Leveraging Managed Care Approaches to Promote Children’s Behavioral Health: Day 1

Tuesday July 21, 2015
The Holiday Inn Inner Harbor Baltimore
## Day 1 Agenda

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<th>Time</th>
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<tr>
<td>Welcome</td>
<td>Welcome, Introductions &amp; Purpose of the Meeting</td>
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<td>Customizing Children’s Behavioral Health Care within a Medicaid Managed Care</td>
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<td>Break</td>
<td>Enviornment</td>
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<td>Break</td>
<td>CMS Guidance: Informational Bulletins</td>
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<td>Managed Care Strategies: Contract Monitoring, Provider Network Adequacy, and</td>
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<td>Break &amp; Snack</td>
<td>State Teams Break-Out Groups: Apply Lessons Learned to the Work Plan</td>
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<td>Break</td>
<td>Panel Presentation and Discussion: Care Coordination Approaches</td>
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<td>State Mini-Poster Presentations: State Goals and Plans to Date</td>
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<td>Wrap-Up and Planning for Day 2 – Instructions for Day 2 Affinity Groups</td>
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## State & Team Faculty Pairings

<table>
<thead>
<tr>
<th>State</th>
<th>Faculty Name</th>
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<tbody>
<tr>
<td>Arkansas</td>
<td>Denise Sulzbach</td>
</tr>
<tr>
<td>Colorado</td>
<td>Dayana Simons</td>
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<tr>
<td>Hawaii</td>
<td>*</td>
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<tr>
<td>Illinois</td>
<td>Sheila Pires</td>
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<tr>
<td>Kentucky</td>
<td>Shannon Robshaw</td>
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<tr>
<td>New Mexico</td>
<td>Michelle Zabel</td>
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<tr>
<td>New York</td>
<td>Suzanne Fields</td>
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<tr>
<td>North Carolina</td>
<td>Deborah Harburger</td>
</tr>
<tr>
<td>Ohio</td>
<td>Jody Levison-Johnson</td>
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<tr>
<td>Tennessee</td>
<td>Kelly English</td>
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Customizing Children’s Behavioral Health Care Within A Medicaid Managed Care Environment

Sheila A. Pires, Human Service Collaborative
Customizing Children’s Behavioral Health Care within a Medicaid Managed Care Environment

Sheila A. Pires
Senior Partner, Human Service Collaborative
Core Partner, Technical Assistance Network for Children’s Behavioral Health
Senior Consultant, Child Health Quality Programs
Center for Health Care Strategies
Topics to be Covered

I. Child Medicaid Population: Behavioral Health Prevalence and Patterns of Behavioral Health Utilization and Expenditures

II. Trends in the Organization and Financing of Services

III. Approaches to Customizing Service Delivery and Financing
Prevalence of Child Behavioral Health Disorders

- “An estimated 13-20% of children in the United States (up to 1 out of 5 children) experience a mental disorder in a given year...”

- About 1 out of every 10 youth is estimated to meet the Substance Abuse and Mental Health Services Administration (SAMHSA) criteria for a Serious Emotional Disturbance (SED), defined as a mental health problem that has a significant impact on a child's ability to function socially, academically, and emotionally

- 3.3% of 15-year olds and 9.8% of 17-18 year olds have a need for SUD treatment
Mental Health - Costliest Health Condition of Childhood

Mental Health Disorders
- $8.90

Asthma
- $8.00

Trauma Related Conditions
- $6.10

Acute Bronchitis
- $3.10

Infectious Diseases
- $2.90

Children in Medicaid using behavioral health care:

- Represent under 10% of children enrolled in Medicaid
- Account for an estimated 38% of total Medicaid child expenditures
Children in Medicaid using behavioral health care are an expensive population

- Mean expenses almost 5x higher than for Medicaid children in general:
  - TANF-enrolled: 3x higher
  - Foster care: 7x higher
  - SSI-enrolled/disabled: nearly 9x higher

- Children in the top 10% of BH expense are nearly 18x more expensive than Medicaid children in general

Behavioral health drives expense for high-cost children

<table>
<thead>
<tr>
<th></th>
<th>Children in Foster Care</th>
<th>Children representing top 10% of BH Service expense</th>
</tr>
</thead>
<tbody>
<tr>
<td>Behavioral Health Services</td>
<td>$7,018</td>
<td>$27,654</td>
</tr>
<tr>
<td>Physical Health Services</td>
<td>$5,921</td>
<td>$10,429</td>
</tr>
<tr>
<td>Total Health Services</td>
<td>$12,939</td>
<td>$38,083</td>
</tr>
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</table>
Children in Foster Care Use More Restrictive, Expensive Services in Medicaid

