Enhancing Maryland's Public Behavioral Health System for Children & Youth

A review of Maryland's evolving system of care in the context of national health care reform.

January 2015

Originally issued November 2014

Authors: **Lisa McGarrie, LCSW**
Deborah S. Harburger, MSW
Denise Sulzbach, JD
Kimberly Estep, MA

The Institute for Innovation & Implementation
University of Maryland, Baltimore, School of Social Work

Contributors:
Marlene Matarese, PhD
Jennifer Lowther, LCSW-C
Michelle Zabel, MSS
Ari Blum, LCSW-C

The Institute for Innovation & Implementation
University of Maryland School of Social Work
306 W. Redwood Street
Baltimore, MD 21201
theinstitute@ssw.umaryland.edu
http://theinstitute.umaryland.edu

This document was produced by The Institute for Innovation & Implementation, University of Maryland, Baltimore School of Social Work, and developed under funding from CFDA 93.104 from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration and 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.

This document provides an overview of state-level changes taking place within Maryland's public behavioral health system for children and youth. A discussion of the current and proposed approaches to intensive behavioral health services for youth, the document includes highlights from the 1915(i) and Targeted Case Management Medicaid State Plan Amendments, Care Management Entity and Health Home programs.

Suggested Citation: McGarrie, L., Harburger, D.S., Sulzbach, D., & Estep, K. (2015). *Enhancing Maryland's Public Behavioral Health System of Care for Children & Youth* (Rev. ed.). Baltimore, MD: The Institute for Innovation & Implementation, University of Maryland School of Social Work.

In January 2015, this document was updated to include an additional resource in Appendix I and a revised citation.

Contents

Acronym List

ACA – Patient Protection and Affordable Care Act (P.L. 111-148) of 2010
ACE – Adverse Childhood Experiences
ADAA – Alcohol and Drug Abuse Administration
ASO – Administrative Services Organization
BHA – Behavioral Health Administration
CANS – Child and Adolescent Needs and Strengths Tool
CASII – Child and Adolescent Service Intensity Instrument
CASSP – Child and Adolescent Service System Program
CCO – Care Coordination Organization
CFT – Child and Family Team
CHCS – Center for Health Care Strategies
CHIPRA – Children's Health Insurance Program Reauthorization Act
CMCS –Center for Medicaid & CHIP (CMCS)
CME – Care Management Entity
CMS – Centers for Medicare & Medicaid Services
COE – Center of Excellence
CSA – Core Service Agency
DHMH – Department of Health and Mental Hygiene
DHR – Department of Human Resources
DJS – Department of Juvenile Services
EBP – Evidence-Based Practice
GOC – Governor's Office for Children
ICC – Intensive Care Coordination
LAA – Local Addiction Authority
MAP – Managing and Adapting Practice
MCHP – Maryland Children's Health Program
MCO – Managed Care Organization
MCRS - Mobile Crisis Response and Stabilization
MHA - Mental Hygiene Administration
MMA-Maryland Medical Assistance
MSDE – Maryland State Department of Education
MTS – Mobile Treatment Services
NWIC – National Wraparound Implementation Center
PBHS – Public Behavioral Health System
POC – Plan of Care
PRP – Psychiatric Rehabilitation Program
PRTF - Psychiatric Residential Treatment Facility; also known as Residential Treatment Center (**RTC**) in Maryland
SAMHSA – Substance Abuse and Mental Health Services Administration
SED – Serious Emotional Disturbance
SPA – Medicaid State Plan Amendment
SPMI – Serious and Persistent Mental Illness
TCM - Targeted Case Management

Maryland, as an early adopter of health care reform and an innovator in behavioral health integration and systems of care implementation, continues to move its system forward. This process is informed by and aligned with the national and state level initiatives discussed below, as well as the findings from research conducted over the past two decades. The strong and emerging evidence base for home- and community-based services has propelled Maryland's exploration of system redesign in order to meet the emerging needs of youth and families, as well as align with the changing behavioral health care landscape and focus on quality services and outcomes. Early intervention and treatment of children through a planned, integrated, and quality-driven framework will positively impact the health of children across these domains. The purpose of this document is to delineate the current and proposed structure for the overarching behavioral health system, along with the resulting expanded array of intensive care coordination services for children and adolescents in the context of larger federal reforms.

Background

Findings from the 1997 Adverse Childhood Experiences (ACE) study suggest that exposure to specific stressors during childhood (including growing up in households in which there was recurrent child maltreatment; substance abuse; chronic depression, mental illness, institutionalization, or suicidality; domestic violence; one or no parents; or an incarcerated household member) is common, with two-thirds of adults experiencing at least one ACE. Furthermore, there is a graded, positive relationship between the number of adverse childhood experiences and the development of health risk behaviors and diseases during adulthood, including increase in health risk behavior, mental health disorders, and physical disease.[1] **Chronic exposure to toxic stress (chronic adversity) can physically damage a child's developing brain, with impacts well into adulthood.**[2] However, environmental factors such as the consistent presence of a caring and responsive adult and a therapeutic home environment can buffer the impact of stress.[3]

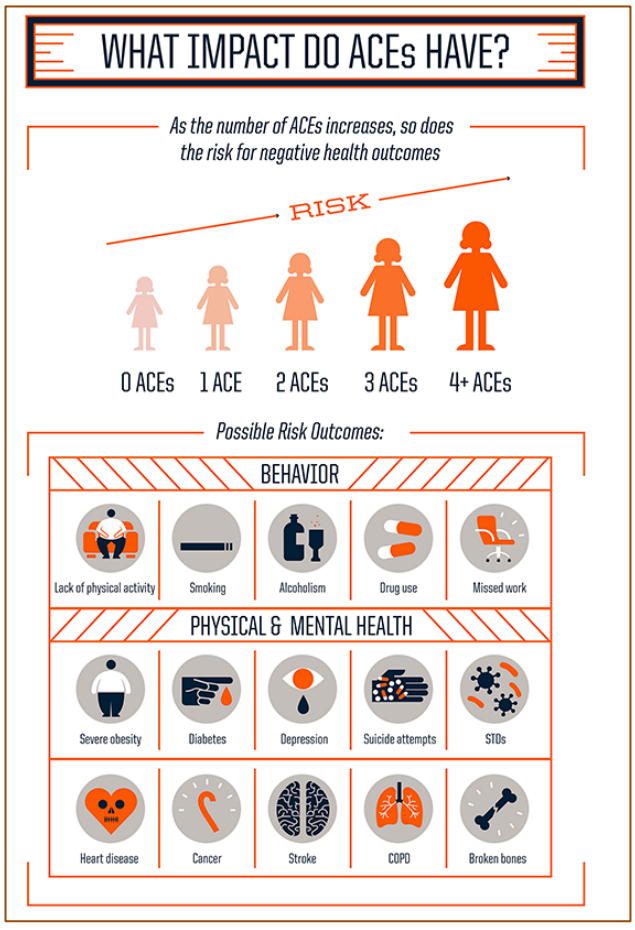

Figure 1: Impact of ACES

From rwjf.org/vulnerablepopulations

It is estimated that **13-20% of children and adolescents in the United States have a diagnosable mental, emotional, or behavioral health disorder,** and suicide is the second leading cause of death for youth ages 12-17.[4] In 2006, 8.9 billion dollars were spent for the treatment of mental disorders in children, representing the highest of any children's health care expenditures, exceeding asthma, trauma-related

