Customizing Care Coordination in Medicaid Delivery Systems for Children with Serious Behavioral Health Challenges: The Use of Care Management Entities and Wraparound Teams

PRESENTERS
Shelia A. Firs
Senior Partner, Human Service Collaborative; Care Partner, Technical Assistance Network
Jody Leskanic-Johnson
Deputy Assistant Secretary, Louisiana Office of Behavioral Health
Elizabeth Murray
Director, System of Care Division, New Jersey Dept. of Children and Families
Jackie Shipp
Director, Community-Based Services, Oklahoma Dept. of Mental Health and Substance Abuse Services
Deanna Simons
Senior Program Officer; Center for Health Care Strategies, Inc.; Care Partner, Technical Assistance Network
Michelle Zabor
University of Maryland Baltimore, Institute for Innovation and Implementation; Lead Care Partner; Technical Assistance Network

Setting the Context

Why Children with Significant Behavioral Health Challenges Need Customized Care Coordination

Children in Medicaid Using BH Care: A High-Cost Population

- Mean Medicaid expenditures (PH and BH) = $8,520 per year
- Nearly 5x higher than for Medicaid children in general ($1,729 per year*)
- TANF-enrolled children – nearly 3x higher
- Foster care – 7x higher
- SSI/disabled – nearly 9x higher
- Expenditures driven more by behavioral – rather, than physical – health service use, except for children on SSI/disability who have slightly higher physical health expense
- Children with top 10% of BH expense are 28x more expensive than Medicaid children in general

Children in Foster Care Use More Restrictive, More Expensive Services in Medicaid

- More likely to use:
  - Inpatient psychiatric services
  - Residential treatment
  - Therapeutic group care
  - Emergency room services
  - Psychotropic medications

- One-fifth the size of the TANF population, but use:
  - Nearly the same amount of dollars for residential, group care and ER visits
  - 3.5 times more for therapeutic foster care

Prevalence/Utilization Triangle

- More complex needs
- Intensive services – 60% of $8
- Less complex needs
- Prevention and Universal Health Promotion – 5% of $8

Children and Youth with Serious Behavioral Health Conditions:
Distinct Population from Adults with Serious and Persistent Mental Illness

- Do not have the same high rates of co-morbid physical health conditions as adults with SPMI
- Have different mental health diagnoses from adults with SPMI (i.e. ADHD, Conduct Disorders, Anxiety), not as much Schizophrenia, Psychosis, Bipolar; and diagnoses change often
- Two-thirds are typically involved with child welfare and/or juvenile justice systems, and 60% may be in special education – systems governed by legal mandates
- Care coordinator’s time is primarily spent on coordination with other children’s systems (i.e. child welfare, juvenile justice, schools), behavioral health providers, family needs/concerns, not coordination with primary care
- To improve cost and quality of care, focus must be on child and family/caregiver(s) which takes time

Customized, Intensive Care Coordination Approaches Are Needed

- Traditional case management and care coordination approaches for adults are not sufficient
- Need for:
  - Lower case ratios
  - Higher payment rates
  - Approach based on evidence of effectiveness

Customized Care Coordination Approaches for Children with Serious Behavioral Health Challenges

- **Care Management Entities**
  - Organizations providing intensive care coordination at low ratios (1:10) using high quality Wraparound* care planning approach

- **High Quality Wraparound Teams**
  - Embedded in supportive organization, such as CMHC, FQHC or school-based mental health center, providing intensive care coordination at low ratios
  - Growing number of states experiencing better outcomes, lower per capita costs

Important Points About Wraparound

- **Wraparound is:**
  - A **defined**, team-based service planning and coordination process
  - A **structured** approach to service planning and care coordination
  - It is **NOT** a service per se
  - The Wraparound care planning process ensures that there is one coordinated plan of care and one care coordinator
  - The ultimate goal is to improve:
    - Outcomes
    - Family and youth experience with care
    - Per capita costs of care – health care’s **triple aim**

What’s Different in Wraparound?

- **High quality teamwork**
  - Collaborative activity
  - Brainstorming options
  - Goal setting and progress monitoring
- The plan and the team process is driven by and “owned” by the family and youth
- Taking a strengths based approach
- The plan focuses on the priority needs as identified by the youth and family
- Focus on:
  - Whole youth and family
  - Developing optimism and self-efficacy
  - Developing **enduring social supports**

In wraparound, a care coordinator coordinates the work of system partners and other natural helpers so there is one coordinated plan
Wraparound is Increasingly Considered “Evidence-Based”

- State of Oregon Inventory of Evidence-Based Practices (EBPs)
- California Clearinghouse for Effective Child Welfare Practices
- Washington Institute for Public Policy: “Full fidelity wraparound” is a research-based practice

Child and Youth Populations Typically Served by CMEs/High Quality Wraparound Teams

- Children and adolescents:
  - With serious emotional/behavioral challenges at risk of out-of-home placement in residential treatment, group homes, and other institutional settings
  - Returning from institutional placements in residential treatment, correctional facilities, or other out-of-home setting
  - At risk of or returning from psychiatric inpatient settings
  - In child welfare
  - Youth at risk of incarceration or placement in juvenile correctional facilities
  - Detention diversion and alternatives to formal court processing for juveniles
  - Other populations (e.g., youth at risk for alternative school placements)

Care Management Entity Functions

<table>
<thead>
<tr>
<th>Service Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Child and family team facilitation using fidelity wraparound practice model</td>
</tr>
<tr>
<td>Screening, assessment, clinical oversight</td>
</tr>
<tr>
<td>Intensive care coordination</td>
</tr>
<tr>
<td>Care monitoring and review</td>
</tr>
<tr>
<td>Peer support partners</td>
</tr>
<tr>
<td>Access to mobile crisis supports</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Administrative Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>Information management – real time data; web-based IT</td>
</tr>
<tr>
<td>Provider network recruitment and management (including natural supports)</td>
</tr>
<tr>
<td>Utilization management</td>
</tr>
<tr>
<td>Continuous quality improvement; outcomes monitoring</td>
</tr>
<tr>
<td>Training</td>
</tr>
</tbody>
</table>