- Nearly 1/3 of children in foster care use behavioral health services – more than the average Medicaid child, or one who is on TANF or SSI/disability
- More likely to use residential and group care, inpatient psychiatric services, crisis intervention, and substance use residential services
- Children in foster care were only 1/5 the size of the TANF population, but:
  - Represented nearly the same amount of dollars for residential and group care and substance use residential services

Cost Drivers for Children in Medicaid Using Behavioral Health Services

• Residential treatment and therapeutic group homes:
  – #1 cost driver in 2008 and 2005 – represents about 20% of all BH expense for under 4% of children using BH care

• Psychotropic medications:
  – 2\textsuperscript{nd} highest cost driver in 2008
  – 3\textsuperscript{rd} highest in 2005

Behavioral health services most likely to be used

- Outpatient Therapy (primarily, individual) 48.2%
- Screening and Assessment 45.2%
- Psychotropic Medication 43.7%
- Medication Management 24.3%
- Family therapy/Family education and training 23.2%
- Wraparound 1.1%
- Therapeutic Foster Care 0.9%
- Respite 0.3%
- Peer Services 0.1%
- Multisystemic Therapy 0.1%
Use of traditional outpatient therapies

• “Based on current evidence of the effectiveness of interventions in community mental health settings, there is no reason to assume that the outpatient mental health services provided to foster children are effective in improving outcome” (James, S., Landsverk, J., Slymen, D. and Leslie, L. Predictors of Outpatient Mental Health Service Use—The Role of Foster Care Placement Change, Ment Health Serv Res. 2004 September; 6(3): 127–141)

• “Results indicate that children who have experienced long-term foster care do not benefit from the receipt of outpatient mental health services” (Bellamy, J., Gopala, G., Traube, D. A national study of the impact of outpatient mental health services for children in long-term foster care. Clin Child Psycholog Psychiatry 2010 Oct;15(4):467-79)
Medicaid Enrollment, Behavioral Health Service Use, and Expense by Aid Category

Medicaid Enrollment, Behavioral Health Service Use and Expense by Age Group

- All Children:
  - Ages 0-5: 41%
  - Ages 6-12: 34%
  - Ages 13-18: 25%

- Behavioral Health Service Use:
  - Ages 0-5: 11%
  - Ages 6-12: 44%
  - Ages 13-18: 45%

- Behavioral Health Service Expense:
  - Ages 0-5: 5%
  - Ages 6-12: 36%
  - Ages 13-18: 59%

Medicaid Enrollment and Behavioral Health Service Use by Race/Ethnicity

# Distribution of Psychiatric Diagnosis among Children in Medicaid

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>%</th>
<th>N</th>
</tr>
</thead>
<tbody>
<tr>
<td>ADHD</td>
<td>54.9%</td>
<td>654,863</td>
</tr>
<tr>
<td>Mood</td>
<td>26.2%</td>
<td>312,642</td>
</tr>
<tr>
<td>Anxiety</td>
<td>22.7%</td>
<td>270,721</td>
</tr>
<tr>
<td>COD</td>
<td>22.8%</td>
<td>272,288</td>
</tr>
<tr>
<td>DD</td>
<td>5.8%</td>
<td>69,541</td>
</tr>
<tr>
<td>Psychosis</td>
<td>4.3%</td>
<td>51,323</td>
</tr>
<tr>
<td>Other DX</td>
<td>1.4%</td>
<td>16,259</td>
</tr>
<tr>
<td>No Dx</td>
<td></td>
<td>766,325</td>
</tr>
</tbody>
</table>

**Notes:**

1) Ns are not unduplicated counts (children may have more than one diagnosis)
2) Percentages are among children with at least one psychiatric diagnosis
Psychotropic Medications Utilization and Expense among Children in Medicaid

- 5.8% of children in Medicaid (1.7 million) received psychotropic medications.
- Only 51% of children prescribed psychotropic medications received behavioral health services.
- Total Medicaid expense for child and adolescent psychotropic medication use in 2005 was $1.6 billion, with 42% of expense represented by antipsychotic use.
- Mean expense by aid category, was:
  - $934 per child, in foster care
  - $916 per child, for those with SSI
  - $475 per child, for children covered by TANF