[1] Felitti, Anda, Nordenberg, Williamson, Spitz, Edwards, Koss, & Marks (1998); Anda, Felitti, Bremner, Walker, Whitfield, Perry, ...& Giles (2006); Anda, Felitti, Bremner, Walker, Whitfield, Perry, ...& Giles (2006)
[2] Jouriles, Brown, McDonald, Rosenfield, Leahy, & Silver (2008); Shonkoff (2012)
[3] Fisher, Burraston, & Pears, (2005); Shonkoff & Garner (2012)
[4] Perou, Bitsko, Blumburg, Pastor, Ghandour, Gfroerer, . . . Huang (2013)

disorders, acute bronchitis, and infectious disease;[5] in 2007, it was estimated that mental and emotional disorders in children and youth cost $247 billion annually when considering all associated costs, including those from lost productivity, drug and alcohol abuse, crime, and related educational costs.[6]

Across the country, the quality of somatic and behavioral health service delivery is at the forefront of rapidly evolving systems of care. Data from the *Faces of Medicaid* report on children's behavioral health highlight the ever-growing need to address the concomitant issues of quality and cost of care. **While only 10% of children in Medicaid are accessing behavioral health services nationally, these same youth represent 38% of the total Medicaid spending for children.**[7] Of the 1.7 million children in Medicaid who received psychotropic medications in 2005, only 51% also received identifiable behavioral health services; 23% of children in Medicaid who were in foster care were prescribed psychotropic medications. An estimated 38% of children in Medicaid who use behavioral health services also have a chronic physical health condition; nonetheless, it is the behavioral health costs that account for the majority of their Medicaid expenditures. This landmark study contrasted with earlier research on populations of adults in Medicaid with serious mental illness for whom overall expenses were driven by physical health care more than behavioral health care.[7]

Federal Priorities in Action in Maryland

Health care reform, steered by The Patient Protection and Affordable Care Act of 2010 (ACA), has accelerated the pace of change and set forth strategies for enhancing our nation's health systems. The legislation had a phased implementation from 2010 through 2014 and is now fully implemented. Key provisions of the law include the ability for young adults to remain on their parents' health insurance until age 26 and for children who were in foster care to remain covered by Medicaid until age 26; no lifetime or annual limits on care; no annual limits on care; expanded Medicaid eligibility; and, the ability to purchase insurance through the health insurance exchange. Through the ACA, states established benchmark plans that specified the minimum coverage for the plans sold through the health insurance exchanges. **Maryland's benchmark plan** is the CareFirst BlueChoice HMO HAS Open Access Plan.[8]

At the end of August 2014, 78,666 individuals had enrolled in qualified health plans and 355,281 individuals gained Medicaid coverage and remained active in Medicaid. Compared to December 31, 2013, the net change in Medicaid enrollment as of August 27, 2014 was +262,737. http://marylandhealthconnection.gov/assets/MHBEMonthlyReport082914.pdf

The Paul Wellstone and Pete Domenici **Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA)** requires that health plans that provide mental health or substance use disorder benefits do not impose less favorable benefit limitations on those benefits than for medical/surgical benefits. MHPAEA was amended by the Affordable Care Act to apply to individual health insurance coverage, in addition to group health plans and group health insurance coverage. In November 2013, the Departments of Health and Human Services, Labor, and the Treasury jointly issued the final rule for the implementation of MHPAEA, and they are actively working to provide support to states and others to effectively implement MHPAEA. In May 2013, Maryland passed two pieces of legislation related to parity. HB1216/SB 581 provides consumers with the right to be made aware of parity requirements and obtain assistance in better understanding their rights. The second bill, HB 1252/SB 582 required compliance with MHPAEA

[5] Soni (2009)
[6] National Research Council and Institute of Medicine (2009)
[7] Pires, Grimes, Allen, Gilmer, & Mahadevan (2013)
[8] https://www.cms.gov/CCIIO/Resources/Data-Resources/Downloads/maryland-ehb-benchmark-plan.pdf

and provided the Maryland Insurance Administration with enforcement authority to ensure compliance.[9]

CMS and SAMHSA, along with the other administrations within the U.S. Department of Health and Human Services, have established a commitment to **quality oversight and continuous quality improvement** for states, communities, grantees and system partners. The HHS National Quality Strategy is to pursue three aims (better care, healthy people/healthy communities, and affordable care) concurrently through six priority areas (www.ahrq.gov/workingforquality).

Figure 2: National Quality Strategy Priority Areas

The National Quality Strategy is supported by the issuance of a series of joint bulletins and information memoranda to states and interested parties. These documents, often interagency in nature, highlight effective programs, provide guidance on successful implementation, and prioritize high quality, effective, and community-based care. Several of the bulletins and memoranda have focused on customizing care for special populations, including youth in the child welfare system and children with serious behavioral health needs. Some of the key bulletins and resources are listed in the Appendices.

One of the most notable bulletins released is the CMS and SAMHSA Joint Bulletin entitled, *Coverage for Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions*, issued on May 7, 2013. This bulletin highlights the tremendous positive impact of intensive care coordination (ICC) using the Wraparound service delivery model for youth with behavioral health challenges. National data from SAMHSA's Comprehensive Community Mental Health Services for Children and their Families Program (commonly referred to as "System of Care grants") and CMS' 1915(c) Psychiatric Residential Treatment Facility (PRTF) Demonstration Waiver[10] show that youth who received this intensive model of care in tandem with other community-based supports and services experienced clinical and functional improvement, increased school attendance, and achieved more stability in living environment, among other benefits.[11] In line with the triple aim strategy of reducing

The CMS and SAMHSA Joint Bulletin from May 2013 **is a pivotal document** that describes support **for financing** home- and community-based services for youth with serious behavioral health challenges. See the *Joint Bulletin* for more on positive outcomes of federal funding initiatives; recommended package of services; & detail on Medicaid financing vehicles for states

http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

[9] Maryland Parity Project (n.d).
[10] The Community Alternatives to Psychiatric Residential Treatment Facilities (PRTF) Demonstration Grant Program was authorized by Section 6063 of the Deficit Reduction Act of 2005 to provide up to $218 million to up to 10 states to develop 5-year Demonstration programs that provide home and community-based services to children as alternatives to PRTFs.
[11] Mann &Hyde (2013)

cost of care, ICC using a high quality Wraparound approach has shown that systems can realize cost savings of approximately fifty percent or more over the cost to place youth in PRTF settings.[12]

Evolution of System of Care

The standard for system design and integration within children's behavioral health systems has been developing for over three decades at the federal level through cross-agency partnerships and grant-funded initiatives to states. While the term *System of Care* was not formally defined until 1986, it was first conceptualized in the early 1980's through the Child and Adolescent Service System Program (CASSP), a federal level technical assistance program that supported all fifty states in the development of System of Care for children with serious emotional disturbance – with an emphasis on interagency collaboration.

The following definition of System of Care has evolved over the past three decades:

> [A system of care is] a spectrum of effective, community-based services and supports for children and youth with or at risk for mental health or other challenges and their families, that is organized into a coordinated network, builds meaningful partnerships with families and youth, and addresses their cultural and linguistic needs, in order to help them to function better at home, in school, in the community, and throughout life.[13]

Even prior to the passage of the ACA, CMS and SAMHSA were providing federal funds to states and communities, including Maryland, to improve the quality, cost, and effectiveness of behavioral health services for children and families. Findings from over thirty years of System of Care work at the client- and system-level have given states a launching point to implement quality programming and oversight for children's behavioral health care. As the recipient of many such grants, Maryland has been well-positioned to leverage these grant mechanisms to strategically implement and sustain systems of care.[14] Since 2007, federal funding from CMS (including the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grant and the 1915(c) PRTF Demonstration Waiver), and SAMHSA (including System of Care grants - MD CARES, Rural CARES, and LIFT), have provided for the capture of detailed information about the impact of intensive home- and community-based services.

