NWI webinar starting soon!

In the meantime, please note…

- Move any electronic handheld devices, especially cell phones, away from your computer and speakers.
- We recommend that you close all file sharing applications and streaming music or video.
- Check your settings in the audio pane if you are experiencing audio problems.
- During the presentation, you can send questions to the webinar organizer, but these will be held until the end.

We encourage you to become a member of the National Wraparound Initiative at www.nwi.pdx.edu

*This webinar and the powerpoint will be available on the NWI website.

national wraparound initiative

national wraparound initiative

National Wraparound Initiative Webinar Series

Using Medicaid Health Homes with Wraparound to Serve Youth Populations with Complex Behavioral Health Needs

January 22, 2013

Presenters:

Eric J. Bruns- University of Washington School of Medicine/NWI
Sheila A. Pires- Human Service Collaborative
Dayana Simons- Center for Health Care Strategies

national wraparound initiative

www.nwi.pdx.edu

national wraparound initiative

The New York Times

The Opinion Pages

WORLD U.S. N.Y. / REGION BUSINESS TECHNOLOGY SCIENCE HEALT

EDITORIAL

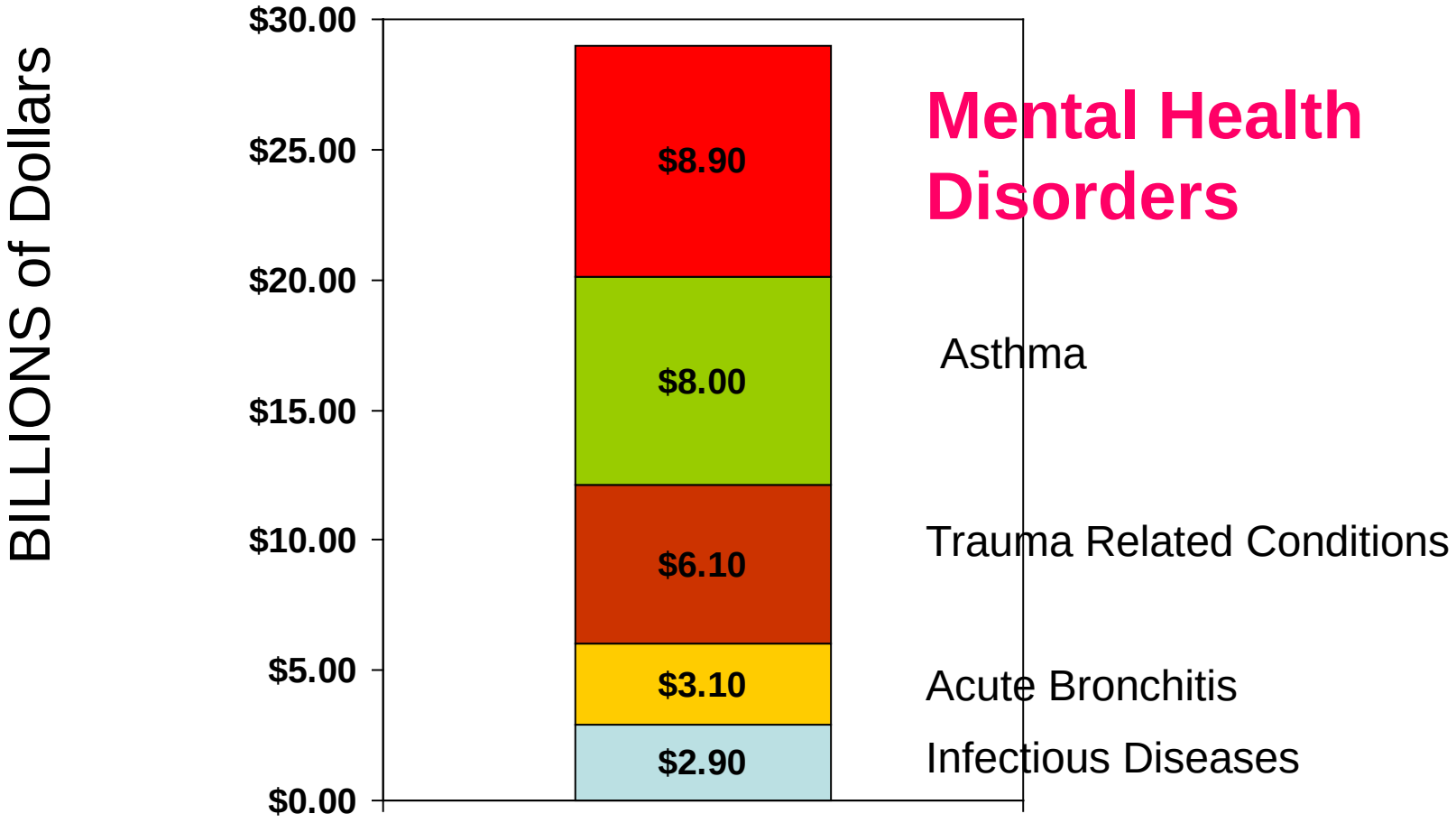
Waste in the Health Care System

Published: September 10, 2012

A new report from a panel of experts convened by the Institute of Medicine estimated that roughly 30 percent of health care spending in 2009 — around $750 billion — was wasted on unnecessary or poorly delivered services and other needless costs. Lack of coordination at every point in the health care system is a big culprit.

The panel cited studies showing that

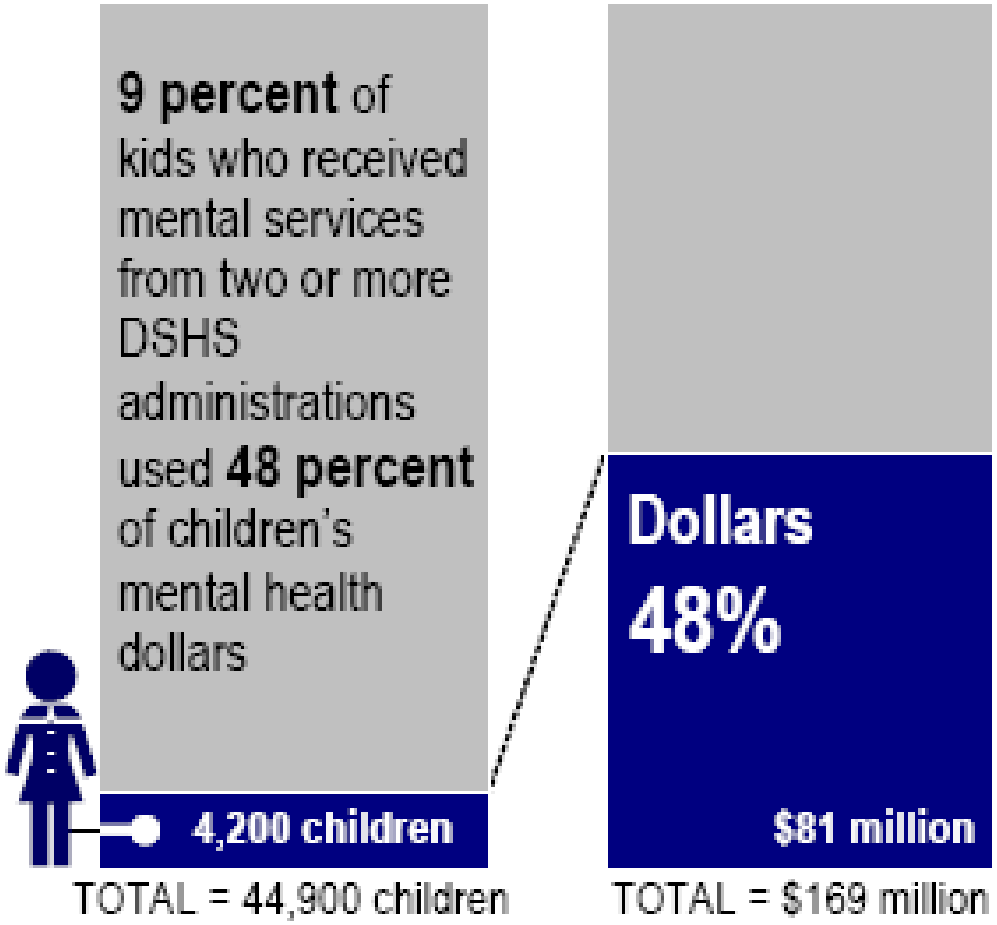
Mental health is the costliest health condition of childhood



Soni, 2009 (AHRQ Research Brief #242)

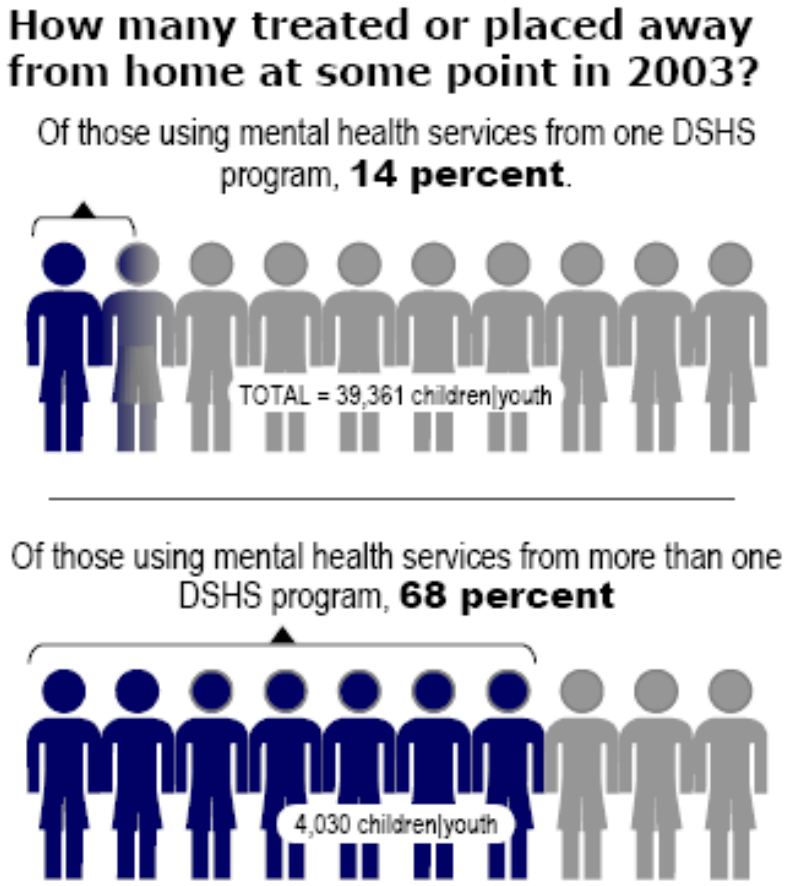
national wraparound initiative

Washington State (RDA, 2004)
The 9% of youths involved with multiple systems consume 48% of all DSHS and HCA resources



national wraparound initiative

Washington State (RDA, 2004)
68% of youths involved in multiple systems are placed out of home in a given year



national wraparound initiative

Why are outcomes so poor and costs so high?

