. Mrs. Jones is concerned that Jeanine is showing little improvement and there has been no discharge planning to put supports in place in Jeanine's home. This is Jeanine's 8th hospitalization. She has never received services from any state agency.

[1]Report from BMS - DHS Medicaid Surveillance and Utilization Review/Quality Assurance, August 2, 1997.

6. **Gaps in Services for Transition-Age Children.**

Children often "fall through the cracks" between the children and adult service systems.

Explanation: Inconsistent, age specific agency mandates and funding mechanisms create problems as children whose mental health needs have been met through special education or DHS custody "age out" and transition to DMHMRSAS, creating waiting lists for adult services and disruption in continuity of care. Transition issues are exacerbated by out-of-state placements, which sever linkages between the child and his or her family and community, and by failure to begin interagency transition planning in a timely manner.

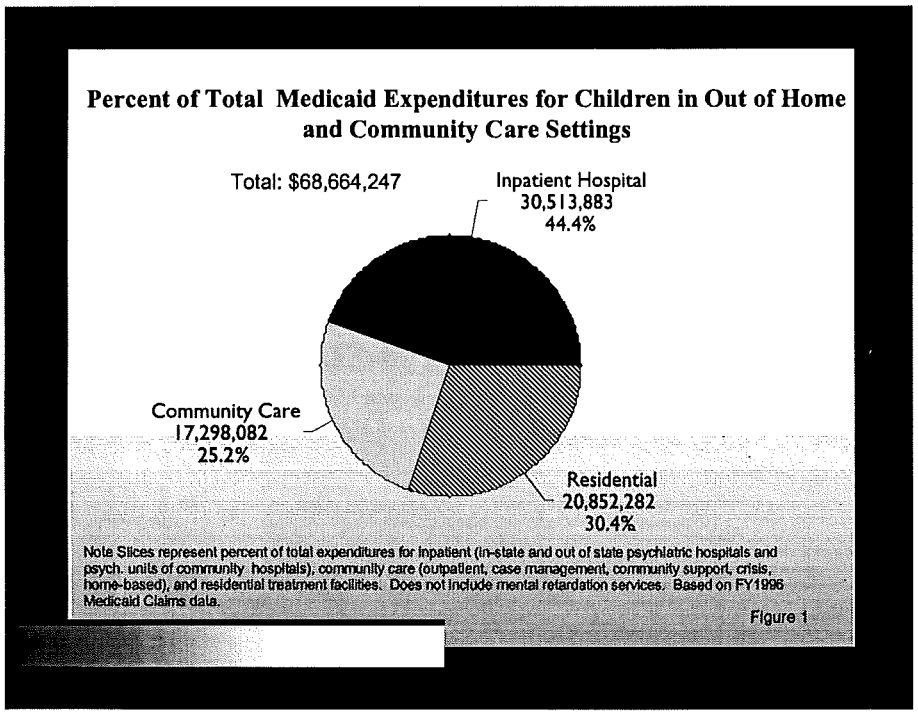
Example: Sean is a 17 year old boy in DHS custody who has been at Lakeview Neuro-Rehabilitation in New Hampshire for four years.* He has a history of abuse, fire-setting and severe behavioral problems which made it impossible for him to remain either at home or with foster parents. On October 1st, DMHMRSAS receives a phone call announcing that Sean is turning 18, and will be returning to Maine. The DMHMRSAS worker, who has a responsibility for participating in planning for children as they reach 18, has had no prior contact with or knowledge about Sean, now has one week to find an appropriate residential placement.

*Lakeview serves primarily children with neurological conditions, autism, developmental delays, mental retardation, neuro-head traumas and/or traumatic brain injury.

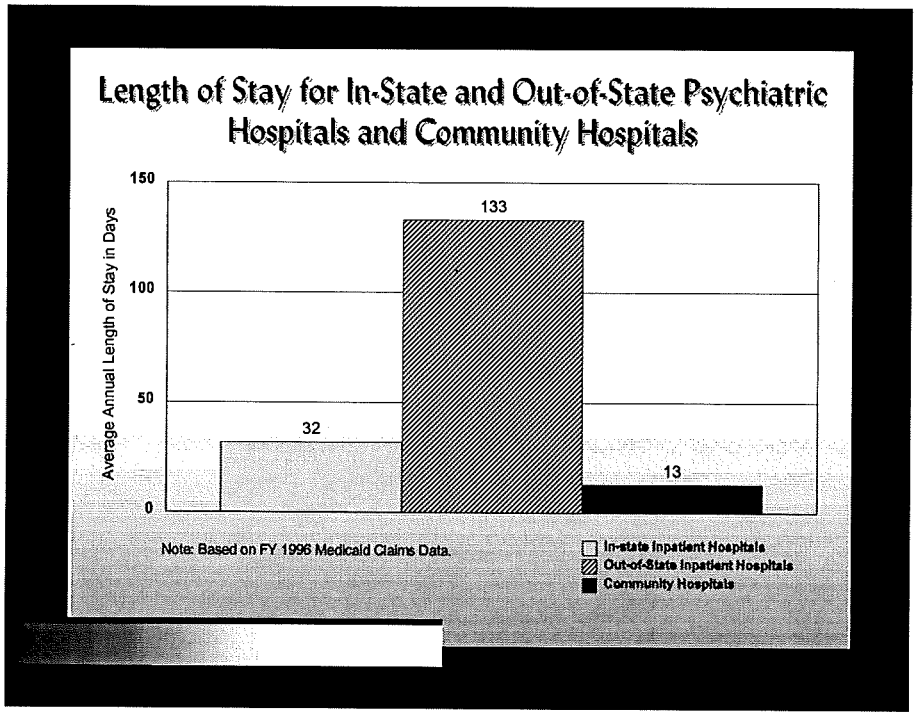
IV. WHAT THE DATA SHOW

In order to assess trends in behavioral health service use and expenditures in the current child and adolescent service system, a series of analyses were conducted using FY 1996 Medicaid claims data. The current analyses focused on Medicaid service use, since Medicaid funding represents the single largest funding source for child and adolescent services, accounting for between 60 percent to 70 percent of all service use. These analyses examined service use and expenditures across the following core service areas: inpatient hospital services, residential/group services, and community-based services. They also looked at the distribution of service use across designated geographic service areas.

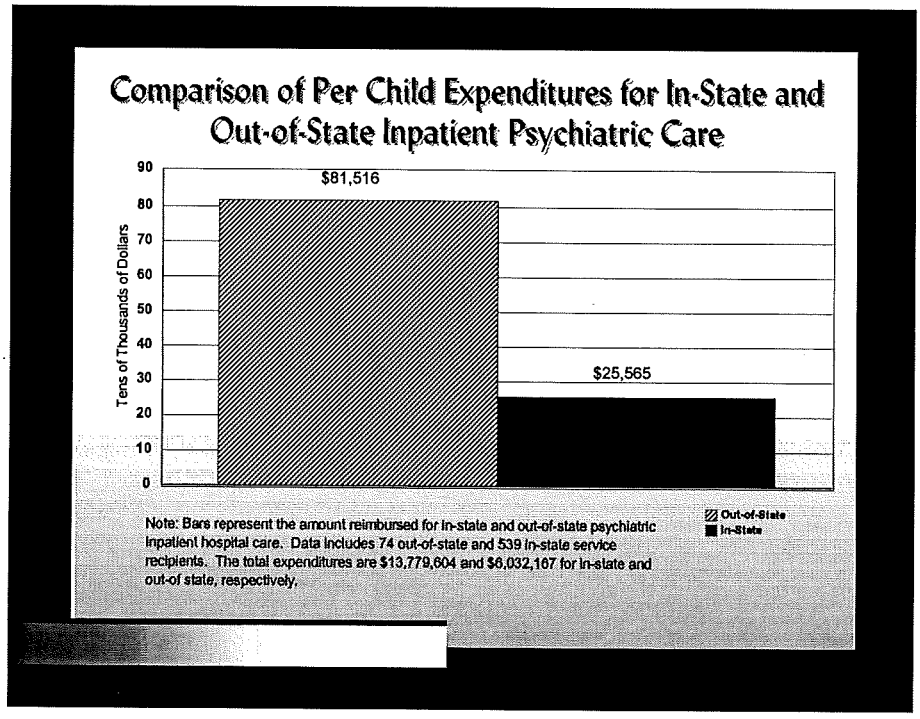
An assessment of FY 1996 Medicaid expenditures shows that $68.7 million dollars were expended on behavioral health related service to children and adolescents in Maine. The following chart shows the distribution of expenditures across three major service areas.



Seventy-five percent or $51.4 Million dollars of the total Medicaid expenditures go toward serving children and youth in the most costly and restrictive out-of-home treatment alternatives including inpatient psychiatric hospitals and residential treatment centers in and out-of-state.

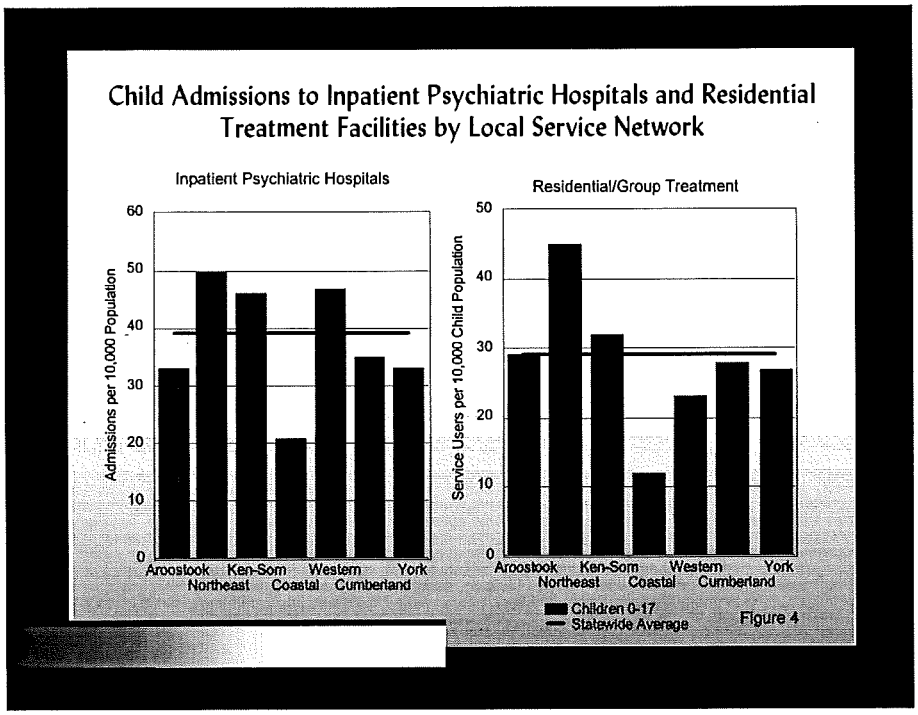


Children stay, on average, 4 times longer in out-of-state inpatient psychiatric hospitals than in instate inpatient facilities. Maine has no long term psychiatric hospitals.

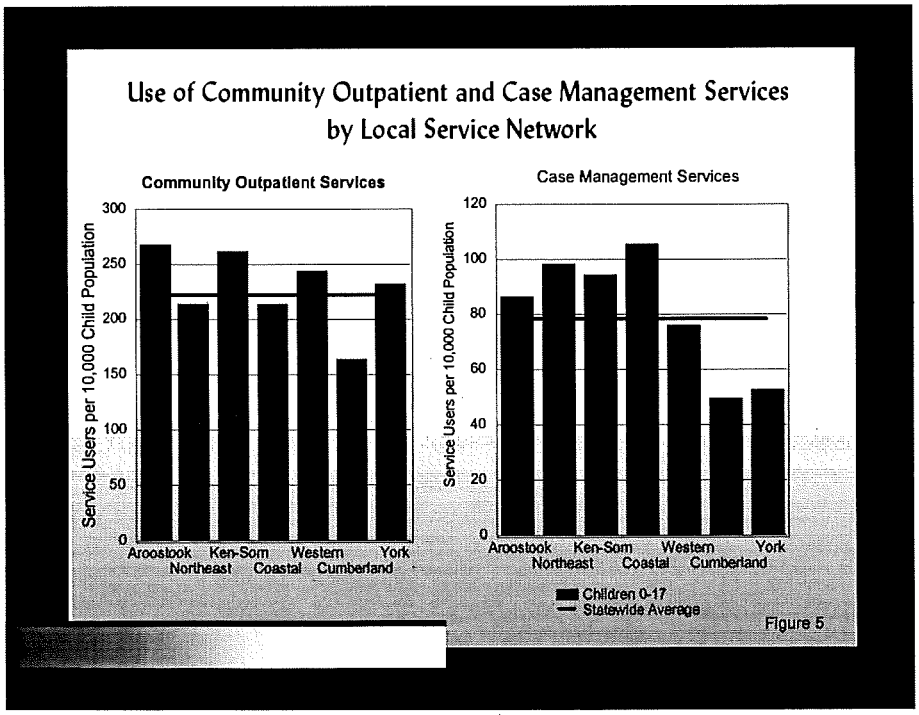


In FY 96 539 children and youth ages 0-17 years were placed in instate psychiatric hospitals* at a per child cost of $25,565 and 74 were placed in out-of-state institutions at a per child cost of $81,516.

*Children cannot stay more than 30 days in psychiatric hospitals in Maine.



Children residing in the Northeast, Kennebec/Somerset and Western local service network areas are more likely to receive services in inpatient psychiatric hospital and residential treatment settings.



Children residing in Cumberland and York local service network areas tend to use community-based services, such as outpatient and case management services less frequently than children residing in other areas of the state.

FACTS ABOUT
MENTAL HEALTH SERVICES FOR CHILDREN IN MAINE

1. It is estimated that between 14 percent and 20 percent (42,000 - 61,305) of children 0 to 18 years of age in Maine have mental health challenges serious enough to require treatment and 9 percent (27, 500) have serious behavioral or emotional challenges.

2. A total of $68,664,247 in Medicaid dollars is spent on behavioral health related services to children annually.

3. Seventy-five percent or $51,366,165 of the total annual Medicaid expenditures go toward serving children in the most costly and restrictive out-of-home treatment alternatives including inpatient psychiatric hospitals and residential treatment centers.

4. In FY96 539 children and youth between the ages of 0 and 17 years are placed in instate psychiatric hospitals on an annual basis at a per child cost of $25,565 and 74 children and youth are placed in out-of-state inpatient psychiatric hospitals at a per child cost of $81,516.

5. The average length of stay in out-of-state psychiatric inpatient facility is more than 3 times longer than inpatient stays in Maine (i.e., 133 days out-of-state versus 32 days instate).

6. Children residing in the Northeast, Kennebec-Somerset, and Western local service areas are more likely to receive services in inpatient hospital and residential treatment settings than children residing in other areas of the state.

7. Children residing in Cumberland County tend to use community-based services such as outpatient clinical, case management, outpatient emergency services, in-home family services, and substance abuse services less frequently than children in other areas of the state.

Note: See Appendix C for child system profile data report

CONCLUSIONS FROM THE DATA

Analysis of Medicaid behavioral health expenditures suggests that there is currently a substantial pool of resources supporting mental health services for children in Maine, and that an extensive array of Medicaid-reimbursable service categories has been developed. However, resources are spread across several agencies, and financial management is not well aligned with policy making authority. In addition, a large majority of all resources are spent on high-cost services, restricting the state's capacity to develop community services, and limiting the total number of individuals who can be served. This pattern of expenditures, which has resulted in part from attempts to maximize federal revenue, is in direct contrast to nationally recognized systems of care, where the majority of resources are directed to lower-cost community services.

V. DMHMRSAS INFRASTRUCTURE

ACCOMPLISHMENTS TO DATE

Over the past two years, DMHMRSAS has undergone a series of reforms which create an effective infrastructure on which to implement a coordinated system of care for children. In 1995, as part of the Productivity Realization Task Force, the Department reorganized its operations, creating three integrated Regional Offices. The Regional Offices serve as an identifiable point of linkage to other service systems at the local level.

Team Leaders with specialized clinical expertise in each of the population areas served by the Department (mental health, mental retardation, children and substance abuse) work under a single Regional Director, making it easy to access specialized services, even if the individual in need doesn't fall neatly within one category or another. This structure also improves coordination between the children's and adult service systems. The full integration of the Office of Substance Abuse into the Department's operational structure will make it possible for substance abuse problems to be addressed as an integral part of all of the Department's clinical interventions and prevention activities.

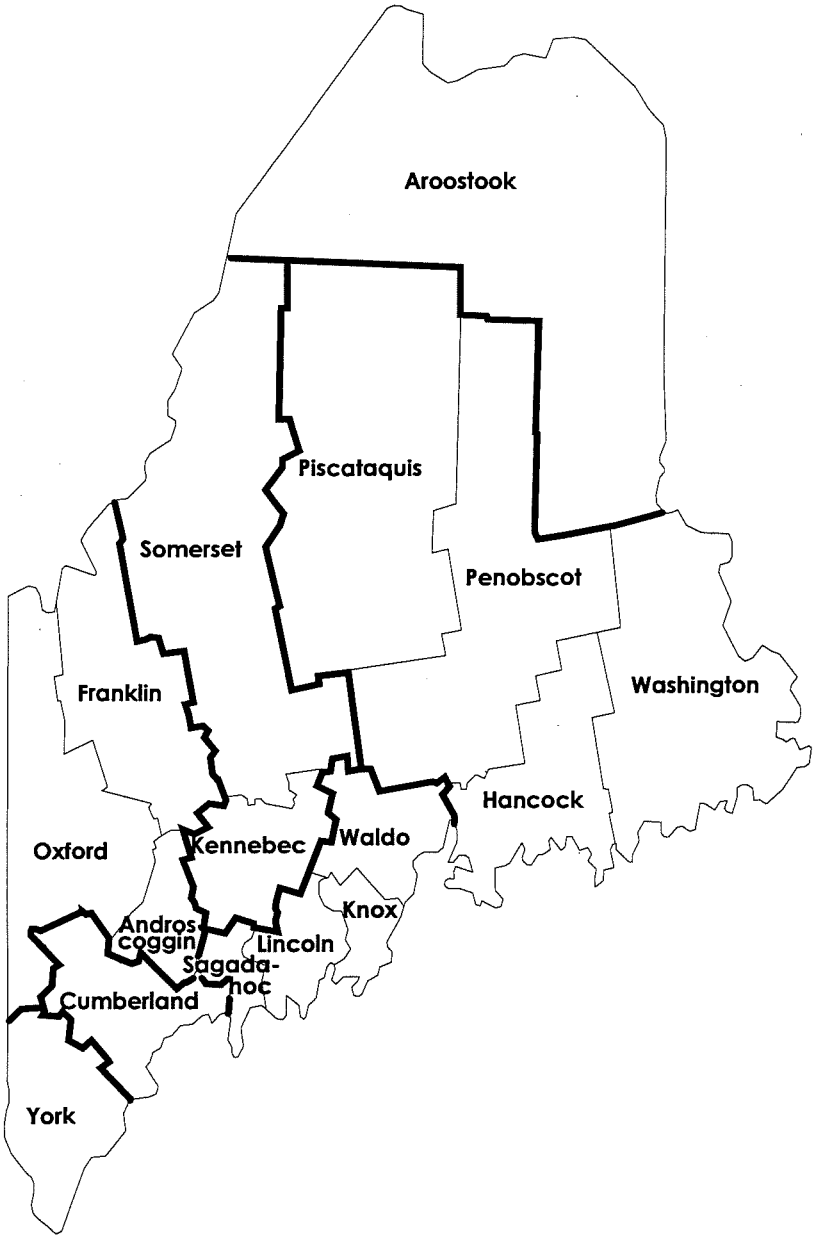
Early in 1996, the Legislature enacted Public Law, Chapter 691, which created seven local service areas and mandated the creation of "Quality Improvement Councils" to ensure stakeholder participation in the planning and monitoring of local service systems. These service areas provide, for the first time, a geographic structure for purposes of planning and systems development, allowing DMHMRSAS to analyze resource allocation and service utilization patterns geographically (see map on next page).

The development of local service network areas has also allowed DMHMRSAS to begin program development in a systemic rather than piecemeal manner. For example, the establishment of seven "Consolidated Crisis Response Systems" in 1997 has created a single, integrated crisis capacity in each local area, greatly improving access and coordination of services. DMHMRSAS has also established a template for the essential ("core") services that need to be in place in each local provider network. Efforts have begun to build core service capacity throughout the state. For example, respite care is now available for families in all seven geographic areas. Ensuring that each geographic area has adequate capacity of all core services is the first step in ensuring equality of access to services.

In the past two years, DMHMRSAS has also substantially strengthened its clinical capacity and quality assurance/management information resources. Statewide and Regional Medical Directors will ensure that DMHMRSAS can provide timely clinical consultation concerning mental health issues, and a new Quality Improvement/Quality Assurance Division will support systems improvements through ongoing outcome evaluation and through regular participation of consumers and family members in service monitoring.

Network Service Areas

ostook Service Network
theast Service Network
Hancock
Washington
Penobscot
Piscataquis
i-Som Service Network
Kennebec
Somerset
ireline Service Network
Knox
Lincoln
Sagadahoc
Waldo
County Service Network
Androscoggin
Franklin
Oxford
nberland Service Network
k Service Network



VI. THE PROPOSED SYSTEM OF CARE

VALUES & PRINCIPLES

A system of care for children must have a single management authority, a single mission, and a common set of values if it is to be effective in serving children and families. The mission and values must be shared by all stakeholders within the system, including the executive, legislative and judicial branches of government; agency staff; parents; providers; communities and payors.

Developing and maintaining a common mission and set of values has historically been impeded by fragmentation of the service system. Like the proverbial blind men and the elephant, each child-serving agency has focused on one aspect of reality. For DHS, child safety is the overriding mission; for DOE, it is child learning and development; for DOC, what matters most is that the child obeys society's laws; and for DMHMRSAS, the primary goal is to improve the child's level of functioning.

In the current system, separation of the different child-serving agencies leads to consideration of each legitimate -- and important -- goal in relative isolation. In addition, each system may hold oversimplified assumptions about the others, believing, for example, that DMHMRSAS serves only children with intact families, or that DHS Child Protective Services harms families by acting too quickly to remove children. Direct care workers, responding to the pressures and responsibilities of their jobs, concerned about the consequences of failing to adequately fulfill their obligations, and operating within different structures and with different professional languages, have often found themselves in conflict.

In contrast, the proposed integrated system of care will support a unified mission and values by providing the opportunity for ongoing dialogue between different service components, and by creating a process for integrating different perspectives into a more complex and holistic picture. Discussions that occurred during LD 1744 workgroup sessions suggest that conflicts of this nature can be resolved when people have an opportunity to see the situation from the other's point of view.

The following principles of practice are based on the vision established in December of 1995 by the Governor's Children's Cabinet, which specified that children's needs are best met within the context of relationships at the family and community levels.[1] These principles will guide the development, implementation and evaluation of the proposed children's mental health system.

[1] Statement of Vision, Mission and Goals of the Children's Cabinet, July 15, 1997

Guiding Principles for a Children's Mental Health System

1. Child and Family Centered.
   The system of care is child and family centered, with the specific strengths and needs of the child and family dictating the types and mix of services to be provided through an individualized planning process which addresses all domains of a child's life with families/guardians as equal full participants.

2. Outcome-Based
   Services provided to a child and family must pursue long-term outcome objectives from a whole life perspective.

3. Community Based.
   The system of care is community-based, with the locus of services as well as management and decision-making responsibility residing at the local level.

4. Least Restrictive and Most Clinically Appropriate Environment/Safety First.
   The system provides access to a comprehensive array of services that address the child's physical, emotional, social and educational needs within the least restrictive, most normative environment, with safety always the first priority.

5. Functional Integration of Supports and Services/Easy Access.
   The system provides services that are integrated, with linkages across all agencies and programs and mechanisms for planning, developing and coordinating services. There are clear roles and responsibilities for different child-serving agencies and a single mechanism (carousel) of access for mental health services so that no matter where a child enters into the system, he/she receives consistent access to the full range of services.

6. Single Point of Accountability for Clinical Services and Supports Management.
   A case management system ensures that multiple services are delivered in a coordinated and therapeutic manner, and that children can move through the system of services in accordance with their changing needs. At the management level, a single agency has clear accountability for ensuring the adequate delivery of children's mental health services.

7. Prevention and Early Intervention.
   The system of care, in order to enhance the likelihood of positive outcomes, promotes prevention, early identification and early intervention for children with, or "at risk of", emotional problems in order to enhance the likelihood of positive outcomes.

8. Transition to Adulthood.
   The system ensures smooth transitions to the community or adult service systems, if needed, as children reach maturity.

9. Rights Protection and Cultural Sensitivity.
   The system protects the rights of children receiving services without regard to race, religion, national origin, sex, physical disability, sexual orientation or other characteristics. Services are sensitive and responsive to cultural differences and special needs.

THE PROCESS OF CARE

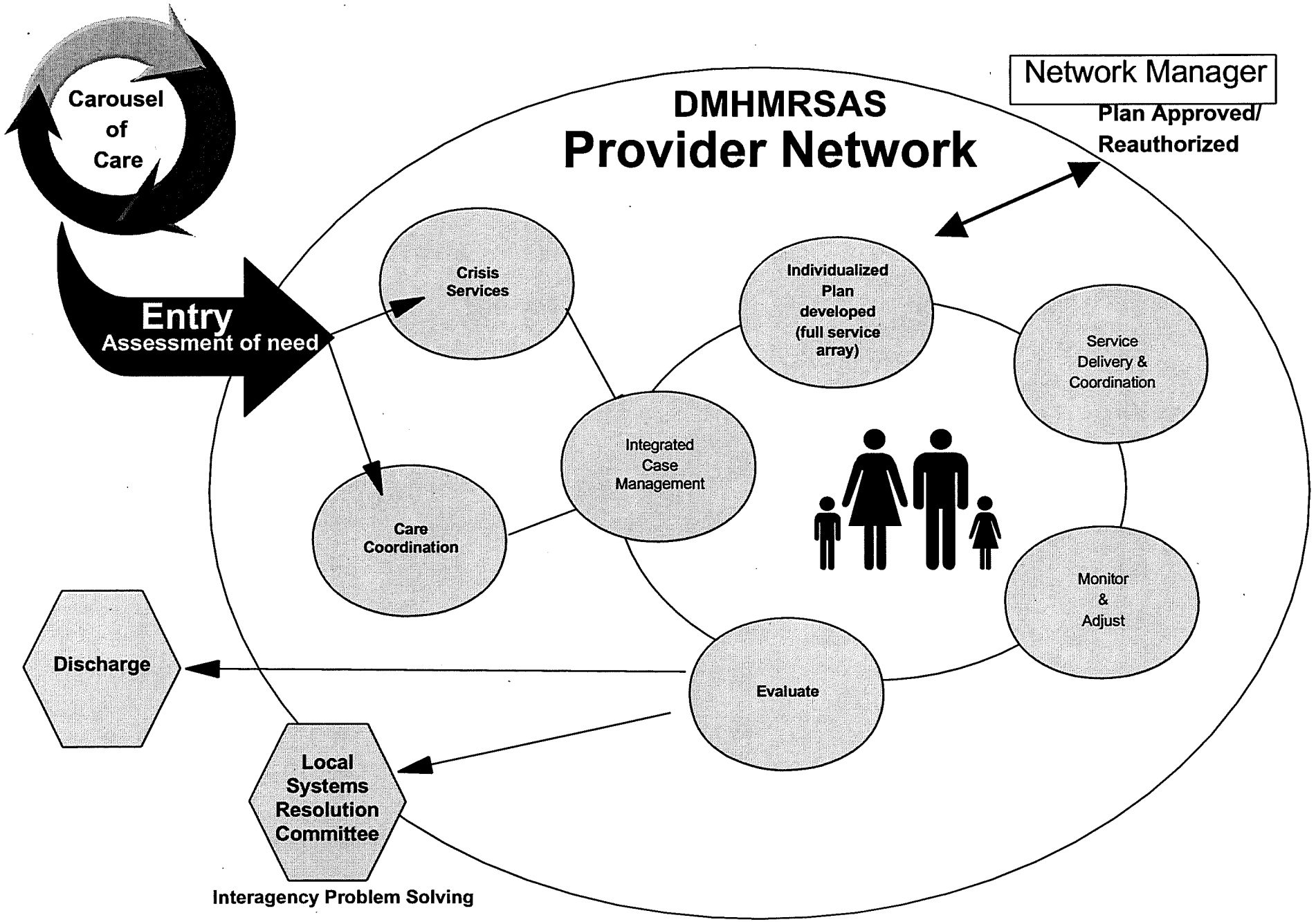
Overview. In the proposed system, entry into an integrated mental health system of care may come from any point in the community, and will occur when a mental health need is first identified. Services and supports will be determined by the family in conjunction with the case manager through an individualized planning process and provided in coordination with other agencies. Access is through a single mechanism so that wherever a child enters the system, the full array of services is available. Parents will be put in contact, upon admission if desired, with another parent who has experience with the system of care through Gaining Empowerment Allows Results (GEAR) (see Appendix E). Services are provided in or near a child's community, through a local provider network. There is a single gatekeeping mechanism (case management) to assure that children receive the appropriate level of care. Management of the system and resources by the network manager occurs to decrease dependence on high cost services, and resources are redirected into building the capacity to serve children in local community-based alternatives. Mechanisms are in place to track outcome measures, do service management, and provide quality improvement to assure system effectiveness and responsiveness (see chart and detailed explanation on next two pages).

Interagency Individual Planning Process: The Child and Family Team. Whenever a child needs the services/supports of multiple systems, direct care workers from each of these systems will come together with the case manager, family and other individuals identified by the family to develop an individual service plan (ISP). In situations involving multiple state agencies, the lead case manager will be selected by the family when not in conflict with statute or court order. This plan, building on the strengths of the child, family and community, will address needs in all relevant life domains, including a place to live, family, school or vocational, social, medical, psychological, legal and safety needs. With the creation of an interagency Child and Family Team, issues across all domains can be addressed in a way that ensures consistency of approach throughout all areas of a child's life. It will also allow use of creative blending of resources across agency lines, the use of natural supports when possible, and coordination of services from multiple agencies into a unified plan of care. The Child and Family Team will work to coordinate across agency boundaries, but will not take the place of any mandated plans which may address one domain within the service plan, e.g., the PET process mandated by special education.

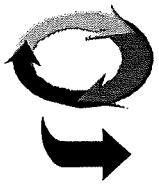
Children's Mental Health Service Array. A full array of services and supports is a key component of the system of care. Six core mental health service components have been identified: prevention; crisis intervention; case management; family and child supports; clinical services; and residential treatment (see matrix on core services). Each core service is available in varying degrees of intensity, depending on the level of need. This service array will be available in all service networks. In addition to the core services, flexible resources will be available to provide for those individual needs identified through the planning process which cannot be addressed through categorical services.

The core service array is intended to provide a blueprint for developing service capacity in each geographic area of the state. As the system of care for children matures, retooling of the core service array may occur. For example, the development of specific "safety net" programs may strengthen or expand one or more core service areas.

