

**SYSTEMS-BASED PRACTICE  
ORGANIZATIONAL AND FINANCIAL STRUCTURES IN MENTAL HEALTH  
SYSTEMS OF CARE  
Updated March 2020**

**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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**\*\*Appendix 1 describes the systems-based practice competency in the RRC Program Requirements**

## OVERVIEW

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

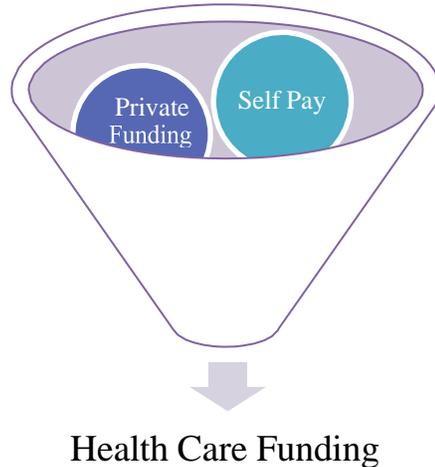
While using this module we recommend referring to other systems-based practice modules, especially the Public Mental Health System and the Family-Driven, Youth-Guided Care modules.

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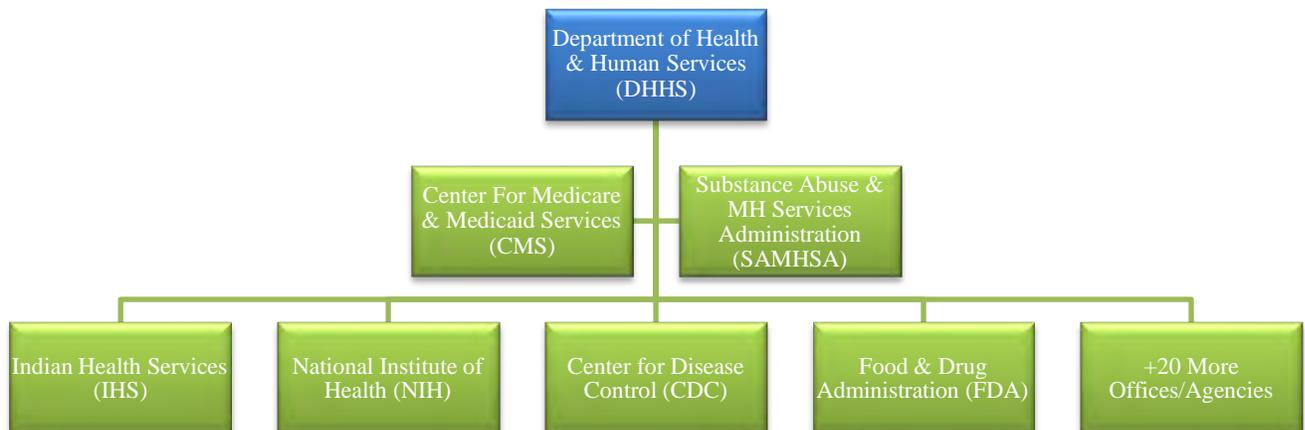
# I. OVERVIEW OF MENTAL HEALTH FINANCING

The funding of mental health care in the United States comes from various private and public sector sources with these funds being accessed and utilized in a complex manner. Public sector funding comes through a variety of programs through federal, state, and local funding. Private funding comes predominantly from private health plans and the insurance industry, but also includes foundations and charities. Finally, there is a small group of individuals who are considered self-pay.