Costs and Residential Outcomes are Robust

CMS Psychiatric Residential Treatment Facility (PRF) Waiver Demonstration Projects:

- Average per capita saving by state ranged from $20,000 to $40,000

Los Angeles County Department of Social Services:

- Found 1.2 month placement costs were $10,000 for Wraparound discharged youths compared to $37,000 for matched group of RTC youths

Wraparound Milwaukee

- Reduction in placement disruption rate in child welfare from 65% to 30%
- School attendance for child welfare-involved children increased from 71% days attended to 86% days attended
- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- Average daily cost increase in residential treatment center from $77 to $90
- Reduction in psychiatric hospital days from 5,000 days per year to 1,010
- Average monthly cost of $3,200 (compared to $7,300 for RTC, $4,000 for juvenile detention, $18,000 for psychiatric hospitals)

Maine

- Experienced 30% net reductions in Medicaid spending, comprised of decreases in PRF and inpatient psychiatric with increases in targeted case management and home- and community-based services

Customization Strategies – Regardless of Medicaid System Design

Customized Care Coordination (May 7, 2013 CMS and SAMHSA Informational Bulletin)

- Incorporate intensive care coordination using Wraparound approach for children with serious behavioral health challenges (growing number of states – MA, LA, NJ, PRF Waiver Demo; CHIPRA Care Management Entity Quality Collaborative states)
- Intensive care coordination rates for this population range from $780 to $1300 per month (CHCS Matrix)
- In fidelity intensive care coordination/Wraparound approaches, all-inclusive cost of care (e.g., admin, care coord, placements, clinical treatment, informal supports) averages $3700–$4200 per month (about $2100 is Medicaid) – compare to $5,000 per month in PRF, higher in psych inpatient

Variation in Types of CME Entities

- Public agency as CME – Wraparound Milwaukee
- New non profit organization with no other role – New Jersey Care Management Organizations
- Existing non profit organization with other direct service capability – Massachusetts Community Service Agencies
- Hybrid – Non profit organization with other direct service capability in formal partnership with neighborhood organization – Cuyahoga County, Oh Coordinated Care Partnerships
- Non profit HMO – Massachusetts Mental Health Services Program for Youth
Integration at the Systems/Medicaid Purchaser Level: Caveats

Research has shown that...

• When adult and child behavioral health dollars are integrated, there is a risk of child behavioral health dollars being absorbed by adult services.
• When physical and behavioral health dollars are integrated, there is a risk of behavioral health dollars being absorbed by physical health services.

Especially in the absence of customization within the design for children with serious BH challenges, risk-adjustment strategies, strong contractual performance measures and monitoring mechanisms

Medical Homes vs. Health Homes

Medical Homes

- All children
- Coordination of medical care
- Physician-led primary care practices

Health Homes

- Children with chronic health conditions, children with serious behavioral health conditions
- Coordination of physical, behavioral, and social supports
- Specialty provider organizations, including behavioral health specialty organizations (e.g., not only medical)

“Integration” with Primary Care in a Wraparound Approach

• Ensuring child has an identified primary care provider (PCP)
• Tracking of whether child receives EPSDT screens on schedule
• Ensuring child has at least an annual well-child visit
• Communicating with PCP opportunity to participate in child and family team and ensuring PCP has child’s plan of care and is informed of changes
• Ensuring PCP has information about child’s psychotropic medication and that PCP monitors for metabolic issues such as obesity and diabetes

Analysis of Medical Home Services for Children with Behavioral Health Conditions

“All behavioral health conditions except ADHD are associated with difficulties accessing specialty care through a medical home”

“The data suggest that the reason why services received by children and youth with behavioral health conditions are not consistent with the medical home model has more to do with difficulty in accessing specialty care than with accessing quality primary care”.

There is a need for more customized, intensive care coordination approaches for children with significant behavioral health challenges.

Accountable Care Organizations

• “I believe, with some exceptions, ACOs will not succeed...it will be difficult for anything but an organization that has been at it a long time to develop the team culture needed to be an ACO”
• “The reason that patient-centered medical homes will not succeed is that health care follows the 80/20 rule - 20% of patients generate 80% of the costs. Those 20% are the chronically ill, and I don’t see how primary care physicians serving those patients add value to their care.”
• “Focused factors of care – that is a term I use for provider organizations that deliver highly specialized care for a certain population, such as those with diabetes...you need specialists for that. They are the opposite of ACOs that do everything for everyone.” –Regina Herzlinger, Harvard Business School, as quoted in Managed Care Magazine Online http://www.managedcaremag.com

Medicaid Vehicles to Support Customized Intensive Care Coordination Using Fidelity Wraparound

• With population pmpm case rate or with care coordination pmpm rate
• 1915(a) – Wraparound Milwaukee, Children Come First (Dane Co WI)
• Targeted Case Management – NJ, MA
• 2703 Health Home SPA – OK (for SED), NJ (for subset of children with SED and co-occurring medical or developmental conditions
• 1915(b) or (c) – LA
• 1915(i) – MD
• Money Follows the Person (GA)
• Balancing Incentive Program (GA)
• CMMI Health Innovations Grant (CHCS and 4-state application)
State Examples

- Intensive Care Coordination/Wraparound
- Structures
- How Embedded within Medicaid Delivery System
- Medicaid Vehicles Used
- Populations Served

Customizing Care Coordination
The Louisiana Experience
July 17 & 19, 2014

Louisiana Coordinated System of Care

The Coordinated System of Care (CSoC) is an initiative to serve Louisiana's youth with significant behavioral health challenges who are in highest need and at greatest risk. CSoC is a component of the Louisiana Behavioral Health Partnership.

CSoC is a philosophy and approach to service delivery that results in improved integration and coordination, enhanced service offerings and improved outcomes.

At full implementation the CSoC will serve 2400 youth.

Specific goals for the CSoC include decreasing the number of youth in residential/detention settings, reduction in the state's cost for providing services by leveraging Medicaid and other funding sources, and improving the overall outcomes for these children/youth and their caregivers.