THE PROCESS OF CARE



THE PROCESS OF CARE

	Activity	Who's Responsible
	**Access/Entry** • Crisis care: Crisis response within one hour; assigned case manager with 24 hours • Urgent care: Child connected with case manager within 24 hours • Non-urgent service need: Child connected with case manager within 7 days • Family connected to GEAR, parent-to-parent support	Network Manager
ISP	**Individualized Services Plan (ISP) Developed** • Assemble team of individuals from all involved systems • Case manager, family & youth determine strengths, needs, goals • Create an Individual Service Plan which may include ---services/supports from service array ---natural supports (e.g., big brother, YMCA, parent to parent) ---services from other systems (e.g., probation, special education) • Lead Case Manager identified through the integrated initiative CM, if applicable • Funding specific to plan includes use of all eligible federal funding streams blended with flexible funds • Plan authorized by Network Manager for 3 months maximum	Child and Family Team Primary Case Manager (or lead CM)
CM	**Plan Implemented** • Provide services on ISP • Coordination of care, linkage to resources • Crisis services, if needed	Coordination by Mental Health Case Manager
M/A	**Plan Monitored/Adjusted** • Ensure service delivery • Work with child, family & other systems to modify plan as needed • Every three months: C & F team assess progress toward individually identified goals and modifies plan as needed. ---Review level of care determination ---Plan reauthorized by Network Manager	Mental Health Case Manager
LCRC	**Grievance/Conflict Resolution** • Grievance procedures followed • Assess to/or service provision to continue during grievance process • Refer to LCRC for interagency conflict resolution/resource management as necessary	Mental Health Case Manager
Eval.	**System Effectiveness Evaluated** • Progress toward goals • Youth and family satisfaction • Restrictiveness of living arrangement • Progress in school • Involvement with law enforcement and correctional system	DMHMRSAS (with input from Quality Improvement Councils and Regional Children's Cabinets)

ore Service Areas	Service Components	Description of Services	Funding Sources
Prevention/ Consultation	Identification of At-Risk Children Consultation Information/Education	Designed to identify problems and intervene early. Information about health and emotional development can identify children "at risk" and trigger treatment services. Education activities inform the community about mental health problems; consultation services address individual cases and assist other agencies in handling mental health problems.	General Fund Medicaid - PHP Part H - IDEA* Pooled Flexible Funding
Crisis Intervention	1-800-Crisis Line Crisis Outreach Teams Crisis Respite Short Term Crisis Stabilization (In and Out of Home) Acute Hospitalization	Involves telephone and crisis outreach support and stabilization services to children and youth in their home, school, or other community settings. Services are available 24 hours a day, 7 days a week. Crisis outreach includes an assessment of risk, identification of immediate needs, development of a crisis stabilization plan, referral and follow-up. Specific crisis interventions may involve activation of a variety of in-home support services, short term out-of-home placement in the community, or short term hospitalization. Specialized services are available for children and adolescents who have experienced abuse and for those who are at-risk for suicide.	General Fund Medicaid - Crisis Services Medicaid - Emergency Services Medicaid - Inpatient Services
ndividual Planning / Case Management	Screening and Assessment Individual Service Planning Homeless Youth Outreach Intensive Case Management	Assessment involves determination of an individual or family's strengths and needs, contributing factors, and existing assets and resources. An individual service plan is built on the results of assessment, taking into account child and family strengths, needs, and preferences. Plans reflect services to be secured, time frames for obtaining services, roles of persons who are natural supports as well as service providers, and measurable outcomes expected. An individual plan is developed through a child and family centered planning process, such as the Child and Family Team. Agencies and programs already involved with the child and/or family are included in planning process. Case management involves brokering services, advocacy, insuring that an adequate treatment plan is developed and implemented, and reviewing client progress. Case management involves aggressive outreach to the child and family and working with a wide range of community agencies and resources.	General Fund Medicaid - Case Management Medicaid - Targeted Case Mgmt. Medicaid - Clinic Services Part H - IDEA* Pooled Flexible Funding Children's MH Block Grant PATH Grant (Homeless)
Family & Child Supports	Respite Parent/Sibling Support Groups Social & Recreational Services	Natural and extended supports designed to strengthen the ability of families/caregivers to maintain children in home and community. Services include in-home respite care, parent and sibling support groups, and social-recreational services. Services provide respite from constant caregiving, and each caregiver's problem-solving, communication skills, behavioral interventions and advocacy.	General Fund Federal Grant - Wings** Pooled Flexible Funding Social Services Block Grant Federal - Family Preservation
Core Clinical Services	Psychological/Psychiatric Evaluation Medication Management Individual, Group and Family Counseling School-Linked Mental Health Services Day Treatment Home-Based Services	Clinical services consist of a wide range of community-based treatment, including specialized interventions for substance abuse, trauma, etc. Problem-oriented counseling, skills training and in-home behavioral interventions to strengthen and stabilize the family living environment to minimize the risk of out-of-home placement. School-linked mental health services provide a variety of educational/psychological assessment & referral, individual & family counseling, special education and other support services geared specifically to support the child or youth in the school environment.	General Fund Medicaid Federal grant - Wings**. Children's MH Block Grant Substance Abuse Block Grant Fed Grant- School Linked MH** Part H - IDEA* Pooled Flexible Funding
Residential Treatment	Therapeutic Foster Care Group Homes Residential Treatment	Out-of-home residential services include specialized therapeutic homes with foster parents recruited and trained to care for children with serious emotional and behavioral challenges. Group homes provide a therapeutic living environment with a specific behavioral or treatment focus shaped in part by common treatment needs of residents with services available in the residence and the community. Residential treatment centers provide round the clock staffing, a therapeutic milieu and addresses educational needs.	General Fund Medicaid - PNMI Title IV-E Substance Abuse Block Grant Children's MH Block Grant LEA - (Educational costs)

s of July, 1998 Part H will become Part C
ot statewide

SYSTEM INFRASTRUCTURE

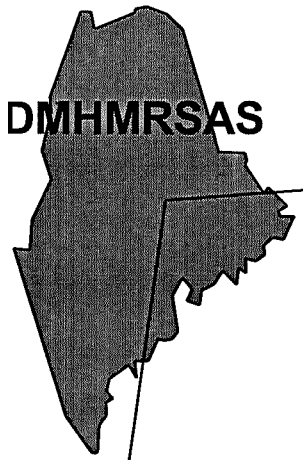
Local Service Networks. The infrastructure for service delivery within the system of care is the local service network. Providers in each of DMHMRSAS' seven local networks will be formed into a network through contract arrangements to provide a seamless system of care including mental health, mental retardation and substance abuse service providers. A network, rather than contracts with individual providers, provides a structure for continuity through shared information, shared resources such as the consolidated crisis system, client choice, multiple points of access into a single system and a "no eject, no reject" policy for the network (not for a single provider.) Under performance-based contracts, each provider within the network will be expected to meet DMHMRSAS standards for uniform assessment, clinical standards, and uniform tracking measures (see section on Quality Improvement).

The management structure for this system will be through the network manager, an independent non-profit entity. Network managers are the service management intermediary through which DMHMRSAS, as the single mental health authority, achieves its policy and program objectives. The Department plans to contract with seven local network managers. These network managers represent the single point of gatekeeping authority and accountability for the assessment of need and delivery of services within the network. The network manager will be accountable for outcome performance standards as outlined in the contract with the Department. This relationship allows the Department greater oversight power than is currently available and will allow the Department to establish relationships between dollars spent and outcomes achieved. The network manager will purchase services from agencies within the network using performance and incentive-based contracts and is responsible for prompt claims payment. Through the contract relationship with DMHMRSAS, network managers also have the responsibility for assessing and developing additional service capacity, ensuring care coordination and that a full service array is available assuring equity of service access regardless of region. Network managers must also insure creation of safety net services, data collection and information sharing within the network.

Coordination with Other Agencies Within the System of Care. As the key link to all other child-serving agencies within the regional network, the network manager is expected to develop working relationships with all other agencies to ensure access, coordination of services across agencies, jointly develop improved interventions in correctional and school settings, and work collaboratively to solve systemic barriers to services.

The Department and its regional offices will retain accountability in the system through its contracts with network managers. In addition to quality improvement functions, the Department is responsible for developing best practice standards and standards and protocols for case management, clinical services, intake and assessment, consumer choice, access, cultural competence, confidentiality, and appeals. The Department also provides a direct service component through case management for children and some crisis functions.

LOCAL SERVICE NETWORK



Network Manager

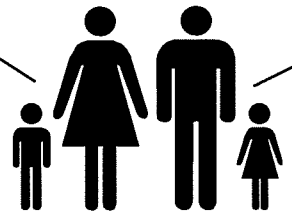
- Capacity Building
- System Management
- Utilization Review
- Plan Authorization
- Care Coordination

Provider Network

service delivery
single access
crisis services

Children's Services Providers

Mental Retardation Providers



Substance Abuse Providers

Adult Mental Health Providers

QIC

Planning

Quality Assurance

INTERAGENCY ROLES AND RESPONSIBILITIES

Overview. In the proposed children's mental health system of care, primary responsibility for the provision of mental health services rests with DMHMRSAS. As the agency designated in statute as having responsibility for serving individuals with mental illness, mental retardation and substance abuse, the Department has the infrastructure, service delivery system and clinical expertise necessary to take the lead in meeting the needs of Maine's children for mental health care.

The Department recognizes that the mental health needs of many children, youth and families served by DHS, DOC and schools are adequately met by those systems. Responsibility for delivering those services will remain within the existing agencies. However, in the proposed system of care, closer linkages between the systems will result in DMHMRSAS playing a major role in developing, providing and monitoring mental health services within the other child-serving agencies. Similarly, the role of the other agencies will be strengthened. For example, DOE will play a greater role in determining the best approach to the learning styles and needs of children in the mental health system, and so forth. This model will allow DMHMRSAS to bring clinical expertise in mental health issues to the other agencies, which will then bring their own emphasis on education, safety, or law-abiding conduct to assist in the overall care of children with mental health problems.

In addition, the network manager in each service area will ensure that crisis services are available to children in all systems; establish linkages with the various agencies to ensure access to the appropriate mental health services; ensure coordination of care within the context of Maine's Integrated Case Management initiative; and manage the triage, referral, and enrollment process in the local system of care.

DMHMRSAS will also provide a "safety net" for children and families who have multiple, complex problems and whose needs cannot be met elsewhere. This will require the maximum possible flexibility of administrative, clinical and financial structures, as social conditions and public policies continue to change rapidly. Although DMHMRSAS has traditionally been seen as the "provider of last resort" for individuals with complex and long-term needs, the current children's system does not support the Department in this role, either fiscally or administratively. The proposed integrated system of care will allow the Department to assume this function.

A Functionally Integrated Structure. In the current system, arbitrary boundaries established by mandates and funding mechanisms have led to the categorization of children as "DHS children" or "mental health children." In a system of care, children do not belong to any system but to their families, guardians and communities. However, children do belong in school and may need the protection of DHS or the attention of DOC. These systems frequently are the first to identify a child's need for mental health intervention. If behavioral needs could be addressed when first identified, many children could be maintained in school, foster care or probation without additional disruption in their lives.

To provide enhanced early identification and mental health support, the Department will redeploy staff to work as mental health consultants to other child serving systems. While still employed or contracted by DMHMRSAS, these clinical consultants/liaisons would work within the assigned system, with day-to-day supervision provided by the host system and clinical services provided by DMHMRSAS.

Interagency Initiatives. Currently, there are many areas where separate agencies duplicate services in an attempt to "fill the gaps" in the fragmented system of care. As DMHMRSAS strengthens its clinical capacity and focuses increasingly on bringing clinical expertise to children whenever and wherever needed, the need for duplication of services will decrease. The "functional integration" described above will allow more effective interagency programming to occur.

For example, stationing a team of mental health clinicians at the Maine Youth Center will lead to better on-site services, earlier identification of emergent mental health problems, and better mental health after-care when the youth is transitioned back to his or her home community. Similarly, focusing mental health early intervention specialists on those clinical issues that are strictly behavioral or cognitive/developmental in nature, and deploying them to work alongside (rather than in competition with) DOE's Child Development Services, should strengthen both systems.

Under the proposed system of care, mental health providers will be available to provide clinical consultation, engage in cross-training activities, support professional development, and provide clinical supervision on an ongoing basis for all of the other child serving agencies. This model places mental health expertise on-site where children and families need it most.

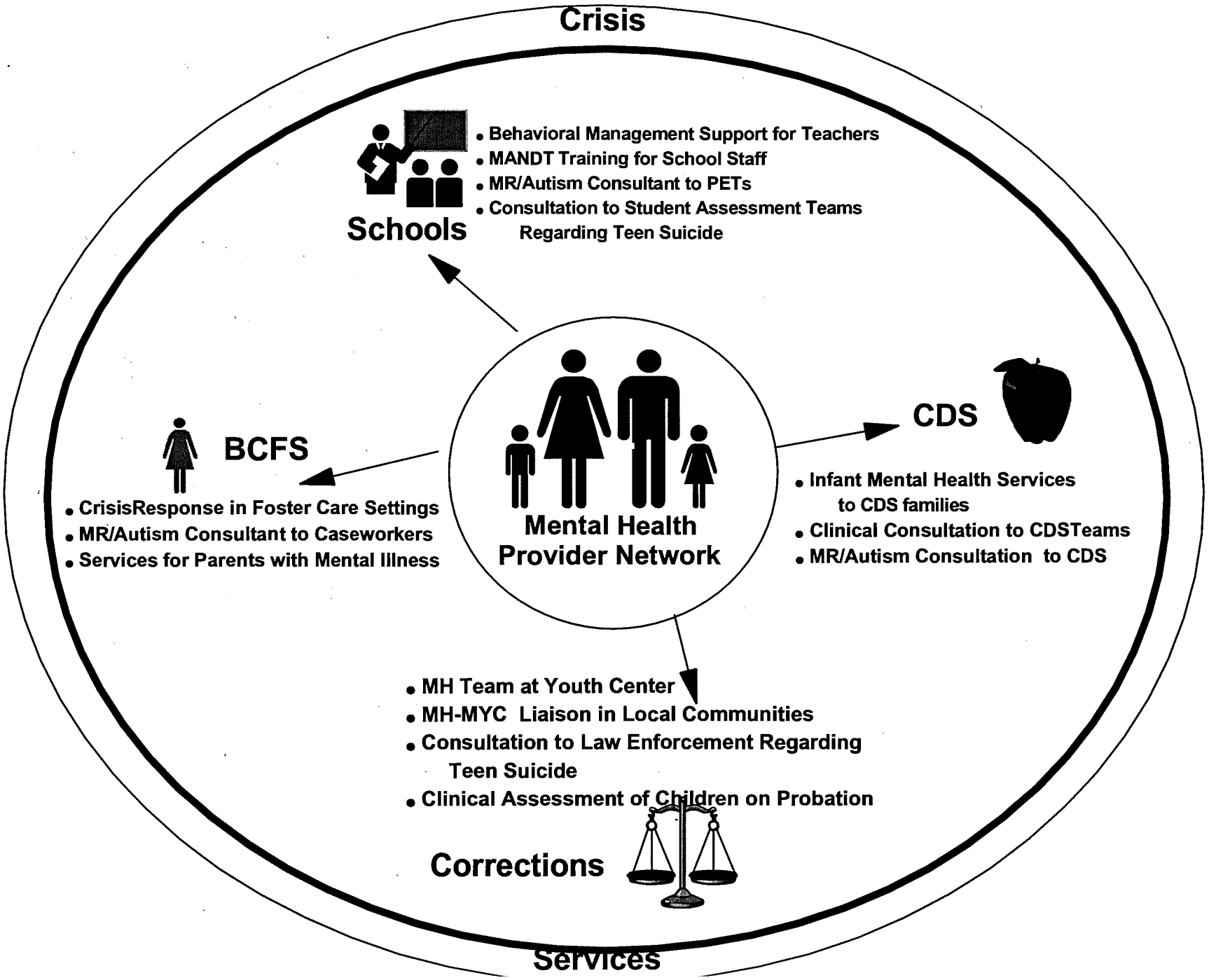
Interagency Problem Solving. To address the needs of children and families who have "fallen through the cracks", the Children's Cabinet has established local case resolution committees (LCRCs) consisting of representatives from all child-serving state agencies and a family member. Pooled, flexible funds have been made available to these local committees to assist in addressing the specific needs of children and families. Cases which cannot be effectively resolved by the LCRCs are sent to the Regional Children's Cabinet (see Appendix D).

Currently, LCRCs meet to provide assistance to specific children and families when the child's needs cannot be met through normal channels. Committee meetings are time consuming, as members must be briefed on the clinical situation and on what alternatives have already been tried. As a result, only a few children can be assisted through this process each month.

The proposed system of care will expand capacity in local service areas and remove artificial funding barriers. Interagency planning for shared responsibility and blended funding to meet the multiple needs of children will occur through Child and Family Teams as part of the routine individual service planning process. This will allow the LCRCs to shift from clinical case review activities to addressing systemic issues such as policy and funding issues, capacity building, identification of service gaps, and conflict resolution for Child and Family Teams.

Eligibility. A single definition of the target population will be developed based on functional need and risk criteria rather than diagnostic criteria. This will facilitate communication between service systems. In addition, any child served within the children's service system will be presumed eligible for adult services, thus smoothing the transition between systems of care.

Local Children's System of Care



FINANCING

The proposed system of care is designed to remove artificial barriers to services by allowing appropriate categorical funds, irrespective of origin, to be combined to provide the services and supports identified in each child's individual service plan. Non-categorical state flexible funds can then be used to meet needs which categorical funding may not be able to fully address. A blended financing scheme allows leveraging of state funds to maximize the use of federal dollars for each child. In addition, resources are used to purchase only what is needed, at the intensity needed, and can be modified to meet the changing needs of the child and family. By mixing categorical and flexible resources in new ways across funding streams, the system of care will financially support services designed to meet the unique needs of the child, rather than requiring the child to fit into an existing (funded) program "slot".

Financial reform is a powerful tool for reshaping the service system. To support the development of the proposed system, several fiscal strategies are proposed, including the restructuring of Title XIX (Medicaid), the redirection of funds from institutional settings to community-based services, leveraging of state resources through the expanded access to federal Title IVE reimbursement for DMHMRSAS, and flexible use of state and federal block grant resources. Use of a portion of the newly created federal Children's Health Insurance Program is included in this proposal as a way to expand capacity and to address the lack of available services for non-Medicaid eligible uninsured or underinsured children. Finally, these fiscal reform strategies are based upon the assumption of continued funding by each child serving agency of those mental health services which fall within the scope of their responsibility.

Submission of a 1915B Medicaid Waiver. DMHMRSAS will submit a separate 1915B Medicaid Waiver for behavioral health benefits to the Health Care Financing Administration (HCFA) for implementation in 1998. A 1915B Waiver is provided to states by the federal Medicaid authority to allow a state to retain federal Medicaid funds at an agreed upon level, and to shift funds from in-patient to community services through assigning services, gaining greater flexibility and management control.

In October, 1996, Commissioner Peet (DMHMRSAS) and Commissioner Concannon (DHS) signed a Memorandum of Understanding that broadly describes how the two departments will plan and coordinate Maine's managed care initiatives. DHS has applied for a waiver to manage Medicaid physical health services. DMHMRSAS, under a separate 1915B waiver, will manage behavioral health Medicaid services. For the past year, DMHMRSAS has been working in conjunction with staff from the DHS Bureau of Medical Services and consumer and provider groups on the technical and design aspects of the new system. The waiver would allow DMHMRSAS to achieve a single point of gatekeeping authority and accountability for the assessment of need and delivery of services, effectively managing Maine's mental health resources, and to reinvest cost savings back into the system. Implementation of a behavioral health waiver is projected to start after July, 1998.

Title IVE Funding. Title IVE is a federal entitlement program providing partial reimbursement for the cost of maintaining AFDC-eligible children in out-of-home care settings. As utilization of institutional care is decreased, there will be a need to expand the capacity for alternative treatment settings within the community such as crisis stabilization programs, therapeutic foster care homes, and transitional living homes. For eligible children, room and board costs for these services are reimbursable through Title IVE. An agreement between DHS (the federally designated agency) and DMHMRSAS would allow the use of these funds to offset room and

board costs for mental health community services. The Department of Corrections has already entered into such an agreement with DHS, and is currently awaiting DHS approval of proposed policies and procedures.

Federal CMHS Mental Health Block Grant. Federal funds are available through a Block Grant mechanism to each state (based on a funding formula) to support the development of a community-based mental health system. DMHMRSAS currently allocates 50% of funds received through the block grant for the provision of mental health services for non-Medicaid eligible children through provider contracts. Beginning with the next block grant cycle, DMHMRSAS will shift all possible block grant funds to the provision of children's services. Additional funds will be targeted toward activities identified as priorities by families for which state funds have traditionally been used. By refinancing these activities with the block grant, state funds will be made available for use as Medicaid match. Intended use of block grant funds includes providing support and training to families involved in system planning through the local QICs; expanding parent-to-parent support activities; and the provision of mental health services not reimbursable with existing categorical funds.

Children's Health Insurance Program. The Children's Health Insurance Program is a newly created federal block grant provided to states (based on a funding formula) for the purpose of providing health care services to uninsured low-income children. A portion of these funds must be used for mental health services. Options available to states include expanding Medicaid coverage to uninsured low-income children; obtaining coverage for children under group or individual plans in the private market; or purchasing services directly from providers. Maine state agencies are currently planning how best to utilize these funds. Inclusion of a portion of these funds within the proposed children's mental health system of care is recommended. Including these federal block grant funds within the proposed new management structure is important in order not to fragment the Medicaid and non-Medicaid components of the system.

State General Fund Revenues. Although considerable work has been done individually by each state agency to maximize federal revenue, there has been no comprehensive effort to maximize federal funds across all child-serving agencies. The use of blended financing tied to the child's individual service plan will enhance the state's ability to utilize general revenues and community development funds to provide community-based services not reimbursable under Medicaid, and to serve non-Medicaid eligible children. With blended funding each agency retains control of its funds and provides the fiscal support for that specific service or function identified on an individualized plan for which that agency has responsibility and/or an identified funding source. Through blending, many of the identified services and support on each ISP can be provided in a way that maximizes all revenue resources. There may not be an existing funding source for all services and supports on each ISP. To address these needs, flexible funds are necessary. While each system has small amounts of flexible resources, the ability to also pool funds from all agencies is recommended in order to enhance flexibility in addressing identified needs which are not fundable through Medicaid or for non-Medicaid eligible, uninsured or underinsured children.

MEDICAID RULE REVIEW

Section Two of LD 1744 requires that the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Human Services review current Medicaid rules for children's mental health services and to adopt new rules consistent with the goal of providing a comprehensive network of children's health services in the least restrictive and most appropriate settings."

In order to implement this section of the Resolve, staff from the two Departments have met a number of times. The following decisions have been made.

- In the longer term (the next 12 to 18 months) a managed care system for children with behavioral health problems will be established. There is currently a committee working on a behavioral health managed care system. This committee has been focused on the structural design for a system to manage care across all of DMHMRSAS's populations. The next phase of this work is to address the specific needs of each population including children within this framework.

- The Departments, with the assistance of an expert consultant, have conducted a review of Medicaid rules applicable to providing care and treatment for children as required in LD 1744. Eleven policies covering fourteen services in the Maine Medical Assistance Manual were analyzed as part of this review. The conclusions are that Maine has done an excellent job of providing a wide range of Medicaid-funded services for children with behavioral health care needs, but that the services have developed as separate entities and often are not part of a comprehensive service plan. The Departments are continuing to work with the consultant to revise the rules consistent with the goals of the 1744 legislation.

- In the short term, a number of actions are being taken to assure that children are placed in the least restrictive and most appropriate settings.

- The Bureau of Medical Services in the Department of Human Services is strengthening its utilization review policies and procedures, including more specific payment authorization for hospital-based services and a more focused review of hospitals' discharge planning efforts. A nurse has been hired by the Bureau to strengthen the capacity of the Bureau to carry out these functions.

- Bureau of medical Services, in a joint effort with the Department of Mental Health, Mental Retardation and Substance Abuse Services is developing a policy which will require providers who serve children that do not have a caseworker to contact the Department of Mental Health, Mental Retardation and Substance Abuse Services before children are discharged from intensive service settings.

- The Departments are reviewing, with the intent of streamlining, licensing rules that govern out-of-home placements for children. Rules and regulations which inhibit placement of children in the least restrictive settings will receive priority attention.

QUALITY IMPROVEMENT

In order to effectively manage an integrated system of care for children and youth in Maine, DMHMRSAS proposes the development of an integrated child information system and accountability structure that includes common data collection tools and procedures, including uniform intake and assessment protocols and common protocols and procedures for monitoring child, family and service system outcomes.

Each of the state child serving agencies currently maintains separate information systems that track limited client descriptive, service encounter and financial information. Since these existing information systems were developed, to a large degree, in isolation, contain different data elements, and are focused predominantly on service and financial information, they provide a limited, fragmented, and incomplete picture of the child and family and their interaction with the service system. The current level of fragmentation within existing information systems makes it difficult to answer with certainty even very basic questions about the individuals served and the services they receive, such as "What is the total number children served with behavioral and emotional difficulties?", thus severely limiting the usefulness of the data for making program and policy decisions.

It is essential for the effective management of the proposed system of care that a comprehensive child information and accountability system is developed that contains the following core components:

Uniform Intake and Assessment Tools and Procedures. These procedures will allow for the systematic collection of child and family descriptive, diagnostic, and level of care information on all children and youth who enter the system of care. This would provide common profile information on all children and adolescents who receive services within the system and capture the behavioral, functional and clinical information necessary to guide decisions on the intensity of services required to most appropriately support the child and family. DMHMRSAS has recently established a Uniform Intake and Assessment Development Task Force to assist in the development of uniform intake and assessment tools and procedures to be used across its designated target populations. This development group, with expanded representation from other interagency stakeholders, would be an appropriate form for the development and implementation of uniform intake and assessment tools and procedures.

Comprehensive Service Use and Encounter Information. This component forms the core of the integrated MIS and would capture child and family specific service use and encounter data across all participating child serving systems. This information is essential for assessing service use and expenditure patterns and trends, monitoring local service system capacity and for evaluating the extent to which services are individualized to meet the unique and changing needs of individual children and their families. The DHS/BMS MMIS Medicaid Claims data system currently captures a large portion (approximately 60% to 70%) of behavioral health related child service encounters. In order to obtain a comprehensive picture of service use within the developing system of care the current Medicaid claims data system would need to be expanded to incorporate all non-Medicaid reimbursable service encounters.

Uniform Individualized Support Planning Protocol and Tracking System. Since the Individual Planning Process is the cornerstone of the system of care, it is essential to assess the quality and integrity of this planning process, including the degree to which plans are individualized and based on the needs of the child and family, the degree to which we

incorporate and build on child and family strengths, and the extent to which goals are clearly articulated and measurable. This tracking system would also assess individual goal achievement, the type and amount of service system and community resources used, personal and resource barriers that prevent the achievement of goals, and the type and number of unmet needs. This tracking system would require an integrated computerized case management system that would serve as an automated case record and planning tool for case managers and as a child outcome tracking system. A number of initiatives are currently underway in state government to design an integrated case management system (MACWIS, DMHMRSAS Case Management Application, etc.) that could serve as the foundation for this system.

System for Tracking Core Child and Family Outcomes. The final component of the proposed accountability system is the development of a system for assessing and tracking key child and family outcomes.

Through on-going work in developing performance-based contracts, DMHMRSAS, in collaboration with DHS and other service system stakeholders (e.g., consumers, family members, and service providers) has identified key performance goals and measurement indicators for each of its' child-service program areas, and has selected from this list of outcome domains the following "core outcome measures":

1. Child Safety - Absence of abuse and neglect
2. Child and family behavioral and emotional strengths;
3. Progress toward individualized goals;
4. Youth and family satisfaction;
5. Restrictiveness of living arrangement;
6. Progress in school;
7. Involvement with law enforcement and correctional system.

The Department will develop uniform assessment tools and data collection methods for each of the above outcome areas and will assume ongoing responsibility for management of the quality improvement process. Over the past six months, the Department's Office of Quality Improvement has collected a number of measurement tools in each of these outcome areas that are currently used in other state systems and in child service system research projects. The Department will establish an interagency stakeholder group to review and select core outcome measures and data collection strategies for regular use in the proposed system of care.

BENEFITS OF THE PROPOSED SYSTEM OF CARE

Currently, Maine's child-serving systems are separate and distinct entities, with separate missions and mandates. Each child-serving agency provides mental health services within the context of its mandated function. Funding streams are also separate, distinct, and limited and flow from the federal level to the state level to the community through insular departmental channels. Whichever system a child enters, that system frequently struggles to provide whatever services are necessary, including mental health services. Children generally have to penetrate deeply into a system or be in crisis before obtaining the array and intensity of mental health services needed. Even then, a full array of services is usually not available unless the child and family are referred to another system or to the local case resolution committee.

In the proposed system of care, children's mental health needs will be identified early, regardless of individual family circumstances. Children will receive the same high quality mental health services regardless of where the child and family lives. Child-serving agencies will each bring their specialized function to the care of children with mental health problems, although DMHMRSAS will have the lead responsibility for mental health treatment. And perhaps most importantly, the new system will flexibly arrange service, supports (and dollars), based on an individual child's needs.

Benefits of the Proposed System of Care

Current	*Proposed*
• Lack of coordination between child-serving agencies	• Comprehensive system of care
• Lack of clear agency roles and responsibilities	• Agencies roles and responsibilities defined functionally
• Fragmented services	• Local service networks with single point of authority
• Access to service limited by point of entry	• Single mechanism for access to full array of services
• Conflicting definitions and priorities	• Uniform definitions and clear set of priorities
• Limited, agency-specific gatekeeping	• Single gatekeeping mechanism for system of care
• Overutilization of in-patient services	• Expanded community-based capacity
• Limited funding flexibility	• Expanded pooled, blended and flexible funding
• Limited youth and family participation	• Partnership model involves youth and family in all decision-making
• Gaps in services for transition-aged children	• Improved transition between children and adult services
• Multiple systems of fragmented accountability	• Single point of accountability
• Lack of uniform MIS and performance measures	• Tracking of uniform cost and outcome measures

VII. INTERAGENCY INFRASTRUCTURE DEVELOPMENT IN SUPPORT OF A SYSTEM OF CARE

The Children's Cabinet, created in 1995 by Governor Angus King, promotes the coordination of policies and service delivery systems to support children, families and communities. The Children's Cabinet builds upon the structure defined by the Legislature in 1994 for the Interdepartmental Council (IDC) and is composed of the commissioners and staff of the departments directly related to children and families: Corrections; Education; Human Services; Mental Health, Mental Retardation and Substance Abuse Services; and Public Safety. Through the efforts of the Children's Cabinet, the following structures and initiatives have been developed:

- The Children's Policy Committee is composed of Bureau Directors and agency staff who coordinate and implement interdepartmental initiatives originating in or brought up to the Children's Cabinet. Activities of this committee include coordination of legislation affecting children's policy; communication regarding department budgets; review of rulemaking; and coordination of new resources. Ongoing committee work includes oversight of out-of-home service provision, new program development, and rate setting for residential treatment centers.

