Medicaid Reimbursement for Wraparound Care Coordination for Children and Youth with Complex Behavioral Health Needs

national wraparound initiative

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Policy Statement and Recommendations to the Centers for Medicare & Medicaid Services (CMS) from the National Wraparound Initiative

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Background

Over the past two decades in particular, the children's services field has made significant advances in determining and supporting best practices for serving the 6 to 8 million children and youth with "serious emotional disturbance" (SED). Children and youth with SED typically present with multiple mental health diagnoses, academic challenges, and family stressors, such as poverty and parental mental health and substance abuse problems.

Although the evidence base for children's behavioral health treatments is expanding, the complexity of the challenges faced by these youth and families often means they are unlikely to respond to any single evidence-based intervention. In addition, two thirds of these youth are involved in multiple child-serving systems (e.g., child welfare, juvenile justice); as a result, coordination of care is necessary to ensure that needs are well prioritized; treatments and other strategies are holistic and matched to needs; families are fully engaged with helpers; and planning is well coordinated so that the fragmented nature of systems does not result in gaps in service, duplication of effort, and/or confusion.

Without community-based care coordination that is intensive, team based, and well implemented, these children and youth are at much greater risk of a disruptive or costly long-term out-of-home placement in settings such as psychiatric inpatient facilities or residential treatment centers. Not only is the evidence base for treatments provided in these settings weak, placements such as residential treatment account for the largest portion of service costs for this population.

The Wraparound Practice Model

Wraparound is a service planning and care coordination approach that is based on a team approach and supports development and implementation of a strengths-based, integrated service plan. For children with serious behavioral health conditions, Wraparound service planning is often conducted by care managers with low caseload ratios (e.g., 1:8-10). Wraparound is included as an effective practice in the recent CMS Invitation to Apply for child health quality improvement grants authorized by the CHIPRA Reauthorization Act. The National Wraparound Initiative (NWI) is currently working to have Wraparound listed in SAMHSA's *National Registry for Effective Practices and Programs (NREPP)*.

Model adherent wraparound aims to achieve positive outcomes by providing a structured,

creative and individualized team planning process that, compared to traditional treatment planning, results in plans that are more effective and efficient and more relevant to the child and family. Wraparound is more intensive than traditional case management or care coordination. The level of effort applied by the wraparound care coordinator is applied to gaining adequate understanding of the child and his/her family, engagement, planning, follow through, and progress monitoring. Wraparound plans are more holistic than traditional care plans in that they address and coordinate behavioral health and other identified needs of the child and his/her family. Through the team-based planning and implementation process, Wraparound also aims to develop the problem-solving skills, coping skills, and self-efficacy of the young people and their family members. Finally, there is an emphasis on integrating the youth into the community and building the family's social support network.

Wraparound Organizational Supports through a Care Management Entity

The Center for Medicare and Medicaid Services (CMS) currently is funding a demonstration of the Wraparound approach through a Care Management Entity provider model. Care Management Entities (CMEs) are public or, more typically, private non-profit behavioral health organizations that serve as a locus of accountability for managing the care of high-utilizing Medicaid populations of children with significant behavioral health challenges. Wraparound Milwaukee is one of the oldest examples (and the 2009 recipient of Harvard's Innovations in Government Award).

CMEs employ a high quality Wraparound approach, intensive care coordinators, and strong clinical supervision to ensure access to a broad array of services and supports, including peer and natural supports, and manage utilization, quality and outcomes at the child and family level. They are often financed through a case rate and draw on multiple funding sources, including Medicaid. Various Medicaid options and provisions are used by CMEs, including 1915 a (as in Wisconsin and Ohio) and Targeted Case Management (as in New Jersey and Massachusetts). CMEs typically utilize web-based, real-time data systems with electronic service record capability.

Research on Wraparound and Care Management Entities

Research shows that intensive care coordination delivered via Wraparound is an effective method for serving youth with serious behavioral health challenges. To date, results of 8-10 (depending on criteria used) controlled (experimental and quasi-experimental) studies have been published in the peer-reviewed literature. A recently published meta-analysis of seven of these studies shows consistent and significant outcomes in favor of the Wraparound group compared to control groups across a wide range of outcomes domains, most prominently residential placement, but also mental health outcomes, school success, and juvenile justice recidivism.

Meanwhile, several states and large jurisdictions have found impacts on residential and cost outcomes. Wraparound Milwaukee has reduced psychiatric hospitalization from an average of 5000 to less than 200 days annually, and has reduced its average daily residential treatment facility population from 375 to 50. New Jersey estimates it has saved over $30 million in inpatient psychiatric expenditures over the last three years. A new policy study by the State of Maine has found reductions of 30% in total Medicaid spending among youth served via its Wraparound Maine initiative. The reduction of expenditures for youth enrolled in Wraparound Maine was driven by a 43% reduction in psychiatric inpatient treatment and a 29% reduction in residential treatment.