**Figure 1 The Health Care Funding Mix**

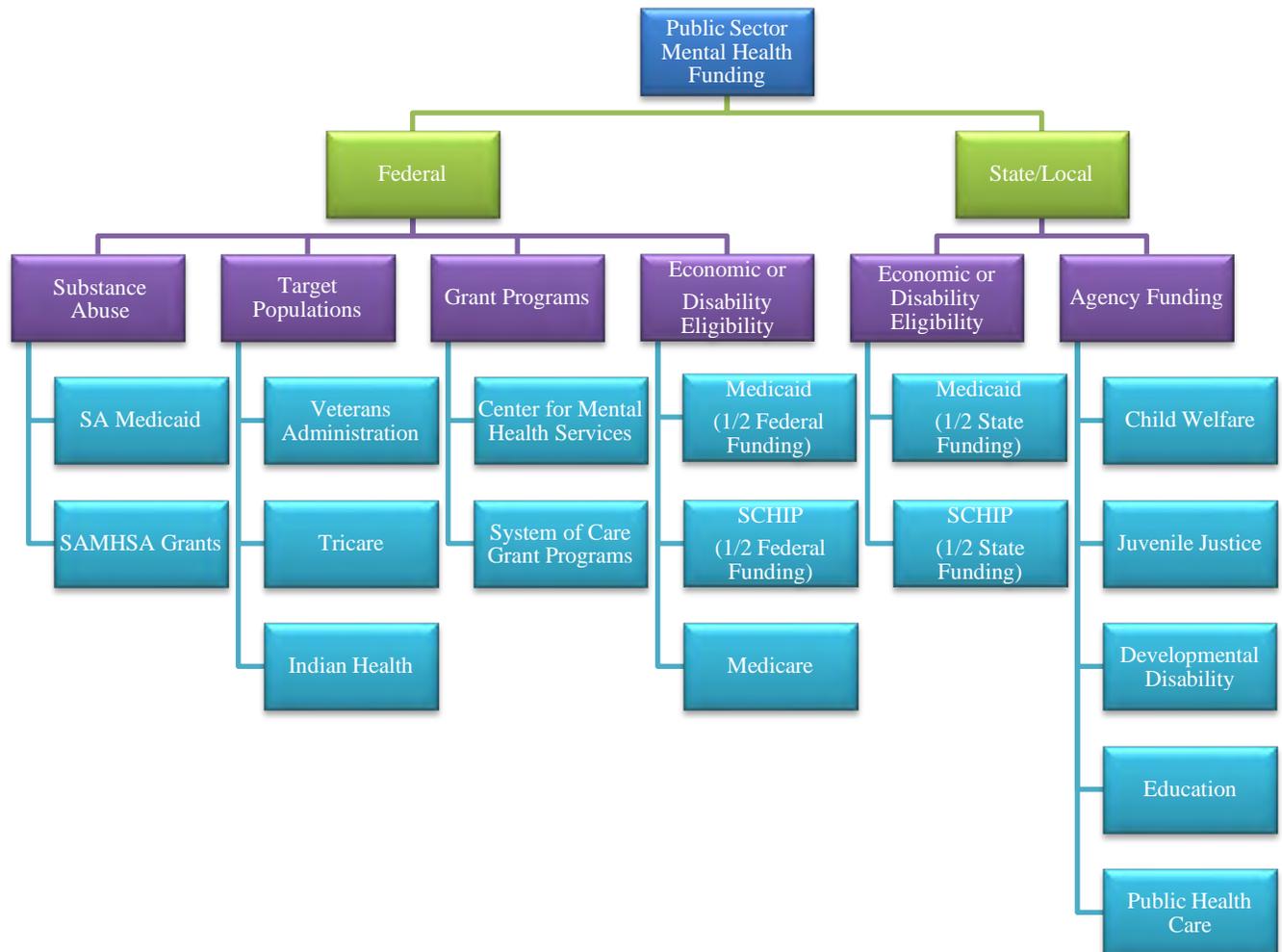
The federal governmental funding stream is the largest component of public funding. Governmental agencies and their structures are vast and ever changing. Public funding for children’s mental health services comes through several federal agencies, most prominent of which is the Department of Health and Human Services (DHHS) under which the Centers for Medicare and Medicaid Services (CMS) provide funding and policy guidelines for the Medicare, Medicaid, and the State Children’s Health Insurance Programs (SCHIP). DHHS also oversees the Substance Abuse and Mental Health Services Administration (SAMHSA), which plays a large role in federal funding. These will be explained in detail in later sections.