- One current initiative under the direction of Children's Policy Committee is the School-Linked Mental Health Services Project. This project has identified major mental health service needs in schools and has developed six local school-mental health pilot projects. Mental health service expansion to schools under the Children's Mental Health Service System Plan will be designed in conjunction with this initiative, and will be based on their recommendations.

- Three Regional Children's Cabinets have been established which mirror the composition of the Governor's Children's Cabinet. The regional cabinets are working on coordination of local services, identification of service gaps, and resolution of barriers to seamless service delivery. With oversight from the regional cabinets, nine local interagency case resolution committees have been formed. These committees work collaboratively with local providers, staff, and families to identify resources and to help families with multiple needs access necessary services. In 1997, the Children's Cabinet distributed $1.07 million in "pooled" funds (contributed by participating agencies) to the three regions for use by the local case resolution committees for the provision of short term, flexible services not available through traditional funding sources.

- A major initiative of the Children's Cabinet, and a key infrastructure component in a system of care, is the integrated case management system. Recognizing that people often have multiple needs requiring multiple service providers, a primary case management system is being developed that will support the family as an integrated whole, and will facilitate access to all needed services. When two or more state or federally funded case managers work with a family, one of these individuals will become the primary case manager. This decision will be made by the family and involved service providers, subject to safety and statutory considerations, for example, a child in a protective case being served by the Bureau of Child and Family Services in DHS. The function of the primary case manager will be to review the assets and needs of the family; determine any

gaps or overlaps in services provided; use a strength-based process to resolve common problems; develop a common case plan based upon the overall case goal; coordinate services; monitor progress; and convene and chair meetings as needed. A master client registry and online resource directory is being developed to support the provision of equitable access.

- An automated system is also being developed to allow for shared information to track integrated data elements. The initial components of the automated system include systems from DHS, DOL, DOC, and DMHMRSAS and community programs such as Community Action Agencies. Issues of confidentiality and client release of information are being addressed through the committee with support from the Attorney General's office. Pilot sites have been selected in Greater Bangor, Downeast, Sanford, Lewiston and Bath. Informational meetings have been held with each of the sites, regional steering committees have been formed, and training and implementation plans are being designed. Implementation is targeted for January, 1998, with each site providing primary case management to ten families.

Also, many administrative functions which were originally managed independently by DMHMRSAS and DHS have been combined under one service center. These functions are auditing and licensing.

VIII. STATE AGENCY ROLE AND RESPONSIBILITY AGREEMENTS

The state child-serving agencies have agreed that the Department of Mental Health, Mental Retardation and Substance Abuse Services will be the lead agency for the children's public mental health service system. While Section 6201 of Title 34-B, MRSA, currently provides DMHMRSAS with statutory authority for overseeing children's mental health services, this statute limits the department's responsibility to children who are not currently receiving services from other systems. In order to create a unified children's mental health system with DMHMRSAS assuming lead responsibility, this statute will need to be amended. Responsibilities of the DMHMRSAS as the lead agency include:

- Design and implementation of a unified children's mental health service system
- Creation and management of provider networks in seven local service areas
- Establishment of a single point of gatekeeping authority and accountability for assessment of children's mental health needs and service delivery within each network
- Establishment of uniform standards and procedures, including uniform intake and assessment; clinical guidelines and program definitions; standards for case management; licensing and certification; procedures to ensure consumer choice; standards of confidentiality; and a grievance and appeals process
- Provision of a single service access mechanism in each service area and available to other children's agencies such as Child Protective Services
- Development of adequate capacity to ensure access to a full array of services in each service area
- Provision of a consolidated crisis response system, including crisis stabilization beds, that serves all children, regardless of custody status or living arrangement
- Care coordination for all clients in the children's mental health system, and participation (when applicable) in Maine's integrated case management system
- Establishment of mechanisms to track individual and system outcome measures
- Management of resources through performance-based contracts with providers, ensuring that services are provided at the appropriate level of care, and that resources are redirected from inappropriate high cost services into needed community-based alternatives
- Provision of continuous quality improvement mechanisms to assure system effectiveness and responsiveness and to ensure clinical "best practices" are used throughout the system

Making DMHMRSAS the "lead agency" in a "unified system of care" does not simply shift the responsibility for serving a subset of children from the other child-serving agencies to DMHMRSAS; nor does it change the overall administrative relationship between the departments. Rather, it creates a clearly defined partnership between agencies for the express purpose of providing uniform, high-quality mental health services to children whenever and wherever it is most appropriate.

Under this model, a variety of arrangements for the delivery of services will be possible, depending on the specific needs of the children and the statutory responsibilities of the child-serving agencies involved. Children who have been adjudicated to the juvenile justice system will remain in the custody of the Department of Corrections, but will receive mental health services through DMHMRSAS. Mental health services will be available on-site at the Maine Youth Center; in the community through joint case management, crisis intervention, individualized services and specialized outpatient programs; and in secure residential treatment programs for adjudicated youth with severe mental health problems. A signed Memorandum of Agreement (see Appendix F) reflects the agreement between DMHMRSAS and DOC to develop the policy, program and administrative components necessary to provide mental health services for youth in the correctional system.

Children who are in the custody of DHS will remain in this legal status, and the mandated role of the Bureau of Child and Family Services (BCFS) will remain unchanged. However, DMHMRSAS will be responsible for the delivery of mental health services, under the terms and conditions of the MOA (see Appendix G1). These terms strengthen the coordination of the two departments, ensure access of children in the custody of BCFS to community mental health services, and develop specialized treatment programs needed to address the specific mental health needs of children in DHS custody.

Similarly, a partnership agreement with DOE is currently being negotiated which will include a wide variety of mental health consultation, assessment and treatment services delivered on-site in local schools and a single process for accessing mental health services to eliminate the need to justify residential services on the basis of educational need based on the School-based Mental Health Initiative. DMHMRSAS and Child Development Services have already agreed to revise the 1994 MOA to reflect new federal law and the new DMHMRSAS structure, and to explore the possibility of the co-location and coordination of Infant Mental Health/Development Specialists with DOE's local Child Development Services sites (see Appendix G2).

The work of operationalizing new interagency relationships will build on the signed Memoranda of Agreement, and will culminate in March, 1998, with signed Memoranda of Understanding between the Department of Mental Health, Mental Retardation and Substance Abuse Services and each of the other child-serving agencies, formalizing new arrangements for the financing and delivery of mental health services for children. As the departments work together to develop the new integrated system of care, further refinement of interagency agreements will be necessary, and new issues (e.g., between child-serving agencies other than DMHMRSAS) will emerge. The signed Memoranda of Understanding will therefore be revised annually, with the ultimate goal of developing a single MOU which would be signed by all child-serving agencies, and which would reflect mutual understanding about the interrelationship among all of the parties.

ADMINISTRATION OF THE MEDICAID BEHAVIORAL SERVICES PROGRAM

The administration of the state Medicaid program involves numerous functions, the majority of which are the responsibility of the Bureau of Medical Services within DHS as the designated federal single state agency. These functions include the submission of state plan amendments, the adoption of rules, and claims processing payment.

In addition to the single state agency requirements, there are other functions which are currently shared between the Department of Human Services and Department of Mental Health, Mental Retardation and Substance Abuse Services as outlined in a 1996 Memorandum of Agreement between the departments (see Appendix H). DMHMRSAS and DHS are currently drafting a Medicaid waiver request which will establish a managed care system for behavioral health services for a designated population in Maine. When this system is in place, the Bureau of Medical Services will subcontract with DMHMRSAS for certain administrative and/or management functions. Such functions as contracting, prior authorization, provider enrollment, certification of medical eligibility, provider relations, utilization review, audit review and budget management will be the responsibility of DMHMRSAS, which may directly deliver or contract for these services (see Report in Appendix I).

During the period of transitioning to this managed care system, the departments have agreed to the adoption of specific rule changes and changes in practice to support the expansion of community-based services identified as underdeveloped in the DMHMRSAS service capacity study (see page 43). Under this agreement, the Medicaid Rule identifying mental health services administered by DMHMRSAS (Chapter 65) will be modified by emergency rule change to expand the definitions of crisis services and therapeutic case management, and to add in-home direct care staff services to the array of services eligible to children through DMHMRSAS provider contracts. The addition of in-home direct care services will allow greater access to staff with specialized behavioral skills. Currently, many children are being placed outside of their homes due to their inability to access these specialized in-home services.

To support this expansion, the departments of DHS and DMHMRSAS have jointly prepared a general fund budget request of $2.3 million (federal Medicaid funds will be $5.6 million) for inclusion in the Governor's proposed budget for FY98 and approximately $4 million for FY99 ($7.38 million in federal Medicaid funds). This will provide additional funds to begin expansion of the community-based services necessary to provide appropriate services to maintain children in their communities, help prevent inappropriate out-of-home placements, and start building the capacity needed to return children home from out-of-state placements.

IX. IMPLEMENTATION PLAN

CAPACITY STUDY

The chart below describes an "ideal" system of mental health care for children with serious mental health problems, based on national experience with state-of-the-art service systems. Capacity estimates have been calculated on the basis of the number of children who would need to access each of the core service components annually in a "fully mature" system of care. The specific configuration described here reflects the most up-to-date assumptions available about the necessary balance between service components, and has been tailored to reflect Maine's rural geography and unique sociocultural and economic conditions.

It is important to recognize that the process of building a comprehensive system does not proceed in a linear fashion. For example, during the initial phases there will be an increased need for crisis services, as the system learns to respond to new challenges and reduces its reliance on inpatient care. As the system matures, the need for crisis services is likely to decrease. It is therefore prudent to develop programs that can be converted to other uses as demand changes. Similarly, the funds currently invested in "excess capacity" (group residential programs and inpatient services) can only be freed up as alternatives become available. "Bridge funding" is therefore necessary to begin the conversion process.

The capacity study describes a system of mental health treatment services for all children in the target population, regardless of custodial status or living arrangement. Some of this capacity will therefore need to be deployed to serve children in environments controlled by the other child-serving agencies, such as school settings, and/or be tailored to the special needs of children in the custody of other agencies.

The capacity study does not, however, reflect programmatic modifications or enhancements that will need to occur in the basic (non-mental health) services delivered by the other child-serving agencies, nor does it address prevention efforts. As the system develops, it will be critical for the collaborative planning process begun with LD 1744 to continue at both the state and local levels. Before new services become operational, any potential impact on other systems will need to be anticipated, and plans made accordingly. At the same time, collaborative efforts (particularly in local schools) can strengthen, enhance and supplement existing prevention initiatives, such as the Healthy Families Program.

The capacity study, following the mandate of LD 1744, does not describe or quantify the services needed by other children with special needs, such as those with mental retardation, autism, or other developmental disabilities. Some of these children are currently served by existing programs (e.g., children's crisis beds), and many face problems of access similar to those of children with mental health needs. Much of the infrastructure and administrative collaboration designed in this plan will serve as a platform for a system of care that meets their needs. However, a parallel analysis and capacity study is needed to ensure the availability of a comprehensive array of services throughout the state. The work of a recent Legislative Task Force on Autism and ongoing planning efforts of the Developmental Disabilities Council will help to inform this process.

LD 1744: System of Care Capacity and Sizing Summary

Core Service Component	Estimated # of Children Needing Service	Required Capacity	Current Capacity (# served or # of beds)	Additional Need (N) / Excess (E) Capacity	Staffing/Resource Needs	Estimated per child Cost	Cost for Additional Services
Core Clinical Services							
Clinical/Outpatient Services	14,998 (75% of target)	14,998 children	8,301 children	6,697 (N) children	84 new positions -based on 1:80 staff /client ratio	$1,440 (per child)	$9,643,680
Home-Based Services	600 (3% of target)	600 families	400 families	200 (N) families	10 two therapist teams (Based on a team seeing 20 families per year)	$5,884 (per family)	$1,176,800
In-Home Behavioral Health Services	800 (4% of target)	800 families	90 families	710 (N) families	178 In-Home Beh. Specialist positions (each position serving 4 families per year)	$7500 (per family)	$5,325,000
Individualized Planning/Case Management							
Therapeutic Case Management	800 (4% of target)	800 children	147 children	653 (N) children	65 ICM positions (Based on avg. caseload of 10-12)	$4,143 (per child)	$2,705,379
Case Management	1,600 (8% of target)	1,600 children	322 children	1,278 (N) children	85 positions (Based on avg. caseload of 15-20)	$3,200 (per child)	$4,089,600
Crisis Intervention							
Crisis Response	1,200 (6% of target)	1,200 children	870 children	330 (N) children	6 FTE Outreach positions	$636 (per child)	$210,000
Crisis Stabilization: Community Crisis Beds	835 (4% of target)	33 (beds) ALOS [1]: 10 days 70% occup.	28 (beds) (715 children)	5 (beds) (N) (120 children)	1-2 crisis workers for each residence	$3,750 (per child)	$450,000
Acute Inpatient	600 (3% of target)	77 (beds) ALOS: 40 days 85% occup.)	163 (beds) (1264 children)	86 (beds) (E) (667 children)	No further development needed	$32,043 (per child)	$0.0 [2]
Residential Treatment							
Therapeutic Foster Care	1000 (5% of target)	822 (beds) (ALOS=270 90% occup.)	636 (beds)	186 (N) (226 children)	1-2 trained foster parents (186 new positions)	$41,099 (per child)	$9,288,374
Group Homes /Residential Treatment Services	400 (2% of target)	219 (beds) (ALOS:180 days 90% occup.)	413 (beds) [3]	194 (beds) (E) (236 children)	No further development needed	$71,280 (per child)	$0.0 [4]
Family and Child Supports							
Respite Services	2,000 (10% of target)	2,000 families	1514 families	486 (N) families	121 Respite workers serving 4 families per year	$1,000 (per family)	$486,000
Totals							$33,374,833

ALOS refers to average length of stay.

[4] A portion of the funding currently allocated to these service areas may be available for diversion to community-based service areas (e.g.,Therapeutic Case Management & Crisis Outreach) once ufficient service capacity is built in the community.

Includes licensed group home and residential treatment beds - does not include utilization of out-of-state beds.

Target Population Assumptions:. 1) 11% of child population 0-21 years (N=386,815) will have mental health challenges serious enough to warrant treatment (N=42,550). 2) To further reduce he target population it was estimated that 47% of those in need would require public system services (19,998). This estimate is based on service use data from other system of care development ites (N.C., D.C., S.C.) showing that approximately 53% of children are served with private sector services.

TRANSITION PLAN

Developing a unified children's mental health system which provides a full array of services will require significant changes in financing: new program development; the implementation of new administrative structures and collaborative arrangements; and major workforce development efforts. To reflect the complexities involved in a change of this magnitude, the Department has developed a five year transition plan for the creation of the necessary service capacity, infrastructure and management mechanisms.

In addition to having a clear vision of what the system should look like (provided by the capacity study), effective management of a complex change process requires careful attention to sequencing and a mechanism for making mid-course corrections. The process will necessarily be incremental, as resources are shifted and capacity develops.

Initially, substantial effort will be focused on the development of effective alternatives to high-cost placements and other services for "heavy users" (the relatively small number of individuals who, due to the lack of appropriate services, consume a disproportionate share of resources). Simultaneously, capacity must be developed to provide early intervention in order to reduce the overall need for high-cost services. As dollars begin to shift, gaps in the service array (particularly for intermediate levels of care) can begin to be filled. Throughout the process, accommodations must be made for the fact that it will take time for the workforce to develop the specialized skills needed to deliver new types of services, and in recognition that as the system develops and becomes more effective, the need for expensive and restrictive services will diminish.

In selecting priority services for implementation, the needs of three populations of children have been targeted: 1) children currently placed out of the state due to the lack of appropriate services; 2) children "at risk" of placement out of state; and 3) children "at risk" of out of home placement due to the lack of appropriate in-home services. Service capacity to be developed immediately includes specialized in-home behavioral care attendant services; therapeutic case management; and expansion of the department's consolidated crisis response system to include additional children's crisis response teams and crisis stabilization beds. Staff from both DMHMRSAS and DHS report that lack of short term crisis stabilization beds results in children being placed inappropriately in hospitals both in and out of state. These priority services provide the cornerstone of a strong community-based system and must be in place in sufficient capacity as the system shifts to ensure children's needs are safely met during the transition.

The capacity study suggests that Maine currently has excess group home and residential treatment capacity. However, there is a lack of intensive residential treatment targeted to specific clinical issues and problem behaviors. For example, children with complicated clinical sequelae to abuse histories, who often self-mutilate or act out against others, currently have few options for specialized treatment in Maine. Developing alternatives for a subset of the children placed in "high-cost" out-of-state residential programs will therefore require the conversion of some existing group home capacity to more specialized treatment programs over the course of the transition.

Currently there is a lawsuit pending in federal court against the Department of Human Services by several families alleging an inability to access, through Medicaid, the necessary home and community-based services to maintain their children with mental impairment in their homes. Services targeted for priority implementation are consistent with those identified by the families initiating the lawsuit. The funding necessary to create and expand the priority services targeted for development within the first year has been included in the Governor's Part II request.

An additional funding strategy to support the return and/or diversion of a targeted number of children from out of state placements is the redirection of Medicaid seed funds into the purchase of appropriate Maine-based services. Through a joint DMHMRSAS/DHS project, a targeted number of children could be redirected from out of state placements, with services coordinated by a DMHMRSAS or DHS case manager. The existing structure of the regional cabinet would be used to ensure effective resource management, prevent cost-shifting between systems, and monitor placements for appropriateness. This would provide a cost neutral mechanism for the planned diversion or return of children placed out of state, while providing another means to develop service capacity in Maine. The redirection of existing Medicaid seed funds is a major financing strategy for the expansion of many of the services identified in the implementation plan.

INFRASTRUCTURE AND SERVICES/SYSTEM MANAGEMENT

Development of an infrastructure and effective management mechanisms are critical to implementation of this plan. The Department's managed care plan (see report in Appendix I) provides the long-range framework for the service system described in this document. Several steps in this direction have already been taken. A Request for Comments on a Network Manager design has been released for public review. Based on comments, a local service network management structure will be finalized, with implementation to be phased in over the next three years. Task forces are already working on service and program standards for uniform intake, assessment, case management and clinical practice. Finally, continuous quality improvement measures including outcome measures, performance-based contracting and consumer-family assessment teams are planned for implementation in 1998.

The Department is considering the option of using the DHS information system, including the Point of Sale Claims system, the Decision Support system, and the automated child welfare case management system.

Along with the creation of local provider networks, the Department will also be working to reform licensing standards to bring regulations in line with the new service structure, and a management information system is being developed to facilitate access, information sharing system management and monitoring. Service planning and resource utilization will both be substantially improved with the development of more sophisticated data systems and computerized system modeling capacity.

ONGOING PLANNING PROCESS

Recognizing that no plan is static and that continual monitoring and modifications will need to be made as the system develops, the Department will continue to work with DHS, DOE, DOC, families and providers and will reconvene the stakeholder workgroup established through this process annually to review progress and make needed modifications and recommendations. Additionally, development of the full service array within a system of care must be consistent with the unique needs and service gaps as identified by the local service areas and their respective Quality Councils. While some core services need to be expanded statewide, service availability varies from region to region. Input from local Quality Councils and family groups, along with local school districts, and DMHMRSAS, DOC, and DHS regional staff, will help to guide specific resource development decisions.

Service Development Sequence *Year 1*						
Service	***Description***	***Unit/Staff***	***Annualized Total Cost***	***Location***	***Funding Source***	***Timelines***
In Home Behavioral Specialist	Direct care staff to provide specialized behavioral supports with in the child's home for 200 children	50 FTE	$1,500,000	Statewide	Medicaid State seed (included in Part II budget request)	1/98 - 6/98
Crisis Response Teams	Clinical staff providing telephone and face-to-face crisis intervention services	3 2 person teams	$210,000	Add 1 team in each Region	Medicaid State Seed (included in Part II budget request)	2/98 - 6/98
Crisis Stabilization Beds	Out of home facility providing short term crisis stabilization, medication management for 77 children	3 beds	$288,750	2 in Reg. II 1 in Reg. III	Medicaid State Seed Title IVE DMHMRSAS Community Reinvestment Funds	4/98 - 6/98
Case Management	Clinical staff to provide assessment, individualized planning, coordination of services, monitoring to serve 400 children	20 staff	$1,280,000	Statewide	Medicaid State Seed DMHMRSAS (included in Part II request)	1/98 - 4/98
Training and Staff Development	Orientation, skill building training for new staff	236 staff	$118,000	As applicable	Medicaid State Seed Title IVE Gen. Revenue (included in Part II request)	1/98 - 6/98

Service Development Sequence *Year 2*						
Service	***Description***	***Additional Unit/Staff***	***Annualized Total Cost***	***Location***	***Funding Source***	***Timelines***
Crisis Stabilization Beds	Add 2 additional beds for total of 5 new beds to serve 43 children	2 beds	$161,250	As determined based on need	Medicaid (see request in Part II budget)	7/98 - 10/98
Case Management	Continued Expansion to serve 400 additional children	20 staff	$1,280,000	Statewide	Medicaid (see request in Part II budget)	7/98 - 6/99
Core Clinical/Outpatient Components	Child psychiatric/psychological assessment, individual/group/family therapy medication management to serve 800 children	10 FTE	$1,152,000	Statewide	Medicaid (see request in Part II budget)	7/98 - 6/99
Training and Staff Development	Orientation and skill building for new staff	400 staff	$118,000	As applicable	Medicaid Title IVE Gen. Revenue (Part II Request)	7/98 - 6/99
In-Home Behavioral Specialist	Expand to serve additional 600 children for a total of 800 in FY99	150 FTE	$4,500,000	Each service area	Medicaid (seed request in Part II budget)	7/98

Service Development Sequence *Year 3*					
Service	***Description***	***Unit/Staff***	***Annualized Total Cost***	***Location***	***Funding Source***
Early Intervention MH/MR/Autism Specialists	Staff with expertise in infant mental health, MR and autism are co-located at CDS sites to enhance, expand full range of prevention and early intervention services from birth - five	16 staff	No additional cost	16 local sites	DMHMRSAS Gen. Revenue Medicaid
Parent Support	Parent-to-parent support provided by GEAR organization	3 staff	$ 75,000	Add 1 each service area	Through diversion of CMHS Block Grant Gen. Revenue
Mental Health Staff Deployed to Maine Youth Center	Provide assessment, individual, group and family therapy and linkages to local provider network upon release	5 FTE	$576,000	Maine Youth Center	To be determined
Intensive Home-Based Services	2 therapist teams provide 13 week intensive in-home clinical intervention	4 2 person teams	$561,922	Targeted to areas of high rate of hospitalization	Medicaid General Revenue
Therapeutic Case Management	Intensive case management with a clinical component. Case load size 10 to 12 families per case manager.	35 FTE	$1,450,050	5 per service area	Medicaid General Revenue
Therapeutic Case Management Liaisons	Case manager to work with youth in community corrections system through DOC regional offices	7 FTE	$290,000	1 for each service area	Medicaid DMHMRSAS Gen. Revenue

Service Development Sequence *Year 4*					
Service	***Description***	***Unit/Staff***	***Annualized Total Cost***	***Location***	***Funding Source***
Therapeutic Foster Care	Develop in conjunction with DHS existing program for children not in DHS custody.	30 beds	$1,520,663	10 beds in each Region	Reinvestment Medicaid Title IVE Gen. Revenue
Core Clinical/Outpatient Services	Expand availability of psychiatric/ psychological assessment, treatment, and medication management to serve additional 2400 children	30 FTE	$3,456,000	Statewide	Reinvestment Medicaid Title XXI General Revenue
Therapeutic case management Liaisons to schools	Clinical/case management to local school districts to provide consultation, assessment, services & liaison to network	7 staff	$290,000	1 in each service area	Medicaid Additional to be determined
Respite Services	Continued expansion of respite services to serve an additional 200	50 FTE	$200,000	All 7 service areas	General Revenue
Parent-to-Parent Support	Continued expansion of GEAR to provide parent-to-parent support	7 staff	$225,000	All 7 service areas	CMHS Block Grant Gen. Revenue
Training & Staff Development	Continued orientation & skill building for new and current staff.	Approx. 400 staff	$118,000	Targeted as needed	Medicaid Title IVE General Revenue
Community Specialized Residential Group Homes	Dual diagnosed small intermediate (6 month) residential treatment program	To be determined	To be determined	To be determined	Redeployment of current group home use

Service Development Sequence: Continued Expansion After Year 4		
Service and Description	***Location***	***Funding Source***
Continued expansion of full array of services in each service area based on local service area's identification of need including: • Clinical/outpatient (44 positions) • Respite (71 positions) • Home-based services (6 teams) • Therapeutic case management (16 positions) • Case management (45 positions) • Conversion of existing group home beds to serving specialized populations such as youth sex offenders; dual diagnosis; independent living for youth in transition.	As identified by each service area	Reinvestment funds Medicaid General Revenue Title XXI
Development of specific school-based and school-linked services as identified by the school/mental health task force	1 in each service area	Reinvestment funds additional to be determined
Shared DHS/DMHMRSAS expansion of treatment services specific to the needs of children in foster care as identified by a joint DHS/DMHMRSAS task force	Statewide	Reinvestment funds Medicaid Title IVE General Revenue

LD 1744
Implementation Plan
First Year Work Plan

Action	*Lead*	*Others Involved*	*Policy/Reg. Statutory Changes*	*Benchmark*	*Timelines*
Plan finalized	DMHMRSAS	Steering Committee	N/A	Copies of plan to HHS Committee Members	12-15-97
Create administrative structure to support implementation of target services	DMHMRSAS: Sawin Millett	DHS - BMS	Emergency rule change of Chapter 65 - Medicaid rules	Signed DHS/ DMHMRSAS Agreement re responsibilities and funding	12-19-97
Identify, assess and provide in-home services to target population	DMHMRSAS: Pauline Miller	DHS-BMS Providers	Contracts amended		12/97 to 7/98
Strengthen existing Medicaid gatekeeping procedures for out of state placements	DHS - BMS: Jim Gorman	DMHMRSAS	Applicable Medicaid rule changes	To be determined	11/97 to 1/98
Formation of 2 local services networks	DMHMRSAS: Nancy Essex	Providers QICs	Possible PL 691 modification	Contracts for services	1/1/98
Completion of Medicaid Waiver	DHS	DMHMRSAS: Sawin Millett	MOA	Submit to HCFA	2/98
Expand crisis response	DMHMRSAS	Regional Offices Providers	Contract amendments	One additional team in reach Region 3 additional beds operational	2/98 through 6/98
Expand therapeutic case management	DMHMRSAS	Providers Families	Standards and protocols Contracts	27 additional case managers	1/98 - 6/98
Expand Behavioral Specialist attendant capacity	DMHMRSAS: Rhama Schofield	BMS Providers	Contract	Additional 200 full time equivalent staff recruited and trained	1/98 - 6/98

LD 1744
Implementation Plan
First Year Work Plan

Action	*Lead*	*Others Involved*	*Policy/Reg. Statutory Changes*	*Benchmark*	*Timelines*
Complete deployment of information technology	DMHMRSAS: Gary Sawyer	DAFS - Bureau of Information Services	N/A	All DMHMRSAS sites and personnel have access to information technology	Completed 6/98
Develop cross-disability uniform intake form	DMHMRSAS: Jay Yoe	Providers Consumers Parents Staff	Unknown	Implement statewide	3/98
Implement diversion of children referred for out of state placement	DMHMRSAS	DHS - BMS Reg. Children's Cabinet	To be determined	Target children referred to DMHMRSAS provided case management, and diversion services	2/98 and ongoing
Create team to review and assess children placed out of state	DMHMRSAS	DHS DOE DOC Reg. Children's Cabinet	To be determined	20% of children placed out of state receive appropriate services in Maine	3/98 - 6/99
Agencies finalize agreements re roles and responsibilities	DMHMRSAS	DHS DOE DOC	To be determined	Signed MOAs	3/98
Develop mental health services for youth at Maine Youth Center	DMHMRSAS	DOC Providers	If needed	Mental health staff deployed to MYC and service provided	3/98 - 7/98

LD 1744
Implementation Plan
First Year Work Plan

Action	*Lead*	*Others Involved*	*Policy/Reg. Statutory Changes*	*Benchmark*	*Timelines*
Develop uniform outcome measures	DMHMRSAS: Jay Yoe	Parents Youth QICs Staff Providers		Pilot Incorporate outcome tools and monitoring in contracts	3/98 5/98
Creation of mental health school group to design mental health/school-based services based on current initiative	DMHMRSAS	Michael Lahti DOE Local school representation	To be determined	Service components identified Budget request prepared, if needed	3/98 - 9/98
Extend the case management tracking system to children's services	DMHMRSAS: Gary Sawyer	DOL	Privacy and security implications	Program contract identified	9/98
Develop care - coordination function	DMHMRSAS: Peter O'Donnell Holly Stover	Consumers Parents Providers	Possible change in licensing standards or Medicaid rules	Implementation of standards	5/98
RFP for Network Manager - Region I	DMHMRSAS: Sawin Millett	QICs BMS		Contract awarded	798 - 1/99
Establish linkage to interagency information sharing	DMHMRSAS: Gary Sawyer	DOL DOC DHS DOE Community Action		Interagency agreements and registry on line	Current - 12/98
Develop additional therapeutic foster care	DMHMRSAS: Team Leaders	DHS Providers QICs	Standards and protocols	Contracts	Beginning 7/98

LD 1744
Implementation Plan
First Year Work Plan

Action	*Lead*	*Others Involved*	*Policy/Reg. Statutory Changes*	*Benchmark*	*Timelines*
Develop secure MH/DOC treatment facility for adjudicated youth	DMHMRSAS	DOC	MOA	Program standards and protocols developed	Beginning 7/98
Continued expansion of therapeutic case management	DMHMRSAS: Team Leaders	Providers	Contracts	75 additional case managers recruited and trained	2/98
Therapeutic case managers assigned to liaison with DOC regional office	DMHMRSAS	DOC Providers	MOA Contract	Staff recruited and trained	Beginning 7/98
Expansion of respite services	DMHMRSAS	Providers	Contract	25 full time equivalent staff available	2/98
Begin co-location of EIS staff at CDS sites	DMHMRSAS	DOE CDS	MOA	Co-location complete a 3 sites	9/98
Training and staff resource development	DMHMRSAS	Muskie Providers	Contract Curriculum	Orientation and skill specific training provided to all new and redeployed staff	Ongoing 2/98-1/99
Formation of 5 local service networks	DMHMRSAS: Nancy Essex	Providers QICs		Contracts	1/99

*Detailed Implementation Plan covers first year only, in recognition that changes made need to occur in resource or infrastructure development sequencing for succeeding years.