CSoC Implementing Regions
Medicaid Vehicles in Louisiana

- CMS Authority:
  - 1915(b) Waiver allows for the use of Managed Care in the Medicaid Program
  - 1915(c) Waiver allows for the provision of long term care services in home and community based settings under the Medicaid Program
- Wraparound Agencies: administrative payment
- Peer Support Services (Youth & Parent): Fee for service payment

Population Served in Louisiana

- Age 21 or under
- DSM diagnosis or exhibiting behaviors indicating a behavioral health diagnosis may exist
- Meets clinical eligibility on the CANS Comprehensive
- Generally involved with multiple child-serving systems
- In or at-risk of out of home placement
**Children’s System of Care**

**Presented by**

Elizabeth Manley
Division Director

---

**Children’s System of Care Objectives**

To help youth succeed...

- **At Home**
  - Successfully living with their families and reducing the need for out-of-home treatment settings.

- **In School**
  - Successfully attending the least restrictive and most appropriate school setting close to home.

- **In the Community**
  - Successfully participating in the community and becoming independent, productive and law-abiding citizens.

---

**Children’s System of Care Values and Principles**

- **Child Centered & Family Driven**
- **Community Based**
- **Culturally Competent**

<table>
<thead>
<tr>
<th>Strength Based</th>
<th>Family Involvement</th>
<th>Individualized</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unconditional Care</td>
<td>Collaborative</td>
<td>Home, School &amp; Community based</td>
</tr>
<tr>
<td>Promoting</td>
<td>Cost Effective</td>
<td></td>
</tr>
<tr>
<td>Independence</td>
<td>Comprehensive</td>
<td></td>
</tr>
</tbody>
</table>

---

**Key System Components**

- **Contracted Systems Administrator**
  - CSA is the single portal for access to care mandated 7/7/1998

- **Care Management Organization**
  - CSA Management Organizations offering a comprehensive model of care serving youth with complex and severe and their families

- **Mobile Respite & Stabilization Services**
  - Crisis response and planning available 24/7/365

- **Family Support Organization**
  - Foster family support and advocacy for parents and caregivers and youth

- **Intensive Case Management**
  - Intensive Case Management Services in the community for youth in a community and their families

- **Out of Home**
  - Out of home and adoption services included

- **DD-Family Support Services**
  - Supportive services, respite, and other services designed to enhance the ability of the family to support a youth with developmental disability and their siblings

- **Substance Abuse Treatment Services**
  - Out of home and adoption services above treatment services (including)

- **Traditional Services**
  - Foster Care, Partial Hospitalization, Inpatient and Outpatient services

---

**Role of Contracted Systems Administrator (CSA)**

CSA creates pathways for youth and young adults by providing access to the right care at the right time.

- **CSA authors services, based on the most recent clinical information that is submitted to them.**

- **CSA does not provide direct services.**

- **CSA has a dedicated child welfare unit.**

---

**Factors That impact Design**

- **Priorities**
  - Serve More
  - EBP’s
  - Care Management
  - System Coordination
  - Reduce Institutional Care
  - Particular Populations

- **Environment**
  - Political
  - Perspectives of Leaders
  - Law Suits/Settlements
  - Crisis/Tragedy
  - Mandates
  - Community Will
  - Economic

- **Structure**
  - Government
  - State vs. County
  - Existing Reality
  - Envisioned Ideal
  - Medicaid Agency
  - Locus of Control

- **Leadership Structure**
  - Perspective of Leaders
  - Government
  - Legal
  - CSOC Leadership

- **Factors That impact Design**

---
The vision of CSOC is to create positive outcomes for children with emotional and behavioral needs and those with intellectual and developmental disabilities by:

- Identifying the child and family’s needs
- Determining the most appropriate Intensity of Service
- Delivering the most appropriate services for the most appropriate length of time
- Using standard assessment tools — the foundation of the Children’s System of Care.

**The Role of Assessment within CSOC**

- Positive Outcomes
- Appropriate Length of Stay
- Appropriate Services
- Appropriate Intensity of Service
- Child and Family Needs

**Intensities of Service (IOS)**

- Inpatient Treatment
- Out of Home Treatment
- Care Management Organizations (CMO)
- Mobile Response & Stabilization Services
- Intensive In-Community (IC) & Behavioral Assistance (BA) Services
- Outpatient Treatment
- Assessment Services
- Access / Triage and Information and Referral (PerformCare)

**Care Management**

Care Management Organizations (CMO’S) Utilize Child Family Teams (CFT’s) within Wraparound Model to facilitate a planning process to address the individualized needs of each youth.

**NJ Department of Children and Families**

New Jersey Department of Children and Families

- Division of Children’s System of Care (formerly DCBHS)
- Division of Child Protection & Permanency (formerly DYFS)
- Division of Family & Community Partnerships (formerly DPCP)
- Division of Women Services
- Office of Adolescent Services

**Oklahoma Systems of Care**
Children and Youth Served

- Children and youth* – Up to age 22
- With SED or co-occurring disorder
- At risk of out of home or out of school placements
- With complex needs served by multiple agencies

*Up to age 26 at Healthy Transitions Sites

Care Coordination

- Care coordination in the wraparound process is designed to facilitate a collaborative relationship among the child with SED, the family and all systems involved. The Care Coordinator ensures that the wraparound process is organized and integrated across all child-serving systems to enable the child to remain in his/her own home community.

Wraparound In Oklahoma

Wraparound teams (Care Coordinator and FSPs) are trained, coached and credentialed through the well-established process managed by the ODMHSAS. Mandatory ODMHSAS sponsored/conducted trainings include:

- SOC Wraparound 101 Training:
  - This is an introductory two-day training focusing on the principles and values of Wraparound. It is an in depth look at the phases of Wraparound and teaches participants how to complete the necessary components including Strengths, Needs, Culture, Discovery (SNCD) assessments, functional assessments, crisis/safety plans, Wraparound plans, and other items.
- SOC Family Support Provider Training is required for FSPs.

