

**SYSTEMS-BASED PRACTICE
FINANCING BEHAVIORAL HEALTH SERVICES FOR CHILDREN AND FAMILIES
SYSTEMS OF CARE
November 2022**

OVERVIEW

Becoming an effective Child & Adolescent Psychiatrist (CAP) takes more than simply applying the art of medicine. Patient care is subject to outside forces such as federal, state, and local policy; administrative practices; and the type of health care financing with which the child/family and clinician system is involved. A systems-based understanding of mental health care delivery thus entails an appreciation of the organizational, administrative, and financial mechanisms at play.

While using this module, we recommend referring to other systems-based practice modules, especially the Public Mental Health System and the Family-Driven, Youth-Guided Care modules.

I. OVERVIEW OF MENTAL HEALTH FINANCING

The funding of mental health care in the United States comes from various private and public sector sources with these funds being accessed, utilized, and blended in a complex manner. Public sector funding comes through a variety of programs from federal, state, and local sources. Private funding comes predominantly from private health plans and the insurance industry but also includes foundations and charities. There is also a small group of individuals who self-pay, without using insurance or public programs.

II. PUBLIC SECTOR FUNDING STRUCTURE

For behavioral health, the majority of funding comes from the government from various sources serving a vast array of populations. This funding comes from a combination of federal, state, and local dollars (See Figure 1).

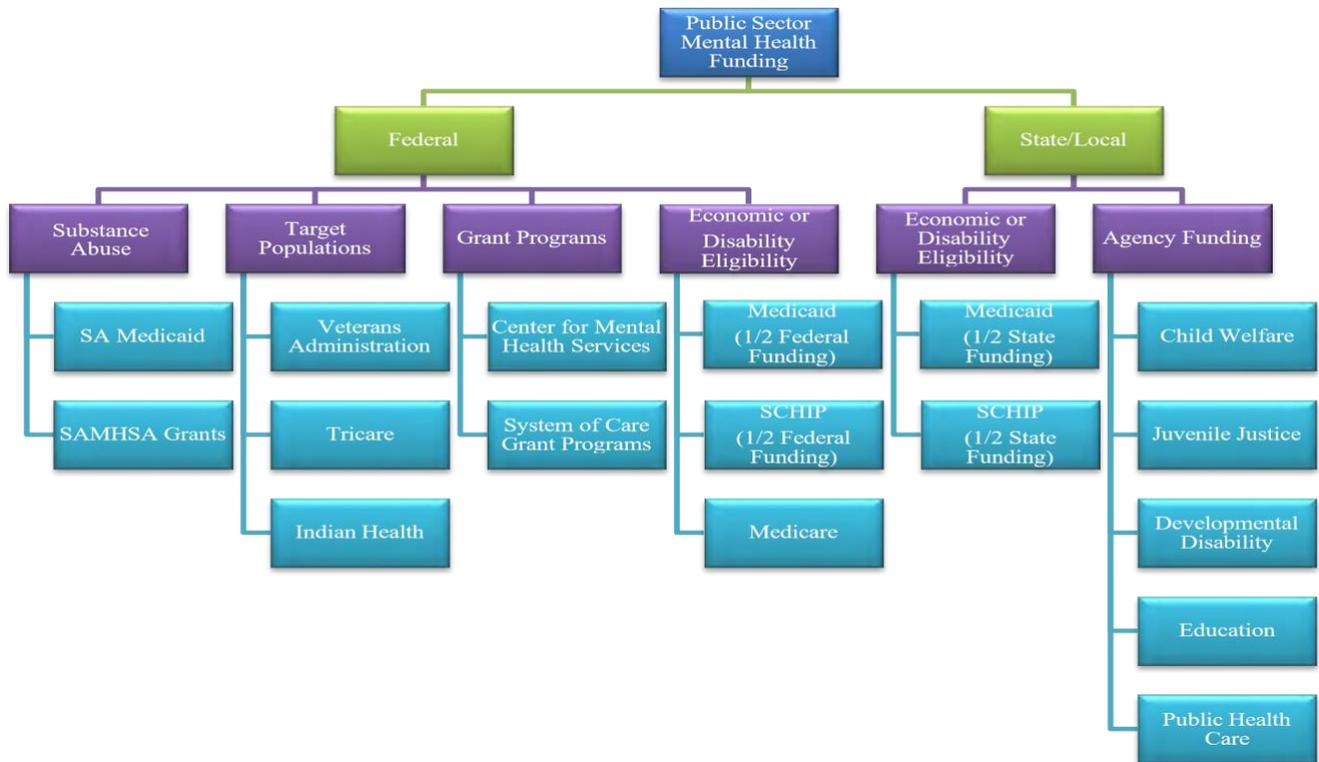


Figure 1 Public Sector Mental Health Funding Components

III. FEDERAL FUNDING STREAMS FOR BEHAVIORAL HEALTH SERVICES

The federal governmental funding stream is the largest component of public funding.