- Child and family needs are complex
  - Youths with serious EBD typically have multiple and overlapping problem areas that need attention
  - Families often have unmet basic needs
  - Traditional services don't attend to health, mental health, substance abuse, and basic needs holistically
    - Or even know how to prioritize what to work on

national wraparound initiative

Why are outcomes so poor and costs so high?

- Families are rarely fully engaged in services
  - They don't feel that the system is working for them
  - Leads to treatment dropouts and missed opportunities

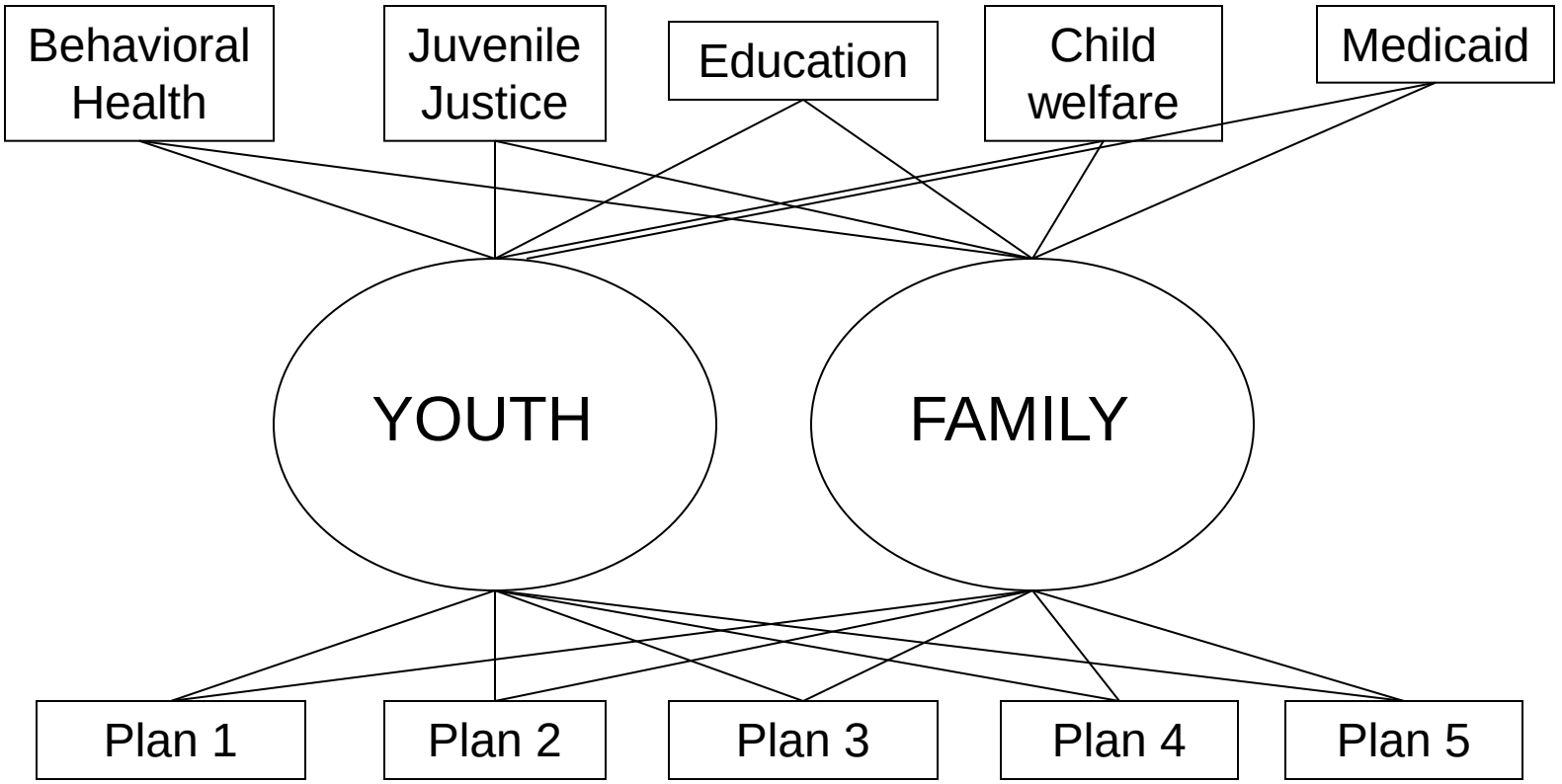
national wraparound initiative

Why are outcomes so poor and costs so high?

- Systems are in “silos”
- Systems don’t work together well for individual families unless there is a way to bring them together
  - Youth get passed from one system to another as problems get worse
  - Families relinquish custody to get help
  - Children are placed out of home

national wraparound initiative

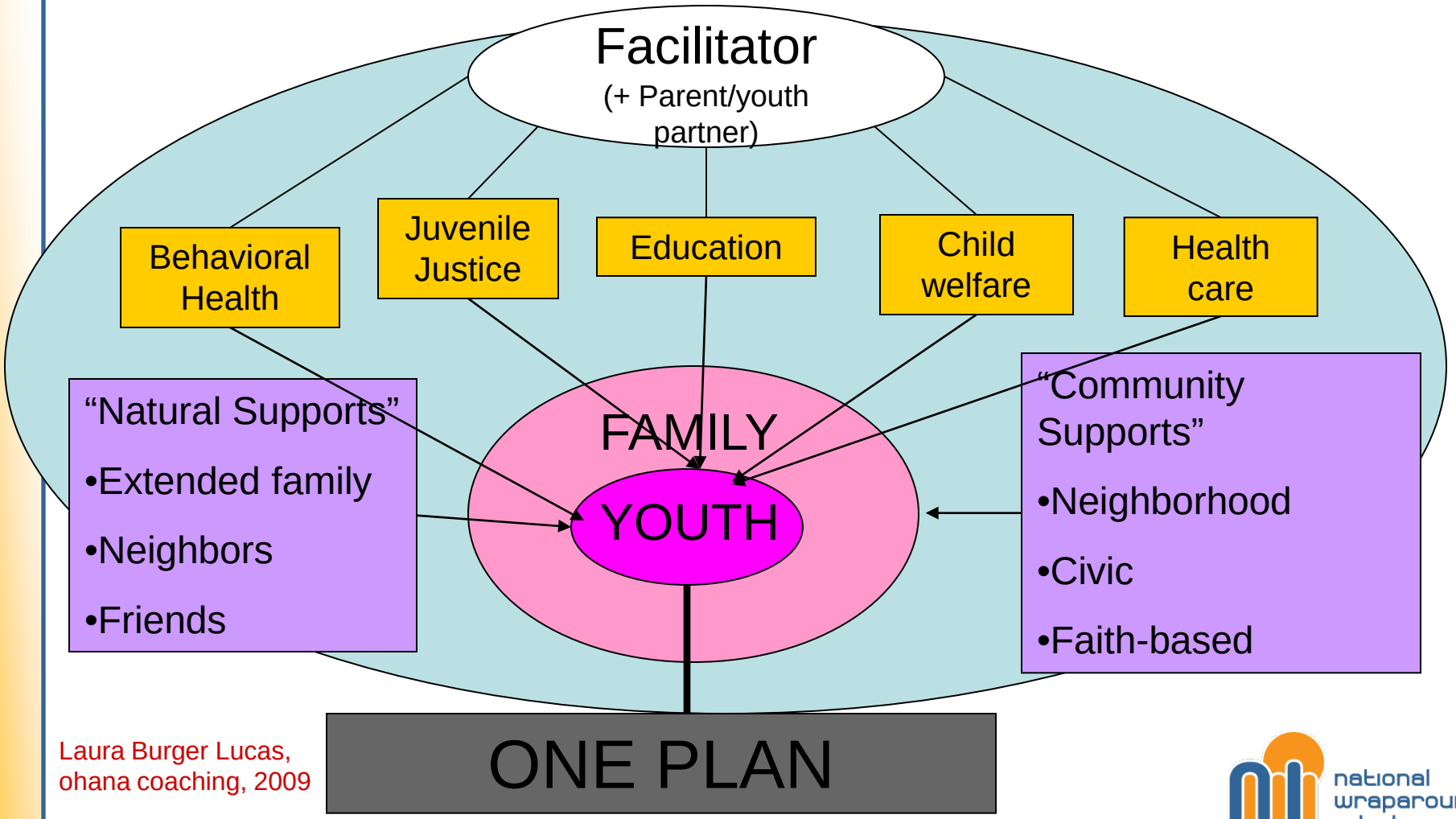
The silo issue: Traditional services rely on professionals and result in multiple plans