Rehab Option of State Plan Amendment

<table>
<thead>
<tr>
<th>Role in Wraparound</th>
<th>HCPC Code</th>
<th>Rate</th>
<th>Timeframe</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Aide</td>
<td>H2019</td>
<td>$ 7.52</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Family Support Provider</td>
<td>H2015</td>
<td>9.75</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Care Coordinator (TCM) – bachelor’s</td>
<td>T1017</td>
<td>16.21</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Care Coordinator (TCM) – LBHP</td>
<td>T1016</td>
<td>21.61</td>
<td>15 minutes</td>
</tr>
</tbody>
</table>
State Context: Massachusetts

- Services are delivered through statewide system (not county-based)
- Direct services are delivered primarily by contracted agencies
- There is the greatest concentration of teaching hospitals in the U.S.
- Medicaid managed care state

The Massachusetts Catalyst: “Rosie D.”

- Federal Class Action Lawsuit (2001) on behalf of children and youth with serious emotional disturbance
- Final judgment issued July, 2007
- MassHealth, found to be out of compliance with “reasonable promptness” and “Early Periodic Screening Diagnosis and Treatment” (EPSDT) provisions of federal Medicaid law

The Remedy

- Statewide Implementation of:
  - Standardized BH screening in primary care
  - Standardized scope of BH assessment, using the Child and Adolescent Needs and Strengths (CANS) tool
  - New home- and community-based BH services, including intensive care coordination with high quality wraparound

Access to Services & Supports: Medicaid Managed Care in MA

- MassHealth (Office of Medicaid)
- MassHealth Managed Care Entities
- Managed Care Program
  - Primary Care Choice Plan
  - Massachusetts Behavioral Health Partnership (MBHP)
  - Massachusetts Behavioral Health Partnership (MBHP) (Behavioral Health Care)
Massachusetts
1115 Waiver, State Plan (TCM)

State Medicaid Agency (MassHealth) – Purchaser

MCO MCO MCO MCO MCO PCCM

Standardized tools for screening and assessment by PCPs
CAMS

Community Services Agencies (CSA)
Non Profit BH and Specialty Providers
(LOCALLY-BASED CARE MANAGEMENT ENTITIES)

Massachusetts Definition of Intensive Care Coordination (Targeted Case Management)

Includes:
• Assessment
• Development of an Individual Care Plan
• Referral and related activities
• Monitoring and follow-up activities

All of which is done using a high quality wraparound care planning process

Massachusetts Populations Served in Intensive Care Coordination

All children under the age of 21, and enrolled in MassHealth Standard or CommonHealth with:
• A diagnosis of SED as defined by SAMHSA OR the Individuals with Disabilities Education Act (IDEA)
And:
• Needs or receives multiple services other than ICC from the same or multiple provider(s)
Or:
• Needs or receives services from, state agencies, special education, or a combination thereof;
And:
• Needs a care planning team to coordinate services the youth needs from multiple providers or state agencies, special education, or a combination thereof

Maryland’s Approach

Michelle Zabel, MSS
Director & Clinical Instructor,
The Institute for Innovation & Implementation

Director,
The Technical Assistance Network for Children’s Behavioral Health (TA Network)
mgzabel@ssw.umaryland.edu
http://theinstitute.umaryland.edu

Copyright 2014
The Institute for Innovation & Implementation
Current/Proposed Funding Mechanisms

<table>
<thead>
<tr>
<th>CME</th>
<th>CCD (proposed)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Funder</strong></td>
<td>Medicaid through State Plan Amendments for Targeted Case Management (and 1115(i) re: population eligibility)</td>
</tr>
<tr>
<td><strong># youth</strong></td>
<td>Up to 370 at any time</td>
</tr>
<tr>
<td><strong>Populations Served</strong></td>
<td>1915(i) State Plan Amendment Targeted Case Management, Tier 3</td>
</tr>
<tr>
<td><strong>Functions and Responsibilities</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Funder</strong></td>
<td>Medicaid through State Plan Amendments for Targeted Case Management (and 1115(i) re: population eligibility)</td>
</tr>
<tr>
<td><strong># youth</strong></td>
<td>Up to 370 at any time</td>
</tr>
<tr>
<td><strong>Populations Served</strong></td>
<td>1915(i) State Plan Amendment Targeted Case Management, Tier 3</td>
</tr>
<tr>
<td><strong>Functions and Responsibilities</strong></td>
<td></td>
</tr>
</tbody>
</table>

**State Examples**

- Care Coordinator Requirements, Certification, Training, Rates, Case Ratios, Supervisory Structure
- Peer Partner Requirements
  - Certification
  - Training
  - Rates
  - Case Ratios
  - Supervisory Structure
- Interface between Care Coordinators and Peer Partners
Wraparound Agencies in Louisiana

- Wraparound Facilitators (Care Coordinators)
  - Engage family and team members
  - Facilitate Child and Family Team (CFT)
  - Monitor plan implementation
  - Prepare for transition
  - Document outcome data
  - Collaborate with Peer Partners
- Paid PMPM ($1035)
- Case ratio: 1 to 10
- Supervisory structure: 1 supervisor to 8 facilitators

Peer Partners in Louisiana

- Parent/Youth Support Specialists
  - Engage parent and youth
  - Provide education/support in wraparound process
  - Provide education on behavioral health issues and services
  - Offer skill building in areas of need identified by CFT
  - Collaborate with Wraparound Facilitators
- Paid Fee-for-Service ($40/hour, rate change pending)
- Case ratio: 1 to 20
- Supervisory structure: 1 supervisor to 4 PSS/YSS

Care Management

- Care Managers are have a BA/BS or masters degree in social service.
- The CMO’s have established a certification process and different levels of certification.
- Care Managers’ are required to attend a series of trainings provided by CSOC.
- Family Support Partners are certified through Rutgers – UBHC. CSOC training partner.
- Care Managers are trained by Family Support Organizations
Care Management

- Care management is provided for youth with both high and moderate needs
- NJ is moving toward a caseload size of 14 with a mixed caseload of high and moderate (currently in transition)
- Care Managers are supervised by a master’s prepared supervisor
- Supervisors have 6 Care Managers on their team

Behavioral Health Home

NJ is currently working on a pilot BHH. The goal of the BHH is to expand the Child Family Team. We are looking to add a nurse and wellness coach to all teams for youth identified with a chronic condition.