**Figure 2 DHHS Flowchart**

## II. PUBLIC SECTOR FUNDING STRUCTURE

For mental 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.

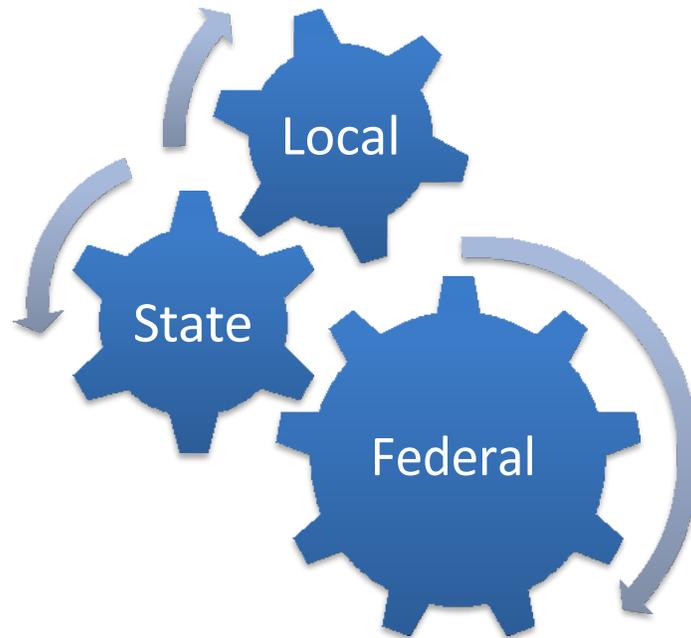


**Figure 3 Public Sector Mental Health Funding Components**

These government-funded programs provide mental health services for child and adolescents. For many, it comes from multiple sources. Federal funding is divided among federally funded insurance programs, grant programs, funding for specific populations, and substance abuse dollars. State/Local funding comes through systems related agencies as well as state contributions to Medicaid and SCHIP.

### III. FEDERALLY FUNDED STREAMS FOR MENTAL HEALTH SERVICES

Although federally funded streams fall under public funding, it is by far the largest stream and therefore needs further clarification.



**Figure 4 The Blend of Public Funding**

Direct federal funding for mental health services can be broken up into two major categories: grant funding and government funded insurance programs. Indirect funding comes through other federally funded agencies.

#### **1. Federal Block Grants:**

Federal block grant dollars, based on an approved state plan, flow down from the federal government to the state to localities/counties/jurisdictions. The money they allocate to various projects is based on each county's priorities, however, it must be consistent with the state plan. Federal funding typically requires a local matching contribution.

The state plan addresses administrative infrastructure requirements and identifies most of the services that are available to eligible individuals within the state. The minimal federal requirement is for state coverage of outpatient, inpatient and case management for adults. Other services are technically optional, but most states have developed some type of service continuum to address the needs of children, adolescents, their families, and other special populations.

The federal government carefully reviews the state plan. As some states have become more creative and expansive in their coverage of mental health services, it is common for there to be considerable communication between the state and the federal government before closure is

reached. In accordance with the state plan, the state distributes funds to counties, local communities, or other defined jurisdictions.

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).