### Percent Distribution of Medication Type by Psychiatric Diagnosis

<table>
<thead>
<tr>
<th>Medication Type</th>
<th>ADHD</th>
<th>Mood</th>
<th>Anxiety</th>
<th>COD</th>
<th>DD</th>
<th>Psychosis</th>
<th>Other DX</th>
<th>No DX</th>
</tr>
</thead>
<tbody>
<tr>
<td>Antipsychotics</td>
<td>24.6%</td>
<td>60.9%</td>
<td>41.0%</td>
<td>51.6%</td>
<td>63.5%</td>
<td>81.1%</td>
<td>53.6%</td>
<td>28.5%</td>
</tr>
<tr>
<td>Mood Stabilizers</td>
<td>6.3%</td>
<td>23.3%</td>
<td>11.1%</td>
<td>15.6%</td>
<td>13.1%</td>
<td>21.7%</td>
<td>12.9%</td>
<td>8.0%</td>
</tr>
<tr>
<td>Lithium</td>
<td>1.4%</td>
<td>8.0%</td>
<td>3.3%</td>
<td>4.1%</td>
<td>3.2%</td>
<td>8.6%</td>
<td>4.9%</td>
<td>1.3%</td>
</tr>
<tr>
<td>Antidepressants</td>
<td>23.0%</td>
<td>62.9%</td>
<td>67.2%</td>
<td>42.1%</td>
<td>40.5%</td>
<td>52.1%</td>
<td>51.5%</td>
<td>49.4%</td>
</tr>
<tr>
<td>ADHD/ stimulants</td>
<td>93.3%</td>
<td>48.0%</td>
<td>47.0%</td>
<td>65.3%</td>
<td>54.9%</td>
<td>42.8%</td>
<td>55.8%</td>
<td>49.4%</td>
</tr>
<tr>
<td>Anxiety</td>
<td>1.8%</td>
<td>5.1%</td>
<td>9.1%</td>
<td>4.0%</td>
<td>9.4%</td>
<td>7.0%</td>
<td>6.5%</td>
<td>6.4%</td>
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N = 1,686,387 (Medicaid enrolled children in 2005 with claims for psychotropic medication)

Children in Foster Care Have High Rates of Psychotropic Medication Use

- 23% of children in foster care are prescribed psychotropic medications vs. SSI (27%) and TANF (4%)
- Children in foster care are more likely to receive 2 or more concurrent psychotropic medications than any other aid category (49%) vs. SSI (46%) and TANF (26%)
- Among children receiving anti-psychotics, 42% are in foster care
- Children in foster care represent 13% of all children prescribed psychotropic medication (but only 3% of all children in Medicaid)
Chronic Physical Health Conditions Among Children in Medicaid Using Behavioral Health Services*

- 38% of children with BH claims also had claims for at least one chronic medical condition
- Pulmonary diseases were the most common physical health condition (overall mean expense of $1,091)
- High-cost medical conditions (e.g. cancer at $19,065) had low frequency

*Using Chronic Disability Payment System (CDPS) Methodology

## Differences in Child Behavioral Health Penetration Rates and Mean Expense by State Management and Payment Arrangement

<table>
<thead>
<tr>
<th>Payment/Delivery Structure</th>
<th>Average Penetration Rate</th>
<th>Penetration Range</th>
<th>Mean Expenditure</th>
<th>Mean Expenditure Range</th>
</tr>
</thead>
<tbody>
<tr>
<td>All FFS</td>
<td>10.4%</td>
<td>2.5% - 17.3%</td>
<td>$5,542</td>
<td>$2,099 to $14,803</td>
</tr>
<tr>
<td>Primarily FFS</td>
<td>7.5%</td>
<td>0.3% - 10.4%</td>
<td>$4,709</td>
<td>$1,862 to $9,172</td>
</tr>
<tr>
<td>Primarily Capitated*</td>
<td>5.1%</td>
<td>1.6% - 8.9%</td>
<td>$3,684</td>
<td>$1,193 to $9,377</td>
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*May understate utilization depending on completeness of encounter data submitted to state agencies. May overstate expenditures, which are extrapolated from FFS expenditures.