Direct funding is when services are directly provided, while indirect funding is for infrastructure, education, and other services.

Federal funding provides both direct funding and indirect funding, including the following:

- Grants, which include non-competitive “block grants” as well as competitive “discretionary grants.”
- Funding for services dedicated to specific populations, such as the Indian Health Service.
- Federally supported insurance programs (e.g., Medicaid, Medicare, and the State Children’s Health Insurance Programs (SCHIP)).
- Funding for data collection and surveillance.
- Funding for technical assistance and education.

A number of agencies in the federal government fund competitive grants, which are intended to target specific populations and/or promote innovation in the delivery of mental health and substance use services.

The Department of Health and Human Services includes multiple government agencies that may touch upon mental health and substance use services. These agencies include the Substance Abuse and Mental Health Services Administration (SAMHSA), the Centers for Disease Control

(CDC), the Agency for Healthcare Research and Quality (AHRQ), the Indian Health Service (IHS), and the Administration for Children and Families, among others (See Figure 2).



Figure 2 Health and Human Services

Federal agencies fund mental health and substance use services through various means, including competitive grants for research as well as service and infrastructure, block (non-competitive) grants, and federal insurance programs.

The Substance Abuse and Mental Health Services Administration (SAMHSA) provides funding for services and infrastructure in the form of competitive grants and non-competitive grants (commonly called “block grants”). For the most part, its grants, training, and technical assistance are separate for mental health and for substance abuse, i.e., SAMHSA’s Center for Mental Health Services (CMHS) provides mental health grants, the Center for Substance Abuse Treatment (CSAT) provides substance use grants, and the Center for Substance Abuse Prevention (CSAP) provides funding for substance use prevention.

CMHS leads national efforts to improve prevention and mental health treatment services for all Americans. CMHS’ mission, as stated on its website, is to lead “federal efforts to promote the prevention and treatment of mental disorders. Congress created CMHS to bring new hope to adults who have serious mental illness and children with emotional disorders.”⁴ There are a variety of targeted goals and multiple CMHS-sponsored grants to promote the pursuit of these

goals. Of particular relevance are CMHS' System of Care grants, administered through the Comprehensive Community Mental Health Services Program for Children and their Families. The Comprehensive Community Mental Health Services Program's System of Care Grants is a competitive six-year grant that represents the largest federal commitment to children's mental health to date. The overall goal is to fund system of care reforms in public sector mental health programs. The grants promote more effective ways to organize, coordinate, and deliver mental health services and supports for children, adolescents, and their families.

Although SAMHSA provides significant funding for mental health and substance use services, other federal agencies also have funding targeted to behavioral health. The Health Resources Services Administration, for example, funds integrated care programs through its Behavioral Health and Primary Care Integration programs and is the source of funding for many programs integrating psychiatry with primary care.

Research in substance use and mental health, including the biological underpinnings of mental illness as well as services research, are extensively funded by federal discretionary grants. Agencies including the National Institute of Mental Health (a part of the National Institutes of Health), the Agency for Healthcare Research and Quality (AHRQ), and the Patient Centered Outcomes Research Institute fund research. In recent history, much of the funding from NIMH for research has focused on biologically-based mechanisms; however, there is a call to increase funding to address access and effectiveness issues in the field.

Two forms of block grants, Mental Health Block Grants (MHBG) and Substance Abuse Block Grants (SABG), are given to states from the federal government. Both are administered by SAMHSA. Block grants are not competitive. The amount that each state receives in block grants depends on the population of the state and is based on a specified formula.

States are required to use MHBG funds for youth with serious emotional disturbances (SED) or adults with serious mental illness (SMI). Block grant funding can be used for programs that are not traditional fee-for-service interventions. While states have discretion as to how to use block grant funds, most states have developed some type of service continuum to address the needs of children, adolescents, their families, and other special populations.