## **2. State Waivers:**

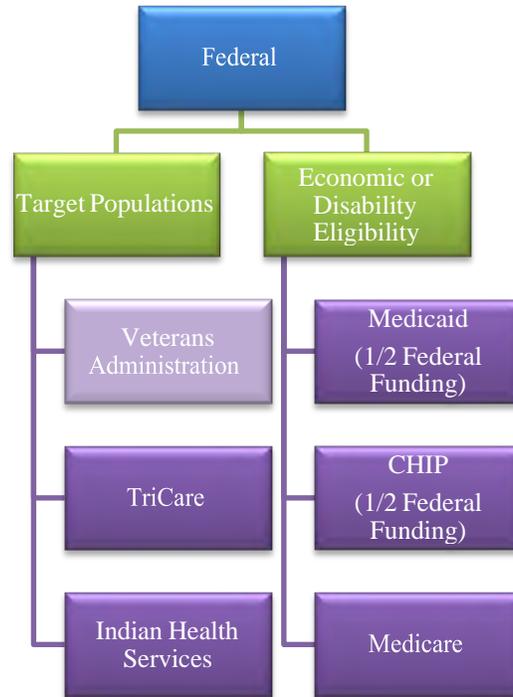
Specific Medicaid eligibility criteria, administrative features, and service options may be waived under a federal process called a Medicaid Waiver. This allows states to access federal money for approved uses that are innovative and non-traditional in nature. A waiver is seen as a mechanism to provide services that would otherwise not be permissible. Many states seek waivers to develop a more flexible and comprehensive service system. There are sets of pre-existing 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 waivers<sup>2</sup>:

- Research & 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 & community-based service waivers that provide long term care for in home or in community settings. The purpose is to avoid or minimize institutional settings. Examples include respite care, in home therapies, and wraparound services.

## **3. 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 5 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 and children involved in other systems, such as child welfare, and 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. An additional, important facet of Medicaid for the child population involves the Early Periodic Screening Diagnosis & Treatment (EPSDT) program, which supports 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 and adolescents and their families. Either public or private providers 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.<sup>3</sup>

However, because Medicaid costs have steadily increased, many states contract mental health services to managed care organizations. Managed care entails the state paying an outside company a fixed sum based on the number of enrollees to *manage* mental 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.

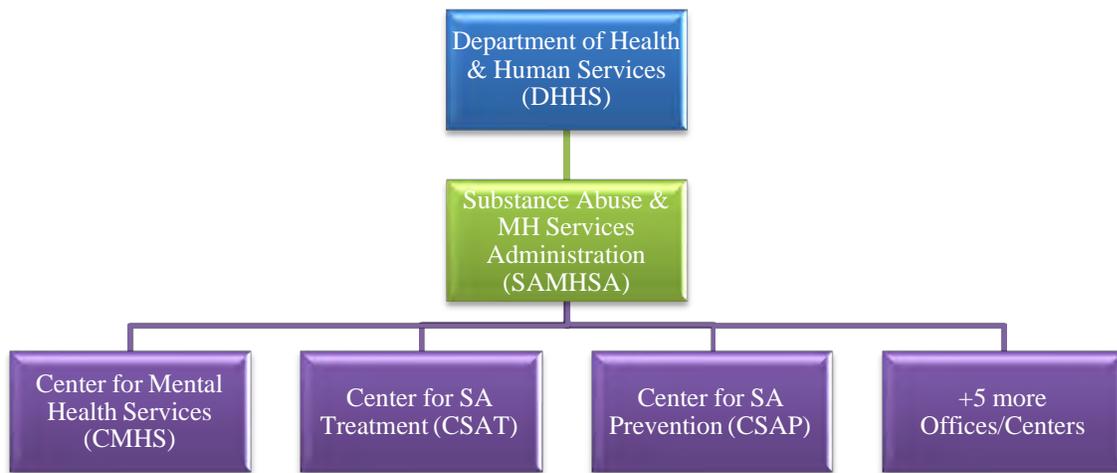
The managed care company's responsibilities include managing the utilization of service, managing the provider network, providing quality assurance, managing rates and claims, and providing customer service.

It is important to appreciate that each state has its own system to administer and oversee Medicaid services. Managed care can also exist within private insurance companies.

- **State Children's Health Insurance Program:** CHIP 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 CHIP insurance benefit if determined by the participating state government. However, typically the mental health coverage within CHIP 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 a health care delivery service 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.