Laura Burger Lucas, ohana coaching, 2009

national wraparound initiative

In wraparound, a facilitator coordinates the work of system partners and other natural helpers so there is one coordinated plan



Laura Burger Lucas, ohana coaching, 2009

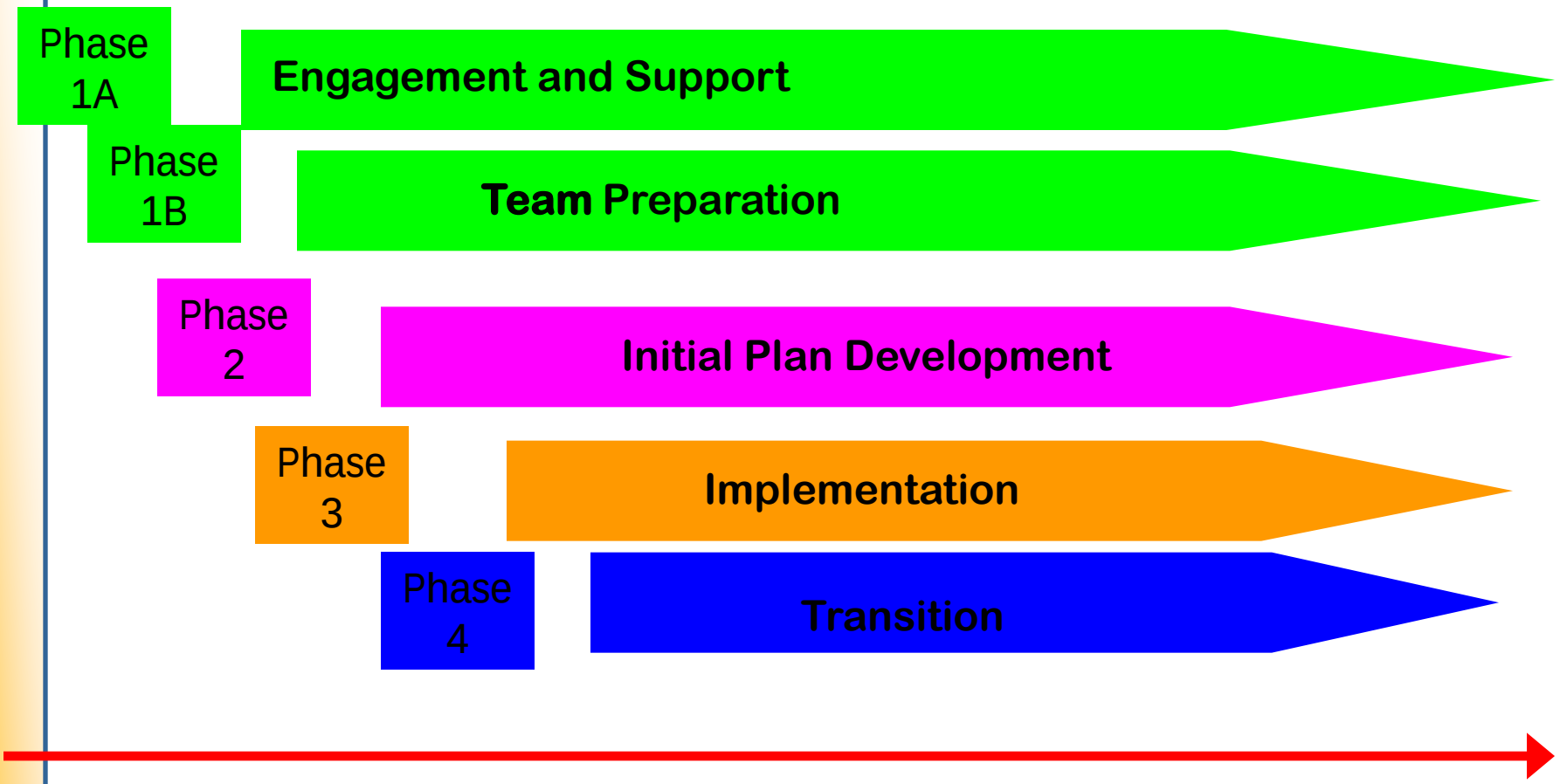
national wraparound initiative

Important points about the wraparound process

- Wraparound is a defined, team-based service planning and coordination process
- The Wraparound process ensures that there is one coordinated plan of care and one care coordinator
- Wraparound is not a service per se, it is a structured approach to service planning and care coordination
- The ultimate goal is both to improve outcomes and per capita costs of care

national wraparound initiative

A practice model:
The Four Phases of Wraparound



national wraparound initiative

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
- A whole youth and family focus
- A focus on developing optimism and self-efficacy
- A focus on developing enduring social supports

national wraparound initiative

Core components of the wraparound theory of change

- Services and supports ***work better***:
  - Focusing on priority needs as identified by the youth and family
  - Creating an integrated plan
  - Greater engagement and motivation to participate on the part of the youth and family
- The process ***builds family capacities***:
  - Increasing self-efficacy (i.e., confidence and optimism that they can make a difference in their own lives)
  - Increasing social support

national wraparound initiative

Does wraparound work? Evidence from Nine Published Controlled Studies is Positive

Study	Target population	Control Group Design	N
1. Hyde et al. (1996)*	Mental health	Non-equivalent comparison	69
2. Clark et al. (1998)*	Child welfare	Randomized control	132
3. Evans et al. (1998)*	Mental health	Randomized control	42
4. Bickman et al. (2003)*	Mental health	Non-equivalent comparison	111
5. Carney et al. (2003)*	Juvenile justice	Randomized control	141
6. Pullman et al. (2006)*	Juvenile justice	Historical comparison	204
7. Rast et al. (2007)*	Child welfare	Matched comparison	67
8. Rauso et al. (2009)	Child welfare	Matched comparison	210
9. Mears et al. (2009)	MH/Child welfare	Matched comparison	121

*Included in 2009 meta-analysis (Suter & Bruns, 2009)

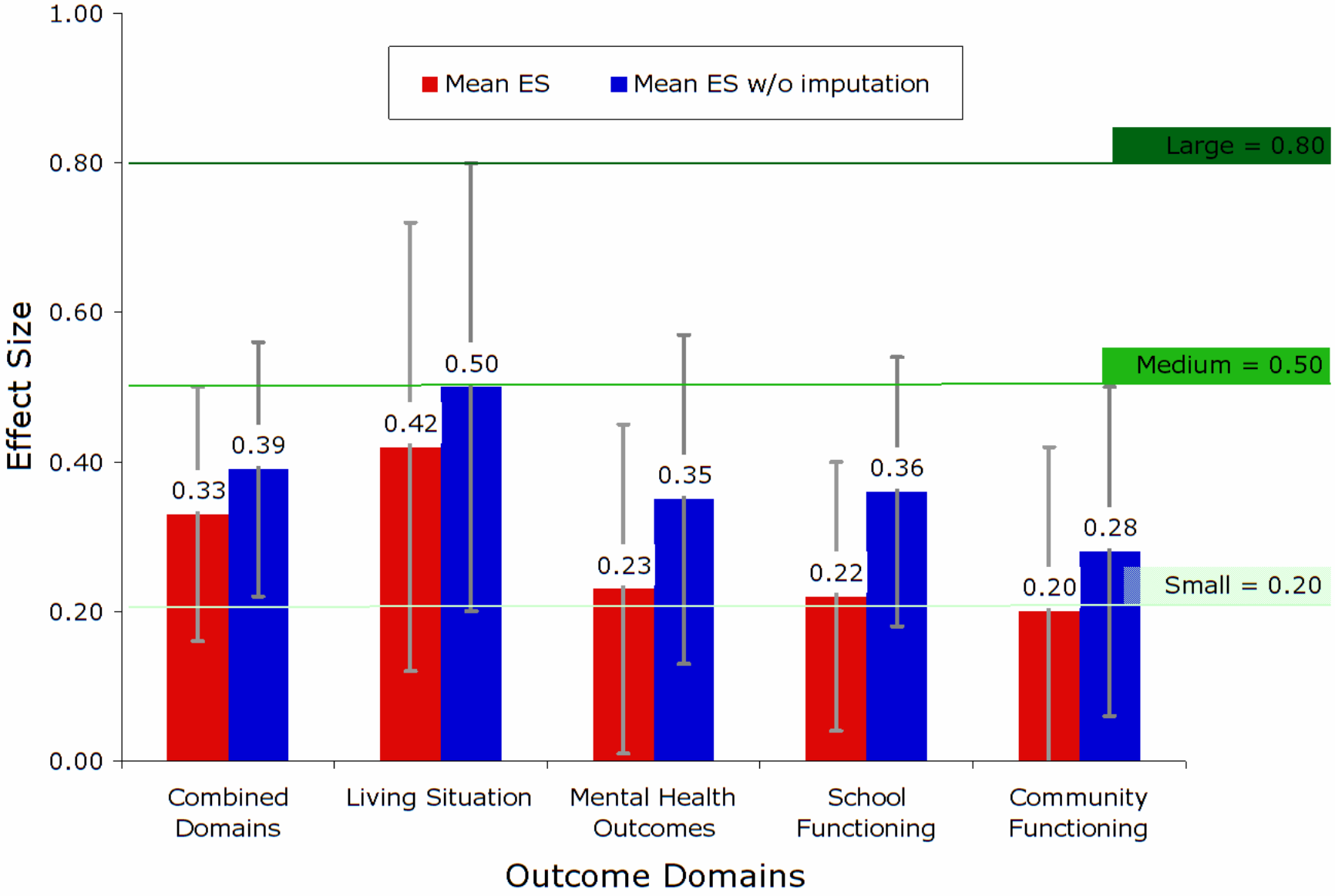
national wraparound initiative

Outcomes of wraparound (9 controlled, published studies to date; Bruns & Suter, 2010)