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

- Do not have the same high rates of co-morbid physical health conditions as adults with SPMI
- Have different mental health diagnoses from adults with SPMI (ADHD, Conduct Disorders, Anxiety; not so much Schizophrenia, Psychosis, Bipolar as in adults), and diagnoses change often
- Among children with serious behavioral health challenges, two-thirds typically are involved with child welfare and/or juvenile justice systems and 60% may be in special education – systems governed by legal mandates
- Coordination with other children’s systems – child welfare, juvenile justice, schools – and among behavioral health providers, as well as family issues, 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) and include social determinants of well-being – takes time
Medicaid Trends – Definitions Matter

- Medicaid re-design: health reform, budget deficits, quality and efficiency
- Renewed interest in managed care, including for populations with high use/cost (e.g., chronic conditions, foster care, SSI)
  - Capitated PH/BH – “integrated” designs
  - Foster care carve outs
- Emphasis on integrated care- medical homes, health homes
- Accountable Care Organization structures
- Renewed interest in various waivers/options
  - 1115, 1915b, 1915i, Money Follows the Person, health homes
Definition of Key Managed Care Design Terms

**Integrated:** financing and management of physical and behavioral health care are integrated (even if BH management is subcontracted out by prime managed care contractor)
*Example: Tennessee, Massachusetts*

**Behavioral health carve out:** behavioral health services are financed and managed separately from physical health care
*Example: Pennsylvania, Colorado*

**Integrated with a partial carve out:** financing and management of physical health and an “acute care” behavioral health benefit are integrated and behavioral health care beyond “acute” is carved out in a separate financing and management arrangement
*Example: Delaware*

**Population Carve Out:** financing and management of behavioral healthcare is in a separate arrangement for a specific population
*Example: New Jersey; Wraparound Milwaukee; Texas*

**Left Out:** services and/or populations that remain in fee-for-service, are not in managed care
*Example: Wyoming*

**Administrative Services Organization (ASO):** purchaser pays management entity an administrative fee, typically not risk-based
*Example: New Jersey, Maryland*
Risk-Based Financing Terms

**Capitation**: Purchaser pays management entity a fixed rate per *eligible* user

- Incentive:
  1. Prevent eligible users from becoming actual users (e.g., engage in prevention; make it difficult to access services)
  2. Control the type and volume of services used

**Case Rate**: Purchaser pays management entity a fixed rate per *actual* user

- Incentive:
  1. Control the type and volume of services used

Trends: **Integration** at the Systems/Medicaid Purchaser Level Caveats

Research has shown that...

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

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

See publications and issue briefs published by the Health Care Reform Tracking Project at: [http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm](http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm)
Trends: Integration at the Provider/Practice Level

- Basic Collaboration – communication
- Co-Located Care – physical proximity
- Integrated Care – practice change/teaming
“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.”

Suggests need for more customized, intensive care coordination approaches for children with significant behavioral health challenges.
Medical Homes vs Health Homes

**Medical Homes**
- All children
- Coordination of medical care
- Physician-led primary care practices

**Health Homes**
- Children with chronic health conditions, children with serious behavioral health conditions
- Coordination of physical, behavioral, and social supports
- Specialty provider organizations, including behavioral health specialty organizations (e.g., not only medical)
Service Coordination/Care Management Continuum

Children/youth needing only brief short-term services and supports

Information and referral help

Children/youth needing intermediate level of services and supports

Service coordination
System navigation help

Children/youth needing intensive and extended level of services and supports

Intensive care management

Trend: Customized Care Coordination Approaches for Individuals with “Chronic” Conditions

For children with significant behavioral health challenges -

- Neither traditional case management, MCO care coordination, nor care coordination approaches for adults are sufficient
  - Need approach based on evidence of effectiveness, i.e. fidelity Wraparound
  - Need lower case ratios (MO health home care coordination ratio is 1:250*; Wraparound is 1:10)
  - Need higher payment rates (MO health home per member per month rate is $78*; CHCS national scan of Wraparound care coordination rate ranges from $780 pmpm to $1300 pmpm)
  - Need intensity of approach that is largely face-to-face, not telephonic
  - Need intensity of involvement with family, schools, other systems, e.g., child welfare

Intensive care coordination using a fidelity Wraparound approach is increasingly considered evidence based

- 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

(*May 7, 2013 CMCS Informational Bulletin)
Customized Care Coordination Approaches Using Wraparound for Children with Serious Behavioral Health Challenges

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

- High Quality Wraparound Teams

  *Providing intensive care coordination at low ratios embedded in supportive organization, such as CMHC, FQHC or school-based mental health center*

Growing number of states – MA, LA, NJ, WI, IL; PRTF Waiver Demo states; CHIPRA Care Management Entity Quality Collaborative states – MD, GA, WY; OK – better outcomes, lower per capita costs.
What Is A Care Management Entity (CME)?