#### 4. Federal Mental Health Grants from the Substance Abuse and Mental Health Services Administration (SAMHSA):

The patchwork of funding streams described above is not sufficient to address all of the mental health needs of communities and its population. In response, the federal government has made a significant effort to pursue innovation in the delivery of mental health and substance abuse services through the policy and funding activities of the Substance Abuse and Mental Health Services Administration (SAMHSA), particularly through competitive grants. SAMHSA is the only standalone agency of the federal Department of Health and Human Services (DHHS). For the most part its grants, training, and technical assistance are separate for mental health and for substance abuse. Our interest here primarily involves SAMHSA's Center for Mental Health Services (CMHS), which provides mental health grants and serves a variety of other important roles at the federal level.



**Figure 6 SAMHSA Flowchart**

- **Center for Mental Health Services:** CMHS leads national efforts to improve prevention and mental health treatment services for all Americans. CMHS' mission, as stated on its Web site, "leads 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."<sup>4</sup> 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.

- **Substance Abuse Grants:** SAMHSA addresses substance abuse, including both prevention and treatment intervention, through block grants and competitive grants that are separate from its mental health grants. The prevention grants are sponsored by SAMHSA’s Community Substance Abuse Prevention (CSAP) Branch. The intervention grants are sponsored by SAMHSA’s Community Substance Abuse Treatment (CSAT) Branch.

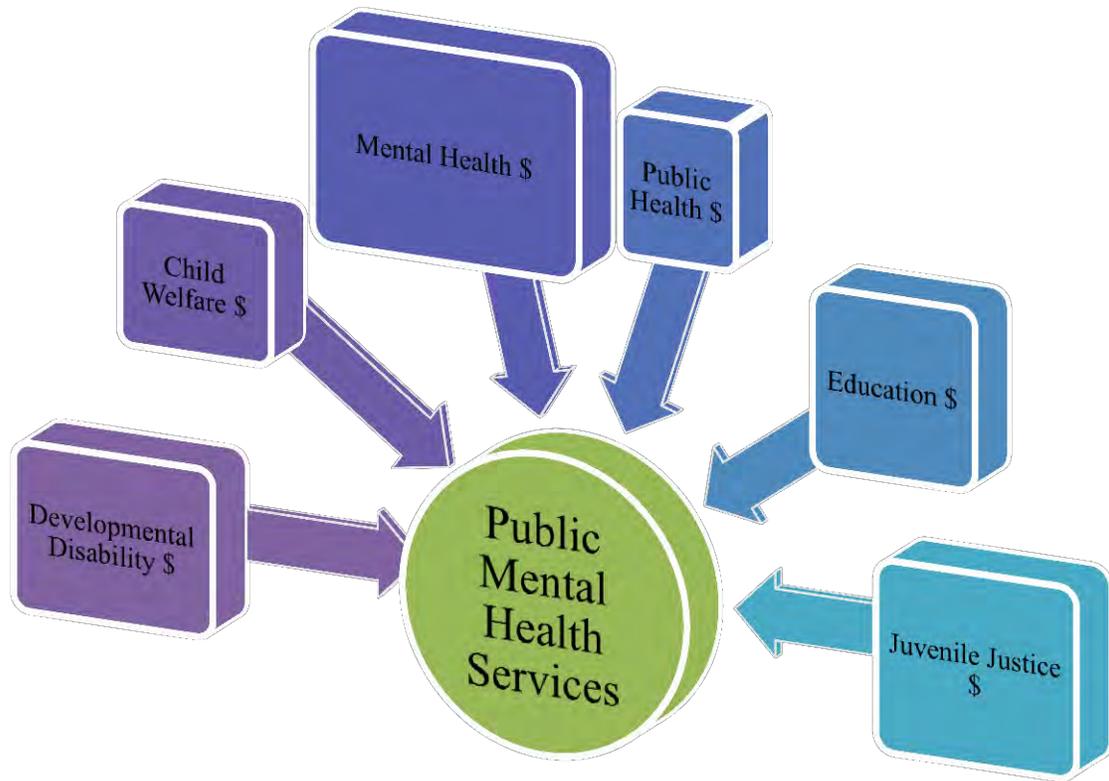
Competitive grants are offered to local jurisdictions and providers to help them address the need for prevention and intervention around substance abuse problems. However, the separation of funding for mental health and substance abuse services within SAMHSA has resulted in very limited support for treatment of comorbid disorders and for joint programming, even though integrated treatment approaches to co-occurring mental health and substance abuse disorders are now regarded as emerging best practices.