APPENDICES

APPENDIX A:

The LD 1744 Planning Process,

Legislative Resolve, and Participant List

The Process to Implement LD1744 /Resolve Chapter 80: Designing A System of Comprehensive Mental Health Services for Children and Youth, and Their Families

Near the end of the first session of the 118th Legislature, members of the Joint Standing Committee on Health and Human Services authored a Resolve "to Plan for Services for Children with Mental Health Needs" which won passage and became Chapter 80 of the laws of 1997.

The impetus for the Resolve was the unusually high incidence of issues relating to children's mental health that came to the committee's attention during the course of the session. Because of the range of children's issues as well as the interdepartmental nature of the problems, the committee drafted the Resolve to address these issues from a comprehensive perspective, rather than in a piecemeal fashion.

The Resolve designated the Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) as the lead department, and instructed the department to prepare the plan in consultation with the Department of Human Services, Department of Corrections and the Department of Education. The comprehensive plan for the delivery of children's mental health services is due for submission to the Joint Standing Committee on Health and Human Services on December 15th, 1997.

Organizing LD 1744 Tasks

The department began organizing its approach to LD 1744 in June, 1997, immediately after the Resolve was approved. DMHMRSAS created a Steering Committee to guide the process by soliciting the participation of key policy level staff from the three other child-serving state agencies. Three members of the Joint Standing Committee on Health and Human Services were appointed from the legislature. Also serving was the Executive Director of the statewide advocacy organization representing parents of children with mental health needs, and two representatives from statewide service provider organizations. DMHMRSAS selected the Director of Internal Operations and the Program Manager for Children's Services. The Commissioner serves on the Steering Committee in an Ex Officio member.

The first meeting of the Steering Committee, supplemented by Children's Services regional team leaders, central office staff and parents of children with mental health needs was held on June 23rd. This session resulted in an initial work plan that addressed preliminary timetables for products specified in the body of the Resolve. This meeting also provided an opportunity for the group to query legislative members about the background of LD 1744, and to explore the parameters of the overall charge to the Departments.

The planning group was encouraged to undertake its charge within a comprehensive framework, employing creativity and innovation, rather than from an incremental, "tinkering" approach. At the conclusion of the initial plenary meeting, it was agreed that the group needed to expand in order to bring additional stakeholders from all quarters to the discussion.

A second meeting was held a week later, attended by over 50 interested individuals. The outcome of this session was to divide the work into three focused groups; Systems/Access; Services and Supports; and Finance. Each work group was facilitated by a member of the Steering Committee and staffed by DMHMRSAS personel.

Planning via Large Committee and Work Groups

From June through mid-September the expanded membership of LD 1744 undertook a planning process that supported specialized/intensive small group work followed by large group meetings on the average of once per month. The purpose of the large group sessions was to provide feedback from the small groups as well as to discuss next steps in the overall planning process. The Steering Committee exercised overall responsibility for shaping the month to month work plans and any changes or modifications to the production timetable set forth in LD 1744.

Each small group worked independently, developing its schedule, agenda and operational focus within the topic assigned. As the small group activity increased, so did the number of participants. Although choice of participation in small groups was left to the individual, facilitators for each group were successful in encouraging diverse representation from all stakeholders. ranging from parents to providers to state agency personnel.

Materials produced within each group, including minutes of meetings, were circulated to members either prior to at their next meeting. DMHMRSAS support staff coordinated the distribution of materials generated from work groups to the general membership at large so that LD 1744 products were available for everyone at the regularly scheduled monthly large group meetings.

Themes from Design Team (Large Group) Meetings:

Three more large group meetings were held during the planning process. Each promoted a theme and purpose endorsed by the Steering Committee that was felt to be timely, especially in the context of the planning cycle.

The **July 22nd meeting** was devoted to presentations from the four state agencies serving children and youth with emotional, behavioral or mental health service needs. The purpose was to familiarize the group with each department's target population, criteria for accessing services, type of services available and level of funding for services.

The agenda was shared by a panel of six parents who related their experiences with the children's service system, which in total touched on all of Maine's child-serving agencies. This presentation illustrated many of the barriers to service access from a first-hand perspective, but also included suggestions and recommendations for system improvement.

Process to Implement LD 1744/ Resolve Chapter 80

The August 20th design team meeting featured a nationally recognized consultant who provided information about successful models that have addressed children's mental health services that are delivered in a collaborative model, involving multiple agencies. The Starks County, Ohio model included many of the key principles that the small working groups had already adopted at this point in the process. These elements included: family-centered system values, easy access to the system from any entry point, commitment to address the multiple needs of multi-agency children cooperatively and using blended funds, and an emphasis on shifting dollars away from hospital and residential placements and toward in-home services and community supports for all children.

Based on first hand experience over the past decade, the consultant cautioned that the simple reorganization of all child-serving agencies into one department, a choice made by a number of states, had not proven effective in correcting fundamental systems problems faced by families in those states that were similar to the problems identified in Maine. However, the group was told that the most favorable condition supporting systems change was evidence of the will for change, noting that LD 1744 reflected the critical components necessary for fundamental change.

Intensive Work Group Activity

By agreement between the Steering Committee and the Joint Standing Committee on Health and Human Services, a systems design preliminary report was scheduled for presentation in early October. The four week period following the national models presentation focused on intensive small work group activity with each group reviewing its products in the context of agreed upon overarching principles, strategies for implementation, and the development of action oriented recommendations. The three work groups met on the average of once a week in order to complete their common mission. Groups set aside some time in their agendas for briefings and reports by state agencies, parents and service providers that were relevant to the topics within the group's specific systems design assignment.

Systems Costs and Service Utilization

In September, departmental staff from each agency serving on the 1744 Data Committee completed a two draft reports for the small groups to consider during the recommendations phase of their work. A Child Service System Capacity Profile detailed service utilization across of the 7 mental health local service networks. This report was based primarily on Medicaid data for Fiscal Year 1996.

The Data Committee also constructed a financial report which combined state general fund appropriations, non-Medicaid federal funds and Medicaid reimbursements identified by broad service categories for each child-serving state agency, based on FY 96 data. The draft report presented "big picture costs" for expenditures impacting children's mental health services, i.e., services agreed to be relevant in meeting the emotional, behavioral and mental health needs of children and their families.

Process to Implement LD 1744/ Resolve Chapter 80

The data revealed expenditures totaling $151 million dollars throughout the whole child-serving system. The cost data showed that just over one-third of all costs were for Maine based Community Services, while the remaining 61.7% of all funds were spent for Out-of-Home Services in hospitals, residential programs and out-of-state placements.

Large Group Meeting - Preliminary Recommendations

The most recent LD 1744 large group meeting was held on **September 16th** for the purpose of having each small work group present its findings and recommendations concerning systems/access, services and supports and financing for a new, comprehensive system of children's mental health services.

The group reports reflected significant commonality with regard to commonly held values and approaches to overcome recognized barriers. Following an interactive discussion between group presenters and the design group at large, the products from each group, including recommendations for the systems design, were given to DMHMRSAS. These materials are to be incorporated in a Preliminary Report on Systems Design, due to the H&HS Committee in mid October. At the conclusion of this meeting it was agreed that the Department would distribute the preliminary report to all members of the system design group, and convene another full meeting to obtain comments and feedback on **October 17th.**

Next Steps in the Process

Over the next month, the Preliminary Report will be utilized as the major document around which local discussion can occur. Specifically, the seven DMHMRSAS Quality Improvement Councils are being asked for their input, comments and suggestions around the proposed systems design for children's services. QIC members are also requested to critique the in the context of current strengths and needs which exist in their local area.

Beyond incorporating comments from the LD 1744 design group, local QIC's and other interested readers at large, it is planned that a revised version of the Systems Design Plan will be written by DMHMRSAS, in consultation with DHS, DOE and DOC. This version, called a Substantive Report will be reviewed by the Children's Cabinet and Governor's Office prior to submission to the H&HS Committee by December 15th, 1997.

APPROVED

JUN 12'97

BY GOVERNOR

CHAPTER

80

RESOLVES

STATE OF MAINE

IN THE YEAR OF OUR LORD
NINETEEN HUNDRED AND NINETY-SEVEN

S.P. 579 - L.D. 1744

Resolve, to Plan for Services for Children with Mental Health Needs

Sec. 1. Comprehensive plan. Resolved: That the Department of Mental Health, Mental Retardation and Substance Abuse Services, referred to in this section as the "department," in consultation with the Department of Corrections, the Department of Education and the Department of Human Services, shall design a comprehensive system of services for children with mental health needs to ensure that children receive services in the least restrictive and most appropriate settings. The system must provide for the reinvestment into children's mental health services of any savings achieved by switching from more expensive to less expensive means of delivering services. The department shall consult with providers, including psychiatrists and psychologists, and consumers and families of consumers of children's mental health services.

1. Plan development. The department shall define children's mental health services and assign areas of responsibility and accountability for providing children's mental health services.

2. Review of services. The department shall review existing children's mental health services and the expenditures for those services by the department and the Department of Corrections, the Department of Education and the Department of Human Services.

3. **Analysis of need.** The department shall analyze the current need for children's mental health services and any gaps and duplications in service delivery.

4. **Study contracting.** The department shall study contracting with public and private agencies and providers for the delivery of children's mental health services.

5. **Design a system.** The department shall design a system for delivering children's mental health services, including a safety net of services for those most in need.

6. **Develop recommendations.** The department shall develop recommendations, including statutory and budgetary changes, necessary to achieve the system designed under subsection 5.

7. **Report.** By December 15, 1997, the department shall submit a comprehensive plan for the delivery of children's mental health services to the Joint Standing Committee on Health and Human Services; and be it further

Sec. 2. Medicaid rules. Resolved: That in order to establish gatekeeper functions and responsibilities for the delivery of children's mental health services, within 30 days of the effective date of this resolve the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Human Services shall review current Medicaid rules for children's mental health services and shall adopt new rules consistent with the goal of providing a comprehensive network of children's services in the least restrictive and most appropriate settings; and be it further

Sec. 3. Progress report meetings. Resolved: That the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Human Services shall meet on a monthly basis with a 3-member subcommittee of the Joint Standing Committee on Health and Human Services before the Second Regular Session of the 118th Legislature to report on the progress of the departments in designing a comprehensive system for the delivery of children's mental health services and designating gatekeeper responsibilities and functions. The subcommittee may not meet more than 4 times; and be it further

Sec. 4. Reimbursement. Resolved: That the legislative subcommittee is entitled to receive, upon application to the Executive Director of the Legislative Council, the legislative per diem, as defined in the Maine Revised Statutes, Title 3, section 2, and reimbursement for travel and other necessary expenses for attendance at progress report meetings; and be it further

Sec. 5. Appropriation. Resolved: That the following funds are appropriated from the General Fund to carry out the purposes of this resolve.

	1997-98
LEGISLATURE	
Miscellaneous Study Commissions	
Personal Services	$660
All Other	600
TOTAL	$1,260

Provides funds for the per diem and expenses of legislative members to participate in progress report meetings with the Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Human Services.

Chil..en's Mental Health Services De..ign Team

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Children's Mental Health Services Design Team

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Dr. Doug	Robbins	Maine Medical Center	216 Vaughn St	Portland, ME 04102	871-2160

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APPENDIX B:

Medical Assistance Rule Review

The Technical Assistance Collaborative

MEDICAL ASSISTANCE RULE REVIEW

Conducted for the Maine Department of Mental Health, Mental Retardation and Substance Abuse Services

October 30, 1997

I. Purpose

This review was conducted for the purpose of assisting the Maine Department of Mental Health, Mental Retardation and Substance Abuse Services review the Maine Medical Assistance rules pertaining to mental health, mental retardation and substance abuse services that are applicable to providing care and treatment for children as required in L.D. 1744 (Section 2). Thirteen (13) policies covering sixteen (16) services in Section II. and Section IV. of the Maine Medical Assistance Manual were analyzed as part of this review.

II. Scope and Methodology of Review

This review was conducted by an analysis of the Chapters and Sections of the Maine Medical Assistance Manual as listed on the Attachment to this report . Effective dates of the reviewed Chapters and Sections are listed in the margin of that attachment.

The methodology for this review was simply to evaluate each Section (rules) by providing a general overview and by asking three basic questions as follows:

1. Overview: The overview will provide a summary of each policy's provisions and requirements in the following areas: definition, eligibility criteria, prior authorization, duration of care, service plan, utilization review and medical necessity. Special features of each policy will be highlighted.

2. Do the rules move the system toward meeting the goal of providing a comprehensive network of children's services in the least restrictive and most appropriate settings ? If yes, in what way ? If no, why not ?

3. What changes need to be made in the rules in order to establish gatekeeper functions and responsibilities for the delivery of children's mental health services ?

4. In what way, if any, do the rules provide the means for switching from more expensive to less expensive means of delivering services ?

III. Findings

Overall the rules reflect a comprehensive range of services being reimbursed under Maine's Medicaid Plan. The rules are broad in scope, they are both restrictive and lessor restrictive in their requirements as reflected below. They reflect a strong desire on the part of the State to assure that all potential service options are made available under Maine's State Medicaid Plan. Indeed many of the rules were written for services already in place in order for the State to maximize federal reimbursement and thus free up more State funds for seed or for services not covered by Medicaid. However, as written they do not promote or reflect a system of care. From the user's perspective they are complex and duplicative, with a number of services more difficult to access than others. This does not appear to be done as an attempt to make these rules more complex but rather the result of long standing practice and demand on various but separate units of state government, both in DHS and DMHMRSAS, to expand reimbursement.

Below is a review of each policy highlighting definition, eligibility criteria, prior authorization, duration of care, service plan, utilization review and medical necessity provisions.

Chapter II - Section 13: Case Management Services

1. Overview

The following Sub-Sections of Section 13 were reviewed: Section 13.01(Definitions); Section 13.02 (Eligibility for Services); Section 13.03 (Duration of Care); Section 13.04 (Multiple Case Managers); 13.08 (Case Management Services for Infants and Children, Birth through age 5, with of at Risk for Developmental Delays) effective 4/29/88 and 3/20/96; Section 13.12 (Case Management Services for Children and Adolescents with Severe Emotional Disturbance, ages 6 through 20); and Section 13.13 (Case Management Services for Children and Adolescents with Serious Emotional Disturbance Ages 11 through 17 residing in Cumberland County).

The definition, eligibility and duration requirements for case management are relatively consistent for targeted case management. The provision for multiple case managers is however inconsistent with professional practice and with child and adolescent service system principles. The state's intention is for there to be a single case manager. The provision was established to assure staff hired staff could work in the child's home and be eligible for federal reimbursement. Otherwise state hired staff would have to be paid with state funds only. Other states have used other service categories to solve this problem. Using another service definition and assuring only case manager is organizing and arranging for services would eliminate the potential for duplication and differences of opinion exist between treating professionals or providers it could create confusion and animosity between and among care providers, educators, the child and his or her family guardian or case workers regardless of the intent of the definition to limit these problems.

Indeed the definition attempts to ameliorate these problems by adding more documentation requirements to reduce the potential for duplication. Thus requiring more work on the part of case managers. This could be avoided by creating a system that requires all parties to work with a single case manager. This type of system is in place in a number of states and indeed is mandated in some states.

The rule also creates many different criteria for children of different ages and even differences for children living in different locales. For example, the reason given for a separate rule for children who have a serious emotional disturbance and living in Cumberland County between the ages of 11 and 17 is that there is a program there sponsored by the Robert Wood Johnson Foundation. I have worked in three states that had between them six systems development grants for both children and adults with major mental disabilities over the past decade and in none of those programs did we create a separate rule for targeted case management in the jurisdictions where the demonstration was taking place. Nor have I seen this done with projects funded for the same purpose by the Center for Mental Health Services (HHS).

Both of the Sub-Categories for children (Cumberland and non-Cumberland County) ages six through twenty (Cumberland, ages 11 through 17 only), only allow targeted case management services for children with severe emotional problems. The definition is quite limited. Indeed more limiting than the requirements for other more restrictive services. HCFA will allow case management services for non severely disabled children and adolescents under a different option thus providing an opportunity for case managers to serve children who may have serious needs but not meet the extreme definition listed in these sub-sections.

Chapter II.- Section 21: Home and Community Based Waiver Services

Home and Community Based Waiver Services for persons with Mental Retardation is a waivered service meaning rules applying to eligibility for Intermediate Care Services can be waived to provide more flexibility in service provision for persons eligible for ICFsMR. However, the process for establishing eligibility (10 steps) and gaining plan approval for each service or aid is both more time consuming and onerous than other services reviewed. Very few children receive services under this category in Maine and this Waiver is slated for renewal in one year. It is recommended the waiver be studied now to determine if changes can be made to assure these services are as flexible as possible for persons needing these services. One question to ask then would be the potential for unbundling care to assure that children can get the services they need through a less onerous and expensive process of determining eligibility and need.

It should be noted that utilization review is provider controlled and that duration requirements are vaguely stated.

Chapter II. - Section 24: Day Habilitation Services for Persons with Mental Retardation

Day Habilitation Services are those services or training for persons with mental retardation that focus primarily upon behavior management, self care, self awareness and physical, sensory, motor and psychological development. These services are generally provided by community-based agencies offering a range of residential, day and professional services for persons with mental retardation and other disabilities.

Eligibility requirements are fairly standard. There are duration requirements that appear to limit the number of days a person can receive services. There are limited standards and approval processes. ICFsMR can provide these services. There are no outside review mechanisms nor are there prior authorization criteria. There is no requirement for these services to be provided under a single comprehensive plan for the child nor is there any requirement to plan services with the educational or other systems. The Bureau of Mental Retardation (BMR) in DMHMRSAS is required to develop service plans for children receiving these services if the child is a client of BMR.

Chapter II. - Section 27: Early Intervention

Early intervention means services provided for children who have or at risk for disabilities, and increase the support base for families, if needed. There are three covered services under the broader heading of Early Intervention. These include Developmental Therapy, Social Work and Collateral Services. Eligibility is based on Medicaid eligibility and Department of Education eligibility requirements. Duration requirements are limited to age requirements (eligibility for public school at age 5). An individual planning process is managed by an Early Childhood Team. Utilization Review is based within the Department of Education. There are no explicit requirements for coordination of care with other caregivers.

Chapter II. - Section 37: Home Based Mental Health Services

Home based services are short-term, crisis oriented, counseling services provided in a child's home or other appropriate setting. Agencies who qualify must be certified by the Bureau of Children with Special Needs (DMHMRSAS). There are both general and specific eligibility requirements. The specific requirements include a child being at risk of removal from the family home or tension related to re-unification to the home.

Duration requirements limit the provision of these services to not exceed thirteen weeks of service delivered within eighteen consecutive weeks. These can be extended with clinical approval. Reimbursement will not be made for services aimed at needs that could more appropriately be met in more traditional settings. Evaluation requirements are very specific. There is a requirement for a comprehensive written plan for this service.

Chapter II. - Section 41: Day Treatment

Day Treatment Services in this Section are part of an integrated educational program. There are also clinic based day treatment services covered under the outpatient reimbursement policy (Section 65). The services "may" be provided in conjunction with a residential treatment program, other mental health program, or a single or multi-district school program provided through the school administrative unit. Eligibility is less stringent than that for outpatient day treatment although medically necessity is determined by a Pupil Evaluation Team (PET) and then subsequently specified in an individual Education Plan. Their are no limits on duration and there is a requirement for an individualized treatment plan solely for this service. There are no specifications requiring this service be integrated with or part of a comprehensive plan for a specific child; thus this service can be provided as part of an educational program outside of a local service delivery system. This policy makes a more detailed explanation of contracting and rate negotiation requirements than for most other services.

Chapter II. - Section 45: Hospital Services

Hospital Services includes both inpatient and outpatient services. While specific requirements for medical necessity are not clearly spelled out in this policy. Duration of care is not covered with the exception of UR requirements. The discharge planning requirements are limited to assuring there are discharge planning procedures maintained in a written record. Linkage to community services is not covered. There are no prior admission requirements for emergency admissions. Continued stay procedures are left to the discretion of each hospital although it is assumed reimbursement limitations account for the relatively short lengths of stay in general hospital units.

Chapter II. - Section 46: Psychiatric Facility Services

Psychiatric Facility Services refers to services of a hospital primarily engaged in providing psychiatric services for the diagnosis, treatment and care of persons with mental illness. Psychiatric Facilities can provide inpatient, partial hospitalization and outpatient services. While the policy references children should only be admitted to the service who can not be served in a lessor restrictive setting, the eligibility criteria related to duration of illness, both prospective and historically are no greater than that required for children to receive lessor restrictive services.

Medical necessity determination and Medical Evaluations are required for admission. Prior authorization for inpatient care except for emergency admissions is required.

There are re-certification requirements at sixty days after admission and every thirty days after 120 days but these are conducted by facility staff. Plans of care are required for partial and outpatient services. Utilization Review is also internal. There are discharge planning requirements which do not require involvement of case management or other

community service staff. A written record of what agencies are available for aftercare is the only requirement that even hints of a systems approach.

Chapter II. - Section 65: Mental Health Clinic Services

Specific and separate requirements are set forth for the eligibility of children, birth to age 5 and children age 6 to 20 for clinic based day treatment, children's family and community support services. For children age birth to age 5, an evaluation is required that establishes either a behavioral impairment, developmental delay, established conditions, biological factors. An interdisciplinary team is required to determine eligibility. It should be noted that there is no reference to using either the same team used for early intervention or for targeted case management for the same age group.

For children age 6 to 20, a child must be diagnosed as having a severe emotional behavioral disturbance, excluding mental retardation or substance abuse as primary diagnosis. The diagnosis must have a duration or risk of duration of more than one year, and results in the child's inability to function in the home, school or community without supportive services. Additionally in order to receive Children's and Family Community Support Services, the child must have a combination of functional impairment or specific symptomotology in one of four areas.

There are no eligibility requirements for Emergency Services, Crisis Resolution and Crisis Support Services. There are other requirements for serving children between the ages 0 to 2.

The difference in the scope of Children's Outpatient Services and Children's Family and Community Support Services seems quite narrow. Child Outpatient is focused on the child limiting collateral contacts. It may be possible to combine these providing more incentive for treating professionals to expand upon their approach where indicated rather than changing codes, treatment plans, etc.

This service requires a single purpose treatment plan and reimbursement for Children's Family and Community Support Services provided for children and their biological or foster families who have a letter of agreement or contract to provide such services by one of two Bureaus in the Department of Human Services.

There are no specific requirements for utilization review, medical necessity or prior authorization for these services.

Chapter II. - Section 96: Private Duty Nursing and Personal Care Services

This service appears to have potential use for children with mental health needs unless the eligible child meets Nursing Facility level of care and requires physical assistance, has limited self-care capability requiring 24 hour care and requires cueing as a result of

cognitive impairment. This rule should be reviewed closely to assure it is both fully and appropriately used in conjunction with other services.

Eligibility, duration and other requirements are consistent with the services provided.

Chapter II. - Section 97: Private Non-Medical Institution Services

Private Non-Medical Institution Services for Residential and Child Care Facilities are community residential facilities for four or more individuals. There are no restrictions on eligibility or duration. There are limited reimbursement restrictions. There are fifteen covered services for which payment to a provider is permitted under the rules of this section. A broad range of staff qualify to provide these services. Case management is an allowable service so long as it is coordinated with case management services provided by case managers who are "outside" the facility. There is a separate written individual services plan requirement. There is a requirement for a discharge summary that only states: " a discharge summary shall summarize the entire case in relationship to the plan of care, except as may be noted in the appropriate Principles of Reimbursement." There is no reference to a discharge summary in the reimbursement section of this policy. There are fewer requirements for this service than any other service reviewed.

Chapter II. - Section 111: Substance Abuse Treatment Services

Substance Abuse Treatment Services include two sub-categories of service: Non-Residential Rehabilitation Services and Outpatient Services. Non-Residential Rehabilitation Services are relatively intense, short-term treatment services. They are referenced in the definition as "day treatment" and are often labeled "intensive outpatient services. Outpatient services are considered less intense and of longer duration. Both can include individual, group or family counseling. Indeed the services are actually more of a program rather than an individual service and unlike mental health, the substance services appear to be covered by a single comprehensive treatment plan.

The Non-Residential Services can only be provided for a maximum of 10 calendar weeks, five days a week, six hours a day, excluding collateral contacts. Outpatient services are also limited in duration but for 30 weeks, but no more than 3 hours per week. Eligibility for care is not restrictive but there are limits on pre-admission criteria and limits are set on reimbursement are more stringent than in some of the other services. Case management is explicitly excluded as a reimbursable service under this policy.

Chapter V. - Section 4: Nontraditional PHP Treatment Services

This service is part of the Preventive Health Program/ Early Periodic Screening and Diagnosis and Treatment (EPSDT). The eligibility criteria and duration requirements are standard for EPSDT services. Covered services requirements include both provision for authorization as well as a set of provisions for the "quality" of the services including requirement that the services have scientifically valid evidence of the efficacy of the

proposed treatment or service, not be experimental, be less costly than a comparable service with a comparable expected remedy and not being available through other means or at a reduced cost to the public. This is an extraordinary set of requirements not found in definitions or provision for any other service. Thus the least expensive and least restrictive service is made more difficult or onerous to obtain.

This is the only service reviewed that requires prior authorization. The documentation of medical necessity is also more detailed than found in any other service with the exception of Hospital Services/ Psychiatric Facility both of which require a medical necessity determination. As with other services, there is a requirement for a separate comprehensive plan for this service.

Overview Summary

As noted above these rules include a wide range of eligibility, duration, service plan, prior authorization, utilization review and medical necessity requirements which are inconsistent, duplicative and confusing. The provisions though provide a wide range of services that could become the basis of a comprehensive system of care. It is not unusual that rules written over time, at the request of different departments or providers and/or in response to new federal designations or rules appear inconsistent, duplicative and confusing. These rules are no exception to that problem. On the other hand, Maine is fortunate in developing services that can with improvements be the base of a comprehensive system of care.

IV. L.D. 1744 Questions

1. The policies (rules) in general do not move the system toward meeting the goal of providing a comprehensive network of children's services in the least restrictive and most appropriate settings. Of the fifteen policies reviewed, only the substance abuse treatment policies call for a comprehensive service plan across all services being delivered for an individual. And in this situation "all services" refers only to all substance abuse services. All other services have their own service plans quite separate and distinct from service plans for other services. Interestingly though the substance abuse service policy explicitly excludes case management from reimbursement. The policies allow multiple case managers and indeed there are procedures and protocols governing multiple case managers. PNMI services actually allow a case manager to work within that setting and upon discharge the individual loses the services of that case manager. There are numerous coordinating and committee structures across services none of which intersect. Inpatient discharge criteria are superficial and there are no PNMI discharge criteria with only one sentence referencing the requirement for a discharge summary.

For services provided for children under age 5, there are two distinct local coordinating committees one school based, one not, which establish entry criteria for children into case management and early intervention services, respectively.

Entry criteria for services are quite complex with multiple steps required generally for more preventive low cost care and less restrictive criteria for higher costs services with the exception of ICF-MR services which include 10 labor intensive eligibility and entry steps. Only Non Traditional PHP, the least restrictive service, requires prior authorization. Duration of care requirements and caps no service levels exist for six services not including those with age cut offs, four of which are for the least restrictive services and two of which, psychiatric inpatient and general psychiatric inpatient are internally controlled. Two, Private Duty Nursing and Day Habilitation have caps which may or may not restrict duration and substance abuse services and home based mental health have specific limitations.

In summary, the policies governing these services inadvertently discourage and undermine the concept of a system of care as there is no designated entity responsible for coordination, capacity development and gatekeeping across what appear to be quite complex and overlapping services.

2. Do changes need to be made in the rules in order to establish gatekeeper functions and responsibilities for the delivery of children's mental health services?

Gatekeeper functions could be added to any or all of the services. However, gatekeeper rules without adding rules or setting forth requirements for "system of care" development is only a half a loaf. For example if an independent gatekeeper or even an office in either DMHMRSAS or DHS were established for this function, does this office or independent entity have responsibility for assuring the development and use of lessor restrictive services as stated above ? The benefits as defined in these rules are sufficient to create a comprehensive network of care...they don't guarantee you will have a system of care.

3. In what way, if any, do the rules provide the means for switching from more expensive to less expensive means of delivering services?

The rules **do not** by themselves provide the means for switching from more expensive to less expensive means of delivering services. The service rules could provide the means to reduce expensive services. However they can not provide the means for "switching" from more expensive to lessor expensive services.

There are only two means to accomplish that goal. The first is to amend the State Medicaid Plan to delete optional services that appear to be expensive. These could be substituted by increasing other services through the State seed that is not being used for expensive services.. For example, Psychiatric Facility Services (Ch. 11-Section 46) is optional but all but 6 states are using it. Inpatient Services is required but only in general hospitals.

A significant portion of the $30,513,883 spent by Maine on inpatient hospital expenditures for children, is reimbursed to Psychiatric Facility Services. By deleting this category, access to this services is denied. Given that these services have been included in the benefit package, deleting them now would have repercussions unless a plan for increasing general hospital inpatient psychiatric care or substituting hospital care for community care is put into place well in advance of deleting those types of services.

Secondly you could develop a prior, concurrent or retrospective utilization review system for expensive services without eliminating categories thus reducing providers. This limits the amount of care a person receives in a particular setting but leaves providers in business. However, in this situation as in the option to delete categories of services, the only funds available for re-distribution to community services are state seed funds and you will not be allowed to limit the number of beds in the system. If you don't provide services, federal funds will not flow thus you loose that revenue as illustrated above. Even if you try to shift funds if you aren't successful through utilization review practices, you could be left with a larger bill.

This may also result in a loss of federal funds because the reimbursement level is greater for the more expensive services. For example, if an inpatient day costs $800 and a Non-Traditional PHP unit costs $ 40, you would need to deliver 20 Non-Traditional PHP hours for every inpatient day to draw down the same amount of funds.

A Waiver would allow you to retain funds at an agreed upon level and shift funds through assigning services. This is the only method you can use to assure the re-distribution of funds without losing access to the current levels of federal funds available for services. With a Waiver, you agree to being paid an amount of funds equal to what you were earning in a "base" year for all services minus a small percentage for "savings" (generally 5 or less percent or less). This is generally offset with a cost of living increase. Thus a cap reduces growth while increasing flexibility.