Maryland's System Redesign

Under the mandates of the ACA, states are seeking ways to provide effective and efficient treatment to community members in order to improve individual- and population-based outcomes, while placing considerable efforts into cost containment. Maryland is not unfamiliar with major system change with respect to the structure and operations of the public behavioral health system due to its prior implementation of an 1115 Medicaid Waiver in 1997, which moved Maryland to a mental health carve-out coordinated through a contracted Administrative Service Organization (ASO).

While mental health services moved fully into the ASO model in 1997, substance use services remained within the somatic care benefit package for Maryland Medicaid recipients. Under this structure, physical health, dental, primary mental health and clinical substance use services were accessed through Managed Care Organizations (MCOs). Substance use programming that was not otherwise reimbursable through Maryland Medical Assistance (MMA; aka Maryland Medicaid), such as prevention or coordination of care, was supported largely through state and federal grant dollars. These funds were allocated to Local Addiction Authorities (LAAs). Similarly, state funding

[12] Pires (2014)
[13] Stroul, Blau & Friedman, 2010
[14] See Harburger, Stephan, & Kaye (2013)

is allocated to Core Service Agencies (CSAs), or local mental health authorities, to manage and develop the specialty public mental health service array at the local level. The CSAs and LAAs receive grant funding to contract for services that fall outside of the Medicaid benefit package. These local behavioral health authorities provide direction to the local systems through contract monitoring, systems development and forging key partnerships.

Beginning in 2012, Maryland undertook an intensive system analysis as part of the State's behavioral health integration efforts, which closely examined the financing and administrative structures for both mental health and substance use services. A number of stakeholder forums and opportunities for public comment were held. This process brought to light the need to move from a compartmentalized mental health and substance use framework to a fully integrated behavioral health care system. Four potential models for reform were debated and detailed in a full report.[15]

Ultimately, the Department of Health and Mental Hygiene (DHMH) selected, and in 2014, the Maryland General Assembly approved, the continuation of the carve-out model, adding substance use services to the pre-existing mental health carve-out. This model will shift substance use services into a similar fiscal framework as mental health, all managed by a single specialty behavioral health ASO. The current ASO, ValueOptions® Maryland, has been awarded the new contract for the management of the integrated behavioral health system beginning in winter 2015. A decision was made to integrate the management and oversight of the behavioral health system, not only through the ASO, but also through the merging of the two DHMH Administrations historically responsible for mental health and substance use, the Mental Hygiene Administration (MHA) and Alcohol and Drug Abuse Administration (ADAA). The implementation of CH0460 (HB1510) during Maryland's 2014 General Assembly Session led to this transition being effective on July 1, 2014. The newly formed Behavioral Health Administration (BHA) and the revamped governmental structure and relationships across agencies immediately involved with financial and/or operational oversight of the public behavioral health system (PBHS) is presented in the figure below.

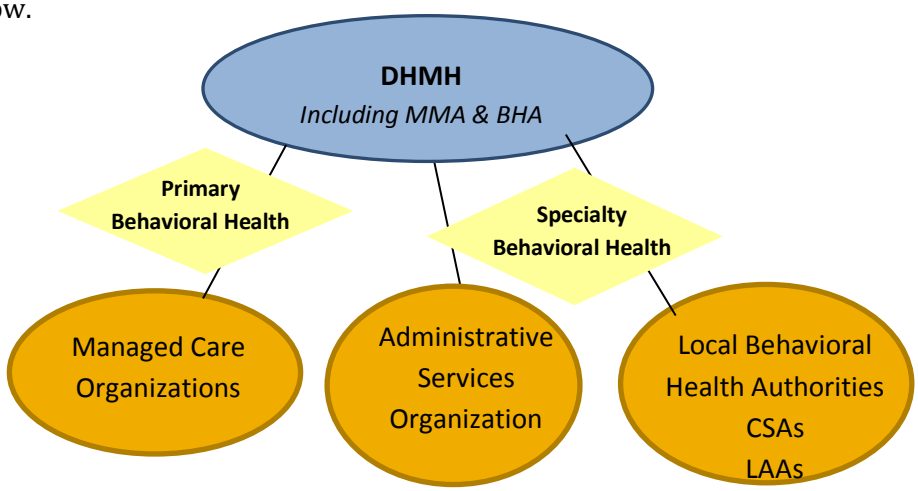

Figure 3: Maryland State-Level Administrative Structure for Behavioral Health Integration

Note: This figure is simplified to illustrate areas of responsibility; the MCOs, ASO, and local behavioral health authorities are in contractual relationships with DHMH for the administration and oversight of components of the public behavioral health system.

[15] Full final report and supporting materials can be found at: http://dhmh.maryland.gov/bhd/SitePages/integrationefforts.aspx

Additionally, in some local jurisdictions, the CSA and LAA have merged to create a local behavioral health authority; however, only a handful of Maryland's 24 jurisdictions (23 counties and Baltimore City) have fully integrated at the local level. It is anticipated that creation of the BHA and implementation of the behavioral health carve-out may encourage additional jurisdictions to integrate their mental health and substance use systems at the local level.

The shifts within the financing and administration of Maryland's system are well underway. A **period of intense system change means new ways of doing business that have the potential to improve the health of our critically vulnerable community members by transforming the way those in need access essential care through a more streamlined arrangement.** A description of changes to the service continuum that are being developed within the children's public behavioral health system amidst the state-level restructuring follows below. A graphic representing the current financing structure for children's behavioral health reflects changes resulting from integration efforts.