Current Reimbursement and Payment Mechanisms

Two aspects of Wraparound that pose challenges for states in terms of Medicaid coverage

are *team planning* and *intensive care coordination*. Medicaid providers who operate on a cost reimbursable basis need to be able to bill for their time participating in a Wraparound service planning meeting for an eligible child. Only a handful of states currently allow for billing for participation in team meetings. Wraparound team meetings often require the presence of several Medicaid reimbursed providers (e.g., psychiatrist, social worker, family support providers, etc.) at one meeting in one physical location. While payment of more than one provider at one time may be allowable under current CMS policy, most states are not allowing for reimbursement for more than one provider, and generally that is the provider with the lowest rate. A clinician on a child's team who will not be reimbursed for her time at a team meeting is simply not going to attend that meeting.

More states could be using Targeted Case Management (TCM) to pay for intensive care coordination for eligible children involved in Wraparound, but the prior Administration's stance regarding TCM has discouraged states from pursuing this option. This is unfortunate, because the intensity of conducting wraparound care coordination is substantial and requires appropriate reimbursement options. Care coordinators in a CME/Wraparound model work with small numbers of children, are charged with mobilizing service planning/revision teams as often as needed, with being on call 24/7, with seeing children and families frequently, and with monitoring utilization, cost and outcomes at the individual child level.

Similarly, the per-member per-month rates for a CME/Wraparound model are significantly higher than, for example, Managed Care Organization care coordination rates. For example, Wisconsin Medicaid pays Wraparound Milwaukee about $1,500 per Medicaid child enrollee. The cost-benefit of allowing this level of payment is that CMEs using Wraparound are averaging monthly costs significantly less than the costs of Psychiatric Residential Treatment Facilities paid for by Medicaid, for example, or inpatient psychiatric hospitalization. In addition, the prior Administration's discouragement of use of case rates or bundled rates has left states unclear about their use for Care Management Entities employing a Wraparound and intensive care coordination approach.

Recommendations for CMS:

1. **Issue clarification to states on billing for providers in team meetings.**

Medicaid rules on team planning should be clarified to reinforce that states are allowed to reimburse all the necessary providers on the team for their time, or, alternatively, to establish a single rate to community provider agencies for team planning meetings (based on a reasonable assumption about the number of providers who typically are involved). This clarification also should address whether the identified child must be present at team meetings; for very young children, this may be unnecessary.

2. **Clarify the allowability of a bundled rate for intensive care coordination and model-adherent Wraparound.**

States using comprehensive evidence-based and best practices that incorporate a range of separate Medicaid-covered interventions should be able to negotiate bundled payment rates with providers. This will reduce unnecessary administrative burden and encourage providers to offer the right service at the right time on an individualized basis. Case rates should be based on realistic estimates of cost and utilization of the covered services and be available on a daily, weekly or monthly-rate basis.

Previous pronouncements from CMS on the need for all case management services to be billed in 15-minute increments has led to ongoing confusion in Regional Offices and states with respect to billing for both Targeted Case Management and rehabilitation services. Many states were directed by their Regional Offices to shift to 15-minute increments for both these services. Since these are not traditional "medical" services, they need not be billed like

traditional medical services. In fact, doing so will only increase the cost of the service, and may limit the number of providers willing to provide the service due to unrealistic and burdensome paperwork requirements.

3. **Issue clarification to states on the use of Targeted Case Management for children with serious behavioral health challenges.**

Confusion around Targeted Case Management and a crackdown under the previous administration has led states to be extremely skittish about the use of this category. States should be encouraged to consider the use of TCM to support intensive care coordination, particularly as utilized in a Wraparound approach, for children with serious behavioral health challenges, including for children with these disorders who are involved in child welfare, juvenile justice and special education systems. The clarification needs to address that the determinant for eligibility for, or exclusion from, TCM is not the child's system involvement but the presence of a serious behavioral health condition.

4. **Consider the use of Care Management Entities as health homes for children.**

The goals and functions of CMEs are consistent with those of ***health homes*** as described in the Affordable Care Act, including: comprehensive care management; care coordination and health/behavioral health promotion; transition care across multiple settings; individual and family support services; and linkage to social supports and community resources. Health homes, like CMEs, focus on improving the quality and cost of care for populations with serious and persistent mental illness and those with one or more chronic conditions (e.g., a mental health condition). As such, CMEs can be conceptualized as *customized* or *specialized* health homes for children and youth with severe behavioral health needs.

CMS has delayed release of regulatory language for health homes so that it may engage in rapid learning activities with other federal partners and stakeholders to prepare for the release of well-informed regulations on health homes. With opportunities in Section 2703 of the Affordable Care Act for states to provide health homes for Medicaid enrollees with one or more chronic conditions or serious and persistent mental illness and added federal support to enhance integration and coordination of primary, acute and behavioral health, ***this is an optimal time to consider the similarities between CMEs and health homes and the potential for CMEs to become health homes for children and youth with severe behavioral challenges.***

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