Attachment

MAINE MEDICAL ASSISTANCE MANUAL

MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES APPLICABLE FOR CHILDREN

CHAPTER	SECTION	SPECIFIC POLICY BY SERVICE
II	13	CASE MANAGEMENT SERVICES
II	21	HOME AND COMMUNITY BASED WAIVER SERVICES FOR PERSONS WITH MENTAL RETARDATION
II	24	DAY HABILITATION SERVICES FOR PERSONS WITH MENTAL RETARDATION
II	27	EARLY INTERVENTION SERVICES
II	37	HOME BASED MENTAL HEALTH SERVICES
II	41	DAY TREATMENT SERVICES
II	45	HOSPITAL SERVICES
II	46	PSYCHIATRIC FACILITY SERVICES
II	65	MENTAL HEALTH CLINIC SERVICES
II	96	PRIVATE DUTY NURSING/ PERSONAL CARE SERVICES
II	97	PRIVATE NON-MEDICAL INSTITUTION SERVICES
II	111	SUBSTANCE ABUSE TREATMENT SERVICES
V	4	NONTRADITIONAL PHP TREATMENT SERVICES

APPENDIX C:

LD 1744 Child Service System Profile

LD 1744 Child Service System Profile

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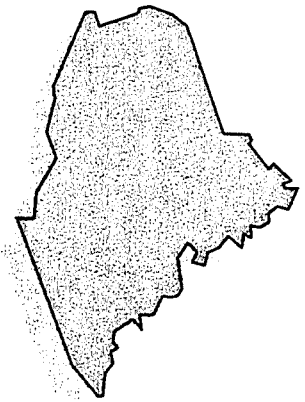
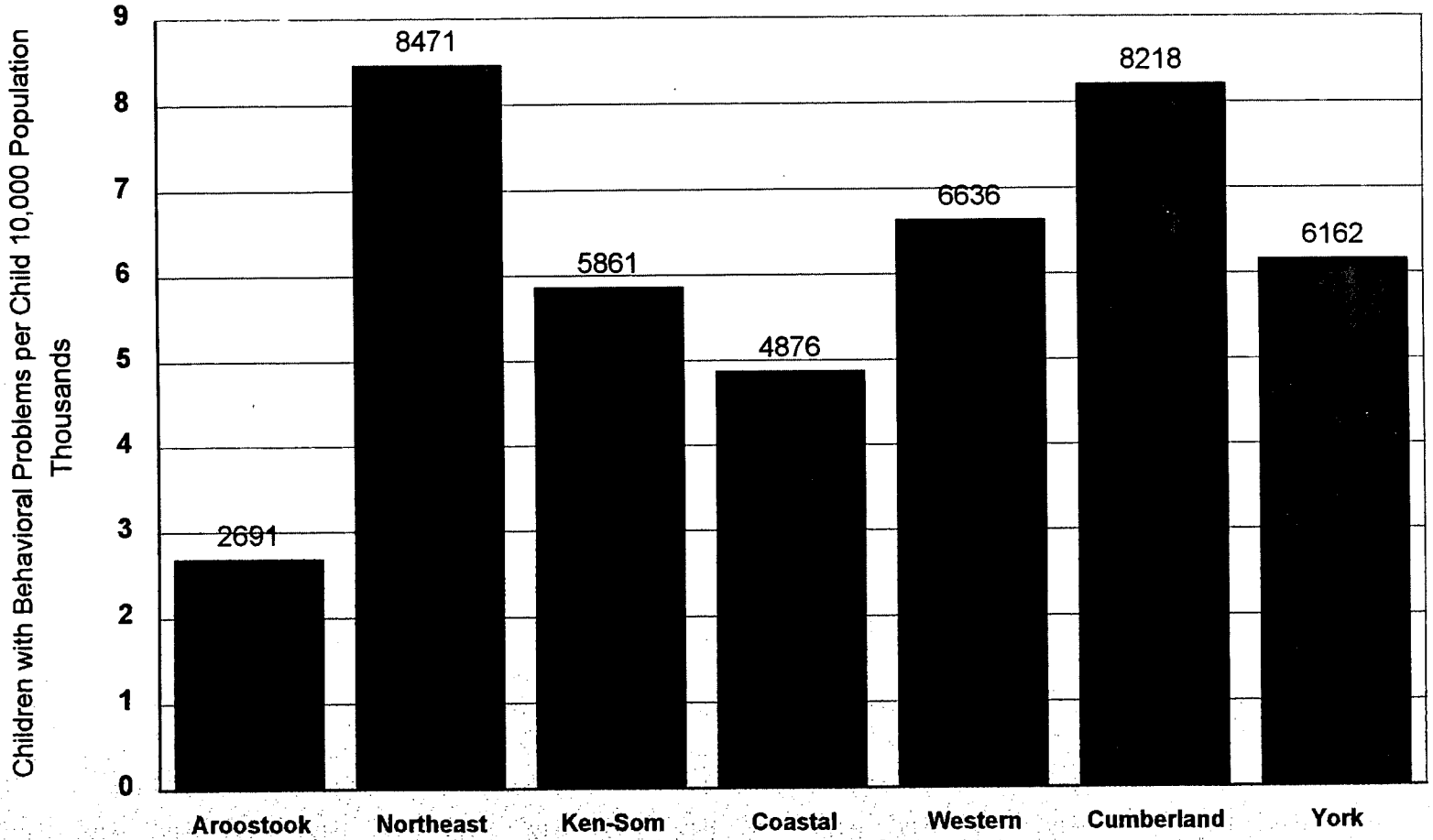


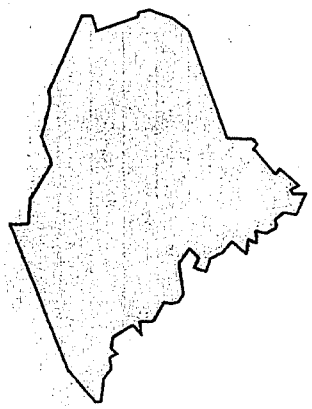
Number of Children with Behavioral and Emotional Challenges by Local Service Network



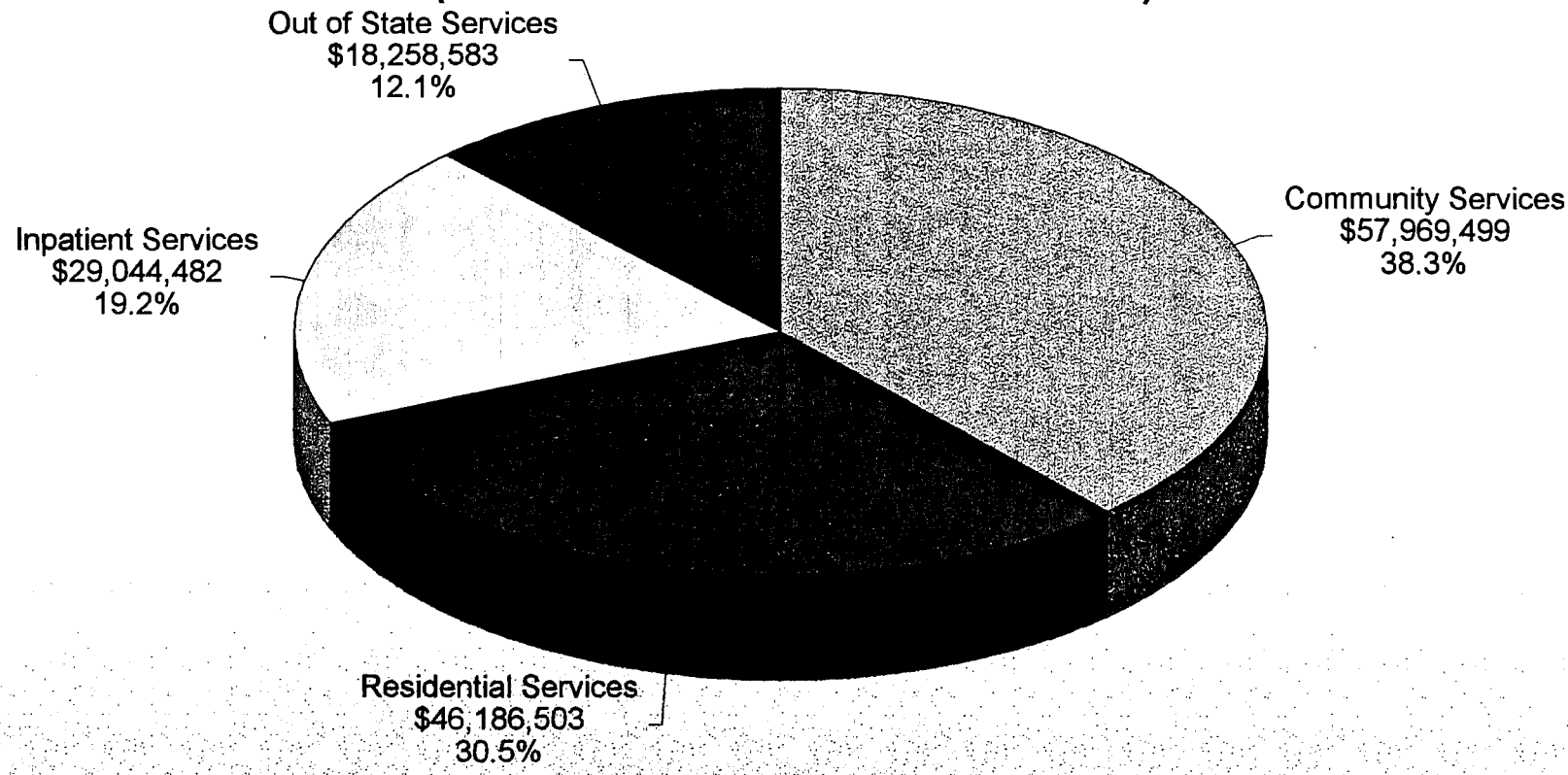
Note: Based on an estimate of the prevalence of children with behavioral and emotional challenges of 14% (SAMHSA) of the Children's population.

Statewide total 42,914

Child Service System Costs and Expenditure Patterns



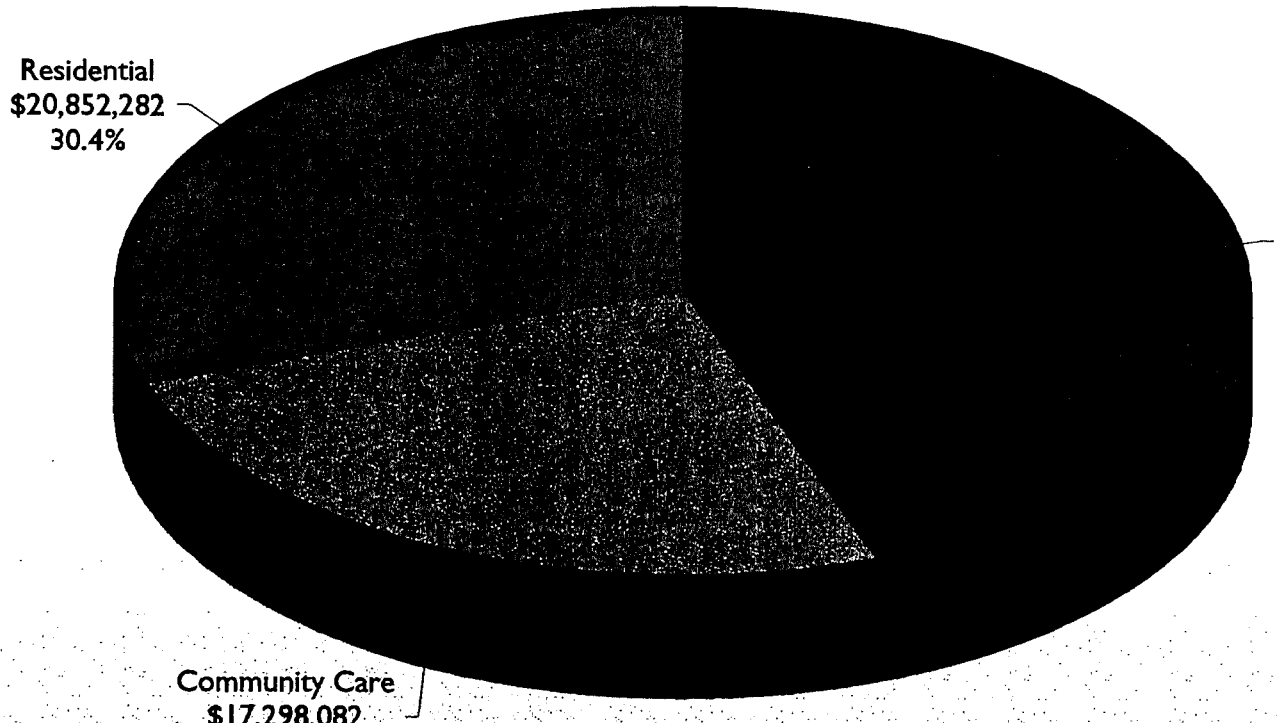
"BIG PICTURE COSTS"
EXPENDITURES WHICH IMPACT CHILDREN'S MENTAL HEALTH SERVICES
(DMHMRSAS, DHS, DOE, DOC)



TOTAL SYSTEM COSTS: $151,459,067

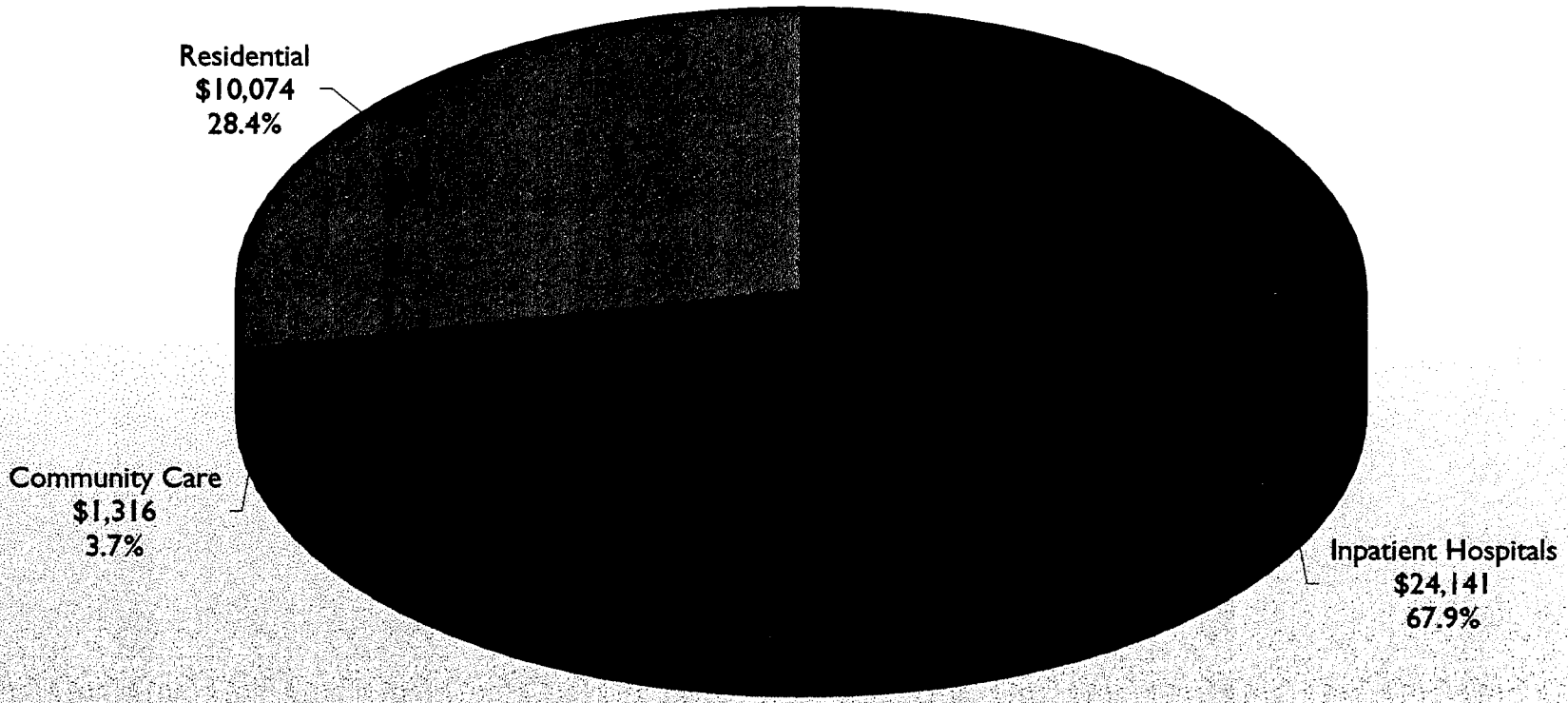
Percent of Total Medicaid Expenditures for Children in Out of Home and Community Care Settings

Total: $68,664,247



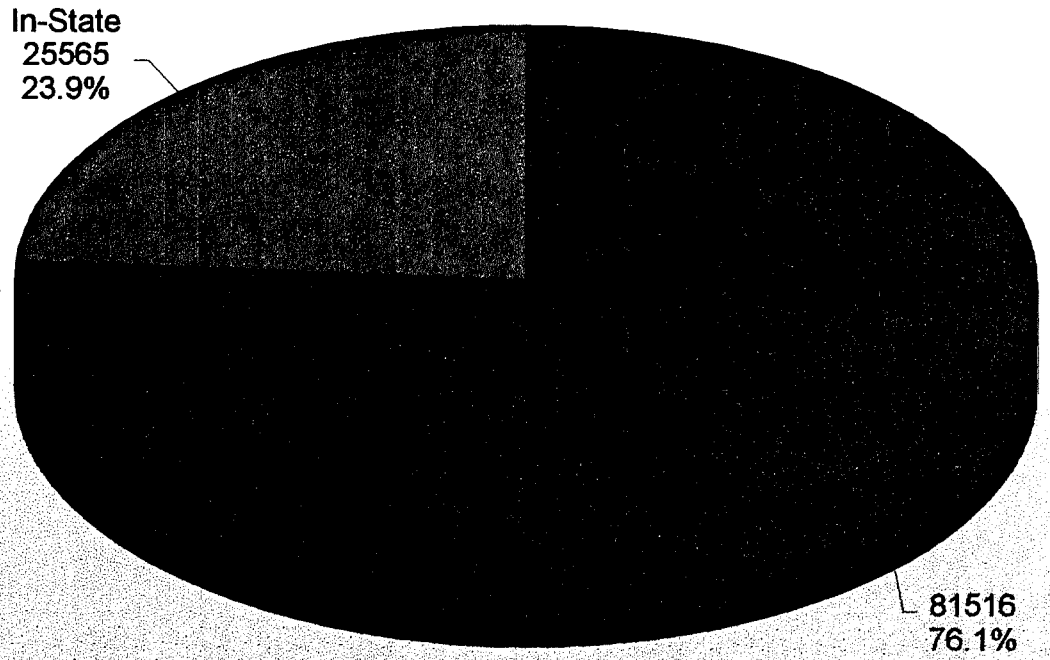
Note: Slices represent percent of total expenditures for inpatient (in-state and out of state psychiatric hospitals and psych. units of community hospitals), community care (outpatient, case management, crisis, home-based), and residential treatment facilities. Based on FY1996 Medicaid Claims data.

Per Child Expenditures by Major Service Area



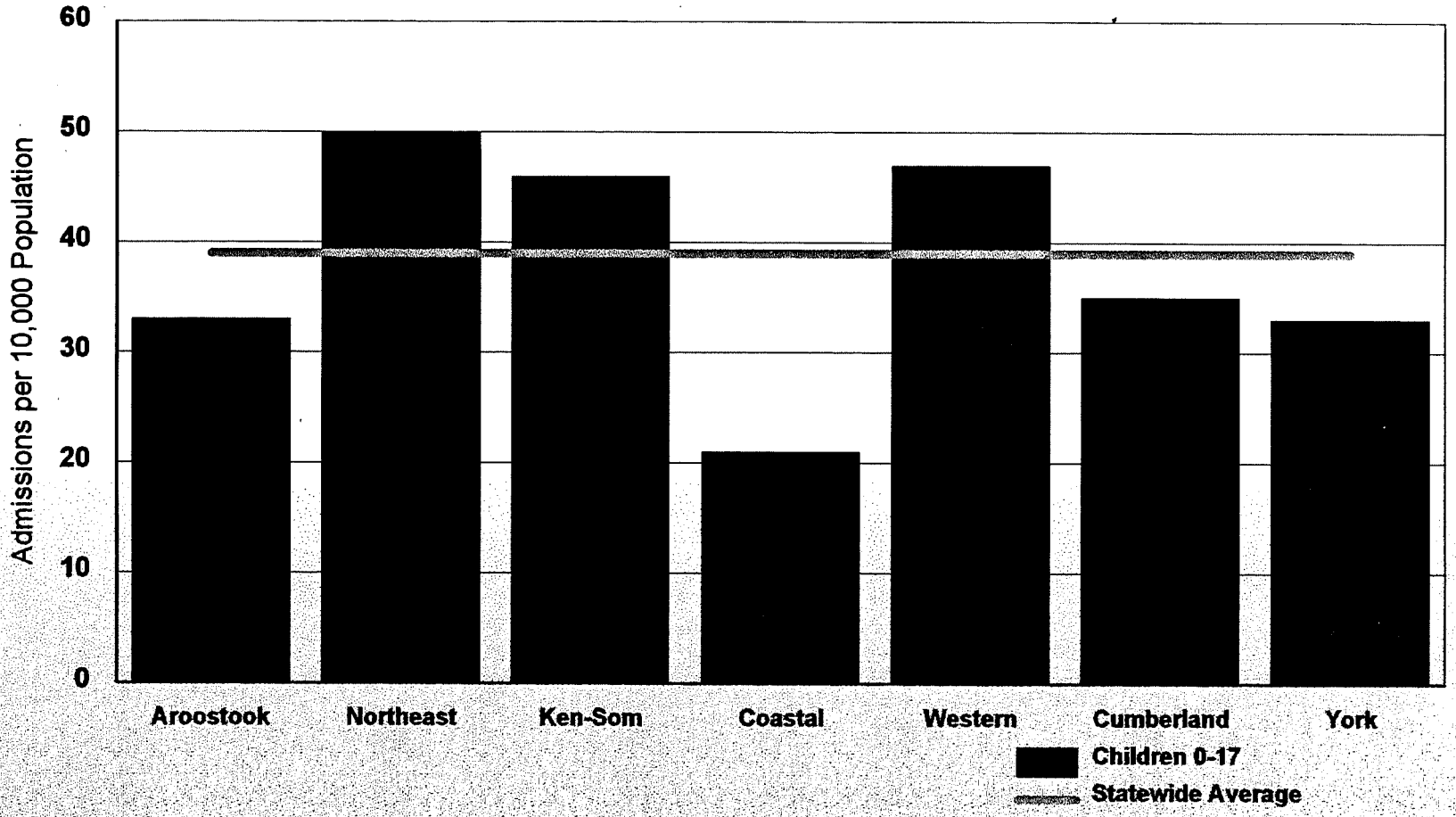
Note: Slices represent amount reimbursed per recipient for inpatient (in-state and out of state psychiatric hospitals and psych. units of community hospitals), community care (outpatient, case management, community support, crisis, home-based), and residential facilities. Does not include mental retardation services. The number of children served in each service area include 1264 inpatient, 14,188 community care, and 1979 residential recipients. Based on FY1996 Medicaid Claims data.

Per Child Expenditures for In-State and Out-of-State Inpatient Psychiatric Care



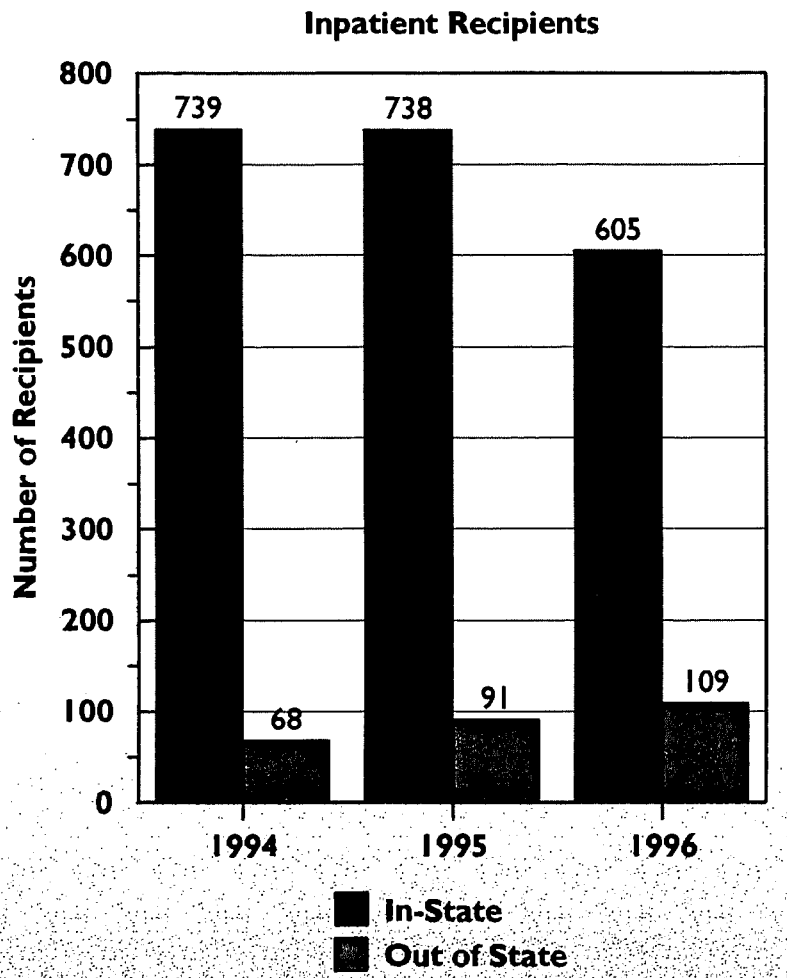
Note: Slices represent the amount reimbursed for in-state and out-of-state psychiatric inpatient hospital care. Data includes 74 out-of-state and 539 in-state service recipients. The total expenditures are $13,779,604 and $6,032,167 for in-state and out-of state, respectively. Based on FY 1996 Medicaid Claims data.

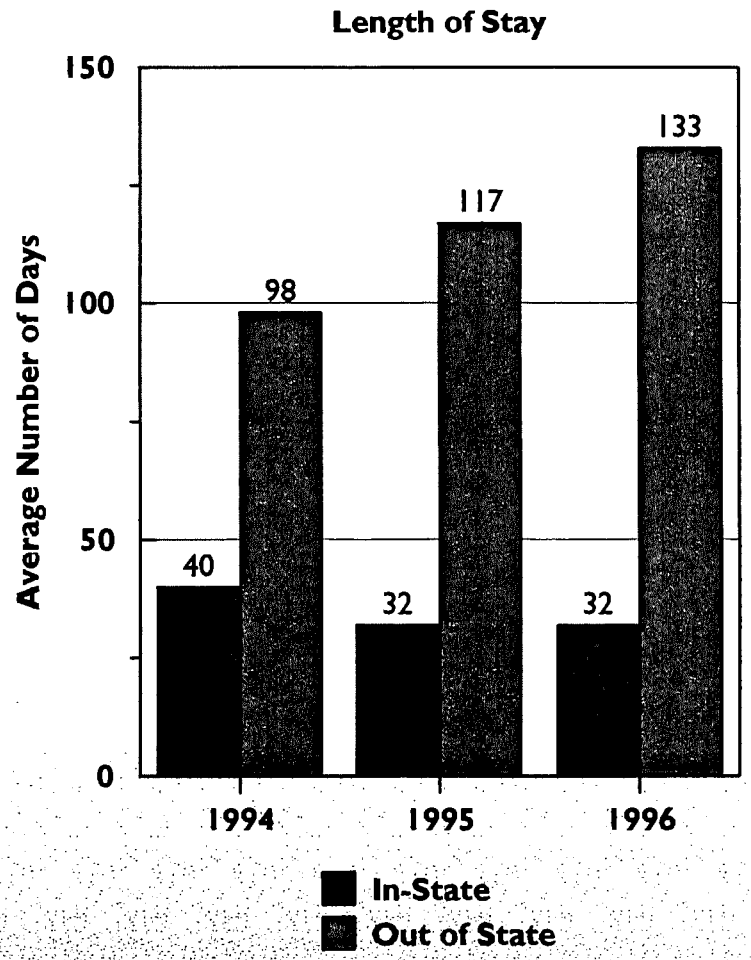
Child Inpatient Psychiatric Admissions by Local Service Network



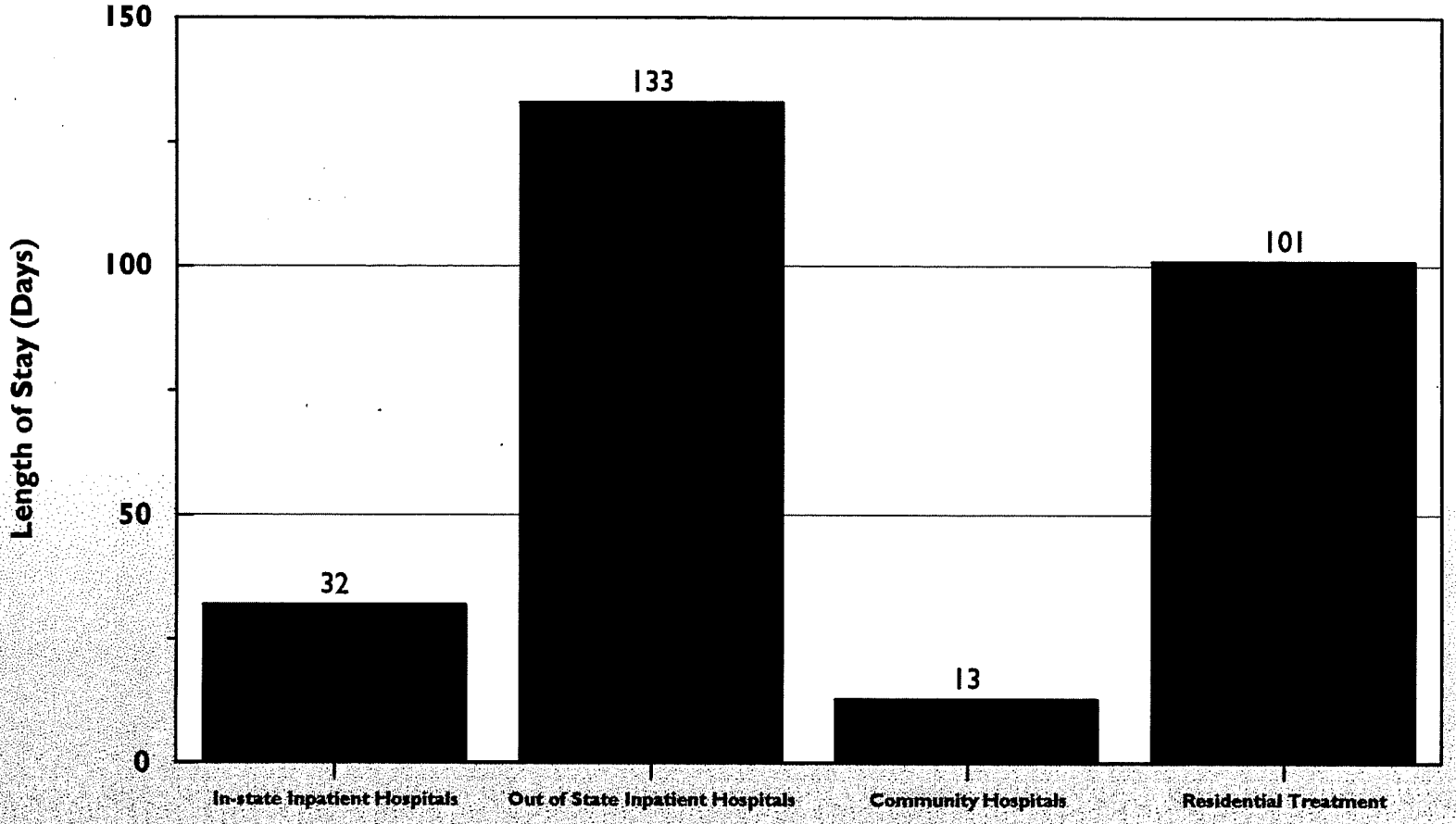
Note: Bars represent inpatient admissions to psychiatric hospitals and psych. units of community hospitals, adjusted for population. The numbers inside the bars reflect the acutal number of admissions. The state-wide total of unduplicated recipients is 954 (as compared to total admissions of 1202). Based on FY1996 Medicaid Claims data.

