NWI webinar starting soon!
In the meantime, please note…

• 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.

*This webinar and the PowerPoint will be available on the NWI website. [http://www.nwi.pdx.edu/webinars.shtml](http://www.nwi.pdx.edu/webinars.shtml)
Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State & Community Profiles

September 16, 2014

Dayana Simons, M.Ed., LMHC
Center for Health Care Strategies

Janet Walker, Ph.D.,
Co-Director, National Wraparound Initiative
(Core partner in the Technical Assistance Network)
Latest research, resources, info on wraparound

Newsletter

Webinars

- September 30th, office hours
- November 18th, new directions in accountability and QA
- April 8th, webinar on costs and cost effectiveness in wraparound
- And today...
Dayana Simons, M.Ed, LMHC

- Senior Program Officer, Center for Health Care Strategies (CHCS)
- Expertise in CME approach for coordination of services/supports
- Managed CME/wraparound for state of Massachusetts
- Began her career as a clinician
Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs

STATE AND COMMUNITY PROFILES

September 16, 2014

Dayana Simons

Center for Health Care Strategies

This presentation is a product of the National Technical Assistance Network for Children’s Behavioral Health, made possible through support from the Substance Abuse and Mental Health Services Administration.
A non-profit health policy resource center dedicated to advancing access, quality, and cost-effectiveness in publicly financed health care

► **Priorities:** (1) enhancing access to coverage and services; (2) integrating care for people with complex needs; (3) advancing quality and delivery system reform; and (4) building Medicaid leadership and capacity.

► **Provides:** technical assistance for stakeholders of publicly financed care, including states, health plans, providers, and consumer groups; and informs federal and state policymakers regarding payment and delivery system improvement.

► **Funding:** philanthropy and the U.S. Department of Health and Human Services.
CHIPRA Quality Improvement Collaborative

- **Goal**: Improve health and social outcomes for children with serious behavioral health needs by:
  - Implementing/expanding a Care Management Entity (CME) model to improve the quality and control the cost of care for children with serious behavioral health challenges who are enrolled in Medicaid or the Children’s Health Insurance Program
- **Participating states**: Georgia, Maryland (lead), Wyoming
- **CHCS** is coordinating entity and lead TA provider
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 and Youth with Serious Behavioral Health Conditions:
Distinct 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

Pires, S. March 2013  *Customizing Health Homes for Children with Serious Behavioral Health Challenges*
Human Service Collaborative
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:
  - MA, LA, NJ, WI, IL, OK
  - PRTF Waiver Demo states
  - CHIPRA Care Management Entity Quality Collaborative states (MD, GA, WY)

(*May 7, 2013 CMCS SAMHSA Joint Informational Bulletin)

**Care Management Entity Functions**

<table>
<thead>
<tr>
<th>Service Level</th>
<th>Administrative Level</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Child and family team facilitation using <strong>fidelity wraparound practice model</strong></td>
<td>• Information management – real time data; web-based IT</td>
</tr>
<tr>
<td>• Screening, assessment, clinical oversight</td>
<td>• Provider network recruitment and management (including natural supports)</td>
</tr>
<tr>
<td>• <strong>Intensive care coordination</strong></td>
<td>• Utilization management</td>
</tr>
<tr>
<td>• Care monitoring and review</td>
<td>• Continuous quality improvement; outcomes monitoring</td>
</tr>
<tr>
<td>• Peer support partners</td>
<td>• Training</td>
</tr>
<tr>
<td>• Access to mobile crisis supports</td>
<td></td>
</tr>
</tbody>
</table>

Pires, S. 2010. Human Service Collaborative
OVERVIEW: Scan of Intensive Care Coordination (ICC) Programs Using High-Quality Wraparound

- 22 programs in 15 states

Methods
- Survey covering operational aspects of ICC/wraparound programs
- Administered to state/county representatives via email, phone
- Compiled into individual state/county profiles

Three program categories
- **Established**: In existence for some time, have outcomes data, continuous quality improvement
- **Evolving**: Have established approaches in parts of the state and are either expanding statewide or revamping approach
- **Emerging**: In the early stages of development
Populations of Focus