- Better functioning and mental health outcomes
- Reduced recidivism and better juvenile justice outcomes
- Increased rate of case closure for child welfare involved youths
- Reduction in costs associated with residential placements

national wraparound initiative

Effects of Wraparound are Significant



Costs and residential outcomes are particularly robust

- Wraparound Milwaukee reduced psychiatric hospitalization from 5000 to less than 200 days annually
  - Also reduced average daily residential treatment facility population from 375 to 50 (Kamradt & Jefferson, 2008).
- Controlled study in Massachusetts found 32% lower emergency room expenses and 74% lower inpatient expenses than propensity score matched youths in "usual care''.
  - Intervention youth spent 88% of days at home and showed improved clinical functioning on standard measures.

national wraparound initiative

Costs and residential outcomes are particularly robust

- New Jersey saved over $30 million in inpatient psychiatric expenditures over the last three years (Hancock, 2012).
- State of Maine reduced net Medicaid spending by 30%, even as use of home and community services increased
  - 43% reduction in inpatient and 29% in residential treatment expenses (Yoe, Bruns, & Ryan, 2011)
- Los Angeles County DSS found 12 month placement costs were $10,800 for Wraparound-discharged youths compared to $27,400 for matched group of RTC youths

national wraparound initiative

CMS Psychiatric Residential Treatment Facility (PRTF) Waiver Demonstration project

- Evaluation compared home- and community-based services (implemented using wraparound) PRTF.
- “Across all state grantees over the first three waiver years, youths maintained or improved their functional status while services cost substantially less than institutional alternatives.
- “In most cases, waiver costs were around 20 percent of the average per capita total Medicaid costs for services in institutions from which enrolled youths were diverted”
- Average per capita saving by state ranged from $20,000 to $40,000 (Urdapilleta et al., 2011).

national wraparound initiative

Wraparound is increasingly considered “evidence based”

- Under review by SAMHSA National Registry of Effective Practices and Programs (NREPP)
- State of Oregon Inventory of EBPs
- California Clearinghouse for Effective Child Welfare Practices
- Washington Institute for Public Policy: “Full fidelity wraparound” is a research-based practice

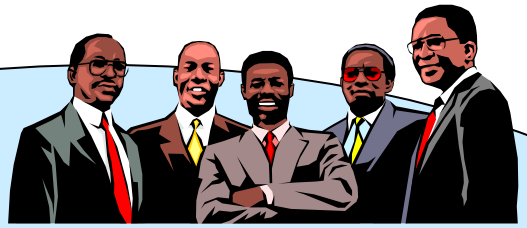
national wraparound initiative

"Full fidelity" is critical to achieving positive outcomes

- Research shows
  - Provider staff whose families experience better outcomes score higher on fidelity tools (Bruns, Rast et al., 2006)
  - Wraparound initiatives with positive fidelity assessments demonstrate more positive outcomes (Bruns, Leverentz-Brady, & Suter, 2008)
- Much of wraparound implementation is in name only
  - Don't invest in workforce development such as training and coaching to accreditation
  - Don't follow the research-based practice model
  - Don't monitor fidelity and outcomes and use the data for CQI
  - Don't have the necessary support conditions to succeed (e.g., fiscal supports, comprehensive service array)

national wraparound initiative

Wraparound implementation requires organizational, system, and funding supports



Hospitable System *Funding, Policies

Supportive Organizations

* Training, supervision, interagency coordination and collaboration

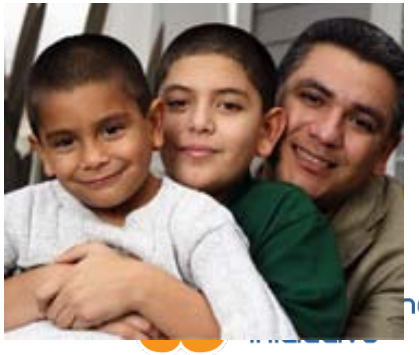
Effective Team

* Process + Principles

national wraparound initiative


7500


Pastor, Priest or Rabbi
Teacher
Therapist
Family or Youth Partner (Peer Support)
Youth
Parents
Aunt/Uncle
Care Coordinator
Neighbor or Friend
Coach
Psychiatrist



National Wraparound Initiative Webinar Series

Using Medicaid Health Homes with Wraparound to Serve Youth Populations with Complex Behavioral Health Needs

Sheila A. Pires, M.P.A.
Human Service Collaborative
Washington, D.C.

January 22, 2013

Section 2703, Patient Protection and Affordable Care Act

Provisions

- Authorizes health home services for Medicaid enrollees *with chronic conditions*
- Authorizes 90% Federal match for 1st eight quarters
- Designed to facilitate access to and coordination of physical and behavioral health care and long term community-based services and supports
- Goal of improving the quality and cost of care and enrollee's experience with care

Health Home Eligibility

- At least two chronic conditions, or
- One chronic condition and at risk for another, or
- One serious and persistent mental health condition

➢ Can target health home services to those with particular chronic conditions or with higher severity of chronic condition, *but cannot target by age*

➢ *Medicaid comparability is waived* – can offer health home services in a different amount, duration and scope than offered to individuals not in health home and *can target by geographic area*

Health Homes vs. Medical 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 (i.e. not only medical)

Analysis of Medical Home Services for Children with Behavioral Health Conditions*

"All behavioral health conditions except ADHD associated with difficulties accessing specialty care through 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".

Sheldrick, RC & Perrin, EC. "Medical home services for children with behavioral health conditions". *Journal of Developmental Pediatrics*, 2010 Feb-Mar 31 (2) 92-9

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

✓ Children with SED do not have the same high rates of co-morbid physical health conditions as adults with SPMI

✓ Children, for the most part, have different mental health diagnoses from adults with SPMI (ADHD, Conduct Disorders, Anxiety; not so much Schizophrenia, Psychosis, Bipolar as in adults)

✓ Among children with serious behavioral health challenges, two-thirds are also involved with child welfare and/or juvenile justice systems and 60% may be in special education – governed by legal mandates

✓ Coordination with other children's systems – child welfare, juvenile justice, schools – and among behavioral health providers consumes most of care coordinator's time, not coordination with primary care

✓ To improve cost and quality of care, focus must be on child and family/caregiver(s)

Pires, S. 2012. Human Service Collaborative

Children in Medicaid Who Use Behavioral Health Care Are an Expensive Population

- *Estimate*: 9.6% of children in Medicaid who used behavioral health care in 2005 accounted for 38% of all spending for children in Medicaid
  - Based on: 1.2M children with FFS expenditure data

Caveats:

- FFS expenditure data applied to children in capitated managed care arrangements
- Expenditures might be less in managed care

Pires, SA, Grimes, KE, Allen, KD, Gilmer, T, Mahadevan, RM. 2013. (in press) *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures*. Center for Health Care Strategies: Hamilton, NJ

Mean Health Expenditures for Children in Medicaid Using Behavioral Health Care*, 2005

	All Children Using Behavioral Health Care	TANF	Foster Care	SSI/Disabled**	Top 10% Most Expensive Children Using Behavioral Health Care***
Physical Health Services	$3,652	$2,053	$4,036	$7,895	$20,121
Behavioral Health Services	$4,868	$3,028	$8,094	$7,264	$28,669
Total Health Services	$8,520	$5,081	$12,130	$15,123	$48,790

* Includes children using behavioral health services who are not enrolled in a comprehensive HMO, n = 1,213,201

** Includes all children determined to be disabled by SSI or state criteria (all disabilities, including mental health disabilities)

***Represents the top 10% of child behavioral health users with the highest mean expenditures, n = 121,323

Behavioral Health Expenditures by Service Type

Top Three Highest Expenditure Services

- **Residential treatment and therapeutic group homes** account for largest percentage of total expenditures – 19.2% of all expenditures for 3.6% of children using behavioral health services

- Outpatient treatment second highest – 16.5% of all expenditures for 53.1% of children using behavioral health services

- **Psychotropic medications** third highest – 13.5% of all expenditures for 43.8% of children using behavioral health services
  - *Total Medicaid expense for child and adolescent psychotropic medication use in 2005 was **$1.6b, with 42% of expense represented by anti-psychotic use***

Pires, SA, Grimes, KE, Allen, KD, Gilmer, T, Mahadevan, RM. 2013. (in press) *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures*. Center for Health Care Strategies: Hamilton, NJ

*Customizing Health Home Approaches for Children with Serious Behavioral Health Challenges Using High Quality Wraparound and Intensive Care Coordination

*State may submit one HH State Plan Amendment that incorporates distinct approaches for adults with SMI and for children with SED, *or*

*State may submit two separate HH SPAs – one for adults with SMI and one for children with SED – but clock starts on 90% Federal match with first one approved

CMS-Funded CHIPRA Quality Collaborative on Care Management Entities (Maryland, Georgia, Wyoming)

What is a Care Management Entity?