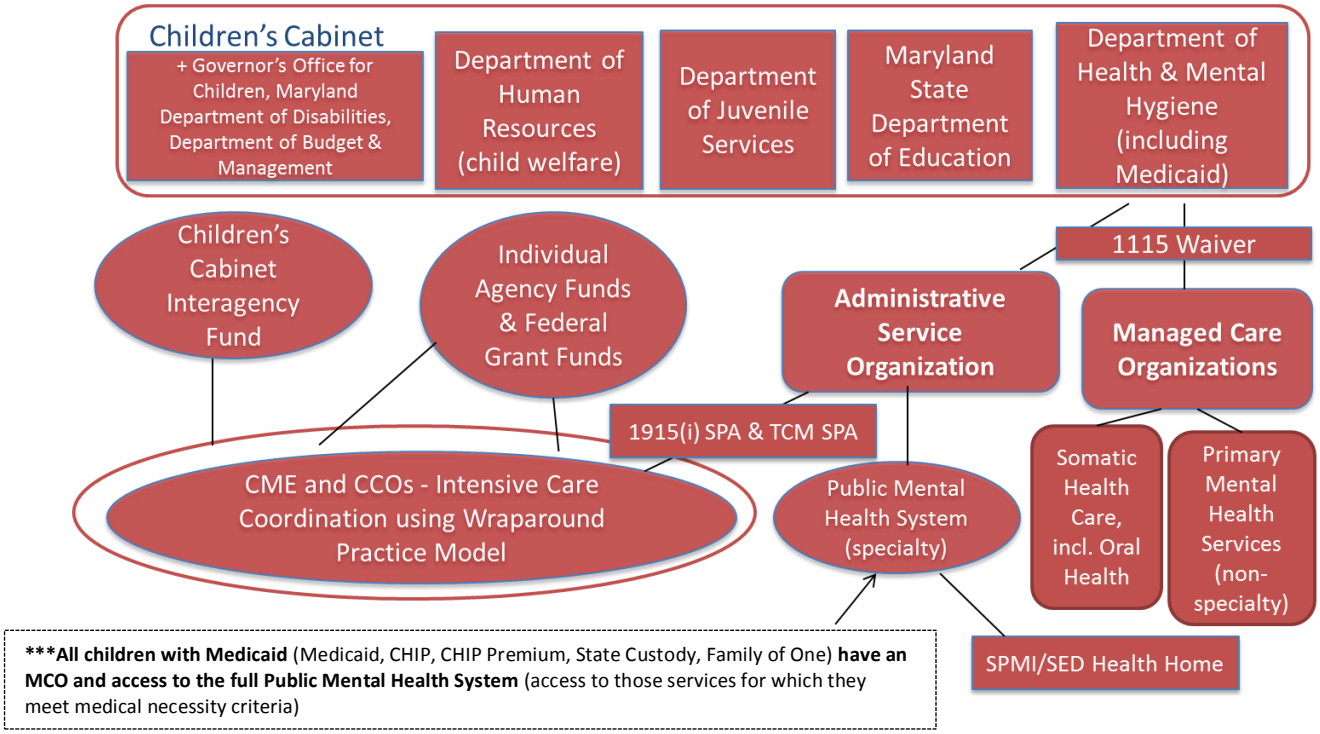

Figure 4: Maryland's Financing of Children's Behavioral Health

Multiple funding mechanisms are in place to support the wide array of services and programs found throughout Maryland's public systems for children with behavioral health needs. As discussed previously, an 1115 Medicaid Waiver is the funding authority for the managed care organizations that provide somatic care to Medicaid participants and the ASO carve-out for specialty behavioral health care. State block grant and federal block grant funds are the primary funding source for the local behavioral health authorities, which, in turn, fund a diverse network of community-based programs not otherwise available through fee-for-service. More recent additions to the financing array include the 1915(i) and Targeted Case Management (TCM) Medicaid State Plan Amendments (SPA), discussed in fuller detail later in this document.

The Children's Cabinet additionally finances a number of child-focused initiatives, including the statewide Care Management Entity (CME) and evidence-based practices. The Department of Human Resources (child welfare), the Department of Juvenile Services, and the Maryland State Department

of Education also provide behavioral health services to children and youth depending on the youth's eligibility and the nature of the funding available. Federal entitlement grants (e.g. Title IV-E, IDEA) and discretionary grants (MIECHV Home Visiting, System of Care grants, Project LAUNCH, etc.) provide extensive support for the development, implementation and sustainability of home- and community-based services for children with or at-risk for behavioral health challenges and their families.

Models for Intensive Care Coordination Services

The Care Management Entity (CME) is a model for centralized, community-based coordination of care using a Wraparound practice model. The CME framework has been implemented and customized around the nation based on factors such as population served, contracting mechanisms, funding sources, quality oversight processes, and the array of additional services and supports in the community. **Detailed examples of how states are developing and adapting the CME model to their systems' needs can be found in a recent technical assistance tool authored by Center for Health Care Strategies (CHCS) entitled, *Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs.***[16] This profile presents highlights from state and community initiatives across a broad spectrum of implementation phases, from states with newly-formed CME models to states with longstanding CMEs that are moving into their next iteration. CHCS describes Maryland's CME as part of the cohort with "evolving" structures, whereby the established model is undergoing statewide expansion while revising the approach to financing via Medicaid options. The main CME constructs are outlined in Appendix III.

Since 2007, multiple federal funding opportunities—namely, the 1915(c) PRTF (RTC) Demonstration Waiver, Maryland CARES, Rural CARES, LIFT, and the CHIPRA Quality Demonstration Grant, have fostered the development of Maryland's CME model. This is the result of Maryland's commitment to serving children and youth in their homes and communities. These grant activities and demonstrations have informed Maryland's redesign of its behavioral health system for children and youth. The CME has evolved from small, local pilot projects to a statewide model that has itself changed from a regional to single, statewide construct. Funding to support the CME has been provided by the Children's Cabinet Interagency Fund, DHMH (through the 1915(c) PRTF Demonstration Grant and MD CARES) and Talbot County Government (through Rural CARES). Maryland CARES and Rural CARES are phasing out in 2014 and 2015 respectively, and Maryland has been exploring additional, sustainable funding options.[17]

One such sustainability strategy that was employed was to modify Maryland's existing Targeted Case Management service for children (TCM; also known in Maryland as Mental Health Case Management) so that it could more effectively serve as the mechanism for providing intensive care coordination (ICC). **DHMH revised its Medicaid TCM service to include a third, more intensive level that uses the Wraparound service delivery model for youth who meet the relevant clinical and financial eligibility criteria. The TCM providers offering ICC using the Wraparound service delivery model are being called Care Coordination Organizations (CCOs) in order to differentiate them from the CME. However, the key functions of the CCO remain the same as those of the CME, and the difference is more associated with the financing of the service.**

Maryland is entering a new phase of its care coordination evolution with the addition of the TCM

[16] Simons, Pires, Hendricks & Lipper (2014)
[17] For information on why Maryland was unable to continue to serve children through a 1915(c)Waiver, please see https://theinstitute.umaryland.edu/topics/soc/docs/Institute%20Comment.pdf

SPA, which brings elements of the grant-funded work into the PBHS, including the Wraparound service delivery model. Part of this effort includes LIFT, Maryland's SAMHSA System of Care Expansion Implementation Grant, which has been the practice round for the CCO concept, whereby a traditional mental health case management (TCM) provider is implementing the Wraparound service delivery model of ICC. A comparison of Maryland's current CME functions versus the CCO design is found in Table 1: Maryland's Intensive Care Coordination Models below.

The ACA made health homes available as another vehicle for states to provide home- and community-based services for those with severe somatic or behavioral health issues, or a combination of both. In 2013, Maryland began offering Health Homes for adults with serious and persistent mental illness (SPMI), children with serious emotional disturbance (SED) and individuals diagnosed with an opioid substance use condition who are at risk for developing another chronic condition. The Health Home approach aims to keep individuals in their home and community by reducing avoidable hospitalizations and emergency room visits. Maryland Health Homes are currently available through approved Psychiatric Rehabilitation Providers (PRP), Mobile Treatment Services or Opioid Treatment Programs.

Health Homes in Maryland are authorized and overseen by DHMH. Health Homes follow a national model of care management that uses a holistic, person-centered approach to working with individual clients to address needs across all domains, with special focus on health and behavioral health. Care management, health promotion, comprehensive transitional care, community referral, and individual and family support are all federally-mandated components of Health Home[18] service delivery. In order for youth to be eligible to be served in a health home, he or she must have a serious emotional disturbance and be at high risk for or have additional chronic conditions. The youth must be enrolled in appropriate companion mental health services.

[18] For a current list of approved Health Homes, please refer to the DHMH website: http://dhmh.maryland.gov/bhd/SitePages/Health%20Homes.aspx

	CME	CCO	SPMI/SED Health Home
Funder	Governor's Office for Children on behalf of the Children's Cabinet	Medicaid through Targeted Case Management State Plan Amendment	Medicaid through Health Home State Plan Amendment
# Youth	Up to 350 at any time	200 first year; ultimately 500-750	Up to 15,000 adults & youth
Populations Served	Stability Initiative SAFETY Initiative Rural CARES (closed for new enrollments)	LIFT, 1915(i) State Plan Amendment, Targeted Case Management Levels I, II, III	Youth with SED enrolled in Psychiatric Rehabilitation Program
Rate	$1171* per member per month	$20.19/15 minutes—up to $1,211.40 per member per month for Level III	$99 per member, per month
Caseload Ratio	1:9 to 1:11	No ratio specified	.5 FTE:125
Referral Sources	Stability Initiative: • DJS • DHR SAFETY Initiative: • Local Schools • Local Care Team • Local Management Board • CSA	All, including youth and family	Family Therapist
Functions and Responsibilities	• **Intensive Care Coordination using a Wraparound service delivery model** • Child and Family Team Facilitation • Utilize assessment tools (e.g., Child and Adolescent Needs and Strengths) • Connections and referrals to natural and professional supports, including peer support • Management of the Plan of Care • Utilization of management information system • Continuous Quality Improvement, including participating in fidelity monitoring, satisfaction, and evaluation activities • Provider network recruitment & management (CME only)		Federally mandated core services: • **Comprehensive Care Management** (Team meetings at least every 6 months) • Comprehensive Transitional Care • Care Coordination • Individual and Family Support • Health Promotion • Referral to Community & Social Support
*CME monthly rate per member is calculated using the contracted daily rate ($38.49 per youth per day)			

Table 1: Maryland's Intensive Care Coordination Models

Care Management Entity

The statewide Care Management Entity (CME) is managed by the Governor's Office for Children (GOC) on behalf of the Maryland Children's Cabinet.[19] Funding for the CME is made possible by the

[19] The Maryland Children's Cabinet is chaired by the Executive Director of the Governor's Office for Children and also includes the Secretaries of the Departments of Budget and Management, Disabilities, Health and Mental Hygiene, Human Resources, and Juvenile Services, as well as the Superintendent of the Maryland State Department of Education.