An organizational entity that serves as the “locus of accountability” for defined populations of youth with complex challenges and their families who are involved in multiple systems

Accountable for improving the quality and cost of care – and experience of care – for populations of children with historically high-costs/poor outcomes and their families/caregivers
New Jersey

Department of Children and Families
Division of Children's System of Care (CSOC)

Contracted Systems Administrator - PerformCare – ASO for child BH carve out

Family Support Organizations
Family peer support, education and advocacy
Youth movement

*Care Management Entities - CMOs

Provider Network

Mobile Response & Stabilization Services

1-800 number
Screening
Utilization management
Outcomes tracking

Dept. of Human Services
Division of Medical Assistance and Health Services (Medicaid)

UMDNJ Training & TA Institute; Rutgers

BH, CW, MA $$ - Single Payor

Use CANS

Adapted from State of New Jersey 2010
MA Children’s Behavioral Health Initiative
(Executive Office of Health & Human Services)

State Medicaid Agency - Purchaser

- MCO
- MCO
- MCO
- MCO
- MCO
- PCCM

BHO

*Locally-Based Care Management Agencies
(called Community Services Agencies) – Non Profit BH and Specialty Providers
- 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

Standardized tools for screening and assessment

*Care Coordination Rate: MA does not use a PMPM rate. However, for comparative purposes (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.

Adapted from State of Massachusetts
High Quality Wraparound Team as a Health Team – Oklahoma

Community Mental Health Center

Health Team for Adults with SMI:
- Nurse Case Manager
- ACT Team
- Adult Peer Counselor

Health Team for Children with SED:
- Wraparound Facilitator
- Intensive Care Coordinator
- Family and youth peer support

*Improve quality and cost of care*

Pires, S. Adapted from State of Oklahoma. 2013
Medicaid Options for Care Management
Entities/High Quality Wraparound Teams

- 1915i (MD)
- Health Homes (OK, NJ)
- Money Follows the Person (GA)
- 1915a (Wraparound Milwaukee)
- 1915b and 1915c (LA, WY)
- Targeted Case Management (NJ, MA, LA)
Redirecting High Cost, Poor Outcome Spending through Care Management Entities/High Quality Wraparound Teams

Strategies:

• Redirect dollars from high cost/poor outcome services (e.g., hospital, emergency room, residential, detention, group homes)

• Invest savings per youth served in home and community-based service capacity

• Promote diversification/”re-engineering” of residential treatment centers

• Population-based all-inclusive case rates or bundled care coordination rates

• Population-focused quality and outcome indicators

• Population-based purchasing approaches tied to performance

Pires, S. 2010. Human Service Collaborative
Coordination with Primary Care through Care Management Entities/High Quality Wraparound Teams

- 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
Trend: Accountable Care Organizations

Perspectives from Regina Herzlinger, Harvard Business School

“I believe, with some exceptions, ACOs will not succeed…it will be difficult for anything but an organization that has been at it a long time to develop the team culture needed to be an ACO.”

“The reason that patient-centered medical homes will not succeed is that health care follows the 80/20 rule – 20% of patients generate 80% of the costs. Those 20% are the chronically ill, and I don’t see how primary care physicians serving those patients add value to their care.”

“Focused factories of care – that is the term I use for provider organizations that deliver highly specialized care for a certain group of patients, such as those with diabetes...you need specialists for that. They are the opposite of ACOs that do everything for everyone.”

As quoted in Managed Care Magazine Online (http://www.managedcaremag.com)
Trends: Foster Care Carve Outs and/or Special Benefits

- TANF and SSI-enrolled children need the same service array as foster care population (while prevalence rate for behavioral health is higher for children in foster care than TANF population, there are many more TANF children)

- Children don’t stay in foster care forever (median LOS in 2012 was 13.4 months) but tend to remain Medicaid-eligible and in need of services

- Can lead to unintended consequence of parents having to relinquish custody to access care (especially an issue for children with serious behavioral health challenges)
Customization Strategies – Regardless Of System Design

Trauma-Informed Screening and Early Intervention
(3/27/13 CMCS and SAMHSA Informational Bulletin and 7/11/13 SMD Letter)