An organizational entity – such as a non profit organization* - that serves as *the* "locus of accountability" for defined populations of youth with complex challenges and their families who are involved in multiple systems

Is accountable for improving the quality, outcomes and cost of care for populations historically experiencing high-costs and/or poor outcomes

*Could also be a high quality wraparound team embedded in a supportive organization (e.g. Oklahoma)

Pires, S. 2010. Human Service Collaborative

Care Management Entity Functions

At the Service Level:

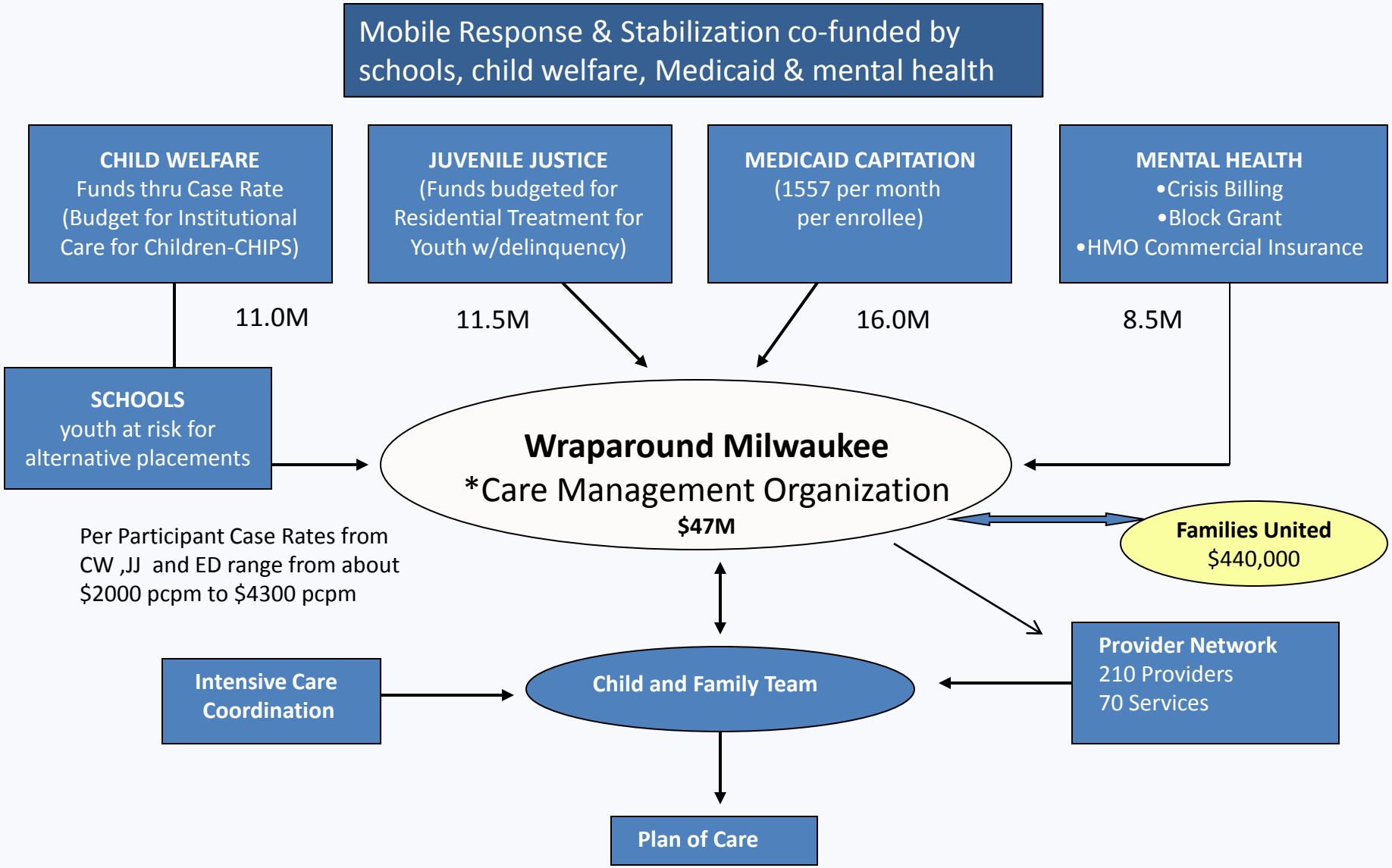
- Child and family team care planning and oversight using high quality Wraparound practice model
- Screening, assessment, clinical oversight
- Intensive care coordination at low ratios (1:8-10)
- Care monitoring and review
- Peer support partners
- Access to mobile crisis supports

At the Administrative Level (directly or in partnership):

- Information management – real time data; web-based IT
- Provider network recruitment and management (including natural supports)
- Utilization management
- Continuous quality improvement; outcomes monitoring
- Training

Pires, S. 2010. Human Service Collaborative

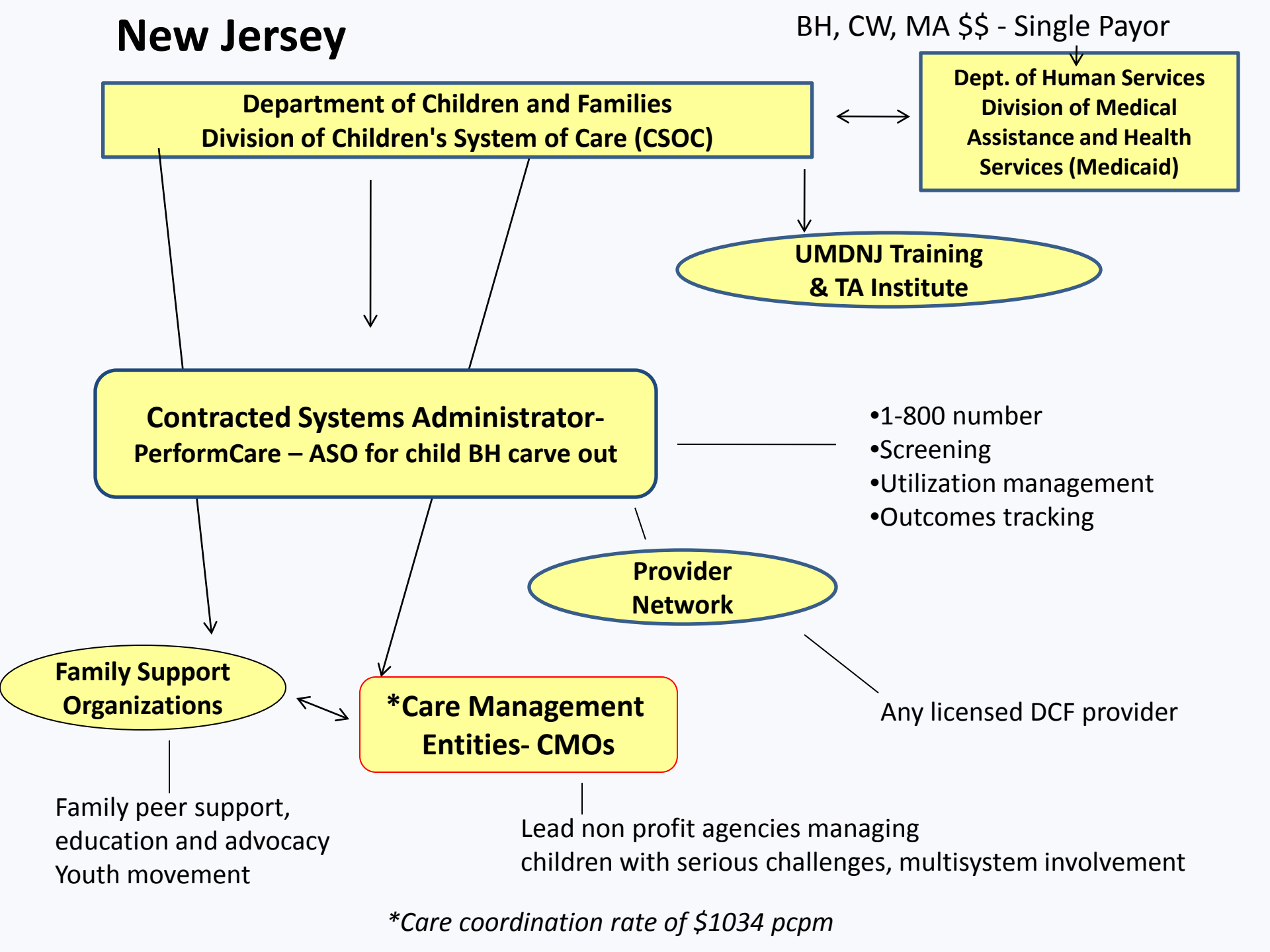
Wraparound Milwaukee (1915 a)



**All inclusive rate (services, supports, placements, care coordination, family support) of $3700 pcpm; care coordination portion is about $780 pcpm*

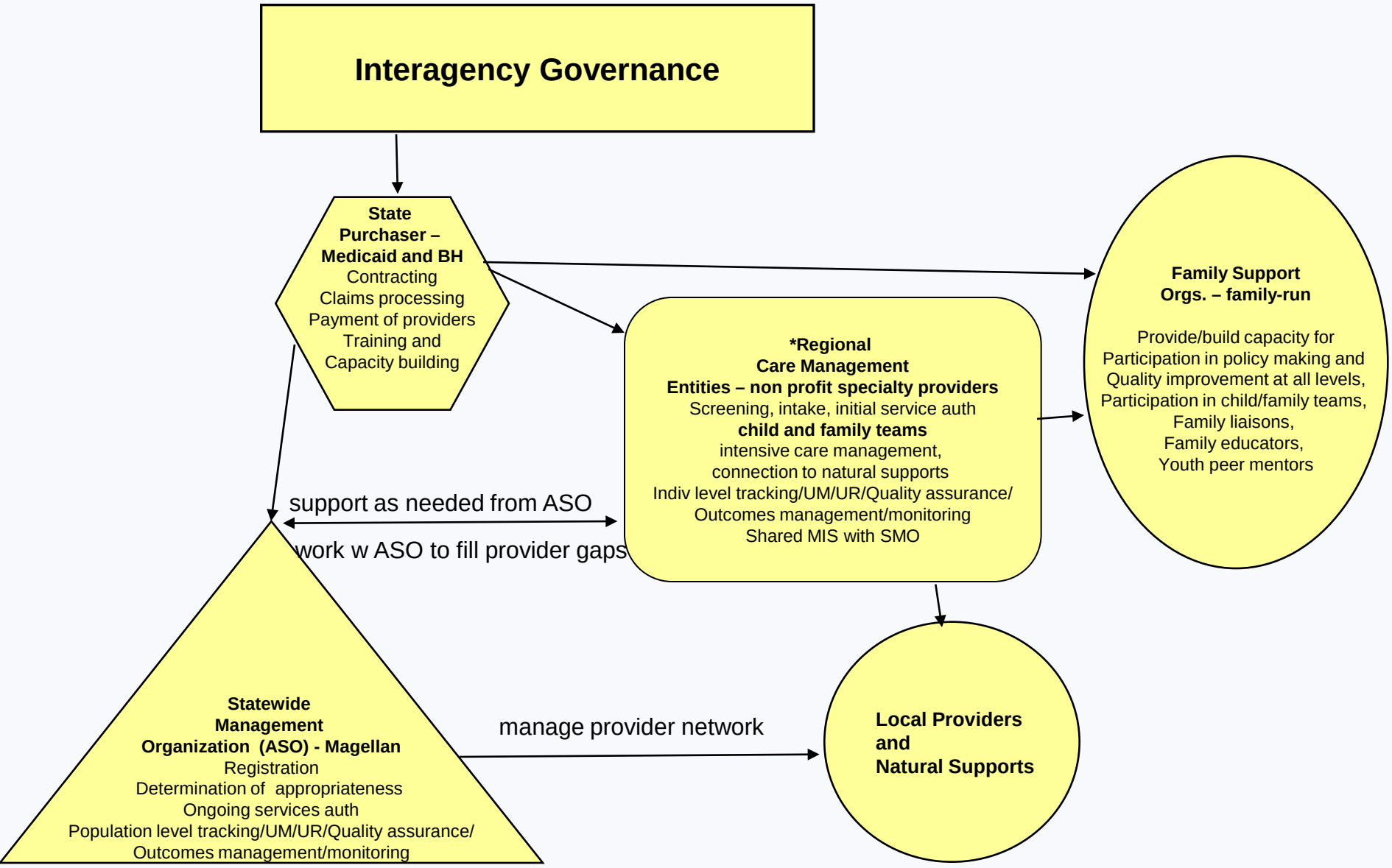
Wraparound Milwaukee. (2010). *What are the pooled funds?* Milwaukee, WI: Milwaukee Count Mental Health Division, Child and Adolescent Services Branch.