#### **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 ratio of federal to state funds varies from state to state with ratios of state participation up to 50%. In some states, 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.<sup>5</sup> At this time, the states have the choice of expanding Medicaid with federal support.

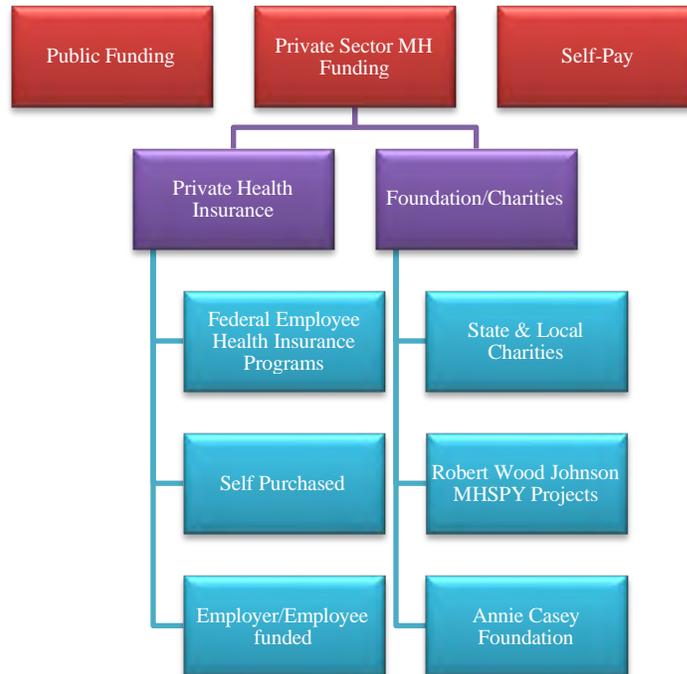
Often, publicly funded services may be implemented within other child-serving agencies leading to combined or “braided funding” that involves the use of funds from other systems of care, including juvenile justice, child welfare, education, developmental disabilities, and public health to name a few. These systems also receive mixed federal and state/local funding. 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 7 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.



**Figure 8 Private Sector Mental Health Funding**

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 where 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 your PCP to other in-network providers thus limiting costs. A PPO allows for more choice and independence as you can see both in and out of network providers. You do not have to choose a PCP and generally do not need a referral for specialty care. Since choice increases, so do your costs. Some Medicaid plans also use many of the same tools and setup of 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 mental/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 a broader services array. 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, the eligible services, and required amount of co-payment required. 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 at times 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 success financially and in terms of clinical outcomes.

- **Providers:** In both private and public sector insurance, there are typically some restrictions on member access to providers. In the private realm, the 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, where 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 are 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 care providing outpatient, including some intermediate forms of intensive outpatient (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 from 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 hospitals. Public sector systems typically have more expansive options along the continuum of care, than do 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, over the past few years there have been two federal acts 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 the quality of care, and contain healthcare costs. It also called for the implementation of the Accountable Care Organizations (ACO) and the Health Home.