While representing a relatively small amount of the state budget, block grants can influence infrastructure change and state priorities in several ways. First, states are required to report specific data and information as part of the block grant program. The data that is collected can bring attention to specific areas and can influence policy maker priorities. Secondly, block grant resources can be influential through "block grant set-asides." Block grant set-asides consist of requirements that a certain percentage of block grant money be used for a specific purpose. For example, in 2014, Congress directed SAMHSA to require states to set aside 5% of block grant money to support programs for individuals with SMI, such as psychotic disorders. As a result, a variety of new first-episode psychosis programs were launched in a number of states.

For some services, the use of federal dollars is not permissible, and the federal government may exclude them from the state plan. In such cases, if the service is deemed essential, it can be financed directly through state dollars, county dollars, or a combination. Another approach may involve using flexible dollars from another child-serving system to cover needed services and

supports. An additional state strategy may involve a request to the federal government for a Medicaid waiver (see below).

Data collection and surveillance

The federal government funds multiple large-scale survey and data repositories related to child and adolescent behavioral health. SAMHSA has a number of datasets, including the National Survey on Drug Use and Health (NSDUH) and the Drug Abuse Warning Network (DAWN) (these and additional datasets can be found at <https://www.samhsa.gov/data/>). The CDC also has an infrastructure for data collection and monitoring of mental health and substance use disorders. For example, suicide, domestic violence, adverse childhood experiences, and rates of disabilities and mental health disorders are tracked through various CDC data sets. The Youth Risk Behavior Survey (YRBS) tracks outcomes such as alcohol use, tobacco use, and high-risk behaviors. HRSA also hosts a number of important data sets related to youth mental health and substance use, including the National Survey of Children’s Health (NSCH).

Federally Funded Insurance:

The federal government provides funds for medically necessary mental health services to enrolled individuals through the funding of six large insurance programs that cover mental health treatment. Five of these insurance programs provide funding for children’s mental health services.

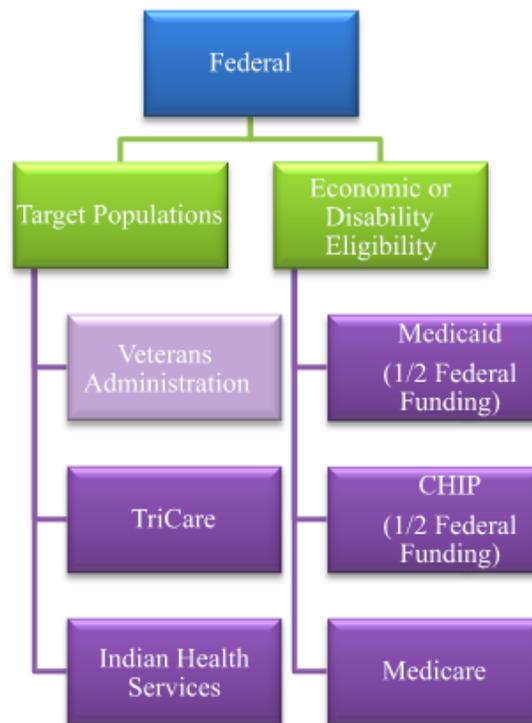


Figure 3 Federal Insurance Programs

Medicaid Program: Medicaid is an entitlement program for physical health and mental health services that is available to specific target populations including families with low income, children involved in certain systems (e.g., child welfare), and those with developmental disabilities. Medicaid is jointly funded by federal and state dollars. Each state determines how to

manage Medicaid for its constituents. Some states allow a child or adolescent to become Medicaid eligible independent of family income if the presence of a mental health disability is documented.

Eligible members are now entitled to medically necessary services, including mental health care, contributing to the growth of many states' public mental health systems. While state requirements for health insurance may be more comprehensive than what is required by the ACA, the ACA has established minimum standards for health insurance in all states. Essential Health Benefits (EHBs) are ten types of medical care that must be covered—with no dollar limits on annual or lifetime benefits—on all individual and small group major medical plans with effective dates of January 2014 or later. These EHBs include behavioral health services, prevention services, and pediatric services like dental and vision care.

An additional, important facet of Medicaid for the child population involves the Early Periodic Screening Diagnosis & Treatment (EPSDT) requirements, which support prevention and early intervention services for both physical and behavioral health.