In-State and Out of State Psychiatric Hospital Utilization for 1994-1996



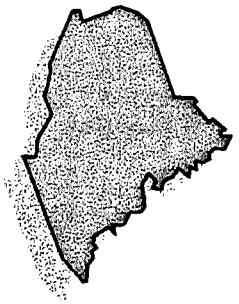


Length of Stay for Inpatient Hospitals, Community Hospitals, and Residential Facilities

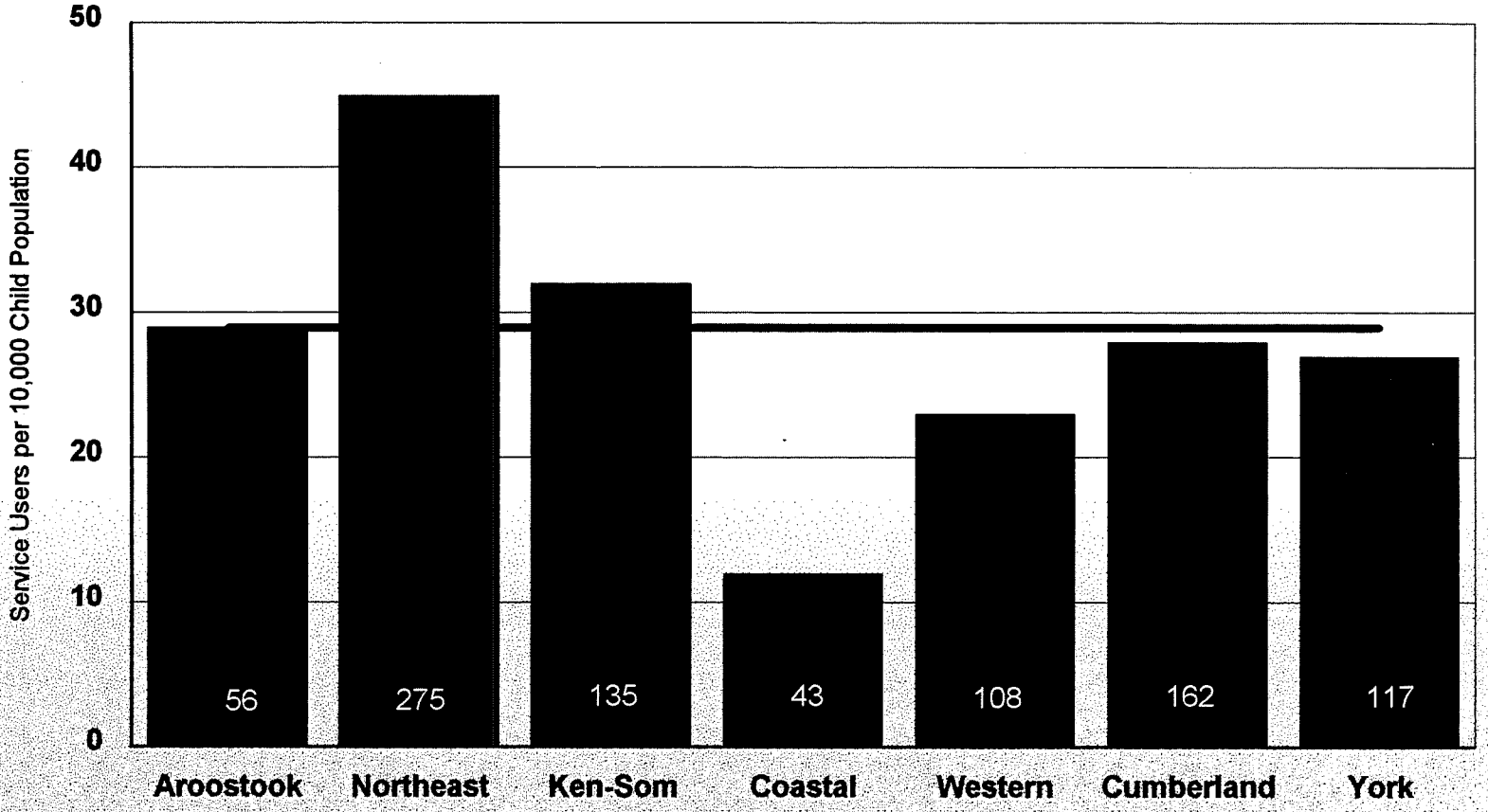


Note: Bars represent inpatient in-state and out of state psychiatric hospitals, psych. units of community hospitals, and residential facilities. Based on FY1996 Medicaid Claims data.

Residential/Group Treatment Services

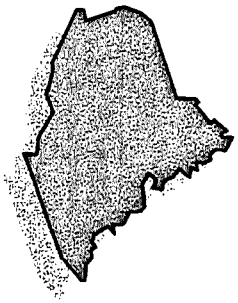


Child Residential/Group Treatment Use by Local Service Network

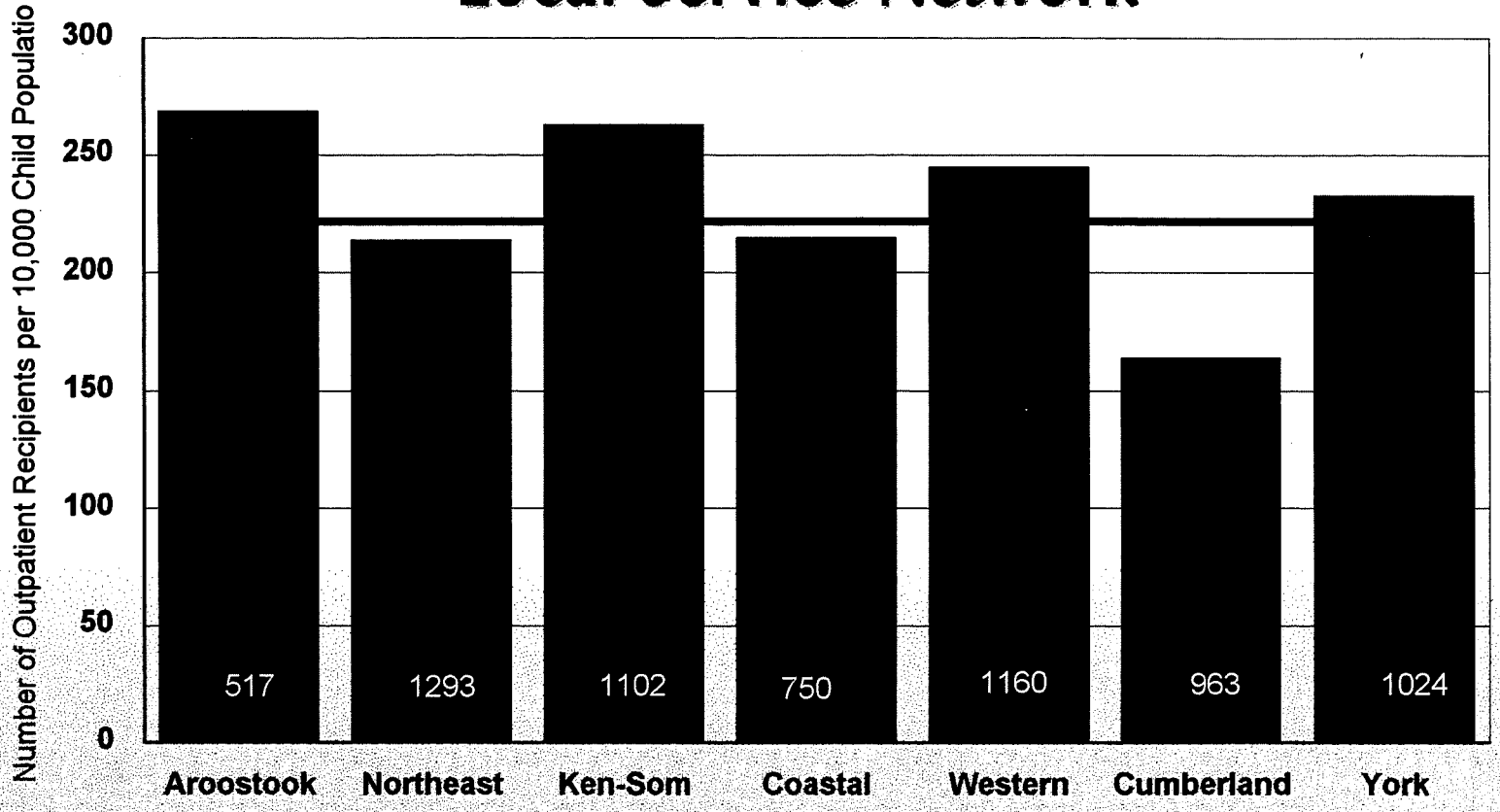


Note: Bars represent the number of residential/group treatment services recipients. The numbers inside the bars reflect the actual number of recipients. Based on FY1996 Medicaid Claims data.

Community-Based Services

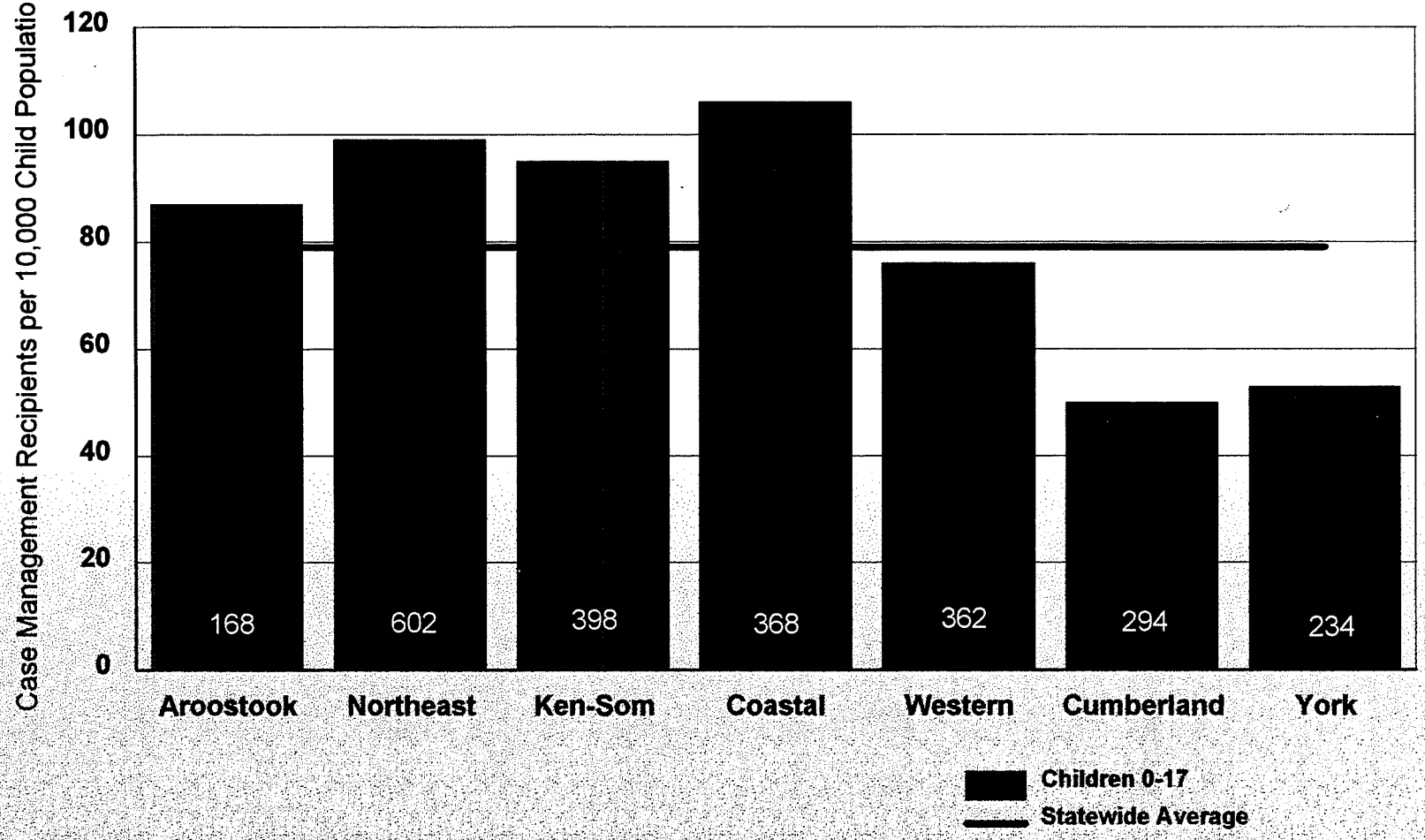


Child Clinical Service Use by Local Service Network



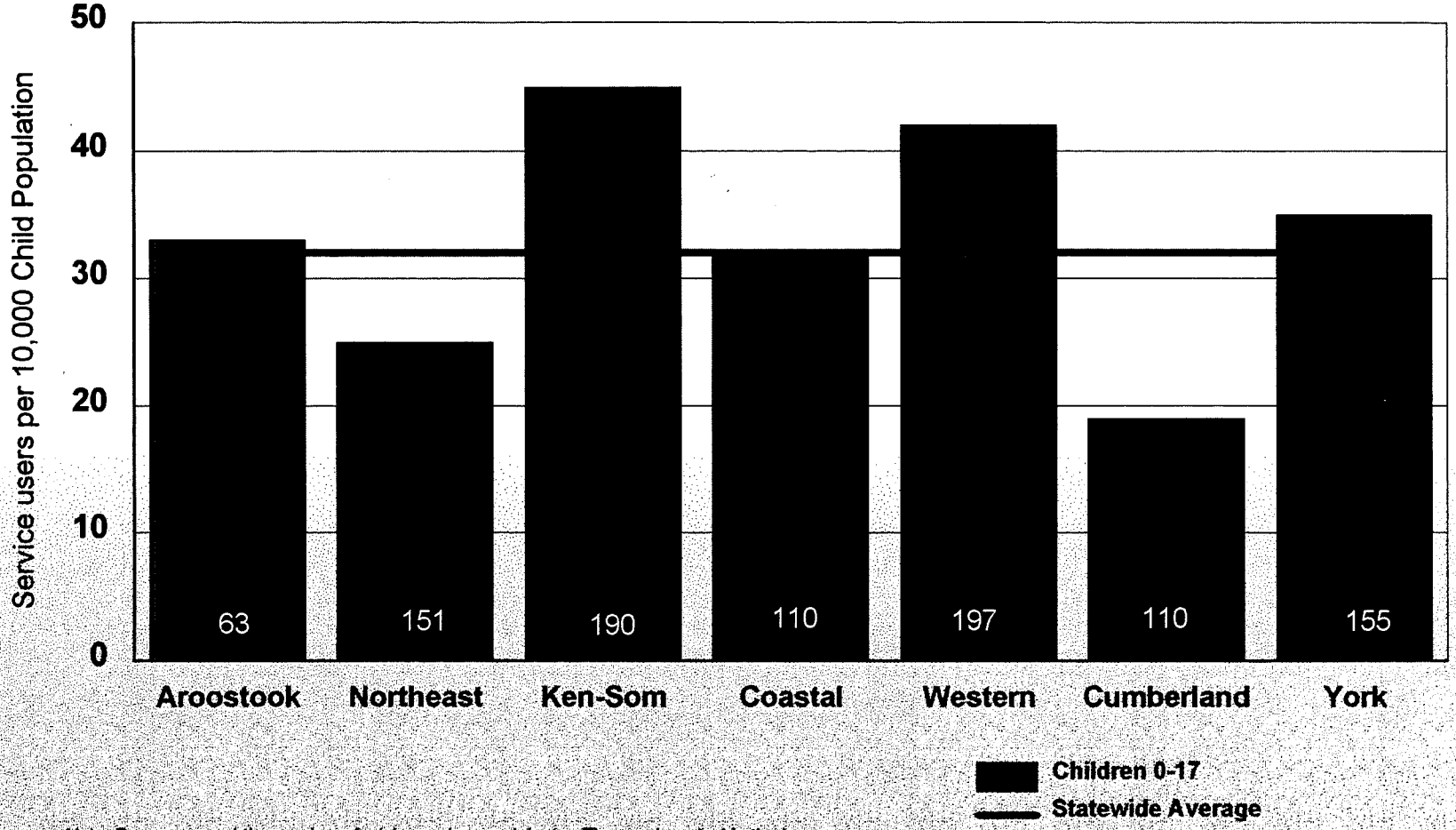
Note: Bars represent outpatient mental health clinical services recipients. The numbers inside the bars reflect the actual number of recipients. Based on FY1996 Medicaid Claims data.

Child Case Management Service Use by Local Service Network



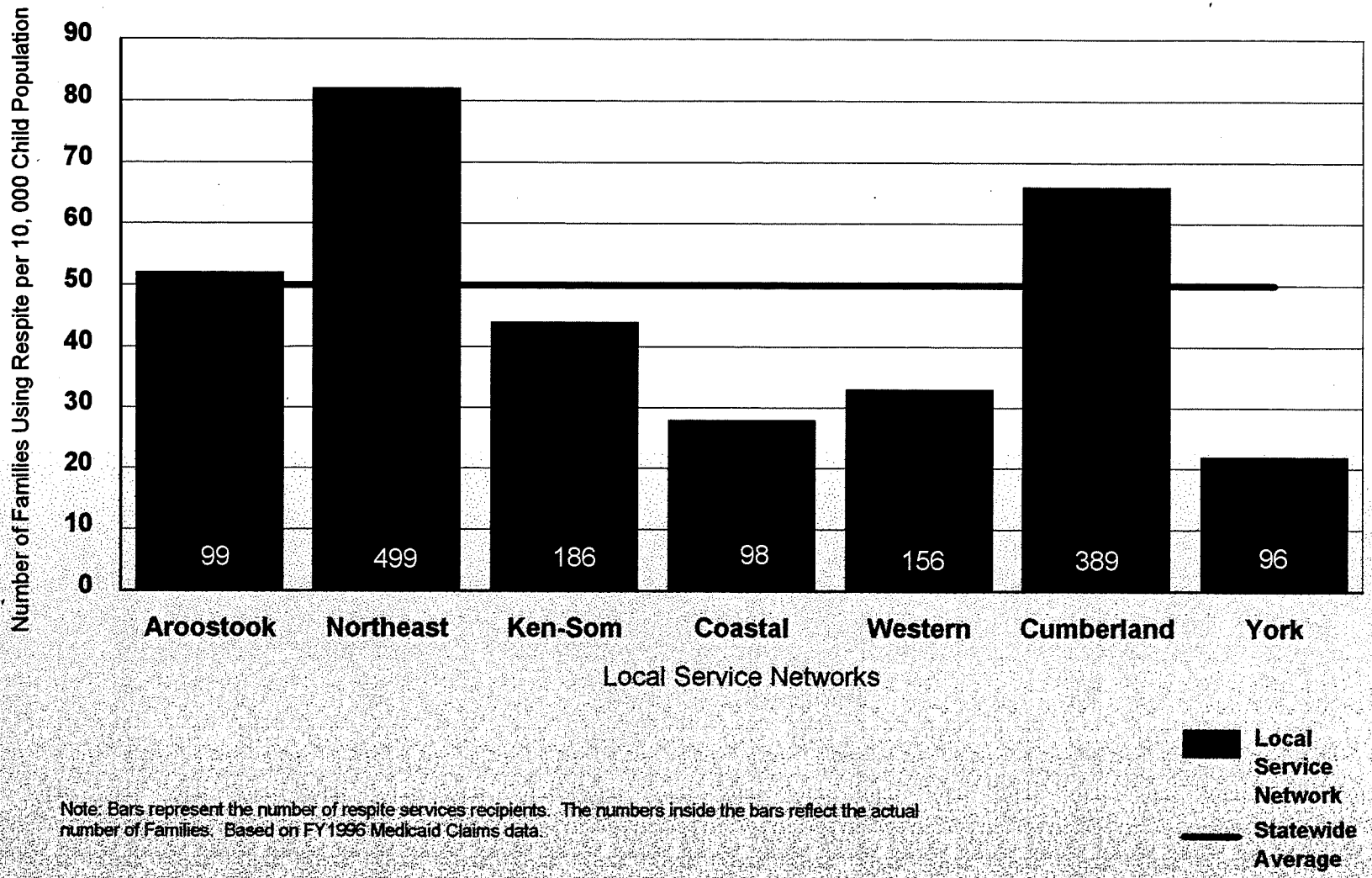
Note: Bars represent the number of case management recipients. The numbers inside the bars reflect the actual number of recipients. Based on FY1996 Medicaid Claims data.

Child Emergency Clinical Service Use by Local Service Network



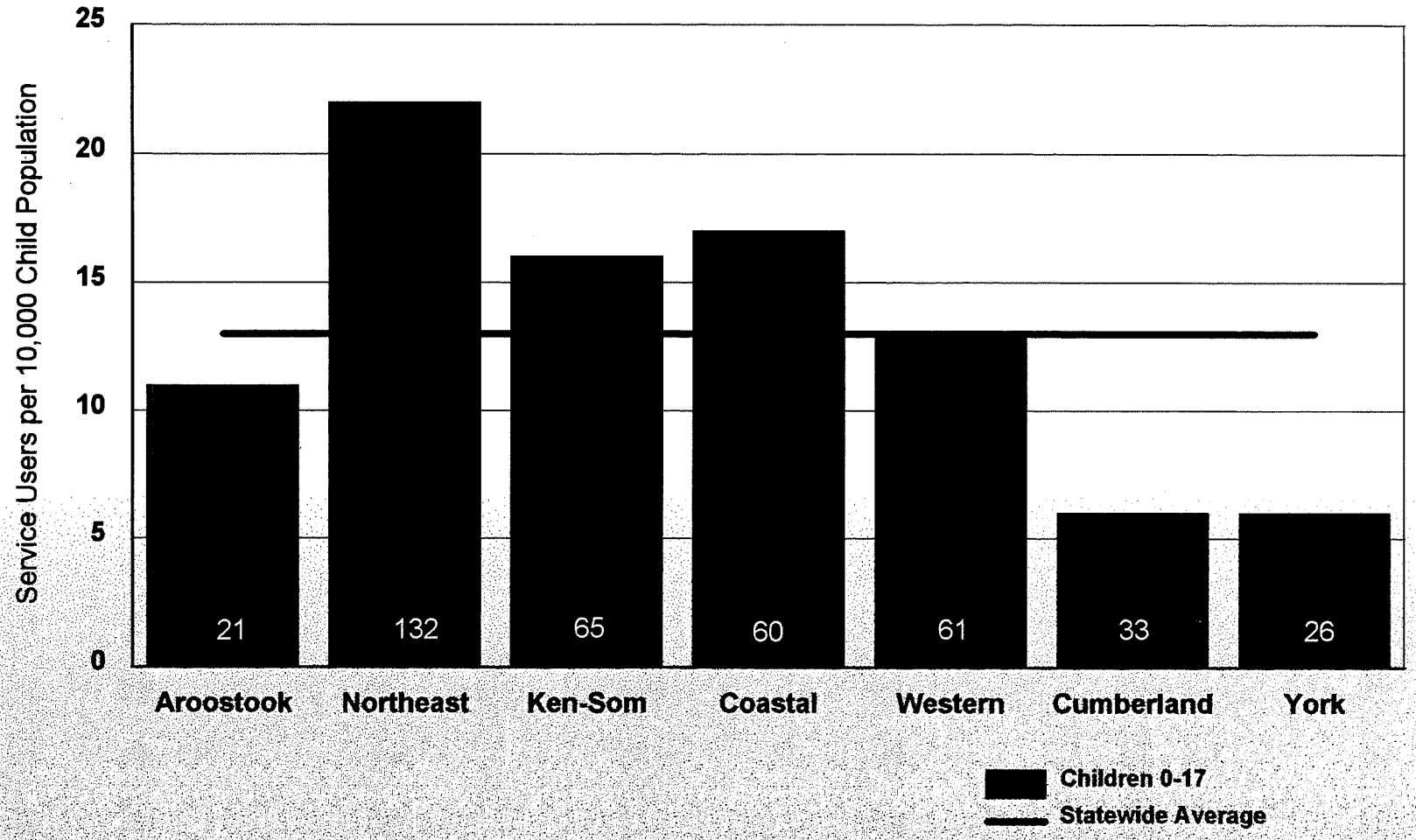
Note: Bars represent the number of crisis services recipients. The numbers inside the bars reflect the actual number of recipients. Based on FY1996 Medicaid Claims data.

Respite Service Use by Local Service Network



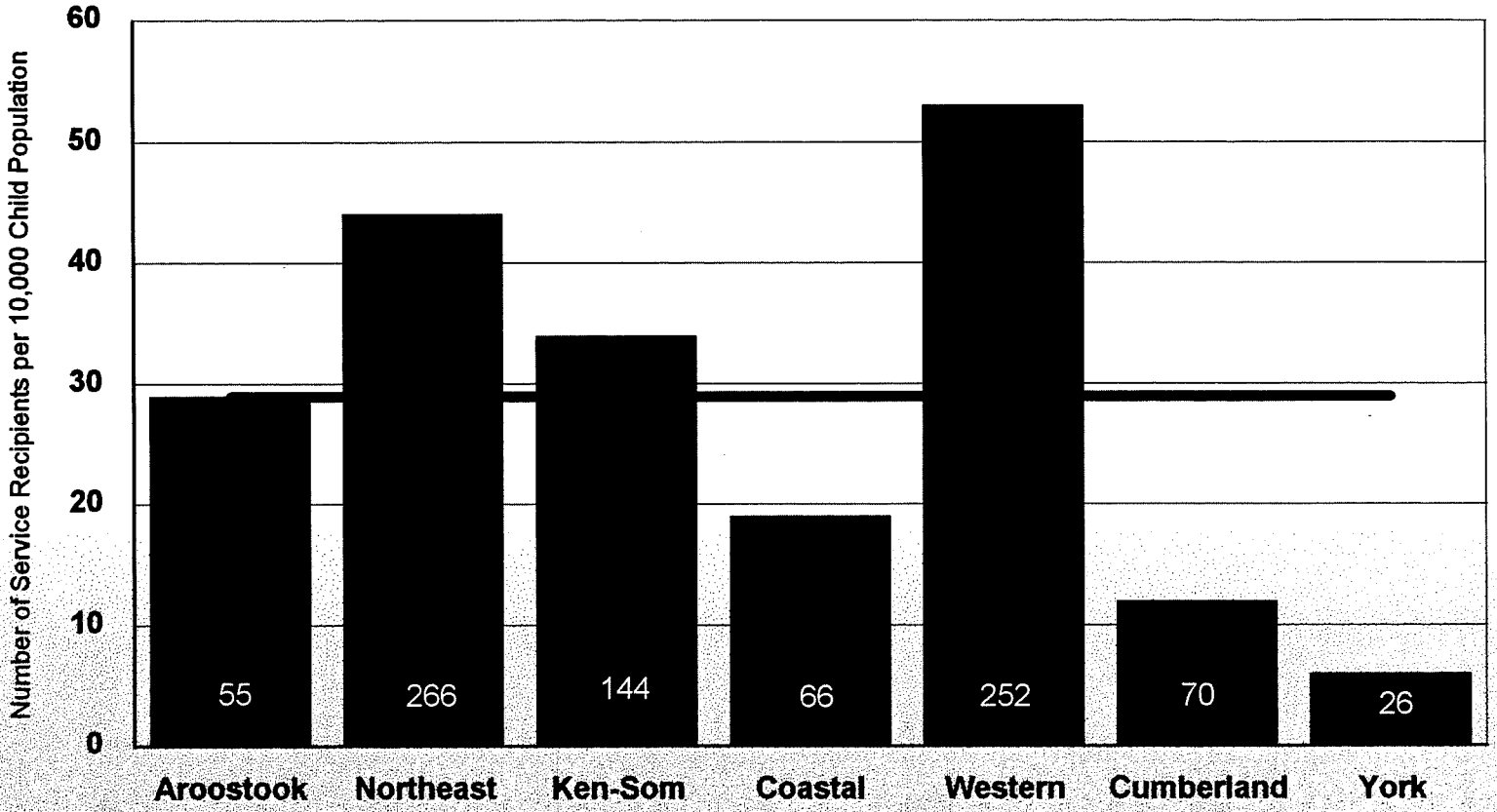
Note: Bars represent the number of respite services recipients. The numbers inside the bars reflect the actual number of Families. Based on FY1996 Medicaid Claims data.

Child Home-based Service Use by Local Service Network



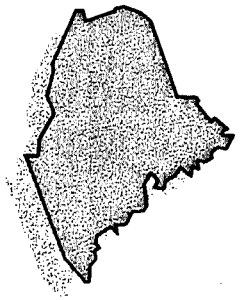
Note: Bars represent the number of home-based services recipients. The numbers in the bars reflect the actual number of recipients. Based on FY1996 Medicaid Claims data.

Child Substance Abuse Service Use by Local Service Network



Note: Bars represent the number of substance abuse services recipients. The numbers inside the bars reflect the actual number of recipients. Based on FY1996 Medicaid Claims data.

Descriptive Profile of Children Served in Community-Based System of Care



Comparison of Children and Families Served - Wings vs. CMHS National System of Care Profile

	Wings (n=275)	CMHS National Study (n=11,497)
Gender: Male	65%	64%
Female	35%	36%
Average Age	12 years	14 years
Single-Mother Families	49%	42%
Families Living with Poverty	50%	67%
Previous Psychiatric Hospitalizations	54%	29%
History of Physical Abuse	44%	35%
History of Sexual Abuse	38%	25%
Mental Health Problems in Family	60%	41%
Family Violence	62%	56%
Family History of Substance Abuse	63%	62%

APPENDIX D:

Local Case Resolution Committees

Local Case Resolution Committees..