- Mandate use of standardized screening tools and inclusion of behavioral and developmental (not only physical health) screens (MA)
- Incorporate state child welfare requirements for physical, behavioral and dental health screens within specified timeframes
  - AZ: Urgent response requiring behavioral health screen within 72 hours of entering care and “fast track” linkage to services
  - MA: Medical screening required within 7 days and comprehensive exam within 30 days, including behavioral health/use of standardized tools
- Require inter-periodic screens when child enters foster care, or changes placement, or tied to length of stay in foster care
- Quality payments for providers meeting trauma-informed standards
- May require enhanced rate (MA)

Customization Strategies – Regardless of System Design Service Coverage

(May 7, 2013 CMCS and SAMHSA Informational Bulletin)

➢ **Cover a broad array** of behavioral health home and community-based services

  MA: In-home services; family peer support; mobile response; therapeutic mentoring; behavior management therapy and monitoring; intensive care coordination using a Wraparound approach

  NJ: Mobile response and stabilization; therapeutic group home care; treatment homes/therapeutic foster care; intensive care management; Wraparound process; behavioral assistance; intensive in-home/community services; transportation; youth support and development

➢ **Cover a range of crisis options**, including a newer generation model of mobile response and stabilization and telebehavioral health capacity (WI, NJ, MA)

➢ **Cover evidence-based practices**, e.g. Trauma-Focused Cognitive Behavioral Therapy, Multisystemic Therapy, Functional Family Therapy, Multidimensional Treatment Foster Care (growing number of states)

Customization Strategies – Regardless of System Design Psychotropic Medications

(8/24/12 and 11/23/2011 CMCS Informational Bulletin and 11/21/11 State Medicaid Directors Tri-Agency Letter on Appropriate Use of Psychotropic Medications Among Children in Foster Care)

- Track and monitor outlier use, e.g. too young, too many, too much (growing number of states like WY, MD) – interface with Drug Utilization Review Board

- Provide consultation to prescribers, including primary care providers (MA, VT)

- Orient MCOs to state’s informed consent and assent policies in child welfare

- Provide coverage and training for treatment alternatives (aggression, sleep disorders)
Customization Strategies – Regardless of System Design
Customized Care Coordination

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

- **Incorporate intensive care coordination using Wraparound** approach for children with serious behavioral health challenges (growing number of states – MA, LA, NJ; PRTF Waiver Demo; CHIPRA Care Management Entity Quality Collaborative states)
  
  - Intensive care coordination rates for this population range from $780 pmpm to $1300 pmpm (CHCS Matrix)
  - In fidelity intensive care coordination/Wraparound approaches, all-inclusive cost of care (e.g., admin, care coord, placements, clinical treatment, informal supports) averages $3700-$4200 pmpm (about $2100 is Medicaid)– compare to $9,000 pmpm in PRTFs, higher in psych inpatient

- Require that every child has a **designated primary care provider** and coordination between physical and behavioral health care providers

- Require coordination with child welfare system and with Part C, CSHCN

Customization Strategies – Regardless of System Design
Data and Performance Requirements

- **Specific tracking and reporting** of:
  - Child behavioral health penetration rates and utilization (services and medications) stratified by age, gender, race/ethnicity, *aid category*, region, diagnosis, service type, medication type.
  - **Performance expectations** (not only HEDIS)
    AZ: PH-access to primary care, adolescent well care visits, annual dental visits, immunization measures; BH-emotional regulation, avoiding delinquency, stability of living situation, substance abstinence, children in psych hospitals awaiting placements
    MI: BH-reduced use of residential treatment, maintenance in the community, improved functioning using Child/Adolesc Functional Assessment Scale (CAFAS)
    NJ: PH-timeliness of assessments and comprehensive exams; exams in compliance with EPSDT guidelines; semi-annual dental checks; immunization measures; BH-access to BH services following EPSDT assessment; clinical and functional outcomes using Child/Adolesc Needs and Strengths (CANS)

Customization Strategies – Regardless of System Design
Values-Based, Goal-Oriented Utilization
Management Criteria

- Access: require no prior authorization for basic behavioral health outpatient services up to certain limit (MA)

- Coordinated Care: require that plans of care developed through Wraparound process determine medical necessity (with outlier management) (AZ, MA, NJ, LA)

- Require no “fail first” criteria to access services or medications

- Prior auth for certain psychotropic meds, e.g., antipsychotics for young children (MD)
Customization Strategies – Regardless of System Design
Orientation and Training

➢ Incorporate orientation/training for MCOs on children with significant behavioral health challenges, foster care population, child welfare system, role of court (MA)