Within federal funding, the Medicaid program is the largest funding stream providing financial support for mental health services, particularly for children, adolescents, and their families. Either public or privately contracted providers (i.e., Managed Care Organizations) can provide Medicaid services:

Managed Care: Historically, Medicaid services were provided on a fee-for-service basis by providers, with management of the program by a designated state entity. Fee-for-service is a system in which providers are paid for the billable services they provide.³

However, because Medicaid costs have steadily increased, many states contract behavioral health services to carved-out managed care organizations (meaning the BH services are carved out from the physical health services and managed separately). Managed care entails the state paying an outside company a fixed sum based on the number of enrollees to *manage* behavioral health needs. For example, the state will pay company X a lump sum of money per month per enrollee to handle all benefits (full capitation) or a subset of benefits (partial capitation) related to mental health services. It is the company's responsibility to contract with providers and pay them on a fee-for-service basis, subcontract the services to agencies, or have their own providers provide the services. The state's risk is now limited as the company is responsible for excess costs, but the company can keep or reinvest money that is not used.

The managed care company's responsibilities include managing the utilization of service, managing the provider network, providing quality assurance, managing rates and claims, and providing customer service.

It is important to appreciate that each state has its own system to administer and oversee Medicaid services and can determine which services they will fund beyond those considered essential health benefits as defined by the ACA. Managed care can also exist within private insurance companies.

State Children's Health Insurance Program: SCHIP is a health insurance program for children and adolescents whose family's income exceeds the Medicaid threshold but is below

the level needed to afford private insurance. Mental health services may be included in the SCHIP insurance benefit if determined by the participating state government. However, typically the mental health coverage within SCHIP is considerably less comprehensive than with Medicaid. It is also jointly funded by federal and state dollars.

Medicare Program: Medicare is a program primarily for the elderly, but it may also cover some individuals with chronic physical or mental disability, including children and adolescents with serious emotional disturbance. Eligibility is based on documentation of the child's disability status.

TriCare Program: TriCare is a program for military dependents through the Department of Defense, which may involve either private or public sector services. The dependents may include children and adolescents.

Indian Health Service Program: The IHS program involves health care delivery for Native American populations.

Veterans Administration Program: The VA program provides physical health and mental health services for former military personnel. This is the one federally funded insurance program that is not directly relevant to children.

State Waivers:

Specific Medicaid eligibility criteria, administrative features, and service options may be waived under a federal process called a Medicaid Waiver. This allows states to access federal money for approved uses that are innovative and non-traditional in nature. A waiver is seen as a mechanism to provide services that would otherwise not be permissible to fund. Many states seek waivers to develop a more flexible and comprehensive service system. There are sets of preexisting waivers that can be used. A specific state can request federal approval of one or more waivers along with its rationale for the request. Waivers, unlike block grants, do not involve the transfer of funds from the federal government to the states. Nevertheless, they need to be understood as part of an overall state funding strategy because the involved services become subject to partial or full federal reimbursement.

There are 3 primary types of waivers²:

- Research and Demonstration Projects waivers
- Managed Care Waivers that help provide services through managed care systems that would otherwise be limited by choice of approved providers
- Home and community-based service waivers that provide long term care for in-home or community settings. The purpose is to avoid or minimize institutional settings

IV. STATE AND LOCAL FUNDING STREAMS

Each state maintains its own rules and regulations regarding the application of the Medicaid program for its citizens, and there is a requirement for states to match federal support provided for Medicaid.

The Social Security Act devised a formula to calculate how much the federal government would contribute relative to the state. This formula is called the Federal Medicaid Assistance Percentages (FMAP). FMAP determines rates based on a state's average income relative to the national average. While every state receives at least an FMAP of 50% (the federal government pays 50% of Medicaid costs, i.e., \$1 for every \$1 spent by the state), other states will receive higher percentages. Some states and local jurisdictions (counties) may be required to cover a small percentage of the Medicaid cost. The State Children's Health Insurance Program (CHIP) is managed in a similar manner.

Medicaid and CHIP eligibility are determined by household income relative to the poverty line. As of 2014, the Affordable Care Act (see below) has created a minimum Medicaid income level based on the federal poverty level. This is referred to as Medicaid expansion and is set to 138% of the federal poverty line as of 2019.5

Often, publicly funded services may be implemented within other child-serving agencies leading to combined or "braided funding" that involves the use of funds from other systems of care, including juvenile justice, child welfare, education, developmental disabilities, and public health. These systems also receive mixed federal and state/local funding. The amount of support from different sources and agencies can vary widely by state and jurisdiction. Even if the services are implemented within the mental health system, funding may still be supplemented by "flexible" dollars that come from other child-serving agencies.