Youth Network
Caribou
Contact: Ginette Rivard
Voice 764-2120 TTY 764-2017

Kennebec and Somerset
Children's Network,
Waterville
Contact: Neil Colan
KVMHC 873-2136 TTY 626-3614

Aroostook

Northeast Case Resolution
Committee
Contact: Julie Caitling
Voice 941-2988 TTY 941-2988

Children's Regional
Coordinating Committee
Auburn
Contact: Larry Sexton
Voice 795-4500 TTY 795-4503

Interagency Case Resolution
Committee
Rockland
Contact: Nancy Duncan
Voice 594-2541 TTY 338-5846

Cumberland County
Case Resolution Committee
Portland
Contact: Susan Lieberman
Voice 822-0126 TTY822-0248

Sagadahoc County
Case Resolution Committee
Contact: Polly Crowell
729-4148 No TTY Available

York County
Case Resolution Committee
Saco
Contact: Susan Lieberman
Voice 822-0126 TTY 822-0248

2/11/97

PHILOSOPHY AND PROCEDURES FOR A LOCAL CASE RESOLUTION SYSTEM

RECOMMENDATIONS FROM THE CHILDREN'S CABINET

The Children's Cabinet has been meeting over the last several months to develop specific recommendations for the establishment of a case resolution system which could provide meaningful support to families for keeping children at risk in their own homes and communities. The system described below is the result of these discussions. It is designed to build on work that has been done previously, particularly in utilizing local case review committees which have already been established.

Certain **principles** underlie this system. These principles are:

- Individualized plans are developed by a **local team**, comprising the people who know the child and family best;
- The plan is **needs driven** rather than service driven;
- The plan is family centered;
- The **parent** is an integral part of the team and has ownership of the plan;
- The plan is **strengths based**;
- The plan is focused on **normalization;**
- Services are **created to meet the unique needs of the child and family;**
- Services are **community based**, accessing more restrictive levels of care only for brief periods of stabilization; and
- Services are **culturally competent.**

The model proposed is **not** a program or a type of service. Rather, it is value based and an unconditional commitment to create services on a "one kid at a time" basis to support normalized and inclusive options for youth with complex needs and their families. It operates on the premise that people at the community level have the best understanding of the needs of the particular child and family, and that they are in the best position to develop solutions with that family and child.

THREE KEY CONCEPTS:

1. **THIS IS A NEW WAY OF THINKING ABOUT SERVICES TO CHILDREN AND FAMILIES. PARTICIPANTS IN THE PROCESS MUST BE COMMITTED TO CHANGE AND BE ABLE TO CHANGE THEIR WAY OF WORKING.**
2. **POOLED FUNDS ARE USED AS A SUPPLEMENT TO, NOT A REPLACEMENT FOR, PROGRAMS AND SERVICES FOR WHICH CHILDREN AND FAMILIES ARE ALREADY ELIGIBLE.**
3. **EVERY EFFORT MUST BE MADE TO REMOVE BARRIERS AT THE LOCAL COMMITTEE LEVEL. CASES MUST ONLY BE REFERRED TO THE REGIONAL CHILDREN'S CABINET, OR SUBSEQUENTLY TO THE CHILDREN'S CABINET, IF RESOLUTION IS BEYOND THE CAPABILITY OF THE COMMITTEE TO RESOLVE.**

ROLE OF REGIONAL CHILDREN'S CABINET:

- Coordinate, support and monitor the work of the Local Case Resolution Committee;
- Allocate pooled flexible funding to Local Case Resolution Committees;
- Provide resolution for cases when Local Committee is unable to agree, or negotiate for appropriate services;
- Collect data from Local Committee, develop regional profile on unmet needs and resources, and evaluate system;
- Serve as link to Children's Cabinet; and
- Refer unresolved cases to the Children's Cabinet.

MEMBERSHIP OF LOCAL COMMITTEE:

Each Committee must have a core membership, with representatives from the Departments of Human Services, Corrections, Public Safety (or a local law enforcement representative) and Mental Health, Mental Retardation and Substance Abuse Services, a public school representative, and parent representatives. Membership from the public agencies must include representation from health, mental health, juvenile justice, substance abuse and education. In addition, membership should be drawn from the following groups:

- Front line and "middle management" from public and private provider agencies;
- Parents (2-3 members; per diem payment to parent representatives);
- Community organizations (e.g., churches, civic groups);
- Business representatives;
- Need a core of constant members with broad representation (needs to be the same people on a regular basis; substitutions interfere with building trust and developing knowledge of the system);
- Other people may be invited because of the particular case being considered; and
- Need to be individuals who have demonstrated the ability to change their thinking and practice in serving children and families, incorporating the guiding principles above.

ROLE OF LOCAL CASE RESOLUTION COMMITTEE:

- Establish criteria for referral based on state guidelines;
- Protect/respect confidentiality (sample statement provided);
- Meets at least monthly;
- Develop a common set of values;

- Identify child and family strengths and needs, based on existing information (e.g., family support systems, evaluations, family and social histories, etc.) with family input at the case review meeting;
- Develop with the family a comprehensive plan to support the child and family;
- Identify strategies and resources needed to implement the plan, including existing resources and pooled funds where appropriate;
- Establish timeframe for implementation;
- Identify primary case manager to work with family to assure plan implementation and schedule for review (at least annually);
- Refer to Regional Children's Cabinet only if barriers to implementation occur, which are beyond the scope or ability of the local committee to resolve. The committee must identify the barriers which interfere with implementation;
- Manage budget assigned to the committee;
- Provide required reports of expenditures to next level committee; AND
- Maintain data as required (e.g., # of referrals, type of referrals, services provided, barriers to plan implementation identified -- both system and fiscal).

GUIDELINES FOR EXPENDITURE OF POOLED FUNDS:

- The child has been accepted for review by the committee;
- Existing resources, including natural support systems, existing categorical program funds, community resources (both fiscal and human), must be committed for those portions of the comprehensive plan for which they are appropriate or eligible;
- The local case review committee has developed a comprehensive plan;
- Pooled funds are used flexibly to fill in gaps identified by the family and committee as being the highest priority for successful implementation;
- Purchase of services is not time limited, but dependent on time frames identified in the case plan;
- Funding resources and the individual case plan are reviewed in accordance with a schedule developed by the local committee, but at least annually, to assure continued appropriateness of particular resources;
- Local Committees may authorize payment of room and board costs for purposes of stabilization or as a part of a treatment plan for a period up to three weeks. Any such expenditures must be reported to the responsible Regional Children's Cabinet; and
- Plans which identify a need for longer term residential services for which other funding resources cannot be identified must be referred to the responsible Regional Children's Cabinet. The Regional Children's Cabinet will collect data on these requests to be forwarded to the Children's Cabinet. Pooled, flexible funding <u>may not be used to pay for room and board costs for anything other than short term as noted above.</u>

ACCESSING LOCAL COMMITTEE REVIEW

Targeted populations for review and resolution are children who have multiple and complex special needs and their families, and those who are served by two or more Departments.

Criteria for referral:

- Past informal efforts at coordinating services among agencies have not been successful
- An appropriate service plan has been difficult to develop due to the severity, multiplicity or unusual nature of the child's problems
- Existing resources, accessed through a single system, appear to have been exhausted;
- Child and family needs exceed the ability of a single agency to meet or resolve; and
- Expertise of multiple disciplines and agencies is required to develop and implement appropriate case plan.

Process for referral

- Individual/Agency supporting referral gets parental permission to present case to the committee. **Parents may make their own referral to the committee for review;**
- Form is completed and, if possible, sent to the committee contact prior to a scheduled meeting, detailing current status of the case and issues to be considered by the Committee; and
- Parents are strongly encouraged and supported to attend the meeting if possible, as are other service providers involved with the child and family. Referrer presents case to the committee (Written material on child and family is returned at the end of the meeting).

Pooled Flexible Funding Available

As of November 1996, funding is available to pool in accordance with this initiative as follows:

		Lapse/Carry Status	Funds to be allocated to the RCCs as follows. RCC will bill assigned department
Department of Mental Health, Mental Retardation, and Substance Abuse Services	$500,000	Funds Carry	Region II
Department of Human Services	$420,000	Funds Carry	Region III
Department of Corrections	$100,000	To Be Determined	Region I
Department of Education	$50,000	Funds Lapse	Region I
Total Available as of November 1996	$1,070,000		

An initial allocation of $200,000 will be allocated to each of the 3 Regions for immediate dissemination to the Local Case Resolution Committees within that Region.

	Telephone	Fax	Mailing Address	E-mail
Region I -Southern Maine [Cumberland & York]				
John Milazzo - DMHMRSAS;	822-0270	822-0295	169 Lancaster St. Portland 04101	
Dan Harfoush-Acting-Department of Corrections ;	822-0800	822-0810	"Maine Youth Center, 675 Westbrook St. So.Portland 04106"	
Andrea Goodman - Department of Human Services	822-2214	822-2146	"509 Forest Avenue, Portland 04101"	andrea.goodman@state.me.us [at central office]
Connie Manter - DOE - Social Studies;			State House Station 23. Augusta.	connie.manter@state.me.us
Karen Rumery - DOE - Middle School & English Language Arts/ Reading	287-5985	287-5927	"23 State House Station Augusta, Me 04333-0023"	karen.rumery@state.me.us
Lt. Dale Lancaster [CID I] - Department of Public Safety	657-5710	657-5748	"Maine State Police. CID I, 1 Game Farm Road. Gray 04039"	
"Region II - Central Maine [Kennebec, Somerset, Franklin, Androscoggin, Oxford, Waldo, Sagadahoc, Lincoln, Knox]"				
Lisa Burgess - DMHMRSAS;	287-4272	287-4052	State House Station #141. Augusta 04333	
Department of Corrections:				
Mark Boger	873-6644	8977-0742	"18 Colby Street. Waterville, Me 04901"	
Ann Therrien	783-5383	783-5368	"PO Box 3098. Auburn, Maine"	
Rachael Cyr Henderson - Department of Human Services;	624-8115	624-8124	219 Capitol St.State House Station #11. Augusta	rachel.c.henderson@state.me.us [at central office]
Donald Reutershan -DOE - Foreign Language;	287-5936	287-5927	"23 State House Station,Augusta 04333-0023"	don.reutershan@state.me.us
Mona Baker -DOE - Special Ed / Personalized Education;			"23 State House Station,Augusta 04333-0023"	mona.baker.@state.me.us
Vacant - DOE - Gifted & Talented				
Lt. Gerard Therrien [CID II] - Department of Public Safety	287-7502	287-7277	"18 Meadow Rd. State House Station 52, Augusta"	

Sgt. John Dyer
- Dept. Public Safety

	Telephone	Fax	Mailing Address	E-mail
"Region III - Eastern and Northern Maine [Aroostook, Penobscot, Piscataquis, Washington, Hancock]"				
Pat O'Brien - DMHMRSAS;				
Barry Stoodley - Department of Corrections	941-3130. [voicemail: 941-4748]	941-3132	10 Franklin St. Bangor. 04401	
Becky Hayes-Boober - Department of Human Services;	561-4197	561-4122	396 Griffin Rd.Bangor 04401	home: bhboober@aol.com work: becky.hayes.boober@state.me.us [at central office]
Nancy Andrews; -DOE - English Language Arts / Writing			"23 State House Station Augusta, Me 04333"	nancy.andrews@state.me.us
William Primmerman - DOE - Health Education	287-4484	287-5927	"23 State House Station Augusta, Me 04333"	bill.primmerman@state.me.us
Thomas Keller - DOE - Science			"23 State House Station Augusta, Me 04333"	tom.keller@state.me.us
Lt. Darrell Ouellette [CID III] - Department of Public Safety	941-4071	941-4675	Maine State Police. 106 Hogan Rd. Bangor	
Also:				
"Valerie Seaberg- Department of Education; Education Team Leader/Policy Director for Personnel, Quality Assurance & Regional Education Services"	287-5806	287-5900	Department of Education.23 State House Station. Augusta 04333	valerie.seaberg@state.me.us
Rhama Schofield	287-4223	287-4268	DMHMRSAS. State House Station 40	rhama.schofield@state.me.us

APPENDIX E:

GEAR Brochure

GEAR representatives are parents of children with developmental or mental health special needs.

they ...

listen
understand
share information
support and encourage
share experiences

Gaining
Empowerment
Allows
Results

GEAR was started by parents who recognized the need for help and support for parents coping with the demands of caring for children with special needs.

GEAR offers...

- encouragement through support group meetings and by phone
- workshops on topics of interest
- local conferences
- social opportunities

GEAR Parent Network
RR 02 Box 664
E. Eddington, ME 04428

GEAR

Parent Network

Parents working together to help each other and their children with special needs

1-800-264-9224

Toll free Number provided by United Families for Children's Mental Health, Inc.

A program of
Crisis and Counseling Centers

Sponsored by:
Department of Mental Health, Mental Retardation & Substance Abuse Services

You are not alone

GEAR parent representatives have the experience of loving and caring for a child with demanding special needs. They know the importance of having someone to talk to who understands what life can be like coping with issues at home, in the community, and at school.

- Parents are not judged or blamed for their child's behavior or other issues.
- Parents can find help through problem solving and the shared experiences of other parents in the GEAR network.
- Through sharing information, parents learn about services for children, how to access them and what has worked for others.
- GEAR emphasizes the strengths of children & families and builds on them.

▸ ▸ ▸ ▸ ▸ ▸ ▸ ▸ ◂ ◂ ◂ ◂ ◂ ◂ ◂ ◂

Contact **GEAR** statewide by calling

1-800-264-9224

to find out more about support groups and other GEAR sponsored activities in your area.

Toll free Number provided by United Families for Children's Mental Health, Inc.

Your local GEAR representative is:

GEAR

Parent-to-parent encouragement happens when two or more parents support each other.

- by phone,
- at local GEAR support group meetings
- at training workshops
- at social events

All sponsored by GEAR to bring parents together.

GEAR exists to facilitate contact between parents to prevent isolation and share knowledge gained by experiences with our children's disabilities and contact with the system of care.

One parent's view...

"This support group for parents of children with special needs has given me a greater understanding of myself, an acceptance of my human imperfections, even as I continue to strive for a greater quality of life. I feel it is so important to be able to relate with others who have 'been there'; who go through the same trials I do, without casting judgment upon me.

The caring is genuine and heartfelt. I experience frustration and uncertainty in a crisis, but I know that I am not alone. I am free to share my feelings amongst those who are sincere and supportive of my efforts, and where I feel safe to express my pain. I am encouraged to continue trying and reinforced by those who have tried methods and had positive results. One step at a time, to a greater understanding of myself and the needs of my 'special' child."

Phone Numbers

Call Services to Children with Special Needs to get 800 numbers for crisis, community support and Respite in your area.

Regional offices of
Dept. of Mental Health, Mental Retardation & Substance Abuse Services - Services for Children with Special Needs

Region 1 - Cumberland & York counties
1-800-492-0846

Region 2 - Kennebec, Somerset, Knox, Waldo, Lincoln and Sagadahoc counties
1-800-866-1814

- Androscoggin, Franklin, Oxford counties
1-800-866-1803

Region 1 - Penobscot, Piscataquis, Hancock & Washington counties
1-800-227-7706

- Aroostook County
1-800-767-9857

My Crisis number is :

Community support:

Agency for Respite:

APPENDIX F:

Department of Corrections/DMHMRSAS
Memorandum of Agreement

MEMORANDUM OF AGREEMENT
BETWEEN
DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES
AND
DEPARTMENT OF CORRECTIONS

PURPOSE

The Department of Mental Health, Mental Retardation and Substance Abuse Services (DMHMRSAS) is the lead executive agency responsible for the children's mental health services system. This responsibility includes: system design and implementation, creation and management of local provider networks that provide a full range of services, establishment of a single gatekeeping authority, establishment of uniform standards and procedures, care coordination, monitoring and evaluation.

The Department of Corrections (DOC) is responsible for diverting from the correctional system, juveniles referred by law enforcement officers supervising youth on probation, providing care and supervision to youths detained or committed in Maine's juvenile correctional facilities, and supervising youth on aftercare from those facilities.

The Departments jointly recognize that many youth in the correctional system have mental health treatment needs, and agree to work together to formalize new roles and responsibilities for each agency in addressing the mental health needs of children in a unified system of care.

The following activities will be undertaken during the period 12/15/97-3/1/98, and will culminate in a signed Memorandum of Agreement Implementation Plan by March 1, 1998.

1. The DMHMRSAS/DOC will jointly develop a clinical team to review treatment needs and to develop a plan for the provision of treatment for children committed to the Maine Youth Center, including staffing levels and a budget.
2. The DMHMRSAS/DOC will jointly develop a protocol for intensive case management (ICM) staff positions in each of the three DMHMRSAS regional offices. ICMs will be assigned to work with regional DOC juvenile caseworkers in assessment and treatment planning for children under supervision of DOC. Relevant clinical information will be shared between the two departments.
3. The DMHMRSAS/DOC will jointly work to develop a secure facility for adjudicated youth who, due to severe mental health disorders, mental retardation or substance abuse issues, would otherwise be inappropriately placed at the Maine Youth Center.

4. The DMHMRSAS will expand its 24-hour crisis response capacity, including the development of additional beds, to assure ability to respond to juveniles under supervision of DOC.
5. The DMHMRSAS/DOC will jointly develop and implement appropriate cross-training curricula for staff of the two Departments.
6. The DOC will provide the DMHMRSAS clinical team access to adjudicated youth and all appropriate records for the purpose of assessing treatment needs and developing appropriate plans of care for children at the Maine Youth Center.
7. The DMHMRSAS/DOC will work jointly to develop necessary financial and administrative structures and mechanisms to support the above activities and other components of a unified system of care.

12/12/97
Date

Martin Magnusson
Commissioner, Department of Corrections

12/15/97
Date

Melodie J Peet
Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services

APPENDIX G 1:

Proposed Department of Human Services/DMHMRSAS Memorandum of Agreement

DRAFT

MEMORANDUM OF AGREEMENT BETWEEN DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES AND DEPARTMENT OF HUMAN SERVICES

The Department of Mental Health, Mental Retardation and Substance Abuse Services and Department of Human Services joint agree to undertake the following activities during the period of 12/15/97-3/1/98, and will culminate in a signed Memorandum of Agreement Implementation Plan by March 1, 1998:

1. The DMHMRSAS will expand the availability of 24-hour crisis services, including crisis beds, for children in foster care and those who come into custody suddenly.
2. The DMHMRSAS/DHS will work jointly to assess the treatment and support needs of mentally ill parents, and to develop appropriate services to strengthen the family and ensure the safety of the child.
3. The DMHMRSAS will establish formal mechanisms to work with the Bureau of Child and Family Services to assure the development of state-of-the-art treatment programs for abused children and for those with severe behavioral problems who need out of home placements. Priority attention will be paid to those children with specific severe behavior disorders who have been or are at risk of being sent out of state.
4. The DMHMRSAS/DHS will work jointly to develop a no reject policy between the state and its providers.
5. The Departments will work together to develop and implement cross-training to include, but not be limited to, trauma, abuse, philosophy and legal mandates (federal and state).
6. The Departments will work jointly to develop necessary financial and administrative structures and mechanisms to support the above activities and other components of a unified system of care.

_____ Date

_____ Commissioner, Department of Human Services

_____ Date

_____ Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services

APPENDIX G 2:

Proposed Department of Education/DMHMRSAS Memorandum of Agreement

DRAFT

MEMORANDUM OF AGREEMENT BETWEEN DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES AND DEPARTMENT OF EDUCATION

The Department of Mental Health, Mental Retardation and Substance Abuse Services and the Department of Education agree to the following framework for discussion and negotiation of respective responsibilities which will occur during the period of 12/15/97-3/1/98, and will culminate in a signed Memorandum of Agreement Implementation Plan by March 1, 1998.

The two Departments agree to:

1. Discuss ways of increasing school staff knowledge regarding access to mental health services, and mental health staff knowledge about the educational system.
2. Define roles and participation of mental health staff on SAT and PET Teams
3. Define mechanisms for access to and utilization of mental health services in addressing mental health needs of children in schools, as identified through the school-based mental health initiative.
4. Work with Child Development Services (CDS) to revise the MOA of 1994 to reflect new federal law and the new DMHMRSAS structure.
5. Explore the co-location and coordination of Infant Mental Health/Development Specialists from the mental health system with Child Development Services from DOE.
6. Work jointly to develop necessary financial and administrative structures and mechanisms to support the above activities and other components of a unified system of care.

_____ _____

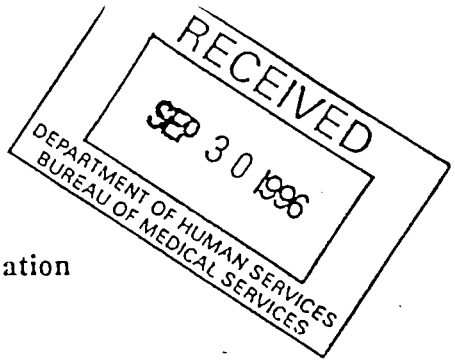
Date Commissioner, Department of Education

_____ _____

Date Commissioner, Department of Mental Health, Mental Retardation and Substance Abuse Services

APPENDIX H:

1996 Memorandum of Agreement between DHS/DMHMRSAS



Interdepartmental Agreement Between

The Department of Human Services and

The Department of Mental Health, Mental Retardation and Substance Abuse Services

I. Legal Basis

The legal basis for the Department of Human Services (hereinafter DHS) and the Department of Mental Health, Mental Retardation and Substance Abuse Services (hereinafter DMHMRSAS) to enter into this agreement is found in Part JJ of P.L. 1991 Chapter 591, An Act Providing Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other funds, and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Year Ending June 30, 1991, June 30, 1992 and June 30, 1993.

II. Purpose

The purpose of this agreement is to set forth the responsibilities of both parties in order to transfer responsibility for the administrative functions and State funding of those Medicaid Services related specifically to programs for the mentally retarded, mentally ill adults and mental health services for children with severe emotional disturbance and/or developmental disabilities from DHS to DMHMRSAS consistent with applicable State and federal laws and regulations. This transfer is taking place pursuant to Section JJ of PL 1991, c. 591, An Act Providing Unified Appropriations and Allocations for the Expenditures of State Government, General Fund and Other Funds, and Changing Certain Provisions of the Law Necessary to the Proper Operations of State Government for the Fiscal Years Ending June 30, 1991, June 30, 1992 and June 30, 1993.

III. Authority and Responsibility

As the designated single state agency responsible for assuring that the State of Maine complies with all Federal statues and rules concerning the operation of the Medical Assistance Program, DHS has the authority to review and monitor the implementation of this agreement. This authority carries with it the responsibility to prepare and submit state plan amendments, conduct the rule-making process in accordance with state and federal statutes relative to changes in the Maine Medical Assistance Manual or pertinent Principles of Reimbursement and to notify DMHMRSAS of any findings of non-compliance with Federal requirements related to functions administered by DMHMRSAS pursuant to this agreement and to collect and receive monies paid by Medicaid identified in any and all state and federal reviews, audits or sanctions. DMHMRSAS has the responsibility for carrying out those activities specified in this

agreement in accordance with Federal requirements and as provided in the State Plan for the Medicaid program and as set forth in policy.

IV. Responsibilities of DMH, MR & SAS

Mental Retardation:

The functions listed below pertaining to Medicaid services for persons with mental retardation and/or related disabilities are transferred from DHS to DMHMRSAS as of the dates noted pursuant to this agreement. The functions are prescribed by the Social Security Act, Code of Federal Regulations, Maine Medical Assistance Manual and all other applicable federal and State Laws, rules, and regulations.

a. Rate-setting for ICF's/MR nursing and group homes not operated by DMHMRSAS, Developmental Training services, Cost Reimbursed Boarding Homes for persons with Mental Retardation, waiver services, case management services for persons with mental retardation and the Community-Supported Living Arrangements (CSLA) program if funded by HCFA. (Rate setting for ICF 's/MR and cost-reimbursed boarding homes effective with transfer of seed account.)

b. Assign staff person who meets qualifications of a QMRP to become a key participant in the annual Inspections of Care and semiannual utilization review of services provided to persons with mental retardation residing in ICFs/MR not operated by DMHMRSAS. DMHMRSAS has a registered nurse to be part of the Inspection of Care Team.

c. Preparation of policies related to Medicaid services for persons with mental retardation to be adopted through rule-making by DHS, Bureau of Medical Services as part of the Maine Medical Assistance Manual. November 1, 1991.

d. Certification and recertification of the need for admission and continued ICF/MR services. December 1, 1991.

e. Initial classifications and reclassifications for ICF/MR and waiver as soon as a nurse is available.

f. Seed account responsibility for services provided effective 12/1/91 and set forth in a above. December 1, 1991.

g. Development of Principles of Reimbursement for ICFs/MR not operated by DMHMRSAS and for cost-reimbursed boarding homes for persons with mental retardation to be adopted through DHS rule-making. December 1, 1991.

h. Auditing of facilities, by the Auditing, Contracting and Licensing Service Center, whose fiscal year ends after December 31, 1991 except for facilities operated by DMHMRSAS.

i. Determination of staffing levels, both permanent and emergency for ICF's/MR and boarding care facilities for persons with mental retardation. December 1, 1991.

j. Development of methodology for determining Medicare Upper Limit and calculation of Medicare Upper Limit compliance for ICF/MR based upon laws/rules/regulations published in the CFR/State Medicaid operations manual/Social Security Act. December 1, 1991.

k. Provider relations concerning interpretation of coverage and reimbursement policies for the services set forth in the paragraphs above. Claims research will be retained by DHS. December 1, 1991.

l. Identification and reporting of suspected Medicaid fraud and abuse to the Medicaid Fraud Control Unit of the Office of the Attorney General.

m. Attendance at administrative hearings requested by providers or recipients concerning decisions made by DMHMRSAS and defense of those decisions at hearings or during further appeal.

Mental Health

The functions listed below pertaining to mental health services funded by Medicaid for persons with mental illness are transferred from DHS to DMHMRSAS as of the dates noted pursuant to this agreement. The functions are prescribed by the Social Security Act, Code of Federal Regulations, Maine Medical Assistance Manual and all other applicable federal and State laws, rules, and regulations.

a. Preparation of policies to be adopted through rulemaking by DHS, Bureau of Medical Services as part of the Maine Medical Assistance Manual and rate-setting for the following services:

Mental health clinic services to adults;
Community Residences for Mentally Disabled Persons
(Private Non-Medical institutions);
Case Management for Mentally Disabled Persons;
Specialized Units in Nursing Facilities for
Persons with Mental Health Needs

Community Support Services;
Other mental health services for adults developed pursuant to this Agreement.

b. Seed account responsibility for mental health services provided to adults, set forth in a. above, and the state share of Medicaid costs for beds added in response to the RFP for AMHI/BMHI replacement beds and funding for state-only costs for private room differential.

c. Keeping BMS apprised of planned policy changes, subsequent clarifications and timely coordination of policies related to Medicaid services for adults with mental illness.

d. Developing residential care and nursing facility programs jointly/collaboratively to meet needs of clients with mental illness and those in need of protective services.

e. Annual certification of compliance with the Keys Amendment to the Social Security Act.

f. Developing standards for services provided by mental health clinics.

g. Provider relations concerning interpretation of coverage and reimbursement policies for the services set forth in the paragraphs above. Claims research will be retained by DHS.

h. Identification and reporting of suspected Medicaid fraud and abuse to the Medicaid Fraud Control Unit of the Office of the Attorney General.

i. Attendance at administrative hearings requested by providers or recipients concerning decisions made by DMHMRSAS and defense of those decisions at hearings or during further appeal.

Children Services

The functions listed below pertaining to mental health services funded by Medicaid for persons with mental illness are transferred from DHS to DMHMRSAS as of the dates noted pursuant to this agreement. The functions are prescribed by the Social Security Act, Code of Federal Regulations, Maine Medical Assistance Manual and all other applicable federal and state laws, rules and regulations.

a. Preparation of policies to be adopted through rulemaking by DHS, Bureau of Medical Services as part of the Maine Medical Assistance Manual and rate setting, in conjunction with DHS, for the following services for which DMHMRSAS provides financial support through a contractual relationship with specified providers:

-Children's mental health clinic services
-Homebased family services
-Case management services

b. Preparation of recommendations for policy changes and rate setting, made in conjunction with other state agencies having fiscal or program responsibility for the services listed below, to be adopted through rulemaking by DHS, Bureau of Medical Services as part of the MMAN:

- Private Non-Medical Institution Services - Residential Child Care Facilities
-Early intervention services - developmental therapies

c. Seed account responsibility for services provided to children, set forth in a. above, where other state agency/federal mandates and current responsibilities do not apply.

d. Keeping BMS apprised of planned policy changes and timely coordination of policies related to Medicaid services for children with severe emotional disturbance and/or developmental disabilities.

e. Developing community based programs jointly/collaboratively to meet needs of children with severe emotional disturbance and/or developmental disabilities and to avoid unnecessary institutionalization.

f. Developing standards for services described above in conjunction with the Department's licensing process.

g. Provider relations concerning interpretation of coverage and reimbursement policies of the services set forth in the paragraphs above. Claims research will be retained by DHS.

h. Identification and reporting of suspected Medicaid fraud and abuse to the Medicaid Fraud Control Unit of the Office of the Attorney General and the Division of Surveillance and Utilization Review.

l. Attendance at administrative hearings requested by providers or recipients concerning decisions made by DMHMRSAS and defense of those decisions at hearings or during further appeal.

V. Responsibilities of DHS

In accordance with Section 1902(a)(5) of the Social Security Act and Section III of this agreement, the Department of Human Services is the single State agency for the Medicaid Program. As such, DHS retains the following Medicaid Program functions:

a. Administer the State Medicaid Plan including the processing and approval of new and amended State plan material.

b. Promulgate rules and regulations that are based on policies developed by DMHMRSAS and are followed in administering the plan including the adoption of rules contained in the Maine Medical Assistance Manual and Principles of Reimbursement for MR facilities and other services funded and administered by DMHMRSAS.

c. Revisions of Principles of Reimbursement for ICF/MR facilities operated by DMHMRSAS.

d. Audit of facilities operated by DMHMRSAS and the audit of all facilities by the Auditing, Contracting and Licensing Service Center under the Maine Department of Human Services.

e. Annual Inspections of Care and Semiannual Utilization Review in ICF's/MR. For ICF's/MR not operated by DMHMRSAS, these reviews will be conducted with the participation of QMRP staff from DMHMRSAS. For state-operated ICF's/MR, the annual IoC's & semiannual utilization review will be done by DHS staff.

f. Processing of claims, third party liability, payment for services and adjustments to payments.

g. Researching claims for providers.

h. Licensing and Certification of ICF's/MR and licensing of adult boarding and foster homes serving persons with mental retardation or mental illness. Regulations for

state licensure remain the responsibility of DHS but any revisions affecting facilities for persons with mental retardation or mental illness will be developed with the participation of DMHMRSAS.

l. Developing residential care and nursing facility programs, including the Bureau of Medical services and the Bureau of Elder and Adult Services, jointly/collaboratively with DMHMRSAS to meet the needs of persons with mental illness and those in need of protective services.

j. Surveillance & Utilization Review of services provided and the reporting of suspected fraud and abuse to the Medicaid Fraud Control Unit of the Office of the Attorney General.

k. Holding administrative hearings required by federal and state law, and pursuant to the DMH's Hearings Manual and make final determinations on issues raised in such hearings.