Children's Cabinet Interagency Fund (state general funds) as well as through grant funds (described above). The CME provides care coordination using the Wraparound practice model to specific populations based on eligibility criteria set forth by the Children's Cabinet. A pool of discretionary funds is allocated to the CME, and the CME holds responsibility for utilizing those funds to meet identified needs on the individualized plan of care (POC), as articulated by the Child and Family Team (CFT). The CME also is responsible for building a provider network for the families it serves, which is often accomplished through relationship-building and/or contractual arrangements. The CME is contracted to serve several youth populations based on criteria outlined by GOC on behalf of the Children's Cabinet, which include:

- **Stability Initiative for Juvenile Justice** - for youth involved with the Department of Juvenile Services. Youth who meet diagnostic criteria for serious emotional disturbance (SED) and who are at-risk for or currently residing in an out-of-home placement, re-entering community after an out-of-home placement, or an adjudicated youth who may be pending placement status for out-of-home placement.
- **Stability Initiative for Child Welfare** - for youth involved in the Department of Human Resources. Youth must meet SED diagnostic criteria, and be at-risk for an out-of-home placement, have an open Child Protective Services/In-Home Services case at the time of referral to the CME; or currently be in out-of-home placement at the congregate (group home) level; or at the time of referral are at-risk for a voluntary placement agreement; or at the time of referral are being reunited with family after an out-of-home placement.
- **SAFETY Initiative** – for youth referred by the local public school systems, Local Care Teams (local interagency teams), Local Management Boards (local leadership from Children's Cabinet agencies), and CSAs. Youth must meet one more of the following at the time of referral: youth, regardless of insurance status, is being discharged from a PRTF with a recommendation for community-based services; youth is enrolled in a school system sponsored Home and Hospital Program; or, youth is experiencing a combination of risk factors and would benefit from cross-discipline and multiple agency resources. Youth must meet at least one of the following three criteria at the time of referral: the youth is being discharged from a Residential Treatment Center (RTC), the youth is enrolled in a home and hospital program, or the youth meets two of the following:
    - Has run away from home
    - Uses substances illegally
    - Has been suspended/expelled from school
    - Has been chronically absent (missing more than 20% of school days)
    - Is failing or has failed a class
    - Displays school avoidance behaviors
    - Has significant involvement with school support teams
    - Has been arrested
    - Has involvement with the Department of Juvenile Services
    - Has failed to meet the terms or conditions of a Teen Court Program
    - Is a victim of maltreatment

Care Coordination Organizations

Care Coordination Organizations (CCO) agencies are authorized through an approval process established by DHMH. They are selected by the local CSAs to serve in this capacity but are reimbursed through the PBHS by submitting claims through the ASO. The CCOs may be regionally procured depending on local preference. The CCOs are Mental Health Case Management/Child and Youth TCM Providers who are responsible for providing Levels I, II and III care coordination as outlined in COMAR 10.09.90. Effective October 1, 2014, all CCOs are responsible for the array of

care coordination services outlined in regulation, as well as incorporating System of Care and Wraparound values and principles into their family-driven work. Any youth covered by Maryland Medical Assistance who is enrolled in the 1915(i) SPA or is medically eligible to receive ICC will be served by the CCO.

The TCM SPA modified the service structure so that CCOs now are designed to offer three levels of care coordination that are available based on clinical need. The CCO is reimbursed in 15-minute units of service:

- Level I (General Coordination): Up to 12 units per month, minimum 2 units face-to-face;
- Level II (Moderate Care Coordination): Up to 30 units per month, minimum 4 units of face-to-face; and
- Level III (Intensive Care Coordination): Up to 60 units per month, minimum of 6 units face-to-face.

Level III is designed to provide high quality Wraparound care coordination to children and youth who meet specified clinical criteria. Youth in Level III are expected to be those who are at or just below a PRTF (RTC) level of care, who have a history of inpatient psychiatric hospitalizations or frequent psychiatric emergency room visits, and can be safely and appropriately served in the community with intensive home- and community-based services. Youth may also be involved with other child- and family-serving agencies (e.g. juvenile justice and child welfare) and must reside in a Medicaid-defined home- and community-based setting.

A Comparison of CME and CCO Functions and Responsibilities

	CME	CCO
Service Delivery	Intensive care coordination using the wraparound service delivery model	Care Coordination: Level 1 – General; Level 2 – Moderate; Level 3 – Intensive using Wraparound service delivery model **(Level III includes 1915(i) and other clinically eligible youth)**
Provider Network Development	CME performs itself, in partnership with local agencies and organizations	Not a specific function of CCO; CCO relies on the PBHS developed by the State and other locally available services and supports
Utilization Management	CME performs itself	Formal responsibility lies with statewide ASO or Medicaid MCOs; CCO monitors utilization at the child/family level and ensures POCs meet quality and cost goals
Discretionary Funds	Funds are managed directly by the CME	Customized Goods & Services are a benefit under the 1915(i). DHMH is exploring options on management of the funds through the CSAs
Quality Oversight	Children's Cabinet, GOC, and CME are responsible	Responsibility will be shared among DHMH, CCOs, and the ASO
Training	CME is required to participate in training through the State's contracted training entity; may procure additional training	CCO is required to participate in training through the State's contracted training entity; may procure additional training

Table 2: Maryland Care Coordination Functions and Responsibilities

Maryland's Public Behavioral Health Service Array for Youth

The benefit package available to youth enrolled in Maryland's Medicaid programs includes access to a generous array of mental health services from community-based outpatient care to more restrictive residential treatment centers. **For youth with more complex behavioral health needs, Maryland has begun to move away from institutional or inpatient care in favor of an expanded array of intensive home- and community-based supports and services.** Maryland's service array is traditional but robust for those children and youth covered by Medicaid or Maryland Children's Health Program (MHCP).

Examples of services within the broader continuum, funded through the fee-for-service system and/or federal, state and local grants, include respite care, mobile treatment, case management, psychiatric rehabilitation, and partial hospitalization programs. Access to these services and supports varies according to clinical criteria and geographic location, as not all services are available in all localities across the state. Additional programs, such as crisis response and emergency room diversion, are grant-funded in some jurisdictions, but again, are not universally available. Other services and supports outside the Public Behavioral Health System (PBHS) include Multi-Systemic Therapy, Functional Family Therapy, Parent-Child Interaction Therapy, Treatment Foster Care, Peer Support, and other community-based and natural supports. Eligibility for these services depends on the funder and associated parameters for each service.

The spectrum depicted below, while not exhaustive, represents a portion of the services available to youth in Maryland's PBHS for children and youth.