➢ Incorporate training for Medicaid providers on effective practices
  • Wraparound approach (MA, MI, NJ, LA, MD)
  • Trauma-Focused CBT and Parent Management Training-Oregon Model (MI)
  • Trauma-informed care (AZ, MA)
  • Screening tools (MA)

Customization Strategies – Regardless of System Design
Administrative and Financing

- **Risk-adjust rates** for children in child welfare and children with serious behavioral health challenges
- Utilize **population case rates** for high utilizing child populations
- **Incorporate special liaison in MCOs** for child welfare-involved children, children enrolled in Wraparound, youth transitioning
- **Incorporate a quality review process that involves families and youth** with lived experience on quality review teams and requires input from other child systems (e.g., child welfare)
- **Hire/contract with family organizations** to serve as family advocate; requirements for MCOs to involve families and youth in staff and advisory capacities
- **Require reinvestment** back into child home and community services
- **Capacity to train, coach and develop** the capacity of providers, administrators, staff, families/youth to implement desired reforms.

For further information, contact:

Sheila A. Pires
sapires@aol.com
Dayana Simons, Center for Health Care Strategies

CMS Guidance: Informational Bulletins
Prevention and Early Identification of Mental Health and Substance Use Conditions (EPSDT) (March 27, 2013)

• While 11% of youth have been diagnosed with a mental illness, two-thirds of youth who have a condition are not identified and do not receive mental health services.

• Half of all lifetime cases of mental illness or substance use begin by age 14.

• The rate of current illicit drug use among all youth (Medicaid and non-Medicaid) aged 12 to 17 is 25% higher than individuals age 18 or older.

• Suicide was one of the top 10 causes of death of students in the United States in 2009. Almost 14% have seriously considered suicide and 6% having attempted suicide one or more times in the past 12 months. The presence of major depression, bipolar disorder and alcohol and drug abuse are frequent risk factors for suicidal behaviors.

• Children exposed to trauma, including maltreatment, family violence, and neglect, exhibit symptoms consistent with individuals diagnosed with PTSD, ADHD, depression, and CD/ODD.
CMCS Informational Bulletin: 3.27.13

• Mental Health and Substance Use Disorder Screening in EPSDT
• Clinical Guidelines and Screening
• Professional Development and Training
  – National Network of Child Psychiatry Access Programs (NNCPAP)
  – American Academy of Pediatrics (AAP)
  – American Academy of Family Physicians (AAFP)
  – Emergency Nurses Association
  – American Academy of Child and Adolescent Psychiatry (AACAP)
  – The Massachusetts Child Psychiatry Access Project (MCPAP)
CMCS Informational Bulletin: 3.27.13

• Clinical Quality Reporting – Screening and Early Intervention
  – Screening for clinical depression and follow-up plan among individuals 12 years of age and older.
  – Use of standardized screening tools for potential delays in social and emotional development during the first three years of life.
  – Follow-up after hospitalization for mental illness among patient six years and older.
  – Child and Adolescent Major Depressive Disorder: Suicide Risk Assessment
  – Maternal depression screening – applies to children with a visit who turned 6 months of age in the measurement period.
  – Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder Medication.
State Initiatives:

- **Massachusetts**
  - Universal Screening for MassHealth members under 21 during well-child visits
- **North Carolina**
  - Assuring Better Child Health and Developmental Program (ABCD)
- **Colorado**
  - Healthy Living initiative Behavioral Health: Focus on Depression toolkit
- **South Carolina**
  - CMS CHIPRA quality demonstration grant project: “Quality through Technology and Innovation in Pediatrics” or Q-TIP
CMS/SAMHSA Joint Informational Bulletin: 5.7.13

Coverage of Behavioral Health Services for Children, Youth, and Young Adults with Significant Mental Health Conditions (May 7, 2013)

- Intensive Care Coordination: Wraparound Approach
- Peer Services: Parent and Youth Support Services
- Intensive In-Home Services
- Respite Services
- Mobile Crisis Response and Stabilization Services
- Flex Funds (Customized Goods and Services)
- Trauma-Informed Systems and Evidence-Based Treatments Addressing Trauma
- Other Home and Community-Based Services
CMS/SAMHSA Joint Informational Bulletin: 5.7.13

• Reduced costs of care:
  – HCBS in the PRTF demonstration cost 25% of cost to serve children and youth in a PRTF = average savings of $40,000 per year per child.
  – State Medicaid agencies’ annual costs per child were reduced significantly within the first 6 months of the program