- Children/youth with serious behavioral health needs/serious emotional disturbance (SED), substance use issues, co-occurring disorders
- Involved/at-risk for involvement in multiple systems (child welfare, juvenile justice, special education)
- At-risk for out of home/institutional placement
- Intellectual/developmental disabilities
- Ages range from 0-25
- Medicaid-eligible

State Highlight: New Jersey Children’s System of Care serves children/youth with developmental and intellectual disabilities, and youth with primary substance use disorder issues in addition to children/youth with serious behavioral health needs
## Eligibility, Screening, and Assessment

### Eligibility/Screening Tools
- Medical necessity criteria
- State-specific tools
- Standardized screening tools:
  - Child and Adolescent Needs and Strengths Assessment (CANS)
  - Child and Adolescent Functional Assessment Scale (CAFAS)
  - Ohio Scales
  - Child Behavior Checklist (CBCL)
  - Youth Self Report
  - Child and Adolescent Services Intensity Instrument (CASII)
  - Child and Adolescent Level of Care Utilization System (CALOCUS)
  - Early Childhood Service Intensity Instrument (ECSII)

### Responsible for Screening
- Managed care organization
- Medicaid agency
- Care Management Entity provider
- Private nonprofit agencies (e.g., Community Service Agencies in MA)
- Prepaid Inpatient Health Plans
- Community mental health service providers
- Regional behavioral health authority
- Child welfare agency
- Contracted systems administrator (e.g., PerformCare in NJ)
- Cross-agency panel (e.g., Dane County, WI)
- External review organization
State Highlights: Eligibility, Screening, and Assessment

- **Massachusetts**: Standardized medical necessity criteria across all MCOs
- **Illinois and Rhode Island**: No standardized screening tools used, but CANS used for ongoing assessments
Care Coordinator Staffing Ratios

- Care coordinator to child/family ratios
  - Typically, do not exceed 1:10
    - **Wraparound Milwaukee**: 1:4 for newly hired care coordinators (first 2 months)
  - Tiered approaches may be higher
    - **Illinois Medicaid**: Tiered approach – 1:10, 1:20, 1:40
<table>
<thead>
<tr>
<th>STATE/COUNTY</th>
<th>CARE COORDINATOR TO CHILD AND FAMILY RATIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ESTABLISHED PROGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>1:10</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>1:10 average</td>
</tr>
<tr>
<td>Michigan</td>
<td>1:10 (if a facilitator has families transitioning out, can be up to 1:12)</td>
</tr>
<tr>
<td>Nebraska</td>
<td>1:10</td>
</tr>
<tr>
<td>New Jersey</td>
<td>1:14 (optimal blended caseload under new unified system – moderate and high-needs youth)</td>
</tr>
<tr>
<td>Cuyahoga County, OH</td>
<td>1:12</td>
</tr>
<tr>
<td>Dane County, WI</td>
<td>1:10</td>
</tr>
<tr>
<td>Milwaukee County, WI</td>
<td>1:8 (if newly hired, 1:4 for first two months)</td>
</tr>
<tr>
<td><strong>EVOLVING PROGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>1:10</td>
</tr>
<tr>
<td>Maryland</td>
<td>1:9 to 1:11 for CME; 1:8 for pending 1915 (i) SPA</td>
</tr>
<tr>
<td>Clermont County, OH</td>
<td>1:15</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>1:8 to 1:10</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1:10 to 1:12</td>
</tr>
<tr>
<td><strong>EMERGING PROGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>El Paso County, CO</td>
<td>1:12</td>
</tr>
<tr>
<td>Illinois (Child Welfare)</td>
<td>1:10</td>
</tr>
<tr>
<td>Illinois (Medicaid)</td>
<td>1:10, 1:20, 1:40 (based on tiered system of intensity level)</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>1:15</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1:10</td>
</tr>
</tbody>
</table>


Information is current as of July 2014.
Supervisor Staffing Ratios

- Supervisor to care coordinator ratios
  - Range of 1:2 (pilot) to 1:12
    - Michigan: No standardized ratio
## Supervisor to Care Coordinator Ratios