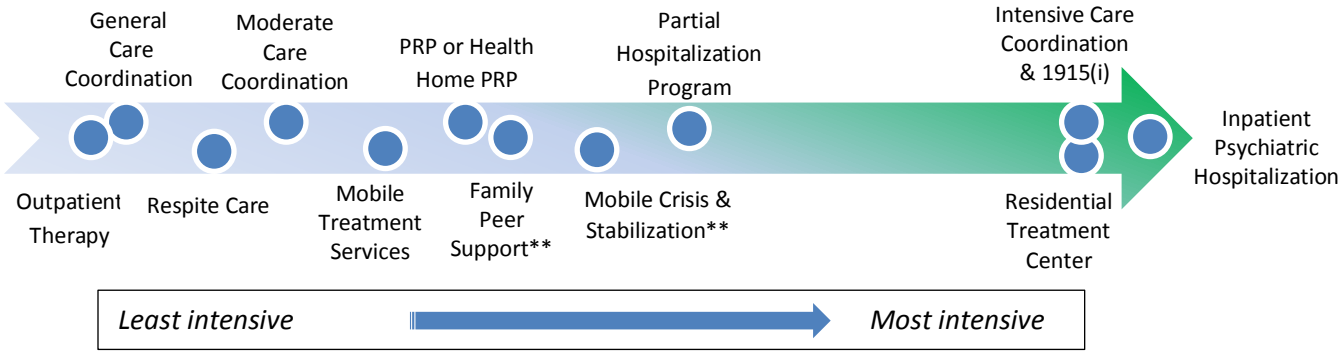

Figure 5: Maryland's Public Mental Health Service Array for Youth

**Grant-funded through State Block Grants in select areas; not a Medicaid service, except through 1915(i) SPA

Substance use services for youth with Medicaid coverage are available via varying levels of outpatient and inpatient services. Medicaid benefits include access to comprehensive assessment, outpatient, intensive outpatient, opioid maintenance treatment, youth residential and inpatient treatment, and medically monitored detoxification. DHMH also has several grant-funded initiatives through state dollars, such as school-based prevention and adolescent "Clubhouses" for youth in recovery, which are available in several jurisdictions.

Children in Medicaid also have access to a pharmacy benefit that can be accessed through the primary care system (MCO) or the specialty behavioral health system. Heeding a national call for better oversight and monitoring of the prescribing of psychotropic medications, particularly for those children in foster care, Maryland established two programs within the Medicaid Pharmacy Program: The Peer Review Program and the Tier 2 & Non-Preferred Antipsychotic Review

Program (Tier 2 & NP). The Peer Review Program, which began in 2011, is a prior authorization program for prescriptions of antipsychotics for Medicaid recipients ages 17 or younger. The Tier 2 & NP Program is also a prior authorization review process that is designed to address additional concerns related to psychotropic medication prescribing practices for children, including the off-label use of antipsychotics.[20]

1915(i) Service Array

The 1915(i) will enable families to access ICC through CCOs along with access to additional home- and community-based, specialized services that are beyond the standard benefits package available to Medicaid participants. Maryland received federal approval of its 1915(i) application in October 2014, and there is a five-year timeline for the services to be made fully available statewide. The State is in the process of establishing county or region-level criteria to determine the readiness of the local infrastructure to begin enrolling eligible youth.

The following services were approved as part of the special Medicaid service array for youth eligible for the 1915(i):

Intensive In-Home Services (IIHS) is a strengths-based intervention with the child and his or her identified family, which includes weekly face-to-face contact and crisis response. This program is designed to work with families in their homes to develop and implement individualized interventions to help the child remain stable in the home and community and avoid hospitalization or out-of-home placement. Separate rates are included for both evidence-based practice (EBP) and non-EBP providers of this service. This represents the first time Maryland has included EBPs as a reimbursable Medicaid benefit for children's behavioral health.

Family Peer Support is provided by peer support partners who work with the family to help them navigate various systems, understand the Wraparound process, actively engage families around their strengths and needs, and work to empower family voice and choice in the process. Family peer support is provided by legacy families with experience accessing behavioral health services on behalf of their own families.

Mobile Crisis Response & Stabilization (MCRS) is a pre-authorized service that includes immediate 24/7 response to urgent mental health needs by a licensed mental health professional, as well as access to short-term, individualized services that assist in stabilizing the youth in the home and community. Before a crisis occurs, the MCRS provider may also meet with the family and CCO to develop the initial crisis plan. Services are fully integrated in the Plan of Care (POC) developed by the Child and Family Team (CFT).

Respite is available as a community-based service in order to provide temporary care services arranged on a planned or unplanned basis. Unplanned respite may be provided on an emergency basis due to an unforeseen event, or to help mitigate a potential crisis situation. Respite provides stabilization and relieves a caregiver from the stress of care giving. Community-based respite may be provided in the home or the local community. Out-of-home respite is provided in community-based alternative living arrangement that is appropriately licensed, registered, or approved, based on the age of individuals receiving services, and whether the respite has capacity to do overnight services.

[20] See https://mmcp.dhmh.maryland.gov/pap/SitePages/Antipsychotics%20Review%20Programs.aspx for more information.

Expressive Therapies are non-traditional therapeutic interventions that include creative modalities for self-expression and personal growth. Some examples include Music, Equine-Assisted Therapy, Art Therapy, and Dance/Movement Therapy.

Customized Goods & Services are flexible funds that can be used to creatively support the strengths and needs of the youth and family and are directly reflected in the goals and strategies of the POC. These funds are used to purchase services that are not otherwise available through the 1915(i) or broader Medicaid benefit for children and youth.

Evidence-Based Practices

Maryland also has been implementing a number of EBPs in regions throughout the state. Functional Family Therapy (FFT), Multi-Systemic Therapy (MST), and Brief Strategic Family Therapy (BSFT) are examples of modalities that are available through various funding streams. Access to these treatments usually requires system involvement, such as with juvenile justice, but does not typically require insurance coverage; at this time, programs are funded primarily by state funds through the lead child- and family-serving agency. For example, the Department of Juvenile Services has extensively funded FFT and MST in some areas of Maryland. Availability of the EBPs varies by geographic region and slot capacity.

Additionally, Managing and Adapting Practice (MAP) is being implemented through a collaboration between The Institute, PracticeWise, LLC, and community behavioral health practitioners as a way to train the current and future workforce. MAP uses a web-based platform that enables behavioral health clinicians to access elements of EBPs to inform the clinical treatment process with clients. The Institute currently is working in focused areas of the state with small cohorts, including outpatient clinic staff and University of Maryland field instructors and students. Over the next several years, the plan is to fully develop a statewide network of clinicians who are trained and certified to use MAP.

Looking Ahead: Implementation of Quality Practice

Good clinical outcomes are based not merely on availability and utilization of EBPs, promising practices and service delivery models; *they are critically dependent on the quality of implementation planning, how well providers deliver the practices, the level of stakeholder involvement and the obtainment of buy-in at the community level.* While initial investment in programmatic reach is important, current research on evidence-based programming demonstrates the critical link between quality implementation and anticipated positive outcomes.[21] States, communities and providers are at-risk of an implementation gap if they do not focus on implementation drivers—those critical components that will affect change at the individual and population levels. Training, information-sharing, and organizational change alone are insufficient to realize intended outcomes.[22]

> An implementation gap is what occurs when an otherwise effective intervention is poorly or insufficiently implemented, resulting in inconsistency, unsustainability, and poor outcomes.
> Bertram, Blasé, & Fixsen, 2013

[21] Fixsen, Naoom, Blasé, Friedman, & Wallace (2005)
[22] Fixsen & Blasé (2013)

Much of Maryland's systems reform hinges on intensive care coordination using the full fidelity Wraparound service delivery model. In this model, the implementation drivers are organization (community partnership, financing, system structures, human resource strategies, service array & accountability structures), leadership (State & local systems and context, values), and competency/human resources (supervision, staff competence, coaching, monitoring).[23]

There are several functions related to successful implementation and sustainability of effective practices:

- **Implementation Support**, including Continuous Quality Improvement or CQI, implementation planning, readiness, on-going facilitation, service array development and intervention selection, screening and assessment tools, outreach, marketing, and communications;
- **External Partnerships & Collaboration**, including building relationships with purveyor organizations, connecting cross-agency efforts and initiatives, and promoting partnerships across universities, agencies and organizations;
- **Workforce Development**, including training and coaching, capacity building, and education;
  Policy and Strategic Planning and Financing, including grant writing/management, Medicaid and other federal financing support, rate-setting, policy development, production of white papers, articles, and issue briefs, and support for the alignment of policy and practice; and
- **Research, Evaluation & Data Linking**, including collecting and reporting on a core set of implementation indicators and outcomes, linking administrative data, and utilizing data to answer implementation and larger systems-level impact questions.