Contract Requirements

- Caseloads of 10
- Child and Family Teams
- Strengths Needs and Culture Discovery
- Wraparound Care Plan
- Ohio Scales
- Staff attends all training and coaching required

Billing Wraparound

- Wraparound teams bill fee for service through the integrated MMIS system.
- Request prior authorization:
  - For Medicaid as payor source; and
  - For ODMHSAS state funding as payor source.
  - CC is the highest level of targeted case management.
  - Must submit letters of collaboration with all other providers billing MMIS system.
Intensive Care Coordination: Massachusetts

- 1:10 average care coordinator to youth/family ratio
- Average length of enrollment for youth who graduate from ICC is 11-12 months
- CANS is used as part of a comprehensive psychosocial assessment for ICC
- 1:8 average ICC supervisor to care coordinator ratio

Intensive Care Coordination: Massachusetts

- Care Coordinators:
  - CANS certified
  - Skill- and competency-based training in the delivery of ICC consistent with Systems of Care philosophy and the wraparound planning process and have experience working with youth with SEO and their families
  - Weekly individual supervision with a behavioral health clinician licensed at the independent practice level,
  - Weekly individual, group, or dyad supervision with the senior care coordinator
  - Master’s degree in a mental health field, or bachelor’s degree in a human services field and one year of relevant experience working with families or youth. If the bachelor’s degree is not in a human services field, additional life or work experience may be considered in place of the human services degree. Individuals with an associate’s degree or high school diploma must have a minimum of five years of experience working with the target population; experience in navigating any of the child/family-serving systems; and experience advocating for family members who are involved with behavioral health systems.

Family Support & Training (Family Partners): Massachusetts

- A Family Partner must have
  - Experience as a caregiver of youth with special needs, preferably youth with mental health needs
  - Experience in navigating any of the youth-and family-serving systems
  - Either a bachelor’s degree in a human services field from an accredited academic institution, or an associate’s degree in a human services field from an accredited academic institution and one year of experience working with children, adolescents, or transition-age youth and families; or a high school diploma or equivalent and a minimum of two years of experience working with children, adolescents, or transition-age youth and families. If the bachelor's or associate's degree is not in a human services field, additional life or work experience may be considered in place of the human services degree.

- H0038 $15.60 per 15 minutes

Payment & Financing for All Remedy Services

- No data to build case rate
- Rate setting agency developed 15-minute unit costs for each service
- Managed care entities (MCEs) paid through addition to capitation rate, based on unit rates and assumed utilization
- MCEs not at risk for Remedy services initially – performed an annual reconciliation
Training & Technical Assistance

- The Institute for Innovation & Implementation at the University of Maryland School of Social Work provides training, coaching, policy, and finance support. Fidelity and outcomes monitoring, and evaluation to support the CME and CCOs in Maryland.
- The Institute is a founding member of the National Wraparound Implementation Center (NWIC).
- Wraparound Practitioner Certification:
  - Online trainings
  - In-person training
  - On-Site Coaching
  - Team Observations
  - Document Review
  - Ongoing Certification

(For more information on the Wraparound Practitioner Certificate Program at the UIM SSW, please contact Marlene Matarrese at mmatarrese@ssw.umaryland.edu)

Staffing Requirements

- CMEs in MD must employ:
  - Executive Director
  - Chief of Finance
  - Provider Network Director
  - Clinical Director
  - Care Coordinator Supervisors
  - Care Coordinators
  - Community Resource Specialists
  - Quality Assurance and Data Director
- CCOs have few required personnel (care coordinators, care coordinator supervisors, clinical director) in the proposed SPA; more delineation will occur in the individual RFPs.

Care Coordinator Requirements

- Care Coordinators in MD must:
  - Have a minimum of a bachelor’s Degree and be enrolled in or have completed the Wraparound Practitioner Certificate Program OR
  - Have a minimum of a high school diploma or equivalency,
  - Be at least 21 years old
  - Have been a participant of or are/were the direct caregiver of an individual who received services from the public mental health system
  - Have completed the Family Support Partner Certificate Program and are enrolled in or have completed the Wraparound Practitioner Certificate Program

Case and Supervisor Ratios

- Staff-family Ratio
  - CME: 1:9 to 1:11
  - CCO: 1:8
- Supervisor-care coordinator ratio (supervisors do not maintain a caseload)
  - CME: 1:6 to 1:8
  - CCO: 1:7

Care Coordinator Supervisor Requirements

- Care Coordinator Supervisors in MD must:
  - Have a Master’s Degree in a human services field and two years of experience in a human services position
  - Have at least one year experience working in community-based service provision
  - Have at least one year experience working with children, youth and families
  - Possess an understanding of child and adolescent development
  - Have completed trainings on Wraparound, crisis planning, system of care, and comprehensive screening and assessment tools
  - Be enrolled in or have completed the Wraparound Practitioner certificate program or other equivalent training and certification

Billing Rates

- CME:
  - The state funded rate as of July 1, 2014 will be a full year equivalent of $14,048.62 annual per child (approximately $1170.71 per child per month).
  - This rate is inclusive of CC costs and CME operating expenses for the first year of the CME contract
- CCO:
  - Under the pending TCM SPA, billing units will be in 15-minute increments.
  - Proposed rate in 215-15 SPA (version released for public comment, fall 2013): $24.06/15 minutes or $294.24/week (up to $15,003/year)
  - Proposed reduced rate while child is in a residential placement up to a certain length of stay (40% of regular rate)
Provision of Family Peer Support

- Family peer support is available to families enrolled in care coordination. Family peer support specialists are employed through family support organizations.
- Family Support Specialists must meet the following requirements:
  - Be at least 21 years old
  - Receive supervision from an individual who is at least 21 years old and has at least 3 years of experience providing peer support
  - Have current or prior experience as a caregiver of a child with a SED or young adult with SMI
  - Be enrolled in the Wraparound Practitioner Certificate Program for Family Support Partners
- Under the 1915(i), family peer support will be reimbursed at $15.97 per 15 minute unit for face-to-face services or $7.98 per 15 minute unit for telephonic or non-face-to-face activities
- Youth enrolled in the CME can access peer support through discretionary funds