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

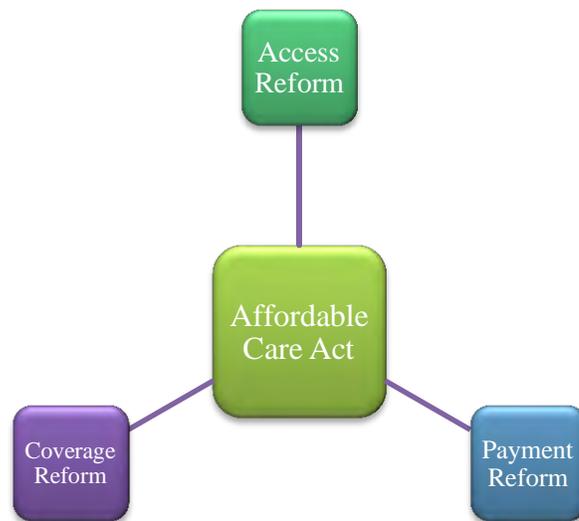


**Figure 9 The Affordable Care Act - A Balancing Act**

- **Quality, affordable health care for all Americans:** Includes the elimination of discriminatory practices, eliminates pre-existing condition limitations, increases dependent age to 26, mandates individuals to have health insurance, and provides increased access to healthcare through employers, the health insurance exchange, and/or tax credits.
- **The role of public programs:** Includes changes and expansion to the 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:** Requirements to provide 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**

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



**Figure 10 Financial Reforms in the ACA**

- **Increases Access:** ACA called for increasing insurance coverage for millions of Americans by changing requirement for employers who offer health care coverage, offering income-based tax credits for the self-insured, and calling for Medicaid expansion. The ACA also calls for setting up Health Insurance Exchanges (see below) to create a competitive marketplace to purchase private health insurance.
- **Coverage Reform:** 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:** 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 ACA, the government created an online marketplace ([www.healthcare.gov](http://www.healthcare.gov)) where individuals or companies can shop for and compare private health insurance plans. This allowed for competition with the hopes of reducing premiums. There are different levels of coverage offered, but all must all minimum standards that include the essential benefits package. This includes mental health and substance abuse treatment.

### **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 (i.e. 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 creations of ACOs. The ACA requires demonstration pilots for creating ACOs for defined Medicare populations. If successful, the hope is 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.

Growth of ACOs in pediatric care have been more modest than for older populations. A collaboration between the American Academy of Pediatrics and Leavitt Partners, LLC, supported studies of Pediatric ACOs. These collaborative studies identified issues in ACO formation and sustainability in pediatric settings, as well as outlining opportunities for the pediatric community.<sup>7</sup>

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



**Figure 11 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 between primary care providers, specialists, and hospitals. The goal is for coordinated, cost-effective, and comprehensive care.<sup>9</sup> 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 National Committee for Quality Assurance (NCQA) requirements state that mental health services are one of the primary responsibilities of the health home.

**2. Mental Health Parity:**

The “Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (MHPAEA) of 2008” was enacted and requires that insurance groups who 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 necessary 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, CHIP, 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 21<sup>st</sup> 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.<sup>10</sup>



### **3. SOC and Healthcare Reform:**

It is important to recognize that both SOC tenants and health care reform are attempting to provide patient and family-centered care. In doing so, ACA has required the development of an essential benefits package that promotes patient and family-centered care. Thus, the ACA is broadening the available mental health and substance abuse services while also trying to coordinate care with the advent of ACOs, improving parity, factoring in patient satisfaction, incentivizing positive outcomes, providing cost effective treatment, and focusing on prevention by incorporating various systems of care.

### **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 grants, government funded insurance programs, and SAMHSA grants. Private sector funding is divided into private health insurance, foundations and charities, and self-pay individuals.

Different sources of funding guide eligibility requirement, 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\*

Residents must demonstrate an awareness of and responsiveness to the larger context and system of health care, as well as the ability to call effectively on other resources in the system to provide optimal health care. Residents are expected to:

IV.B.1.f) Systems-based Practice. Fellows must demonstrate an awareness of and responsiveness to the larger context and system of health care, including the social determinants of health, as well as the ability to call effectively on other resources to provide optimal health care. (Core)

\* Accreditation Council for Graduate Medical Education. Program Requirements for Residency Education in Child and Adolescent Psychiatry.

[https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405\\_ChildAdolescentPsychiatry\\_2019\\_TCC.pdf?ver=2019-03-28-161025-277](https://www.acgme.org/Portals/0/PFAssets/ProgramRequirements/405_ChildAdolescentPsychiatry_2019_TCC.pdf?ver=2019-03-28-161025-277). July 1, 2019.

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