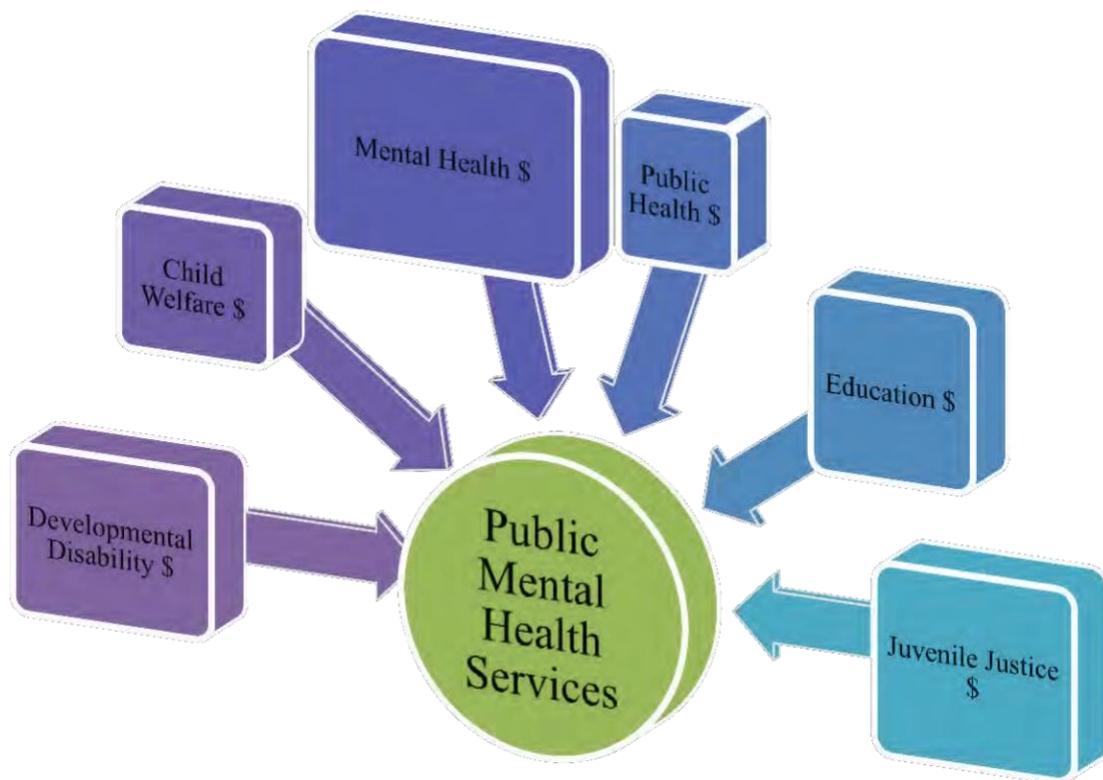


Figure 4 Braided Funding

V. PRIVATELY FUNDED STREAMS FOR MENTAL HEALTH SERVICES

The private mental health system includes private health insurance, health plans, foundations, and charities. Although self-pay does not fall under private sector funding, it does account for a small percentage of overall mental health funding. Self-pay or fee-for-service is based on the consumer's ability to pay directly for the cost of service.

Private insurance entities and health plans provide health care benefits based on the type of insurance coverage or health plan purchased by the consumer. Benefits in private U.S. health care are usually "managed." This managed care system was developed to contain costs while still providing quality care. Managed care systems were originally based on fee-for-service payments in which providers are paid in full for services rendered. They integrate the management and oversight of providers, pharmacy benefits, and administrative functions. Now the most common managed care plans are Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs). HMOs generally entail having an in-network primary care provider with prevention as a focus. All referrals will go through an individual's primary care provider (PCP) to other in-network providers, thus limiting costs. A PPO allows for more choice and independence as one can see both in- and out-of-network providers. A patient does not have to choose a PCP and generally does not need a referral for specialty care. Since choice increases, so do the patient's costs. Some Medicaid plans also use many of the same tools and setup as private managed care organizations. In addition, many large hospital chains have created their own HMOs.

There are wide variations in the levels of coverage available for behavioral health services through private health insurance and health plans, but typically coverage is limited. Inpatient and some level of outpatient treatment are usually covered, and there are few minimum standards or state mandates for private carriers regarding the provision of broader services. In some states, there is a requirement for mental health and substance abuse coverage, but even here there is wide variability regarding the degree of coverage, eligible services, and amount of co-payment. Considerations such as these gave rise to advocacy for parity between behavioral health and physical health (see below).