State Examples

- Access to Services and Supports
  - Provider network
  - Interface with MCOs/BHOs/ASO for Service Authorization
- Coordination with Primary Care, Courts, Schools

Services & Supports in Louisiana

- State Plan service array
  - Inclusive of evidence-based practices
  - Community-based alternatives
  - Out of home placement options
- Specialized Services for youth in CSoC
  - Parent Support & Training
  - Youth Support & Training
  - Crisis Stabilization
  - Independent Living/Skills Building
  - Short-term Respite
- Natural supports

Authorization Process in Louisiana

- Statewide Management Organization (SMO) receives and reviews plan of care created and authorized by the Child & Family Team (CFT).
- SMO approves authorization based on indications from CANS, Independent Behavioral Health Assessment and CFT recommendations.
- SMO builds and monitors authorization to ensure youth receive appropriate level, frequency and duration of care.
Coordination in Louisiana

• State level
  – Entire managed behavioral healthcare system is partnership of:
    • Office of Behavioral Health
    • Medicaid
    • Department of Children and Family Services
    • Department of Education
    • Office of Juvenile Justice
  – Established Governance Board through Executive Order
  – Meetings: Judges, provider associations, etc.

• Regional level
  – Community Teams
  – Child and Family Teams
  – Relationships
    • Judges
    • Schools
    • Informal/Natural supports

Outpatient Services

• Referral to Perform Care is not required for outpatient services, such as outpatient counseling, psychiatric evaluations/medication monitoring, anger management, etc.
• NJ MentalHealthCares maintains a thorough directory of services and can be accessed by visiting njmentalhealthcares.org or calling 866-202-HELP

Intensive In-Community Services

Our in-community services are flexible therapy services that are provided at the home or other in-community sites.

IIC

Intensive In-Community Services - Psychotherapy services provided in the youth’s home.

BA

Behavioral Assistance - Under a plan developed by an IIC therapist, the BA will work to modify specific behaviors of the youth.

What are IIC and BA Services?

Focuses on (re)engaging the family into community based services (must have CMO or MRSS involvement)

- Securing appointments
- Preparing for appointments
- Processing through transition
- Address symptom reduction
- Time limited
- Focused on skill strengthening
- Provided based on an evaluation of need
- Part of a comprehensive plan of care
- Provided in the community
IIC is Not:
"In Home Therapy" delivered in the home only for the convenience of the family
A long-term service

BA is Not:
A way to get supervision for the youth/young adult to get him/her out of the house
A substitute for individual and/or family therapy
Mentoring

CSOC SUBSTANCE ABUSE TREATMENT SERVICES

Available Services:
• Assessment (SA Evaluation, Needs Bio Psychosocial-BPS)
• *Outpatient (OP)
• *Intensive Outpatient (IOP)
• *Partial Care (PC)
• *Long-Term Residential (LT-RTC)
• *Short-Term Residential (ST-RTC)
• Detoxification

*All service authorizations are based on clinical justification.

Access to Community Services

• In 2000, NJ Served Approximately 7000 Children In Community-based Care Management, In-Home and day treatment programs
• In 2013, NJ Served over 44,000 In Care Management, In-Community and day treatment programs (∆+500%)
• In 2003, 40% of newly enrolled children were under 14 years old, in 2013 that percentage had grown to 65%
  Tends to indicate system of care has become more preventative, families are seeking services sooner

Access to Community Services

• Psych Community Homes (PCH)
• Specialty Beds (SPEC)
• Residential Treatment Centers (RTC)
• Group Homes (GH)
• Treatment Homes (TH)

Access to Community Services

• Homelessness
• Substance Abuse
• Mental Health
• Diabetes
• HIV/AIDS
• Access to primary care
• Consultation with NMSP
• Comprehensive mental health services
• Referral to specialty care

CHILDREN’S HEALTH HOME

• Linkage
• Education
• Transportation
• Housing
• O本
• EH</no>
EVERY INITIAL AUTHORIZATION PERIOD FOR ICC AND F&S T:
- Intensive Care Coordination (ICC) 1 unit = 15 minutes
- Family Support and Training (F&S T) 1 unit = 15 minutes
- 192 total units for ICC and F&S T combined, with no maximum units for either

EVERY 90 DAYS FOLLOWING INITIAL AUTHORIZATION:
- Intensive Care Coordination (ICC) 208 units/90 days (13 weeks) 1 unit = 15 minutes
- Family Support and Training (F&S T) 208 units/90 days (13 weeks) 1 unit = 15 minutes*

Note: All authorization parameters are floored not ceiling. If a provider uses up the units authorized in a given time parameter prior to the end of the end date of the authorization, the provider can contact the MCO to request additional units.

Massachusetts CBHI/Remedy Services
- Intensive Care Coordination (Wraparound)
- Family Support & Training (Family Partners)
- In-Home Therapy
- In-Home Behavioral Services
- Therapeutic Mentoring
- Mobile Crisis Intervention
- Crisis Stabilization *

Massachusetts 1115 Waiver, State Plan (TCM)

Managed Care Entity Authorization Parameters for Services

CBHI Coordination and Governance
Maryland’s Public Behavioral Health System

- Maryland has an **1115 Waiver**, which creates the following structures for Medicaid service delivery:
  - HealthChoice—MCOs for somatic health and dental
  - Behavioral Health Carve-Out—Fee-For-Service
  - Administrative Service Organizations (ASO)—ValueOptions (new contract awarded in early 2015)
  - Maryland eligible youth are assessed for the fee for service PBHS and referred through the SPA. Access specialty services through the SPA.

- **Discretionary Funds (CME Only)**—General funds allocated per youth per day to support components of the Plan of Care not otherwise funded. (All State-only or grant funds)

- **Residential Services**
  - Medicaid funds inpatient or RTC stays (Medical Necessity)
  - Custodial agency funds group home or foster care placement, with some Medicaid reimbursement through the Rehab Option.