New Jersey



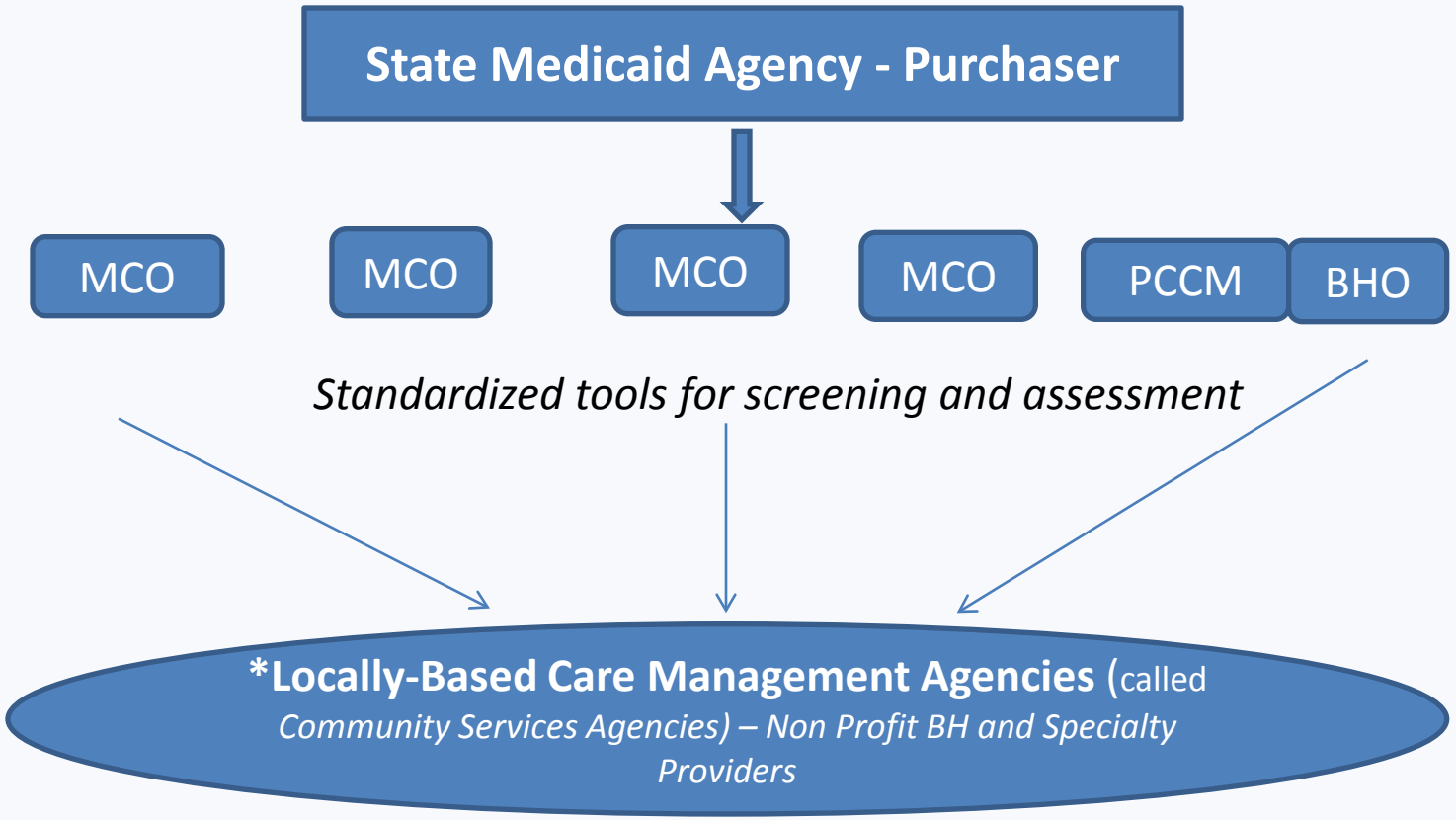
**Care coordination rate of $1034 pcpm*

Louisiana (1915 b and 1915 c waivers)



*Care coordination rate of $1035 pcpm

Massachusetts (1115 Waiver and SPA)



- Ensure Child & Family Team Plan of Care
- Provide Intensive Care Coordination
- Provide peer supports and link to natural helpers
- Manage utilization , quality and outcomes at service level

**Care Coordination Rate: Massachusetts does not use a PMPM rate. However, for comparative purposes , (if assuming a productivity standard of approximately 26 hours a week, and an average caseload of 10), the 15-minute rate for Care Coordination and Family Support &Training may appear to suggest a PMPM of $1,100 - $1,200.*

Health Home Provider Standards	Care Management Entity Activities
Provide quality-driven, cost-effective, culturally appropriate, and person-and family centered health home services	Provide family-driven, youth-guided, culturally and linguistically competent care that is community-based, flexible and individualized
Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines	Employ the evidence-based *Wraparound* model of care planning and care management to coordinate all services and supports needed by the youth.
Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders	Build resiliency in youth and families by promoting connections with behavioral health prevention and wellness services
Coordinate and provide access to mental health and substance abuse services	Coordinate and provide access to mental health and substance abuse services
Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings.	Coordinate and provide access to comprehensive care coordination services using the *Wraparound* model of care planning
Coordinate and provide access to chronic disease management, including self-management support to individuals and their families	Foster connections to natural supports and services that can help youth and families be successful at home, school, and in the community.
Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services	Provide access to peer and family support services to help youth and families successfully navigate multiple service systems
Coordinate and provide access to long-term care supports and services	Coordinate and provide access to needed supports and services across all domains of the youth's life including school, home, and community
Develop a person-centered plan of care for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services	Create a plan of care that serves as a guide to the youth's clinical and non-clinical health care and social services needs
Demonstrate a capacity to use HIT to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices	Employ HIT to support data-driven decision making , facilitate communication among team members, including with youth and family caregivers, and provide feedback to providers
Establish a continuous quality improvement program, and collect and report on data that permits an evaluation	Participate in quality improvement activities and collect and report on data.

Core Health Home Services

- Comprehensive care management
  - *Identifying, screening and assessing children appropriate for HH*
  - *Youth and family engagement*
  - *Mobilizing child and family team*
  - *Development and updating of coordinated plan of care*
  - *Monitoring of clinical and functional status*

- Care coordination and health/mental health promotion
  - *Ensure coordinated implementation of plan of care*
  - *Support youth and family to make and keep appointments and to achieve goals*
  - *Facilitate linkages for youth and family and among providers and systems*
  - *Ensure communication across providers, systems and with youth and families*
  - *Provide health/behavioral health information, education and linkage to resources*

- Transitional care across settings; includes follow-up from inpatient and facilitating transfer from pediatric to adult systems
  - *For children, other out-of-home treatment settings, e.g. residential treatment, and unique youth transition issues*

- Individual and family support services
  - *Family and youth peer support (families/youth with lived experience)*

- Linkage to social supports and community resources

- Use of health information technology

High Quality Wraparound Team (with Access to Physician and Nurse Care Manager) as Team of Health Care Professionals **Oklahoma**

Coordination with Primary Care in a Wraparound Approach

For children with complex behavioral health challenges enrolled in Health Home, Care Management Entity or Wraparound Team of Health Care Professionals --

- ✓ Ensures child has an identified primary care provider (PCP)
- ✓ Tracks whether child receives EPSDT screens on schedule
- ✓ Ensures child has an annual well-child visit (more frequent if on psychotropic medications or chronic health condition identified)
- ✓ Communicates with PCP opportunity to participate in child and family team and ensures PCP has child's plan of care and is informed of changes
- ✓ Ensures PCP has information about child's psychotropic medication and that PCP monitors for metabolic issues such as obesity and diabetes

Pires, S. 2012. Human Service Collaborative

Important to Ensure --

- Health home functions do not duplicate those of other management entities (and cannot be billed for twice) – for example, patient-centered medical homes, managed care organizations, Targeted Case Management providers
  - Develop matrices that show distinct functions of each and interface between health home and these other entities