All of these functions are essential to the initial and ongoing implementation of services and interventions. Of particular note with regard to Maryland's System of Care is the use of functional screening and assessment tools. The Child and Adolescent Needs and Strengths (CANS) is a trauma-informed instrument that is used by a number of child-serving agencies around the state for initial and ongoing assessment. CCOs and the CME use CANS at intake and reassessment (on a 90-day cycle) to allow for information-gathering that guides practice. The Maryland Department of Human Resources uses the Maryland CANS with all children and youth placed out-of-home and will be implementing the CANS-Family for youth receiving in-home services.[24]

The Child and Adolescent Services Intensity Instrument (CASII) and Early Childhood Services Intensity Instrument (ECSII) have been adopted as a tool for eligibility determinations and reassessment of youth. In conjunction with Certificate of Need documentation, the CASII/ECSII are planned for use by CSAs and the ASO to evaluate eligibility for the 1915(i). Maryland's RTCs, the ASO, and Department of Juvenile Services have also been trained on the CASII in order establish a consistent measure of clinical progress throughout the state for the PRTF level of care.

Training, peer-to-peer exchange, and technical assistance are essential components of implementation and quality improvement. Local implementation teams, comprised of service providers, coaches, and funders, have been successful at managing the implementation process. A data-driven, collaborative approach enables local teams to adjust policies and practices, provide additional training, or make other modifications or course-corrections to address challenges as they arise. Additionally, Maryland's CSAs have joined together to form a CSA Leadership Learning Community to support knowledge exchange and information-sharing among local behavioral health leaders. This Learning Community will be enhanced with presentations (in-person and web-based)

[23] Bertram, Blasé, & Fixsen (2012); Bruns, Hust, Matarese & Zabel (2012)

[24] For more information on the use of the CANS in Maryland, please visit https://theinstitute.umaryland.edu/topics/sat/cans_Implementation.cfm.

by national and local experts on best practices within thematic areas prioritized by local implementation partners.

Maryland has several entities involved in the oversight of the intensive community-based services outlined in this document. The structure for continuous quality improvement is based on the protocols set forth by the oversight body.

	Quality Oversight Agency	Quality Indicators[25]
CCO	MMA, BHA, ASO, CSAs	Frequency of CFT meetings, Compliance with Reportable Events, Staffing Structure, Consumer Complaints, Claims data (utilization and billing), Wraparound Fidelity*
Health Home	MMA	Client progress on multiple somatic health indicators; preventive care; ED admissions/hospitalizations
CME	GOC, on behalf of the Children's Cabinet	Wraparound Fidelity, contract compliance

Table 3: Quality Oversight

* Sample of indicators in the 1915(i) State Plan Amendment

In the near future, Maryland plans to launch an Electronic Health Record for providers using intensive care coordination and the Wraparound service delivery model. TMS WrapLogic, made possible through the National Wraparound Implementation Center, will include data on youth receiving services from the CME and CCOs and allow for local- and state-level access to program quality indicators. TMS WrapLogic has been customized for Maryland's unique provider array through consultation with local and national experts.

The Maryland Children's Cabinet and DHMH have partnered with The Institute to collect fidelity data including gathering feedback from families served using the Wraparound model through CCOs and the CME using the Wraparound Fidelity Index (WFI-EZ). At the request of the funding entities, The Institute provides data analysis and reports on the domains covered by the WFI-EZ, including family satisfaction with services and overall experiences with the Wraparound model.

Additionally, Maryland Children's Cabinet and DHMH recognize the importance of implementation factors to achieve positive outcomes for families and are considering fidelity monitoring tools, including the Wraparound Structured Assessment and Review (WrapSTAR). The WrapSTAR process goes above merely measuring a site's adherence to the Wraparound model to also assess key implementation drivers rooted in years of implementation science research, as well as community and system supports found to be essential for sustaining a Wraparound initiative. This holistic approach allows for a robust understanding of about what can be done to improve outcomes for families and staff and the degree to which local sustainable infrastructure for workforce development and implementation has successfully yielded high-quality practice.

Conclusion

Like many states, Maryland has experienced considerable systems changes over the past several years. New federal funding opportunities have enabled Maryland to expand its array of effective home- and community-based services, presenting a new array of challenges and opportunities for successful implementation. Informed by lessons learned nationally and research-based best

[25] This is not an exhaustive list of quality indicators, and measures are subject to change based on decisions of the respective oversight body.

practices, State and local agencies, families and youth, providers, and advocates together are propelling Maryland toward a more cost-effective, quality-driven system of care that will undoubtedly reap positive outcomes across multiple domains children, youth, and families.

Works Cited

Anda, R. F., Felitti, V. J., Bremner, J. D., Walker, J. D., Whitfield, C., Perry, B. D., ... Giles, W. H. (2006). The enduring effects of abuse and related adverse experiences in childhood: A convergence of evidence from neurobiology and epidemiology. *European Archives of Psychiatry and Clinical Neuroscience, 256*, 174–186

Bertram, R.M., Blase, K.A., & Fixsen, D. L. (2012). *Improving outcomes and programs: Implementation Frameworks 2013.* University of Houston: http://www.sw.uh.edu/

Bruns, E.J., Hust, J., Matarese, M., & Zabel, M. (2012). *Through the looking glass: Implementing wraparound practice though the lens of implementation science*. Georgetown University Training Institutes, Orlando, FL.

Center for Health Care Strategies. (2011). *Care management entities: a primer*. Available from the Center for Health Care Strategies' website: www.chcs.org

Edwards, V.J., Holden, G.W., Felitti, V.J., & Anda, R.F. (2003). Relationship between multiple forms of childhood maltreatment and adult mental health in community respondents: results from the adverse childhood experiences study. *The American Journal of Psychiatry, 160*(8), 1453-1460. doi:10.1176/appi.ajp.160.8.1453

Felitti, V.J., Anda, R.F., Nordenberg, D., Williamson, D.F., Spitz, A.M., Edwards, V., Koss, M.P., & Marks, J.S. (1998). Relationship of childhood abuse and household dysfunction to many of the leading causes of death in adults. *American Journal of Preventive Medicine, 14*(4), 245-258. doi: http://dx.doi.org/10.1016/S0749-3797(98)00017-8

Fisher, P.A., Burraston, B.O., Pears, K.C. (2005). The early intervention foster care program: permanent placement outcomes from a randomized trial. *Child Maltreatment*, *10*, 61–71

Fixsen, D.L. & Blasé, K.A. (2013). *Overcoming barriers to implementation.* An Institute of Medicine Workshop: Evidence for Violence Prevention Across the Lifespan and Around the World. Available from the IOM website: http://www.iom.edu/~/media/Files/Activity%20Files/Global/ViolenceForum/2013-JAN-23/0204-Fixsen.pdf

Fixsen, D.L., Naoom, S.F., Blasé, K.A., Friedman, R.M., and Wallace, F. (2005) *Implementation Research: A Synthesis of the Literature*. Tampa, FL: University of South Florida, The Louis de la Parte Florida Mental Health Institute, Department of Child & Family Studies.