Because Medicaid is the insurer of last resort, the mental health service needs of children and adolescents enrolled in Medicaid who also have some type of private insurance are typically reviewed first by the private insurance carrier. If the requested service is a covered service and medical necessity is determined to be present, private coverage begins. If the service is denied by private insurance or is not a covered service but the service is deemed medically necessary by the publicly funded entity, then Medicaid or other applicable public sector coverage will take effect. Another variation occurs when a service initially approved by private insurance is subsequently denied, as with some inpatient psychiatric care. In many instances, Medicaid will approve continued treatment at that level of care, and financing shifts from private to publicly funded care.

Foundations, Private Grants, and Charitable Supports: Financial support for mental health is made available to communities and providers through grants from foundations, charities, and other sources. Charitable support often helps sustain routine operational activities and expenses for an organization. Foundation funding may be targeted for a particular population or area of need and in some cases supports innovative system development and change. For example, in

the 1980s, the Robert Wood Johnson Foundation provided communities around the country with System of Care grants intended to help communities develop the capacity to address the needs of children and adolescents with complex needs and their families through carefully monitored pilot projects. These grants were instrumental in the growth of a community-based system of care approach to public sector children and adolescents and their families.

VI. SOURCE OF FUNDING IMPLICATIONS ON ACCESS TO CARE AND THE CONTINUUM OF CARE

Eligibility: Regardless of the funding source, all programs maintain some restrictive eligibility criteria for entry and continuation of treatment services. Privately funded services typically are organized to provide intensive triage and case management components to manage access to more intensive and costly care (hospital and sometimes residential care), while maintaining minimal or limited criteria for participation in outpatient service delivery.

At times, limitations in service capacity serve as inadvertent cost-containment mechanisms, as when some youth in need of treatment are placed on waiting lists, sometimes for extended periods of time. Some states and local communities have contracted with private managed care companies to introduce cost containment mechanisms into public Medicaid systems with varying financial and clinical success.

Providers: In both private and public sector insurance, there are typically some restrictions on member access to providers. In the private realm, providers may be limited to those contracting with the insurance group who accept discounted payments. With some private insurance, the family may have to pay a significant share of the cost.

In HMO settings, the panel may be limited to a relatively small provider group, and in this way family choice may become limited.

Similar restrictions may apply in public sector programs in which members need to accept services from employed or contracted professional staff designated by the public mental health authority. However, within the public mental health system, there needs to be some degree of provider choice available to members, and this is monitored by the federal government. In some circumstances, single case agreements can be made with a provider who is currently not contracted with their insurance.

Service Array: Along with the multiplicity of funding streams supporting mental health services, there is also a multiplicity of rules and regulations regarding eligibility for care that emanate from the policy and administrative structures that manage these different programs. Virtually all programs provide for services along the traditional continuum of outpatient care, including some intermediate forms of intensive outpatient (e.g., intensive outpatient or facility-based day treatment) and short-term/intensive/acute inpatient care.

The type of continuum of services in public sector and private insurance systems varies from state to state. In addition, there may be variability within local communities.

Access to different types of services does not uniformly exist across funding sources. For example, private insurance may pay for partial hospital day treatment care only in hospital-based programs, whereas a publicly funded day treatment program may require attendance at a specific school-based program.

Public sector systems typically provide state hospital inpatient care (sometimes longer stays), although many states are actively downsizing and/or closing their state psychiatric hospitals. Public sector systems typically have more expansive options along the continuum of care than private insurance systems. Public sector services may include intensive case management, school-based services, and mental health services for the programs of other service systems (e.g., child welfare shelters and juvenile detention facilities). In addition, intensive, community-based wraparound approaches and innovative services have been developed in recognition of the special needs of youth with severe mental health disorders and others who are involved in multiple child-serving systems. Private insurance companies are now beginning to use wraparound services as a useful and cost-effective intervention for children and adolescents requiring higher service intensities to stabilize in community settings.

VII. THE IMPACT OF GOVERNMENT POLICY CHANGES

Once you think you understand the policies that guide mental health system structure and financing, they change. It is essential that as psychiatrists, we keep up with policy changes as this plays a role in providing quality care, accessing resources, and payment for services. Although there are numerous policies of which to be aware, there have been two federal acts over the past few years that have and will further impact financial aspects of providing mental health care.