<table>
<thead>
<tr>
<th>STATE/COUNTY</th>
<th>SUPERVISOR TO CARE COORDINATOR RATIOS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ESTABLISHED PROGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>1:8</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>1:8 average</td>
</tr>
<tr>
<td>Michigan</td>
<td>No standardized ratio</td>
</tr>
<tr>
<td>Nebraska</td>
<td>1:7</td>
</tr>
<tr>
<td>New Jersey</td>
<td>1:6</td>
</tr>
<tr>
<td>Cuyahoga County, OH</td>
<td>1:12</td>
</tr>
<tr>
<td>Dane County, WI</td>
<td>1:8</td>
</tr>
<tr>
<td>Milwaukee County, WI</td>
<td>1:6</td>
</tr>
<tr>
<td><strong>EVLVING PROGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>1:6</td>
</tr>
<tr>
<td>Maryland</td>
<td>1:6 to 1:8 for CME; 1:8 for pending 1915(i) SPA</td>
</tr>
<tr>
<td>Clermont County, OH</td>
<td>1:5</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>1:5</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>1:8</td>
</tr>
<tr>
<td><strong>EMERGING PROGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>El Paso County, CO</td>
<td>1:2 (pilot)</td>
</tr>
<tr>
<td>Illinois (Child Welfare)</td>
<td>1:8</td>
</tr>
<tr>
<td>Illinois (Medicaid)</td>
<td>1:8</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>1:6</td>
</tr>
<tr>
<td>Wyoming</td>
<td>1:10</td>
</tr>
</tbody>
</table>

Role of System Partners

- Family and youth peer support
  - some programs (LA, MA, MI fund peer support through Medicaid SPA; NJ uses Medicaid Admin funds and other programs use state funds or grant funding, but in general, peer support is recognized as important and is offered

- Psychiatric consultation
  - Some have standard availability (e.g., 2-8 hours per week)
  - Not all programs offer consultation

- Others
Financing Approaches: Rates for Care Coordination

<table>
<thead>
<tr>
<th>Range of Case Rates</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>Daily</td>
<td>$22.00 (WAM)</td>
<td>$85.00 (RI)</td>
</tr>
<tr>
<td>Monthly</td>
<td>$415.00 (IL-Med)</td>
<td>$1,670.67 (Dane)</td>
</tr>
<tr>
<td>Annually</td>
<td>$14,048.62 (MD)</td>
<td></td>
</tr>
<tr>
<td>Per episode</td>
<td>$12,000.00 (PA)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Range of Fee-for-Service Rates</th>
<th>Low</th>
<th>High</th>
</tr>
</thead>
<tbody>
<tr>
<td>15 minutes</td>
<td>$16.38 (OK)</td>
<td>$87.51 (MI)</td>
</tr>
<tr>
<td>1 hour</td>
<td>$18.50 (WY)</td>
<td></td>
</tr>
</tbody>
</table>

Rates may have a daily, weekly, monthly, or annual cap.
## Care Coordination Rates and Billing Structure