VI. Financial and Program Responsibility

The DMHMRSAS agrees to assume financial and programmatic responsibility for all functions performed by DMHMRSAS under this agreement. DMHMRSAS agrees to repay the Department of Human Services any federal matching funds withheld by the federal government due to audit findings or program compliance reviews of services provided after effective dates contained in this agreement or for reviews of services provided directly by DMHMRSAS prior to the effective date of this agreement. Repayment will be either by financial order or by offsetting future deposits to the General Fund for Services provided directly by DMHMRSAS.

Following audits of cost reimbursed boarding care facilities and ICF's/MR, any cost settlements resulting in recoupment will be collected by DHS. For audits for operating years ending after 12/31/91, the state share of any recoupment will be transferred to the appropriate account in DMHMRSAS or DHS prorated according to period funded by respective Departments. If not collected within 60 days, the Federal recoupment will also be prorated and funded by the respective Departments as it becomes due. If, after 60 days, payments are made by check from the provider, the state and Federal share will be credited to the appropriate account in DMHMRSAS or DHS. If DMHMRSAS enters into an agreement with the provider to collect the overpayment by offsetting future payments, the Federal share of the collections will be reimbursed to DMHMRSAS. The Department of Human Services reserves the right to pursue

recovery of existing accounts receivable, including those presently under appeal, and any such collections will be credited to the appropriate account in DHS. Effective 12/1/91 DHS will send a weekly report to DMH/MR on all transactions in the Accounts Receivable for services seeded by DMHMRSAS.

In the event an established debt becomes collectible, as defined in 22 MRSA §1714-A, and is not repaid or an agreement signed for repayment of the debt DMHMRSAS shall refer to DHS for further action pursuant to 22 MRSA §1714-A.

For any cost settlement payments DHS will provide the state share for audits for all facilities with operating years ending on or before 12/31/91 and by DMHMRSAS for audits thereafter. DMHMRSAS must notify DHS of all cost settlement payments to be processed in order to draw down the Federal match.

DMHMRSAS agrees to comply with the provision of 22 M.R.S.A. §1714-A, regarding collection of debts and recapture of depreciation as it relates to the sale of ICFs/MR and cost reimbursed boarding homes. All recapture of depreciation and debt due the State for sales which occur on or before November 30, 1992, should be deposited in the appropriate account at DHS. Regardless of the date of transfer, DMHMRSAS staff will notify the DHS of any funds recaptured through the sale of ICFs/MR so that the Federal share may be repaid.

VII. Administrative Costs

The time spent by staff of the Department of Mental Health, Mental Retardation and Substance Abuse Services in administrative activities related to these activities will be eligible for Federal matching funds at a match rate of 50%, except for the time of health professional staff, as defined by Federal regulations, and the support staff for those professionals, which will be eligible for match at the rate of 75%. Enhanced funding will be provided at the 90% FFP for the design, development and installation of mechanized claims processing and information and referral system. Written substantiation of this administrative time must be available for review by representatives of the Department of Human Services and the Health Care Financing Administration if match is to be claimed. Claims for this match must be submitted to the Bureau of Medical Services no less often than quarterly, no later than 15 days after the end of the quarter. Federal matching funds will be deposited to the General Fund unless positions have been authorized to be funded from Federal allocations, or except for those items identified in Appendix 1. In the event of a Federal disallowance of any of this match, the FFP will be deducted from subsequent deposits to the General Fund from claims from the Department of Mental Health, Mental Retardation and Substance Abuse Services for administrative match. The Department's cost allocation Plan is provided in Appendix 2.

VIII. Liaison

It is recognized that the effectiveness of any agreement is measured by the manner with which it is implemented, and it is expected that some concerns will emerge in this process. Therefore, the acceptance of this agreement confirms that each Department will designate staff to serve in a liaison capacity to identify and resolve concerns and develop specific procedures to insure an orderly, ongoing process.

IX. This agreement will be effective July 1, 1996 upon signature and until such time as it is amended as agreed by both Departments or terminated by the Maine Legislature.

Kevin W Concannon — 9/24/96

Kevin Concannon
Commissioner
Department of Human Services

Date

Francis Finnegan — 9/24/96

Francis Finnegan
Director
Bureau of Medical Services

Date

Melodie J Peet — 9/10/96

Melodie Peet
Commissioner
Department of Mental Health, Mental
Retardation & Substance Abuse Services

Date

APPENDIX I

Federal funds earned for expenditures charged by the University of Southern Maine (Muskie Institute) will be used to reimburse the federal share of expenditures to the University of Southern Maine.

State funds will be used to pay a portion of the state share of expenditures for training activities provided by USM (Muskie). The remaining state share of cost will be provided by USM.

APPENDIX II

STATE OF MAINE

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION

AND SUBSTANCE ABUSE SERVICES

COST ALLOCATION PLAN

CLAIM FOR FEDERAL FINANCIAL PARTICIPATION

JULY 1, 1996

Table of Contents

OBJECTIVES OF THE PLAN

The objective of the cost allocation plan is to quantify the administrative costs of the Department of Mental Health, Mental Retardation and Substance Abuse Services and, further, to distribute those costs in a fair and equitable manner to the programs administered and/or serviced by the Department. Once this allocation has been achieved, the plan will then provide the methodology to assess to what extent certain federally assisted programs should bear their fair share of the costs incurred in support of those programs.

LIST OF PROGRAMS

MENTAL HEALTH SERVICES

The Department is establishing seven local service network (LSNs) in geographically distinct areas encompassing the entire state. Along with a Quality Improvement Council, each network of providers will be organized to adhere to principles and standards required by the Department. Services that will be available through the network include: housing and residential support; case management; vocational; social rehabilitation; treatment services such as medication prescription and monitoring, psychotherapy, other professional services; inpatient services and 24 hour crisis services.

CHILDREN'S SERVICES

As in Mental Health services, Children's services will be available through the seven local service networks. Services that will be available include: case management, crisis, consultation, day treatment, community support, home based, homeless, outpatient, residential, respite, social/recreational and wraparound.

MENTAL RETARDATION SERVICES

This program assures that services and programs available to the citizens of Maine are equally available to individuals with mental retardation and individuals with autism and their families. Mental Retardation services include residential, crisis intervention, day programming, respite supported employment, supported living, transportation, professional services, recreation/leisure and voucher.

SUBSTANCE ABUSE

This program plans, develops, implements, coordinates and evaluates all of the State's alcohol and other drug abuse prevention and treatment activities.

OFFICE OF ADVOCACY

The Office of Advocacy investigates claims and grievances of clients of the Department. The Office also advocates for compliance with all laws, administrative rules and regulations, and institutional and other policies relating to the rights and dignity of these clients, and act as a monitor of restrictive and intrusive treatments. In addition, the Office of Advocacy is designated investigator agent of the Department under the mandate of the Adult Protective Services Act (22 M.R.S.A., Section 3470 et seq.).

DEVELOPMENTAL DISABILITIES OFFICE

The Developmental Disabilities Office provides staff support to Maine State Planning and Advisory Council on Developmental Disabilities. The Office assists the Council in improving and enhancing the network of services available to developmentally disabled persons of all ages in Maine.

AUGUSTA MENTAL HEALTH INSTITUTE

The Augusta Mental Health Institute is mandated to treat adults who require intensive 24-hour psychiatric services from the following counties, Androscoggin, Cumberland, Franklin, Kennebec, Knox, Lincoln, Oxford, Sagadahoc, Somerset, Waldo and York. All services are provided without regard to race, creed, color, sex national origin, ancestry, age, physical handicap, or ability to pay.

BANGOR MENTAL HEALTH INSTITUTE

The Bangor Mental Health Institute provides patient-centered multidisciplinary treatment, habilitation and rehabilitation to adults with psychiatric illness severe enough to require psychiatric hospital services and for whom no alternative treatment is available. The Bangor Mental Health Institute serves northern and eastern Maine.

AROOSTOOK RESIDENTIAL CENTER

The Aroostook Residential Center operates on a 24-hour per day/seven days per week basis. Residents must be 18 years or older and experiences behavioral adjustment difficulties. The primary purpose of the Center is to provides residential services and behavioral training aimed at increasing functional dependence to help the adult client live in the mainstream of society. These services include teaching basic skills, such as, personal hygiene, daily household cleanliness, individual and group social and recreational skills and overall community socialization.

ELIZABETH LEVINSON CENTER

The Elizabeth Levinson Center serves mentally fragile children with severe and profound mental retardation, ages birth through twenty, and is a combined residential and medical program. The children are accepted to the facility through the Interdisciplinary Team (IDT) process and approved by the Medicaid criteria.

DESCRIPTION OF DMHMRSAS ADMINISTRATIVE UNITS AND ALLOCATION BASES

Commissioner's Office

The Commissioner's Office has the overall responsibility for the programming and administration of the mental health, mental retardation and substance abuse service systems. This unit is allocated to all program areas and state operated facilities based on total dollars expended (Method A).

Division of Systems Operations

This Division creates, for the first time, a regional administrative structure that integrates all disability groups. Regional Directors will provide leadership and a single point of authority for all behavioral health and developmental services, ensure that hospital and community services work to compliment rather than to compete with each other, and oversee the development of Local Service Networks. The cost for this Division is allocated to all program areas and state operated facilities on the basis of the distribution of employees (Method B). The sub-units of this Division are the three regional offices and Facility Operations.

Region I, II and III

Costs are allocated based upon a time study (Method C) except for the Regional Director which is allocated based on the distribution of employees (Method B).

Facility Operations

Costs are allocated to state operated facilities on the basis of distribution of employees (Method B).

Division of Administration

This Division will focus on integrating funding sources to streamline operations while ensuring maintenance of effort for various disability groups, developing performance-based mechanisms and redistributing resources to the most cost-effective programs. The introduction of techniques to better manage care will also be the responsibility of this Division. The cost for this Division is allocated to all program areas and state operated facilities on the basis of the distribution of employees (Method B). The sub-units for this Division are Human Resources, Management Information Systems, Accounting, Reimbursement, Managed Care and Consent Decree/Legal Services.

Human Resources

Human Resources is responsible for employee relations, benefits management and other personnel related activities for all personnel reimbursed under the DMHMRSAS budget. In addition, Human Resources is responsible for all payroll activities related to DMHMRSAS Central Office personnel. The cost for this unit is allocated to all program areas and state operated facilities on the basis of the distribution of employees (Method B). The payroll supervisor renders payroll services exclusively to Central Office personnel. The cost of the payroll supervisor is based on employee distribution within Central Office (Method B).

Management Information Systems

This Unit exists to design, implement and support information technology throughout the Department. Encompassed in the mission of this Unit is the selection, installation and on-going support of hardware, networks, desktop productivity software and decision support mechanisms. Because of the distribution of activities within the MIS unit, the costs are allocated based upon a time study (Method C).

Accounting

The Accounting unit reviews and analyzes monthly accounts for all program areas and institutions and monitors the state account for contributing matching funds for Medicaid programs: mental retardation, mental health and children's services. This unit also implements budgeting, monitoring and control and financial management activities. Maintains accounting and budget control for the state Medicaid "seed" funds for DMHMRSAS programs eligible for federal match. Because of the distribution of activities of the Accounting unit, the costs are allocated based upon a time study (Method C).

Reimbursement

This office supports revenue activity related to billing and collections from all payors including third parties for services rendered directly by DMHMRSAS programs or facilities. Because of the potential distribution of activity across several program areas, the costs for this unit are allocated based upon a time study (Method C).

Managed Care

The Managed Care unit is comprised of key staff with financial and program experience. The unit is responsible for coordinating input from stakeholders representing children, adult mental health, mental retardation and substance abuse

services to develop a strategy and design for implementation of managed care elements in the Department's service structure. Specific functions include staffing the managed care steering committee and subcommittees; researching current program and funding practices and producing reports as needed; drafting design proposals for review by senior administration and steering committee; coordinate managed care implementation with DHS staff; work with regional and program staff to implement design components, etc. Because this unit will design and implement a comprehensive managed care system, the costs are allocated to all program areas and state operated facilities based on total dollars expended (Method A).

Consent Decree/Legal Services

The Office of Consent Decree/Legal Services is responsible for monitoring the implementation of the Department's three consent decrees, overseeing the public guardianship program and analyzing statutory and regulatory issues involving the Department. The guardianship program, utilizing the statewide case management system, provides services to individuals with mental retardation who are incapacitated, in need of protective services and who have no family members or friend willing or able to serve as guardian. As the guardianship program is solely for mental retardation, costs will be directly allocated to the mental retardation program (Method D). Distribution of activities for the other components of the Office, will be allocated based upon a time study (Method C).

Division of Programs

This Division will strengthen the capacity of the system to do data-based planning and evaluation, to convey a program vision and to implement principles of continuous quality improvement(CQI). CQI efforts will include increased involvement of consumers and family members in all aspects of policy making and operations, the use of normative data to trigger intensive program and budget reviews and a variety of training and technical assistance activities to bolster levels of clinical and technical expertise. Costs are allocated based on distribution of employees (Method B). The sub-units of this Division are Quality Assurance and Training, Technical Assistance and Consultation, Advocacy and Consumer Affairs, Mental Health, Mental Retardation and Children Program Systems and Substance Abuse.

Quality Assurance and Training

The Quality Assurance portion of this unit is responsible for coordinting the program monitoring and review activities of the Department. The unit will work with the Quality Improvement Councils, Program Evaluation Teams and regional offices in performing quality improvement activities, including establishment and monitoring of client outcomes for services, program evalution and community evalutation. Particular emphasis in these activities is given to information provided

directly by consumers relating to their experiences of the Department's contract services.

The training portion of this unit will focus on the provision of appropriate in-service training, workshops, consultation in order provide cutting edge information and skill building in the fields of mental retardation, mental health children's services and substance abuse. This effort is aimed at the Department's staff but will also include contractor agency staff and consumers. As part of this effort, the Department will work in conjunction with the Muskie Institute's Center for Public Sector Innovation to create a Center for Learning. This effort will be in concert with the Department's visions and mission of an integrated and responsive system that listens and responds to the voices of consumers and continues the work of system reorganization. Costs are allocated to all program areas and state operated facilities based on total dollars expended (Method A).

Technical Assistance and Consultation

The Technical Assistance and Consultation unit is the nucleus for information, training, technical assistance and consultation around specific areas of services that cut across all disability groups including trauma, client-directed service approaches, multicultural issues, deafness, women's issues and HIV Aids. The team is available for consultation and resource deployment for particular individuals and agencies for the regional offices and local service networks, and across all disciplines including mental health, mental retardation, substance abuse, for children, adolescents and adults. The team is responsible, when appropriate, for needs assessments, program development and policy direction. Costs are allocated to all program areas and state operated facilities based on total dollars expended (Method A).

Office of Advocacy and Consumer Affairs

Advocacy is responsible for providing case advocacy for the clients in the Department through 13.5 positions assigned. The Office provides case study and assessment, case supervision and management for all clients including Medicaid eligible clients, and provides direct care consultation to state agencies and courts. Costs are allocate based upon a time study (Method C). Consumer Affairs is responsible for assisting consumers in developing a variety of skills which will help them to become aware of themselves as having lives beyond the limitations imposed by illness and the systems, to raise their level of satisfaction with their own lives by sponsoring programs which allow them to use, improve, or gain recognition of their gifts and talents. As there are three Consumer Advocates, one for each program, costs will be directly charged to the appropriate program (Method D).

Mental Retardation Program Systems

The Mental Retardation Program Systems unit is responsible for the coordination of mental retardation programs and for the planning, promotion, operation and policy development of the complete and integrated statewide community programs for persons with mental retardation and autism. The Mental Retardation Program Manager is responsible for the development of clear and effective policies governing the operation of all programs and for providing support to Regional Directors and Regional Mental Retardation Team Leaders in the operation of all programs for persons with mental retardation or autism. Activities performed by the unit include monitoring services and expenditures under the Home and Community-Base Program waiver and managing case management services. The costs for this unit are directly charged to the mental retardation program (Method D).

Mental Health Program Systems

The Mental Health Program Systems unit is responsible for planning mental health programming across the State, expanding community mental health programs, encouraging the participation of community residents in these programs, gaining increased understanding of community mental health programs, encouraging the participation of community residents in these programs, gaining increased understanding of community mental health needs and securing state and local financial support. The costs for this unit are directly charged to the mental health program (Method D).

Children Program Systems

The Children Program Systems unit is responsible for serving "children in need of treatment" with particular reference to children aged 0 to 5 years who are developmentally disabled or who demonstrate developmental delays, and to children aged 6 to 20 years who have treatment needs related to mental illness, mental retardation, developmental disabilities or emotional and behavioral needs that are not under current statutory authority of existing state agencies. Activities include managing case management services. The costs of this unit are directly charged to the children's services program (Method D).

Substance Abuse

The Substance Abuse unit develops comprehensive plans for combating alcohol and drug abuse and established operating and treatment standards. It provides training, consultation, technical assistance and service delivery strategies to help schools and communities reduce the problems attributable to tobacco, alcohol and other drugs, DEEP provides or oversees education, evaluation and/or treatment for all OUI offenders in the State of Maine in order to lessen the incidences of

injury and fatalities which result from drinking and driving. The costs for this unit are directly charged to the substance abuse program (Method D).

State Forensic

The Forensic Evaluation Office evaluates the mental health of persons who have committed crimes and the court requires a judgment as to whether an individual is competent to stand trial. Because of the potential distribution of activity across several program areas, the costs for this unit are allocated based on a time study (Method C).

ALLOCATION BASES AND PROCEDURES

Methods

A. Allocation of costs based upon each unit/program percentage of total costs.

B. Allocation of costs based upon the percentage of personnel distributed across Department sub-units.

C. Allocation of costs based upon a time study of 10 randomly selected days in each quarter, based upon the time spent of available worked hours on different program areas.

D. Charged directly to a particular program because all activities relate exclusively to that particular program.

APPENDIX I:

Draft Managed Care Plan

DRAFT: DECEMBER 5, 1997

DEPARTMENT OF MENTAL HEALTH, MENTAL RETARDATION AND SUBSTANCE ABUSE SERVICES

REPORT ON MANAGED CARE PLAN TO THE HEALTH AND HUMAN SERVICES COMMITTEE

BACKGROUND

The Department of Mental Health, Mental Retardation and Substance Abuse Services (the Department) has explored the potential for funding and administering services through a managed care plan over the past two years. This is consistent with the Department's recognition that better organized systems for the delivery and financing of services will lead to reduced gaps in services, less reliance on the most restrictive of service options and more opportunity for higher quality and more individualized care.

The creation of local service networks in seven regions of the state (c. 691, PL 1995) was the first step in this process. Since then the Department, in partnership with the Department of Human Services (DHS), has further explored the potential for managing benefits (services) covered by the state Medicaid plan for persons who are eligible for Medicaid. At present the two departments are preparing a Waiver proposed to enroll select Medicaid recipients in a program which will allow for prior authorization, to access all necessary behavioral health services[1] within the capitated benefit package.

The Department is proposing the necessary changes in its delivery system and infrastructure to manage all behavioral health services for persons who are enrolled in Medicaid. This process will require changes in policy, financing and programs over the next several years. Managing the behavioral health benefit for persons who are Medicaid recipients is an initial step towards implementing a managed care strategy for many of the Department's recipients. The Department created a statewide Steering Committee in 1996 to advise on the development and implementation of this initiative. This Committee is made up of consumers, family members, representatives of DHS, the Department of Education, DMHMRSAS and other statewide provider and advocacy organizations and providers.

The Current System

The current Medicaid behavioral health system is comprised of general hospitals and other inpatient facilities; clinics; individual practitioners; community mental health centers; and substance abuse agencies. Services provided by these agencies include:

[1]behavioral health is a term used to describe mental health and substance abuse services

- Inpatient psychiatric services
- Inpatient detoxification services
- Outpatient mental health services
- Mental health clinic services
- Community support services
- Targeted case management
- Home based mental health services
- Psychological services

The administration of these services to Medicaid beneficiaries are the responsibility of two agencies: the Maine Department of Human Services and The Maine Department of Mental Health, Mental Retardation and Substance Abuse Services. A Memorandum of Understanding (MOU) developed in 1996 outlines the respective roles and responsibilities of the two agencies for the development of Medicaid behavioral health managed care initiative.

Managed Care Strategy

The Department's initiative focuses on the development of a managed care strategy for delivering behavioral health services for select persons who are Medicaid recipients and strategies to address some of the current issues in the behavioral health system. The initiative has seven goals:

- Controlling service utilization and costs through the implementation of managed care principles.
- Enhancing linkages between general health and behavioral health providers.
- Unifying management authority and accountability for all behavioral health services provided to select Medicaid recipients.
- Designing a financing and delivery system for these Medicaid recipients that assures timely access to cost effective, high quality, and appropriate services in the least restrictive setting.
- Developing a managed care program which is consumer centered.
- Providing incentives for the delivery of services that foster independence, improve functional ability and /or maintain an individual's well-being.
- Creating a federal-state-private partnership that is committed to the above goals.

This plan is aligned with public sector behavioral health managed care plans being developed in Connecticut, North Carolina, Pennsylvania, Michigan, Washington, Utah, Arizona, California and Maryland wherein local or regional governmental entities or non profit organizations are contracting with the state mental health/substance abuse authority to manage care. Several of these states, Connecticut, Maryland and North Carolina, are using one administrative services organization to assist the state in the managing

behavioral health services while other states are requiring local or regional management of behavioral health services.

This approach is different than the private sector models used in Iowa, Massachusetts, New Mexico, Tennessee and as used by Maine's DHS for primary healthcare. The primary difference between the public and private sector managed care systems is the utilization of the existing public system. Public sector managed care systems often re-invest savings into the service system rather than paying large profits to for- profit vendors. Public sector managed care systems also have a stronger, oversight and leadership role of the state mental health/ substance abuse authority. The major difference between the DHS model and the DMHMRSAS model is reflected in this distinction. In Maine, DMHMRSAS has basic responsibilities for persons who are not Medicaid eligible who also need their care managed through this system and has responsibility for expenditures of non-Medicaid funds for services not reimbursable by Medicaid for persons who are eligible. DMHMRSAS also has significant legal responsibilities for behavioral health services for those who are Medicaid eligible thus making the public sector model more desirable and warranted. DHS does not have the same responsibilities or system to manage.

The Department's Basic System Design

Below is a description of the Department's proposed Medicaid managed care program. Included is a description of eligible populations, enrollment requirements, covered services, access and gatekeeping requirements, appeals, the financing model, and the responsibilities of DMHMRSAS, the statewide Administrative Services Organization and Network Managers. In addition, the selection process for Network Managers and the Administrative Services Organization is described below.

Eligible populations

The Department is proposing to assume the responsibilities for managing the behavioral health benefits currently administered by the Department of Human Services for select Medicaid recipients. The targeted Medicaid recipients who would be included in the proposed initiatives would include:

- Aid to Families with Dependent Children (AFDC).
- AFDC-related.
- Supplemental Security Income (excluding individuals over the age of 65).
- SSI-related (excluding individuals over the age of 65).
- SOBRA eligible children and pregnant women.
- Transitional Medicaid eligibles.
- Children eligible for Medicaid who are under protective custody

Participation in the program for these recipients will be statewide and will be mandatory. Individuals will not participate in this initiative if they:

- Have Medicare coverage; except for the purpose of Medicaid-only services;
- Are covered by other insurance;
- Are residing in a nursing facility;
- Have an eligibility period less than three months;
- Have an eligibility period that is only retroactive;
- Reside in jail or a state operated IMD;
- Are receiving care in a hospital on date of enrollment.

Enrollment

Recipient enrollment in the program will be mandatory and will be performed either through the enrollment broker engaged to provide enrollment services for the current DHS managed care initiative or through the Department's selected managed care vendor (discussed below).

Services

The attached list of services will be covered under this initiative. Behavioral health services (e.g. pharmacy) not covered under the Waiver will be obtained in the same manner as under the regular Medicaid program. Medicaid recipients participating in this initiative will be informed of the services not covered and the process for obtaining these services.

Access and Gatekeeping Requirements

The Department will be responsible for assuring access to services and for care coordination, which includes what, is normally termed "gatekeeping". The Department will assure services under a "no eject/ no reject" requirement. This means that the Department will assure access to services needed by a recipient. Access includes assuring the availability of a full array of services for every enrolled Medicaid recipient, information and education provided including the operation of a 24-hour toll frees number for information and simplified information for every enrollee. Access also includes a requirement for:

- outreach and for emergency services to be available for all members within an hour of a request for service;
- urgent services to be accessible within twenty four hours;
- routine services to be available within a week;
- service locations to be established within thirty minutes of a person's residence where possible;
- child care arrangements for families;

- communication and physical accommodation;
- choice of providers where available;
- access to on call services during non business hours;
- culturally competent services; and
- reimbursement for out of pocket expenses to get to service locations.

Care Coordination includes the gatekeeping responsibility, care coordination for all enrollees including intensive care management for individuals at high risk, referral and discharge planning and arrangements for high cost care.

Gatekeeping includes determining the appropriate level and type of care for each person needing service, assignment to the agreed upon service ad provider for specifically agreed upon times, and planning for follow-up care. Arrangements will be made for case management. The enrollee's functional level, risk, history and diagnosis will determine the type and amount of case management and other services provided.

Appeals

Enrollees may appeal any service-related decision including admission, continued stay, termination and level of care. For example, if the appeal is concerning a decision made about emergency services, the appeal must be reviewed and a decision made within one hour. For urgent services, the decisions must be made within twenty-four hours. For routine services, the decision must be made within one week.

Financing Model

The Department will be fully capitated for a carve out of behavioral benefits. The Department will be responsible for meeting the federal and state capitation requirements. The Department will enter into a performance contract with Network Managers as described below and Network Managers will be responsible for contracting for a full array of services for Medicaid enrollees living in the designated geographic area. Those contracts will be fee for service contracts. In addition, the Department will enter into a contract with a qualified vendor who will assist the Department in meeting risk requirements and providing infrastructure support as described below.

The capitated amount the Department receives will be based on funds spent for approved services (benefits) in a base year to be determined by DHS and the Department and approved by HCFA. The amount will be carved out of the DHS capitation for its mandatory Medicaid managed care program and transferred to the Department. For example, if the amount spent for behavioral health benefits in FY 1996 was $168 million and FY 1996 was determined to be the base year, then that amount would be the amount capitated to the Department. As part of a Waiver agreement with HCFA, the state would determine what amount of that capitation was to be saved. Generally, states are asked to save 5%, which is taken off the top by HCFA. At the same time, HCFA will approve an

annual cost of inflation based on overall health care cost inflation index (e.g. medical consumer price index. For this program, the Department will require all additional funds saved be re-allocated to services within each of the regions. Additional information regarding how funds are spent and tracked is listed under the responsibilities of the Department, Network Managers and ASO below.

Department Responsibilities

The Department will be responsible for contracting with a single statewide-qualified managed care vendor (ASO) and up to seven Network Managers. The Network Managers will have responsibility for contracting with up to seven regionally based networks consisting of providers of behavioral health services. The Department in cooperation with the ASO/ Network Managers will be responsible for:

- Written criteria for provider selection and credentialing; clinical, service authorization and financial performance standards; access and service related standards;
- Grievance and appeal procedures for providers; agreement with HMOs regarding referral protocols for Medicaid recipients identified needing behavioral health services; and
- Protocols for accessing out of network services in emergency, unique situations.

The Department will also be responsible for quality management and quality assurance. The Department has undertaken an extensive process for ensuring quality improvement through the development of Quality Improvement Councils, which operate to assist in the planning, and oversight of mental health services. The responsibility of the Councils will be expanded to include oversight and planning for mental retardation and substance abuse services over the next year. The Councils include a broad base of representatives including providers, service recipients, family members and community leaders.

Network Manager

The Network Managers will be discrete regionally designated non-profit organizations. They will have responsibility for organizing a single system of carethrough a panel of mental health, mental retardation and substance abuse providers. Their responsibilities include:

- Assessment and Projection of Service Capacity - This includes completing a review of unmet service needs collaboratively with Quality Improvement Councils.
- Service Capacity Development - This includes assessing ongoing service capacity and developing new services to respond to services needs within the designated service area.
- Assuring Care Coordination - Network Managers will provide member services including assuring information is available 24 hours a day and providing outreach and education. Network Managers will develop and oversee continuity of care

agreements, uniform discharge planning, assignment of case managers and use of uniform intake and assessment tools and standardizing treatment planning. This also includes assuring low incidence and specialty services will be made available and arranging for out-of-network services.

- Procurement and Contracting for Services - Network Managers will contract for services with eligible providers. Network Managers will assure that providers will comply with performance requirements. They will credential providers, reimburse providers and assure flow of information to assure services can be properly authorized and verified.
- Appeals - Network Managers will be responsible for responding to all appeals by providers and recipients regarding service decisions within the timeframes established by the Department. If the provider or recipient is not satisfied with the result of the appeal the Department will be responsible for resolving such appeals.

Administrative Services Organization

The Department is proposing that these benefits be managed separately from the general health benefits administered by DHS through health maintenance organizations. The initiative will be managed statewide through a contract between the Department and one qualified administrative services organization (ASO). The Department will enter into a risk-comprehensive contract with the administrative services organization. The administrative services organization will be responsible for the following functions:

- Utilization management service authorization - The ASO will be responsible for performing service authorization functions for all behavioral health benefits. Specifically, the vendor will be responsible for pre-authorizing all requests for mental health and substance abuse admissions to inpatient hospitals and authorizing requests for services for all outpatient and community services identified above.

- Payment Authorization/ Claims processing - The ASO will be responsible for developing and administering the claims submission process for all credentialed providers. In addition, the ASO will be responsible for adjudicating claims against services authorized and be responsible for reimbursing providers. The ASO will also establish and negotiate rates for services in the benefit package. the Department and DHS will provide the necessary guidance and oversight on the rate setting process developed by the ASO. In addition, the ASO will comply with the necessary state and federal guidelines for processing claims. The ASO will also be responsible for verification of Medicaid eligibility with the Department of Human Services.

- Developing Management Reports - The Department will need to monitor the activities of its vendor and the behavioral health system. It is proposed that frequent management reports will be necessary to assure proper oversight and monitoring. At a minimum the Department will request the following reports from its ASO:

    - Utilization and expenditure reports

- Provider practice and referral patterns
- Management reports (against standards established by the Department and DHS)
    - Requests for authorizations
    - Authorizations versus denials
    - Timeliness of authorization
    - Timeliness of payments
    - Grievances and appeals re: authorization/payments

The vendor will be selected through a competitive procurement process. It is anticipated the vendor will be operational by early SFY 98-99.

Network Manager Selection Process

The Department has developed the Network Manager model over the past year with input from staff of the Department, DHS and the Department's Managed Care Steering Committee. After receiving this input, the Department released the basic design on November 21, 1997 to consumers, families, interested organizations and providers in a Request for Comment (RFC) for comment and feedback. The Department will host information sessions across the state this month and will answer all questions about the design in writing prior to the comment due date of January 22, 1998. Input regarding the Department's managed care design will be obtained through the RFC process and a review by the Health Care Financing Administration Afterwards, the Department proposes to release a Request for Proposals and will select the Network Managers through a competitive procurement process. It is anticipated Network Managers will be in operation during FY 1998-99.