1. Affordable Care Act:

With the passing of the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (together referred to as the Affordable Care Act or ACA), there was a shift in healthcare delivery priorities. New priorities included the need to increase access to mental health services, improve quality of care, and contain healthcare costs. It also called for the implementation of Accountable Care Organizations (ACO) and the Health Home.

The ACA contains 10 major sections.⁶ It is best seen as a balancing act.



Figure 5 The Affordable Care Act: A Balancing Act

- **Quality, affordable health care for all Americans:** This includes the elimination of discriminatory practices and pre-existing condition limitations, increases dependent coverage to age 26, and provides increased access to healthcare through employers, the health insurance exchange, and/or tax credits. The ACA also established that insurance companies must provide Essential Health Benefits (EHBs). These are the ten categories of health care that insurances are required to cover, including ambulatory services, emergency services, hospitalization, maternity/newborn care, behavioral health, prescription benefits, rehabilitative services, laboratory services, preventative and wellness services, and pediatric care.
- **The role of public programs:** Includes changes and expansion to Medicaid and CHIP.
- **Improving the quality and efficiency of health care:** Discusses linking payment to quality outcomes, Medicare sustainability, improving payment accuracy, and the development of new patient care models to include Accountable Care Organizations and the Health Home.
- **Prevention of chronic disease and improving public health:** Emphasizes a focus on prevention, early identification and intervention, community health, and public health innovation.
- **Health Care Workforce:** Encourages innovation in health workforce training, recruitment, and retention.
- **Transparency and program integrity:** Requires the provision of certain information to the public and to minimize fraud and abuse within programs.
- **Improving access to innovative medical therapies**
- **Community living assistance services and supports**
- **Revenue provisions:** Explains tax implications, contribution changes/limits, fees, and special deductions.

- **Reauthorization of the Indian Health Care Improvement Act:** Modernizes this health care system and improves health care delivery and quality to American Indians and Alaska Natives

In terms of financial changes that impact mental health, the ACA called for reform in 3 categories: access, coverage, and payment.

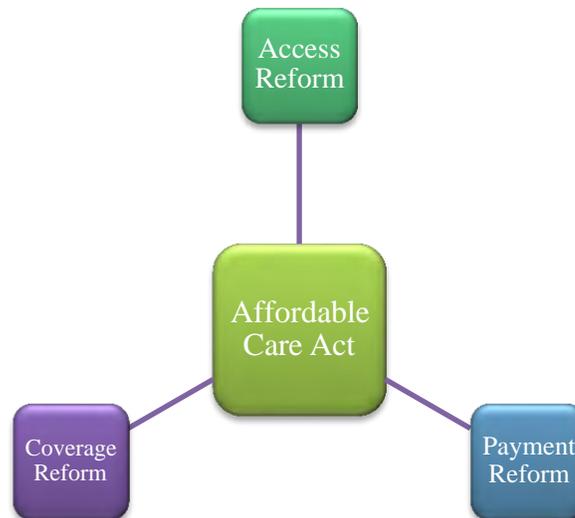


Figure 6 Financial Reforms in the ACA

- **Increases Access:** The ACA called for increasing insurance coverage for millions of Americans by changing requirements for employers who offer health care coverage, offering income-based tax credits for the self-insured, and calling for Medicaid expansion. The ACA also called for setting up Health Insurance Exchanges (see below) to create a competitive marketplace to purchase private health insurance.
- **Coverage Reform:** The ACA called for eliminating preexisting condition limitations, eliminating limits on coverage, increasing the age of adult dependents to 26, and requiring coverage for preventive services recommended by the United States Preventive Services (USPS) Task Force and the Center for Disease Control (CDC).
- **Payment Reform:** The ACA called for increased psychotherapy payments, a move towards case and capitation rates, linking payment to performance, and accounting for prevention into rates.

Health Insurance Exchange/Marketplace:

As part of the ACA, the government created an online marketplace (www.healthcare.gov) where individuals or companies can shop for and compare private health insurance plans. This allowed for more competition with the hopes of reducing premiums. There are different levels of coverage offered, but all must have minimum standards that include the EHBs, as described above.

Accountable Care Organizations:

The ACA supports the development of Accountable Care Organizations (ACOs). These are defined legal entities that create a network of physicians, practices, hospitals, and other healthcare platforms (e.g., labs) that will coordinate efforts to take care of defined populations of 5000 or more. The goal is to contain costs by avoiding redundancy, sharing information through technology, and focusing on preventive services.