<u>Options to Avoid Duplication with Targeted Case Management</u>

- *Replace TCM with HH SPA*

- *Distinguish TCM and HH populations: e.g., keep TCM for children at high risk and designate HH for children with most serious, complex behavioral health challenges*

- *Distinguish TCM and HH functions for same population/ HH as augmentation of TCM - HH rate does not include aspects of care coordination provided through TCM function*

Important to Ensure --

- Sufficiency of rate
  - In Care Management Entity approaches nationally, care coordination rate ranges from about $780 pmpm to about $1300 pmpm

Other Lessons

**New York's Chronic Illness Demonstration Project: Lessons for Medicaid Health Homes.* December 2012. Center for Health Care Strategies

- Establish much closer connections from the outset between the organizations responsible for care management and provider organizations
- Address data sharing issues and needs
- Ensure reimbursement for location and enrollment of high risk, high cost enrollees
- Extensive education required to build good relationships with other organizations, be clear on roles, build consistent communication mechanisms
- "Given the intensity of the job, it was difficult to hire the right people to do community-based case management with clients, and there was considerable turnover…**Need workforce training** that prepares case managers to provide coordinated patient-centered care… and *a particular emphasis on training peer support specialists"*

Contact Information:

Sheila A. Pires
sapires@aol.com

Poll Question

Is your state doing a health home for persons with SMI; does it incorporate high quality Wraparound for children?

- Not doing a health home for SMI
- Doing health home for SMI - incorporates high quality Wraparound
- Doing health home for SMI - does not incorporate high quality Wraparound
- Don’t know whether my state is doing a health home for SMI
- State is doing health home for SMI - don’t know if it includes high quality Wraparound

CHCS
Center for
Health Care Strategies, Inc.

NWI Webinar: Using Medicaid Health Homes with Wraparound to Serve Youth Populations with Complex Behavioral Health Needs

January 22, 2013

Dayana Simons, M.Ed., LMHC

Senior Program Officer,

Center for Health Care Strategies, Inc.

This document was developed under grant CFDA 93.767 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, these contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

Objectives

1. CHIPRA Care Management Entity (CME) Collaborative

2. CHCS' Role

3. Resources

CHCS Priorities

Our work with state and federal agencies, Medicaid health plans, providers, and consumers focuses on:

- **Enhancing Access to Coverage and Services**
- **Improving Quality and Reducing Racial and Ethnic Disparities**
- **Integrating Care for People with Complex and Special Needs**
- **Building Medicaid Leadership and Capacity**

Maryland, Georgia and Wyoming Collaborative CHIPRA Grant Project

- **Goal**: Improving the health and social outcomes for children with serious behavioral health needs by:
- Implementing and/or expanding a Care Management Entity (CME) provider model to improve the quality - and better control the cost - of care for children with serious behavioral health challenges who are enrolled in Medicaid or the Children's Health Insurance Program.

CHCS Technical Assistance to the Collaborative: Background on Resources

CHCS is:

- Coordinating entity for the states in the CHIPRA Collaborative
- Responsible for the Quality Framework and Internal "Independent" Evaluation
- Lead Technical Assistance Provider:
  - Webinars
    - 2010 Series, 2011 Series, 2012 Series
  - Monthly Individual Technical Assistance Calls
  - Quarterly All-States Meetings
  - Shared Online Resource Space for Collaborative States
  - Fact Sheets (e.g. *Care Management Entities: A Primer)*
  - Matrix of Standardized Assessment Tools Used to Guide Clinical Decision-making
  - Matrix on Options for Structuring a CME model
  - **Scan of States Using Medicaid to Finance Family and Youth Peer Support**
  - **Case Rate Scan for CMEs**
  - **Using CMEs for BHH Providers: Sample Language for SPA Development**
  - Learning Communities (national and state) www.chcs.org

The ACA Language: Provider Standards

- Establish a continuous quality improvement program, and collect and report on data that permits an evaluation of increased coordination of care and chronic disease management on individual-level clinical outcomes, experience of care outcomes, and quality of care outcomes at the population level.

http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-001.pdf.

The ACA Language: Provider Infrastructure

- **Designated providers** (as defined in section 1945(h)(5) of the Act)
- **Team of health care professionals**, which links to a designated provider (as defined in section 1945(h)(6) of the Act)
- **Health team** (as defined in section 1945(h)(7) of the Act)

The ACA Language: Provider Infrastructure

- Designated providers:
  - E.g. “physicians, clinical practices or clinical group practices, rural health clinics, community health centers, community mental health centers, home health agencies, **or any other entity or provider** (including pediatricians, gynecologists, and obstetricians) **that is determined appropriate by the State and approved by the Secretary**.”

The ACA Language: Provider Infrastructure

- Team of health care professionals, which links to a designated provider
  - E.g. “physicians and other professionals that may include a nurse care coordinator, nutritionist, social worker, behavioral health professional, or any professionals deemed appropriate by the State and approved by the Secretary…”
  - …” may operate… as free standing, virtual, or based at a hospital, community health center, community mental health center, rural clinic, clinical practice or clinical group practice, academic health center, or any entity deemed appropriate by the State and approved by the Secretary.“

The ACA Language: Provider Infrastructure

- Health team
  - …"should be an interdisciplinary, inter-professional team…"
  - …" must include the following providers: medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers (including mental health providers, and substance use disorder prevention and treatment providers), doctors of chiropractic, licensed complementary and alternative medicine practitioners, and physicians' assistants."

Using Care Management Entities for Behavioral Health Home Providers: Sample Language for State Plan Amendment Development

CHCS Center for Health Care Strategies, Inc.

TECHNICAL ASSISTANCE TOOL

OCTOBER 2012

Using Care Management Entities for Behavioral Health Home Providers: Sample Language for State Plan Amendment Development

As states explore health home opportunities presented by the Affordable Care Act to improve the quality and cost of care for individuals with serious and persistent mental illness and/or other chronic conditions, they may want to consider Care Management Entities (CMEs) to serve as behavioral health home provider for children and youth with severe behavioral health needs.

CMEs serve as centralized accountable hubs for the coordination of all care for children with complex behavioral health challenges who are involved in multiple systems and their families. These entities can provide a customized approach to behavioral health homes for individuals with historically high health care costs and poor health and social outcomes. CMEs provide: A youth guided and family-driven strengths-based approach that is coordinated across agencies and providers; intensive care coordination; home- and community-based services; and peer supports.

Since health home-required services are similar to CME functions, the CME model offers the potential to serve as a health home. Required services which include: (1) comprehensive care management; (2) individual and family support services; (3) care coordination and health/behavioral health promotion; (4) linkage to social supports and community resources; and (5) transitional care across multiple settings/systems, are similar to functions of CMEs. Health homes are also required to use health information technology to facilitate service linkages.

BACKGROUND

This resource was developed by the Center for Health Care Strategies (CHCS) through its role as the coordinating entity for a five-year, three-state Quality Demonstration Grant project funded by the Centers for Medicare & Medicaid Services under the Children's Health Insurance Program Reauthorization (CHIPRA) Act of 2009. The multi-state grant is supporting lead states Maryland, and partner states Georgia and Wyoming, in implementing or expanding a CME approach to improve clinical and functional outcomes, reduce costs, increase access to home- and community-based services, and increase resiliency for high-utilizing Medicaid- and CHIP-enrolled children and youth with serious behavioral health challenges.

This technical assistance resource was created to help the states participating in the CHIPRA CME Collaborative think through key elements of a behavioral health home, utilizing CMEs as designated providers for specialized populations. The language may be employed in the context of a broader SMI/SED State Plan Amendment, as described in Section 1945(h) (5) of the Affordable Care Act. The guide includes recommended language, references to ACA provisions and state examples in the "comment boxes" throughout. It is not intended either to suggest or ensure the approval of a health home State Plan Amendment by CMS. Health homes may not be targeted by age and CMEs represent one approach to behavioral health homes that would need to be launched in tandem with other models that may more aptly address the needs of adults with behavioral health needs.

Visit www.chcs.org for more information on the CHIPRA CME Collaborative.

This document provides sample language to help states structure their dialogue with the Substance Abuse and Mental Health Services Administration and submission to the Centers for Medicare & Medicaid Services regarding the use of CMEs as behavioral health homes. It can help state Medicaid agencies articulate how CMEs may serve as designated health home providers for children and youth with Serious Emotional Disturbances (SED). The document includes recommended language and references to ACA provisions and state examples in "comment boxes." A future guide will address the ACA opportunity for CMEs to function as health teams within supported organizations such as community mental health centers.

States pursuing health home SPAs must ensure that there is no duplication of services (e.g., between health homes and medical homes), and may therefore need to develop and submit separate supporting documentation that explains how duplication in health home services will be avoided.

The health home state plan amendment (described in the November 16, 2010 State Medicaid Director Letter, https://www.cms.gov/smdl/downloads/SMD10024.pdf) is submitted electronically to CMS. The web-based submission process is outlined in the December 22, 2010 CMCS Informational Bulletin https://www.cms.gov/CMCSBulletins/downloads/CIB-12-22-10.pdf). This document is intended to replicate the fields required for the health home SPA. In the interest of aligning with an already CMS-approved health home SPA, the format of this document matches the PDF version of the approved RI CEDARR health homes SPA. (It should be noted, however, that the RI CEDARR SPA is focused on a broader population of children with special health care needs.) Headings and sections are SPA template language.

The document was developed under grant CFDA 93.767 from the U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services. However, the contents do not necessarily represent the policy of the U.S. Department of Health and Human Services, and you should not assume endorsement by the Federal Government.