Jouriles, E. N., Brown, A. S., McDonald, R., Rosenfield, D., Leahy, M. M., & Silver, C. (2008). Intimate partner violence and preschoolers' explicit memory functioning. Journal of Family Psychology, 22, 420-428.

Mann, C. & Hyde, P.S. (May 7, 2013). Joint Bulletin: Coverage for Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions. Centers for Medicare and Medicaid Services and Substance Abuse and Mental Health Services Administration. Available from: http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

Maryland Parity Project (n.d.). www.marylandparityproject.org

National Research Council and Institute of Medicine. (2009).*Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*. Committee on the Prevention of Mental Disorders and Substance Abuse Among Children, Youth, and Young Adults: Research Advances and Promising Interventions. Mary Ellen O'Connell, Thomas Boat, and Kenneth E. Warner, Editors. Board on Children, Youth, and Families, Division of Behavioral and Social Sciences and Education. Washington, DC: The National Academies Press.

Pires, S. (2014). Children in Medicaid with Behavioral Health Challenges, presented at CMS Grand Rounds on May 8, 2014. Human Service Collaborative.

Pires, SA, Grimes, KE, Allen, KD, Gilmer, T, & Mahadevan, RM. (2013). Faces of Medicaid: Examining Children's Beahvioral Health Service Utilization and Expenditures. Center for Health Care Strategies: Hamilton, NJ. Available from https://www.chcs.org

Shonkoff, J.P. (2012). Building a new biodevelopmental framework to guide the future of early childhood policy. *Childhood Development, 81*(1), 357-367. doi:10.1111/j.1467-8624.2009.01399.

Shonkoff, J.P., & Garner, A.S. (2012). The lifelong effects of early childhood adversity and toxic stress. *Pediatrics, 129*(1), e232-e246. doi:10.1542/peds.2011-2663

Simons, D., Pires, S.A., Hendricks, T., & Lipper, J. (2014). Intensive Care Coordination Using High-Quality Wraparound for Children with Serious Behavioral Health Needs: State and Community Profiles. Available from the Center for Health Care Strategies website: www.chcs.org

Soni, Anita. *The Five Most Costly Children's Conditions, 2006: Estimates for the U.S. Civilian Noninstitutionalized Children, Ages 0-17*. Statistical Brief #242. April 2009. Agency for Healthcare Research and Quality, Rockville, MD. http://www.meps.ahrq.gov/mepsweb/data_files/publications/st242/stat242.shtml

Stroul, B., Blau, G., & Friedman, R. (2010). Updating the system of care concept and philosophy. Washington, DC: Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.

Appendices

Appendix I: Key Federal Informational Bulletins & Letters

Joint CMCS and SAMHSA Informational Bulletin
DATE: January 26, 2015
SUBJECT: Coverage of Behavioral Health Services for Youth with Substance Use Disorders
http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-01-26-2015.pdf

CMCS Informational Bulletin
DATE: October 29, 2014
SUBJECT: Delivery Opportunities for Individuals with a Substance Use Disorder
http://www.medicaid.gov/Federal-Policy-Guidance/downloads/CIB-10-29-14.pdf

CMCS Informational Bulletin
DATE: July 7, 2014
SUBJECT: Clarification of Medicaid Coverage of Services to Children with Autism
http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-07-07-14.pdf

CMCS Informational Bulletin
DATE: November 27, 2013
SUBJECT: Update on Preventive Services Initiatives
http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-11-27-2013-Prevention.pdf

Joint CMS and SAMHSA Informational Bulletin
DATE: May 7, 2013
SUBJECT: Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions
http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-05-07-2013.pdf

CMCS Informational Bulletin
DATE: March 27, 2013
SUBJECT: Prevention and Early Identification of Mental Health and Substance Use Conditions
http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-03-27-2013.pdf

CMCS Informational Bulletin
DATE: August 24, 2012
SUBJECT: Collaborative Efforts and Technical Assistance Resources to Strengthen the Management of Psychotropic Medications for Vulnerable Populations
http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-24-12.pdf

CMCS Informational Bulletin
DATE: December 3, 2012
SUBJECT: Coverage and Service Design Opportunities for Individuals with Mental Illness and Substance Use Disorders
http://medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-12-03-12.pdf

Tri-Agency Letter
DATE: July 11, 2013
SUBJECT: Trauma-Informed Treatment
http://medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

ACF Informational Bulletin
DATE: April 17, 2012
SUBJECT: Promoting Social and Emotional Well-Being for Children and Youth Receiving Child Welfare Services
http://www.acf.hhs.gov/sites/default/files/cb/im1204.pdf

Appendix II: Additional Resources

- For informational briefs, reports, webinars, and other materials on children's behavioral health, including Medicaid utilization and expenditures, visit the Center for Health Care Strategies: www.chcs.org

- For information on child development, toxic stress, executive function and more, visit the Harvard Center for the Developing Child: http://developingchild.harvard.edu/

- To read *Mental Health Surveillance Among Children — United States, 2005–2011*, which includes an overview of mental health disorders in the U.S., visit the Centers for Disease Control and Prevention: http://www.cdc.gov/mmwr/preview/mmwrhtml/su6202a1.htm

- For an overview on *Analyzing Child and Adolescent Expenditures and Service Use Across Systems,* written by Sheila Pires for The TA Telescope, please go to: http://origin.library.constantcontact.com/download/get/file/1114009451637-544/Quarterly+Financial+Mapping.pdf

- For information and updates on health care reform nationally, go to: http://www.healthcare.gov

- For the National Quality Strategy, go to http://www.ahrq.gov/workingforquality/#

- For information and weekly updates on federal health reform implementation as well as each state's response to the Affordable Care Act, go to: http://www.kidswellcampaign.org/

- For frequently asked questions and responses on health reform and Medicaid, go to: http://medicaid.gov/State-Resource-Center/Frequently-Asked-Questions/CMCS-Ask-Questions.html

- For information and updates on the impact of health reform on public and private payers and provider organizations serving children, families and adults with complex health and human service needs, go to: www.openminds.com/

- To read a letter from The Institute for Innovation and Implementation to the U.S. Senate Finance Committee on barriers to behavioral health care for Medicaid recipients and policies and programs to improve the quality of behavioral health care for people with behavioral health needs, please visit https://theinstitute.umaryland.edu/topics/soc/docs/Institute%20Comment.pdf

Appendix III: CME Functions & Structures

Care Management Entity (CME) Functions and Structure Options
(Structures in bold text are applicable to Maryland's current CME configuration)

FUNCTIONS	STRUCTURE OPTIONS
Wraparound and Care Coordination	• **CME performs itself.** • Contract with another organization.
Access to Family and Youth Peer Supports and Advocacy	• CME hires its own peer support staff. • Contract with a family-run organization. • **Use peer supports as a billable service.**
Access to Crisis Supports	• CME operates its own mobile response and stabilization service. • **Use crisis supports contracted by the state**. • Use the crisis capacity that exists in Medicaid managed care organization (MCO) networks of providers.
Provider Network Development and Management	• **CME performs itself**. • The state performs, sometimes working with a statewide ASO. • Medicaid MCOs perform.
Utilization Management	• **CME performs itself**. • Formal responsibility lies with statewide ASO or Medicaid MCOs; CME monitors utilization at the child/family level and ensures care plans meet quality and cost goals.
Quality Improvement and Outcomes Management	• **Responsibility is typically shared among purchasers, CMEs, and other statewide management entities such as ASOs, with the CME playing a critical role at the child/family level.**
Training	• CME performs itself. • **CME shares the function with the state**.

Source: Center for Health Care Strategies. (2011). Care management entities: a primer. Available from the Center for Health Care Strategies' website: www.chcs.org

Table 4: CME Functions and Structure