In 2011, the Department of Health and Human Services (DHHS) created rules for the creation of ACOs. The ACA requires demonstration pilots for creating ACOs for defined Medicare populations. If successful, the hope is that similar models will be adopted by private insurance and other entities. In addition, a Pediatric Demonstration Project was undertaken to help in the development of Pediatric ACOs.

The National Committee for Quality Assurance (NCQA) drafts standards for ACOs, and CMS has written the regulations for ACOs based upon current pilot demonstrations.⁸



Figure 7 The Health Home within ACOs and ACA

Health Home:

The Health Home or the Medical Home is seen as an approach to providing comprehensive medical care by promoting patient- and family-centered care through collaboration among primary care providers, specialists, and hospitals. The goal is for coordinated, cost-effective, and comprehensive care.⁹ This is of special importance for those with chronic illnesses and serious mental health disorders. Please see the primary care module for a detailed explanation.

The importance here is that the ACO model integrates the concepts of a Health Home. Of further importance to mental health is that the NCQA requirements state that mental health services are one of the primary responsibilities of the health home.

Mental Health Parity:

The “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008” requires that insurance groups that were offering mental health or substance abuse coverage make it comparable to and no more restrictive to access than medical coverage. This includes copays, coinsurance, out-of-pocket maximums, limitations on utilization, out-of-network providers, and medically necessity determinations.

Ironically, the law did not require insurance plans to offer mental health or substance abuse coverage. It also did not require them to cover any specific MH or SA disorders (i.e., autism, eating disorders, etc.) or any specific treatments (i.e., ABA therapy, ECT, etc.).

The ACA has since extended the reach of parity. This is due to the fact that the ACA considers MH and SA treatment as one of the ten essential health benefits. Medicaid, SCHIP, and plans purchased through the Health Insurance Exchanges will include MH and SA coverage.

The DHHS released the Mental Health and Substance Use Disorder Parity Action Plan in 2018, required by Section 13002 of the 21st Century Cures Act. The Action Plan includes actions from HHS, the Department of Labor, and the Department of the Treasury related to ongoing implementation of the MHPAEA.¹⁰

The 21st Century Cures Act (2016) enacted a variety of changes to the mental health and substance use system. These included authorizations for increased funding for substance use services, further strengthening the federal parity act, and making changes to SAMHSA's structure and organization.

VIII: CONCLUSION

Health care financing comes from public and private sector funding. Public sector funding is divided between federal, state, and local contributions. State and local funding occurs through agency funding and its contribution to government funded insurance programs. Federal funding is primarily broken down into block and discretionary grants, government funded insurance programs, data and surveillance structures, and training and technical assistance. Private sector funding is divided into private health insurance, foundations and charities, and self-pay individuals.

Different sources of funding guide eligibility requirements, providers, and service arrays. It is important to understand the ever-changing government policies that impact mental health care.

There are many reasons for child and adolescent psychiatrists to be attentive to the organizational and financial structures that influence service delivery. Our ability to provide quality mental health care can be positively supported or diminished by these system parameters. Additionally, our active participation and dialogue with the stakeholders who define and oversee organizational, administrative, and financial practices can serve to promote clinically informed decision-making, system change, and improved patient care.

APPENDIX 1

SYSTEMS-BASED PRACTICE: ORGANIZATIONAL AND FINANCIAL STRUCTURES OBJECTIVES* Knowledge

The resident will demonstrate an adequate knowledge of:

- 1) Public funding for mental health services.
- 2) Five public programs that provide funding for children's mental health services.
- 3) Medicaid eligibility requirements in their state.
- 4) CHIP program eligibility requirements in their state.
- 5) SAMHSA contributions to services and service arrays for children and families.
- 6) Private funding of services for children and families.
- 7) Issues that affect access to services and continuum of care.
- 8) Problems and concerns of mental health systems.

Skills

The resident will demonstrate the ability to:

- 1) Collaborate with families, other professionals and agencies to promote quality care.
- 2) Facilitate adequate delivery of funded services for youth and families.
- 3) Advocate for and educate individual youth and their families about appropriate services and ways to access the services.

Attitudes

The resident will demonstrate the commitment to:

- 1) Encourage families to educate themselves and participate in decision-making regarding how resources will be used for their child.
- 2) Appreciate the system challenges and opportunities in providing quality care for youth and families.

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