Example of Customized Language for CME

- **C. Health Promotion**
- *1. Service Definition*
- OVERARCHING STATEWIDE DEFINITION: (*Statewide definition will be state-specific)*
- **CME HEALTH HOME SPECIFIC DEFINITION**: Health promotion assists enrollees and their families in implementing the Individual Care Plan and developing the skills and confidence to independently identify, seek out, and access resources that will assist in: (1) managing and mitigating the enrollee's behavioral health condition(s); (2) preventing the development of secondary or other chronic conditions; (3) addressing family and enrollee engagement; (4) promoting optimal physical and behavioral health; and (4) addressing and encouraging activities related to health and wellness. This service will include the provision of health education, information, and linkage to resources with an emphasis on resources easily available in the families' community and peer group(s). This service will be performed by the CME care coordinator (bachelor or master level), or the family partner depending on the exact nature of the activity.

Example of Customized Quality Measure for CME

- **Goal 1: Improve Functioning:** The Child Adolescent Strengths and Needs (CANS) evaluation tool is completed with all enrollees and caregivers and provides information about functioning in multiple areas (e.g., problem presentation, risk behaviors, caregiver strengths and needs, child safety, functioning, strengths). It is a strengths-based, information integration tool that provides a profile of children and their families along a set of six dimensions related to service planning and decision making. It monitors outcomes of services—dimension scores have been shown to be valid outcome measures in various levels of care and settings, including residential treatment, intensive community treatment, foster care and treatment foster care, community mental health, and juvenile justice programs. The tool is administered at enrollment, at any time the enrollee transitions to different level of care or at six months (whichever comes first), and at discharge.

1. Clinical Outcomes

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
The percentage of enrollees who show improvement on CANS	CANS	*Numerator:* Number of enrollees with improved functioning on CANS *Denominator:* Number of enrollees to whom CANS was administered	The state will use the CME IT system to collect and store CANS data. Monitoring of progress towards identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes. In addition, [*Enter state name*] will use the following sources of data to monitor the impact of its health home (HH) program on quality: (1) an outcomes survey administered to all CME families on intake and yearly thereafter; (2) charts (either electronic or paper); and (3) a client satisfaction survey. The state exercised prudence in selecting measures to not overburden CME or IT staff with new data collection and analysis. Standard, validated measure specifications where they exist will be used to increase the ability to make comparisons across populations, programs, and states.

2. Experience of Care

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
The percentage of enrollees who report increased resiliency	California Healthy Kids Survey Resiliency Module	*Numerator*: The number of enrollees who report increased resiliency *Denominator*: All CME enrollees administered the CA Health Kids Survey Resiliency Module	The CA Health Kids Survey Resiliency Module will be administered at entry, six months, discharge, and six months post discharge, with data stored in the CME IT system. Monitoring of progress toward identified health home goals will be accomplished through the analysis of reports submitted on a regular basis by the CME health homes.

3. Quality of Care

Measure	Data Source	Measure Specification	How Health IT Will Be Utilized
The percentage of CME plans of care that meet Wraparound Fidelity Index (WFI) parameters	National Wraparound Initiative Wraparound Fidelity Index	*Numerator*: The number of CME plans of care that meet WFI parameters *Denominator*: All CME plans of care	CME plans of care are stored within the CME IT system; plans of care will be measured against WFI standards annually. Monitoring of progress toward identified health home goals will be accomplished through the analysis of reports submitted regularly by the CME health homes.

Case Rate Scan for Care Management Entities

INDIANA	
CME	Indiana Choices: Dawn Project
Case Rate	Adopted state-wide, fixed per-member-per-day (PMPD) case rates that are tiered based in part on the youth's Child and Adolescent Needs and Strengths (CANS) assessment. The rates are: $54.02, $95.97, $148.09, and $224.38 (which, for the purposes of this document, translate to a range of $1,645 to $6,825 per-member-per-month [PMPM]). Rates are paid by the referring agency and cover care coordination, administration, all placements, services and supports except Medicaid and fixed expenses. Medicaid services are billed separately.
Case Rate Calculation	The tiered case rate was determined by a cost model developed by psychologist Anthony Broskowski and Choices Chief Financial Officer, Shannon Van Deman, which established a shared risk arrangement for child welfare and juvenile justice. The rate is tiered to remove eligibility criteria for youth with serious emotional disturbance, broadening the scope of the care management entity (CME) to include youth with lower-intensity needs. The tiered rate for each youth is based on the CANS assessment and information on the youth's previous placement history.
Pooled/Braided Funds	Braided funds from child welfare and juvenile justice. The funding model in Indiana is now state-based instead of county-based and the child welfare agency holds all of the funds. When the juvenile justice system makes a referral, child welfare is still the payer.
Child Welfare	Child welfare agency pays Choices a case rate for each child it refers.
Education	Not Applicable
Juvenile Justice	Detail Not Available
Medicaid	Not Applicable
Mental Health	Not Applicable
Other	Not Applicable
Considerations	• Rather than thinking of costs first, define the target population and services to be provided; then determine costs. • Tailor case rates to the state, rather than simply adopting other states' case rates. • Encourage the collection of data on service utilization and costs of specific youth; capture the data immediately, if possible. • Try to make funding as flexible as possible.
Outcomes	• Indiana Choices has shown a reduction in child risk behaviors, as measured by the CANS assessment. • From November 2008 - January 2010: – Despite serving youth with more intensive needs, Choices youth averaged 1.77 out-of-home placements while the Indiana Department of Child Services (DCS) averaged 2.64 out-of-home placements; – Youth in Choices had an average length of stay in out-of-home placements of 222 days, while DCS had an average length of stay in out-of-home placements of 595 days; – 83.2% of youth referred to Dawn outside of residential treatment remain out of residential treatment; – Youth referred to Dawn with multiple needs, and at imminent risk for, but not yet living in a residential treatment facility have a larger increase in strengths and decrease in needs at discharge than youth who are in residential facilities when referred; – Youth in Dawn have a lower cost/day ($126.94 vs. $293.24); increased length of stay (341 vs. 270 days); and decreased total cost ($43,286.54 vs. $79,174.80), than youth in residential treatment; and – For each 100 youth diverted from residential treatment to Dawn, DCS saves approximately $3M.
Notes	The Dawn Project previously operated exclusively in Marion County. The state took this system state-wide for all youth across systems and implemented a statewide case rate. Total CME funding as of FY 2012 is about $11M/year for approximately 200 youth/day statewide. Current funding is about $16M/year for approximately 330 youth/day statewide. Northern Indiana Team Choices (NITCH) was a one-year pilot that aimed to decrease the number of youth in residential treatment across 20 counties in northern Indiana. The intervention targeted youth with extensive placement history and ended in September 2011. The Dawn program is now operating in those communities.

Scan of States Using Medicaid to Finance Family and Youth Peer Support

CHCS Center for Health Care Strategies, Inc.

State	Medicaid Funding Source	FY Peer Support Provider (Service) Title	Definition	Components of Service	Billing Codes	Billing Amounts	Qualifications, Training and Supervision
State Plan Amendment							
AK	State Plan Amendment (SPA)	Peer Support Specialist (Peer Support Services)	Peer Support Services is a type of rehabilitation service that is expected to increase the recipient's ability to function within their home, school, and community. This category of services may be provided on the premises of a Community Behavioral Health Services Provider (CBHP), in the recipient's home, or in any community setting appropriate for providing the services as specified in the recipient's behavioral health treatment plan. These services are rendered by the CBHS provider's staff – in this case, the peer support specialist – who is performing the service as a regular duty within the scope of their knowledge, experience, and education.	A Peer Support Specialist is working within the scope of his or her training and experience, and as directed by a directing clinician in a community behavioral health provider (CBHP) services organization. A Peer Support Specialist performs responsibilities that may include: provision of psychosocial evaluation and education related to a patient's behavioral health condition; and counseling, teaching needed life skills, encouraging, and coaching behavioral health patients. He or she has specialization or experience in providing rehabilitation services to recipients with a severe behavioral health condition (adults experiencing serious mental illness or children experiencing severe emotional disturbance), but may have less than a master's degree in psychology, social work, counseling, or a related field.	H0038 Peer Support Services-Individual (delivered to the youth) H0038-HR Peer Support Services-Family (with patient present) (delivered to the adult caregiver) H0038-HS Peer Support Services-Family (without patient present) (delivered to the adult caregiver)	$17 per 15 minutes Max. 100 hrs per State Fiscal Year (SFY) $17 per 15 minutes Max. 180 hrs per SFY $17 per 15 minutes Max. 180 hrs per SFY	A peer support specialist is a person who: ▪ Meets all the qualifications of a behavioral health clinical associate (see below); ▪ Is competent to provide peer support services by virtue of having experienced behavioral health issues in self or family; and ▪ Is supervised by a mental health professional clinician who the behavioral health services provider has determined is competent to supervise peer support services. A behavioral health clinical associate is a person who: ▪ Has specialization or experience in providing rehabilitation services to recipients with a severe behavioral health condition (adults experiencing serious mental illness or children experiencing severe emotional disturbance), but may have less than a master's degree in psychology, social work, counseling, or a related field; ▪ Is working within the scope of

CME Core Services

Include:

- **Intensive Care Coordination (at low ratios)**
- **High Quality Wraparound Care Planning**
- **Family and Youth Peer Support**

Access to:

- Mobile Crisis Response and Stabilization
- Comprehensive array of HCBS (e.g. intensive in-home therapy) – need good Rehab Option

Visit CHCS.org to learn more about the CHIPRA CME Collaborative

dsimons@chcs.org

www.chcs.org

national wraparound initiative

The **National Wraparound Initiative** is based in Portland, Oregon. For more information, visit our website:

www.nwi.pdx.edu

A Life in the Community for Everyone
SAMHSA
Substance Abuse and Mental Health Services Administration
U.S Department of Health and Human Services

The National Wraparound Initiative is funded by the Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, United States Department of Health and Human Services.