- **Behavioral Health Homes**—Designed around the population of adults with SPMI, although youth with SED can be served.

Role of the ASO

- Manage the Behavioral Health Carve-Out, which will include CCOs and providers of 1915(i) services.
- Deliverables related to the 1915(i) (per RFP) include:
  - Designate a staff member to be the liaison with responsibility for oversight and problem resolution.
  - Register providers of specialized services.
  - Review and authorize requests for specialized services.
  - Jointly determine with local mental health authorities medical eligibility for admission using needs-based eligibility criteria.
  - Ensure that POCs for each participant reflect all behavioral health services authorized and develop a mechanism to assure that participants are actively engaged in behavioral health treatment.
  - Conduct on-site audits of providers.

Proposed Services under the 1915(i)

Maryland has a robust public mental health system; these services will fill gaps in the current home- and community-based provider array:
- Care Coordination (provided by CCO who is a TCM Provider)
- Community-Based Respite Care
- Out-Of-Home Respite
- Mobile Peer Support
- Intensive In-Home Services (differentiated from Therapeutic Behavioral Services and from Psychiatric Rehabilitation Programs)
- Expressive & Experiential Behavioral Services (art, dance, drama, music, equine, horticultural)
- Customized Goods and Services

Eligibility and Authorization Process for Care Coordination Services

- For populations served by the CME, eligibility screenings are performed by referral sources (DHS, DHR, CSA, LCT, LMB, public local school systems)
  - After the referral source gatekeeper has determined that a youth is eligible and has referred the youth to the CME, the CME’s Clinical Director reviews the referral and authorizes enrollment.
- For the 1915(i) SPA, eligibility screenings are performed by the CCO based on Certificate of Need (CON) documents (psychiatric/psychosocial assessments). The clinical information will be compared to the MD Medicaid medical necessity criteria (MNC) for this level of care.
  - the ASO, in a team decision process with the CSA, will review the CON documents and complete a CASHI assessment. When the CON is determined to meet the MNC, the ASO authorizes all of the medically appropriate behavioral health services.
Interagency Coordination

- At the state level, the Children's Cabinet (which funds the CME) is chaired by the Executive Director of GOC and comprised of the Secretaries of the Departments of Budget and Management, Disabilities, Health and Mental Hygiene, Human Resource (child welfare), Juvenile Services, and the Superintendent of the Maryland State Department of Education
- At the practice level, the CME's program plan must:
  - Describe how it will develop or improve upon positive relationships the lead agencies (e.g., DSS, DJS)
  - Describe how it will enhance their current relationships with the direct services provider community to facilitate appropriate linkages and services to families
- CCOs and CMEs are required to commit to coordination with all agencies involved in the participant’s POC and work with the State and local child and family serving agencies to develop a network of clinical and natural supports in the community to address strengths and needs identified in each POC

Quality Monitoring/Evaluation in Louisiana

- National Wraparound Initiative Tools
- Wraparound Fidelity Index (WFI EZ):
  - Office of Behavioral Health is currently conducting the WFI EZ with all five Wraparound Agencies
- Document Review Measure (DRM):
  - SMO will use the DRM to compliment the WFI EZ with all five Wraparound Agencies
- Planned evaluation activities with University of Washington Wraparound Evaluation & Research Team

State Examples

*Evaluation, Quality Monitoring and Outcomes*

Tracking Outcomes in Louisiana

- Child and Adolescent Needs and Strengths Assessment (CANS) scores
- Out of Home placements
- Psychiatric Emergency Department utilization
- Inpatient Psychiatric utilization
- Home and Community Based Service utilization
- School suspensions and expulsions
- Costs
CANS Scores

Out of Home Placements (3/1/12 to 3/31/14)

- Percent of CSoC children and youth who had restrictive placements prior to enrollment in WAA: 31.4%
- Percent of CSoC children and youth place in restrictive placement after enrolling in WAA = 18.3%

CSoC Children Inpatient Psychiatric Utilization

Home and Community-Based Service Utilization

School Performance/Conduct (Suspensions and Expulsions)

School Performance Measures

*based on quarterly data reported by CSoC Wraparound agencies

CSoC Expenditures

Waiver Services and WAA Payments
CSoC Expenditures

What Have We Learned?

- The system of care model works
  - Less children in institutional care
  - Less children accessing inpatient treatment
  - Closure of state child psychiatric hospital and RTCs
  - Very few children in out-of-state facilities
  - Children in out-of-home care have more intense needs than prior to the system of care development
  - Wraparound works
  - Less youth in detention centers – many reasons, not necessarily because of the system of care
- Federal funding support under Title XIX

Evaluation Quality Monitoring

- All providers certified on CANS Tool
- Certification for BA and FSO
- Credentialing for IIC/IHH
- Utilization Management by CSA
- Contracting monitoring by CSOC
- Child Family Teams
- WFI is used by CMO’s
- Management by data

NJ Department of Children and Families
Fiscal Year 2014 $1.65 Billion
Overall Department Budget

NJ Department of Children and Families
Fiscal Year 2014 $498 Million
Children’s System of Care
A Continuum of Care: Mobile Response
Working hard to keep children & youth successfully at home & avoid hospitalization or placement.

Out of Home Treatment
Authorizations (which provide access to out of home care) is reduced due to more access and availability of community resources.

A Continuum of Care: Care Management Organization (CMO)
Serving over 10,000 children, with a focus on the high need youth and their families

A Continuum of Care: Mobile Response

Out of Home Treatment

A Continuum of Care: Out of Home Treatment
Currently, most youth receiving out of home treatment are adolescents

NJ DCF CHILDREN’S SYSTEM OF CARE (CSOC)
Authorized Out-of-State Placements
Number of youth in Out-of-State placements at the first of the month

Out of Home Authorizations—Unique Children
E Team - OU

- Measurement (E-TEAM) Department of the University of Oklahoma. The E-TEAM is a full service social research department with senior researchers, data analysts, technical writers, data base developers and managers, and a pool of research assistants representing decades of experience in all phases of research data processing and analysis. Belinda Biscoe Boni, Ph.D., Associate Vice President, Public and Community Services, at the University of Oklahoma, College of Continuing Education, is the Director of E-TEAM.