<table>
<thead>
<tr>
<th>STATE/COUNTY</th>
<th>RATES AND BILLING STRUCTURE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ESTABLISHED PROGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>Louisiana</td>
<td>$1,035.00/child per month (administrative payment to ICC/wraparound provider); $137.00/child per month (administrative payment to MCO)</td>
</tr>
<tr>
<td>Massachusetts</td>
<td>$23.74/15 minutes (master’s level care coordinator); $18.88/15 minutes (bachelor’s level care coordinator)</td>
</tr>
<tr>
<td>Michigan</td>
<td>$87.51/15 minutes (1915(b) waiver rate); $412.68/meeting, up to 4 per month (1915(c) waiver rate)</td>
</tr>
<tr>
<td>Nebraska</td>
<td>$840.70/child per month</td>
</tr>
<tr>
<td>New Jersey</td>
<td>$550.00/child per month (bundled care management rate for youth with both moderate and high needs)</td>
</tr>
<tr>
<td>Cuyahoga County, OH</td>
<td>$22.89/child per day</td>
</tr>
<tr>
<td>Dane County, WI</td>
<td>$1,670.67/child per month</td>
</tr>
<tr>
<td>Milwaukee County, WI</td>
<td>$32.00/day for Wraparound Milwaukee (based on 8 families); $22.00/day for REACH (based on 12 families)</td>
</tr>
<tr>
<td><strong>EVOLVING PROGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>Georgia</td>
<td>$721.05/child per month</td>
</tr>
<tr>
<td>Maryland</td>
<td>$14,048.62/child annually (approximately $1,170.71 per month for the CME); Rates for ICC under pending 1915(i) SPA are in development</td>
</tr>
<tr>
<td>Clermont County, OH</td>
<td>N/A (SAMHSA grant funds and local contributions currently pay for salaries and benefits)</td>
</tr>
<tr>
<td>Oklahoma</td>
<td>$16.38/15 minutes (fee-for-service Medicaid rate)</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td>$12,000/episode of care (approximately; paid from MCO administrative budgets)</td>
</tr>
<tr>
<td><strong>EMERGING PROGRAMS</strong></td>
<td></td>
</tr>
<tr>
<td>El Paso County, CO</td>
<td>$40.66/15 minutes up to 4.25 hours; $476.06 for 4.25 to 8 hours</td>
</tr>
<tr>
<td>Illinois (Child Welfare)</td>
<td>TBD - Tiered based on placement of child at time of enrollment. Specific rate information is not yet available.</td>
</tr>
<tr>
<td>Illinois (Medicaid)</td>
<td>$415.00/child per month</td>
</tr>
<tr>
<td>Rhode Island</td>
<td>$85.00/day (Medicaid rate for wraparound services provided through Family Care Community Partnerships). RI Medicaid provided initial approval for billing for wraparound services as of 7/1/2014. The wraparound rate and methodology for claiming are still in development.</td>
</tr>
<tr>
<td>Wyoming</td>
<td>$18.50/hour (in pending TCM SPA); CME currently receives a per member per month rate from the state and pays a per member per month rate to vendors.</td>
</tr>
</tbody>
</table>

Financing Approaches: Sources

- Medicaid
  - Waivers: 1115, 1915 (a),(b), and (c) waivers
  - State plan amendments
  - Money Follows the Person, Balancing Incentives Program
- State general funds (child welfare, juvenile justice)
- Grants (SAMHSA block grants, system of care)
- Local revenue (public health, substance use tax dollars, county tax match)
  - Livingston County, MI
- Pooled/blended funding
  - Wraparound Milwaukee
Staff Training and Development

• Wraparound certification and training
  ► UMD Institute for Innovation and Implementation
  ► Vroon VanDenBerg
• State-required certification, skill- and competency-based training programs (e.g., MA)
• CANS certification
• Ongoing supervision (individual, group, dyad)
Provider Networks

- Entities responsible for provider network development
  - Managed care organization (LA, MA)
  - Prepaid Inpatient Health Plans (MI)
  - Regional Behavioral Health Authorities (NE)
  - State entity/agency (NJ Children’s System of Care, GA DBHDD)
  - Care Management Entity (Wraparound Milwaukee)
  - Administrative Services Organization (El Paso County, CO)
Evaluation, Monitoring, and Outcomes

- **Evaluation and monitoring – university partnerships**
  - OH – Case Western Reserve
  - GA – Georgia State University
  - PA – University of Pittsburgh
  - MD – University of Maryland

- **Utilization management**
  - Administrative services organization, MCO and CME are typically responsible parties

- **Proprietary electronic health records systems**
  - NJ CYBER
  - Choices’ Clinical Manager
  - Wraparound Milwaukee’s Synthesis
Key Takeaways from Across Programs

- One size does **not** fit all
- Early and ongoing stakeholder engagement is key to successful implementation
- Learning the languages of state agencies, funders, providers, etc. facilitates collaboration
- Think about sustainability from the very beginning
Resources


• Care Management Entities: A Primer (http://www.chcs.org/resource/care-management-entities-a-primer/)

And coming soon... 3 Quick Reference Snapshots on Intensive Care Coordination Using High-Quality Wraparound:

• Care Coordination Rates and Billing Structure
• Supervisor to Care Coordinator Ratios
• Care Coordinator to Child and Family Ratios
Contact Information:

Dayana Simons
Senior Program Officer
Center for Health Care Strategies
Core Partner, Technical Assistance Network for Children’s Behavioral Health
dsimons@chcs.org
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