Youth Information System (YIS)

YIS provides a wide range of reports for use by managers, site personnel and community stakeholders also provides a wide range of reports for use by managers, site personnel and community stakeholders. YIS tracks the following:

- Process monitoring: Referrals, enrollments, discharges
- Flex fund expenditures
- Wraparound implementation
- Outcomes measures: periodic (6-month) assessments.

Outcomes

After Six months, SFY2013 (n=836)

- Reduced Days of Out-of-Home Placement 49%
- Reduced School Detentions 51%
- Reduced Number of Youths Self-Harming 42%
- Reduced Arrests 66%
- Reduced Contacts with Law Enforcement 51%
- Reduced Days Absent from School 46%
- Reduced Days Suspended from School

Massachusetts Quality/Fidelity Monitoring

- Wraparound Fidelity Assessment System - MA WFAS (NWI)
  - Wraparound Fidelity Index (WFI 4) – initially
  - Wraparound Fidelity Index Parent/Caregiver
  - Treatment Observation Measure (TOM)
  - Document Review Measure (DRM) - initially
- MCE Medical Record Review (standardized tool)
- System of Care Practice Review - SOCPR (USF)
Massachusetts Outcomes Tracked

Multiple process variables including:
• Utilization of:
  • Mobile Crisis Intervention
  • Inpatient Psychiatric
  • Home and Community Based Services
• Out of Home placements
• Costs

Outcomes & Evaluation

• Fidelity and quality of the CME is monitored by The Institute at UMSSW under contract with GOC.
• The Institute utilizes the WFI-EZ, COMET, TOMS, IOTTA, California Health Kids Survey - Resilience & Youth Development Module, and Family Empowerment Scale data from the families being served to monitor and measure ICC/Wraparound quality and fidelity.
• Use of TMS WrapLogic will support the fidelity monitoring and the additional data collection.
• Resiliency measures are incorporated into the WFI process as part of CHIRPA.
• Outcomes related to clinical and functional status and cost are being assessed, both independently and through the use of an administrative comparison group.

Reasons for Discharge from the CME: July to December, 2013


Semi-Annual Trend in Successful Completions: July, 2012 to December, 2013

Wraparound Fidelity Index – Short Term (WFI-EZ)

Decisions about service are based on input from youth and family.
Family is part of a team including more than just family and one professional.
Family and team created a written plan that describes what will happen and how it will happen.
Team meets regularly (at least every 30-45 days).


Additional CME Outcomes

- 75% of youth discharged to a stable, non-restrictive living situation (parent or relative's home, regular foster home, adoptive home, or living independently) during the first and second quarters of FY14. This is an increase from the previous reporting period (68%) and the first and second quarters of FY13 (63%).
- The number of CANS Needs items on which youth demonstrated need for intervention (score of 2 or 3) at discharge has remained consistently low, with an average of 5.5 (sd=5.70) out of 41 items during the first and second quarters of FY14.
- These continued improvements in youth outcomes may reflect Maryland Choices, LLC adapting to the demands of serving as Maryland’s single Statewide CME provider and working on ways to improve its implementation of the Wraparound model over the past 18 months.

Costs of Care: Results from MD’s PRTF Demonstration

- Youth enrolled in the PRTF Demonstration Grant and served by the CME had an average per member, per year cost of care of $32,987 (Medicaid costs only; n=174).
- Youth enrolled in a PRTF during the same time (not served by the CME) had an average per member, per year cost of care of $153,417 (Medicaid costs only; n=1,119).
- These costs include the capitated MCO rate, medications, inpatient hospitalizations, oral health care, home health services, and all services covered by Medicaid.

Federal Medicaid Guidance

7/12/13 State Medicaid Directors’ Tri-Agency Letter on Trauma-Informed Treatment
7/12/13 Informational Bulletin on Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions
7/12/13 Informational Bulletin on Prevention and Early Identification of Mental Health and Substance Use Conditions
8/24/12 Informational Bulletin on Resources Strengthening the Management of Psychotropic Medications for Vulnerable Populations
11/21/11 State Medicaid Directors Tri-Agency Letter on Appropriate Use of Psychotropic Medications Among Children in Foster Care

Resources

Faces of Medicaid: Examining Children’s Behavioral Health Service Utilization and Expenditure
http://www.r4c.org/publications/257/download?item_id=9032753
Making Medicaid Work for Children in Child Welfare: Examples from the Field
Innovating Health Home for Children with Serious, High-risk Challenges
http://www.r4c.org/sf-doc/Innovating_Health_Home_for_Children_with_Serious_High-risk_Challenges.pdf
Psychotropic Medications Quality Improvement Collaboration: Improving the Use of Psychotropic Medications Among Children in Foster Care
http://www.r4c.org/sf-doc/Avoiding_Psychoactive страшная façon de vie: Item ID=1642120
CUMPA Care Management Quality Collaborative
http://www.r4c.org/SF-Doc/1656124/1656124.pdf
Return on Investment in Systems of Care Children with Behavioral Health Challenges
Massachusetts CBH website: www.mass.gov/health/children/behavioralhealth
Kaiser D. O. Patrick (United States District Court, District of Massachusetts, Civil Action Number 03-CVS-MAAP
National Wraparound initiative website: www tờ-rc.org/care
Building Systems of Care A Primer, 2nd edition
http://psulfid.georgetown.edu/72377.html

For further information, contact:

Shelia A. Rice, Director Human Services Collaboration snierson@comcast.net
Judy Loven-Akesson Deputy Assistant Secretary Office of Behavioral Health 225.242.6522 jloven@com.gov
Michelle Zabel, Director The Institute for Innovation & Implementation mzb@ssw.umaryland.edu
Oriole B. Patrick (United States District Court, District of Massachusetts, Civil Action Number 03-CVS-MAAP
National Wraparound initiative website: www.tor-rc.org/care
Building Systems of Care A Primer, 2nd edition http://psulfid.georgetown.edu/72377.html
sd = standard deviation? spell?
Taylor Hendricks, 6/26/2014