• Improved school attendance and performance
• Increase in behavioral and emotional strengths
• Improved clinical and functional outcomes
• More stable living situations
• Improved attendance at work for Caregivers
• Reduced suicide attempts
• Decreased contacts with law enforcement
CMS/SAMHSA Joint Informational Bulletin: 5.7.13

• 1905(a), 1915(c), and 1915(b) Authorities
• 1115 Authorities
• 1915(i) State Plan Amendment
• Section 2703 Health Homes
• Money Follows the Person Rebalancing Demonstration (MFP)
• Balancing Incentive Program (BIP)
Clarification of Medicaid Coverage of Services to Children with Autism (July 7, 2014)

• Autism Spectrum Disorder (ASD) includes:
  – Autistic Disorder
  – Pervasive developmental disorder not otherwise specified (PDD-NOS)
  – Asperger Syndrome

• Treatment Approaches:
  – Behavioral and communication
  – Dietary
  – Medication
  – Complementary and alternative medicine
CMCS Informational Bulletin: 7.7.14

• Medicaid Authorities:
  – 1905(a)
  – 1915(i) State Plan Home and Community-Based Services
  – 1915(c) Home and Community-Based Services (HCBS) waiver programs
  – 1115 research and demonstration programs
EPSDT Benefit Requirements: Assure the right care to the right child at the right time in the right setting

• All children, including those with ASD, must receive EPSDT screenings designed to identify health and developmental issues, including ASD, as early as possible.

• Under EPSDT states need to ensure that all covered services are available and that families of enrolled children, including children with ASD, are aware of and have access to a broad range of services to meet the individual child’s needs.

• EPSDT requirements have implications for existing 1915(c), 1915(i), and 1115 programs that are also discussed in the bulletin.
 Adolesence is the time most of the people who become addicted develop their addiction.

 More than 90% of adults with SUDs started using before age 18; half of those began before age 15.

 The earlier a person begins using, the more likely the substance use disorder will develop and continue into adulthood.

 Youth with SUDs also have high rates of co-occurring mental health disorders.

 SUDs increases the risk for mental health disorders and vice versa, and the majority of youth with SUDs have a co-occurring mental health disorder.
CMS/SAMHSA Joint Informational Bulletin: 1.26.15

- Medication-Assisted Treatment
- Case Management/Targeted Case Management
- Continuing Care
- Recovery Services and Supports
  - Youth Peer-to-Peer Recovery Coaching/Peer Mentoring
  - Technological Support Services
  - Parent/Caregiver Support
- Residential Treatment
CMS/SAMHSA Joint Informational Bulletin: 1.26.15

• Identification
  – Screening
  – Assessment

• Outpatient Treatment for Youth with Substance Use Disorders
  – Individual Counseling/Therapies
  – Group Counseling
  – Family Therapy
  – Intensive Outpatient Treatment
  – Partial Hospitalization
CMS/SAMHSA Joint Informational Bulletin: 1.26.15

- Medicaid Financing
  - 1905(a) Authority
  - Early and Periodic Screening, Diagnostic and Treatment (EPSDT) Services
  - 1915(b) Authority
  - 1915(c) Authority
  - 1915(i) State Plan Amendment
  - Section 2703 Health Homes
  - 1115 Authority
CMS/SAMHSA Joint Informational Bulletin: 1.26.15

- Quality Reporting
  - National Committee for Quality Assurance
  - National Outcome Measures
  - Program Integrity
Suzanne Fields, University of Maryland

Managed Care Strategies: Contract Monitoring, Provider Network Adequacy, and Payment Strategies
Proposed Regulation Medicaid Managed Care

- Time and distance standards would be required for certain specialties

- CMS requests comments on whether a different type of standard should be used such as provider-to-patient ratios

- CMS requests comments on if standards should be set for pediatric and adult behavioral health care
Proposed Regulation Medicaid Managed Care

Minimum factors a state must consider in developing network adequacy standards:

– Anticipated Medicaid enrollment;
– Expected utilization of services;
– Taking into account the characteristics and health needs of the covered population;
– Number and types of health care professionals needed to provide covered services;
– Number of network providers that are not accepting new Medicaid patients;
– Geographic location and accessibility of the providers and enrollees.
Network Adequacy Exceptions

– The standard by which an exception would be evaluated must be specified in the contract and

– must be based, at a minimum, on the number of health care professionals in that specialty practicing in the service area

– The state must monitor enrollee access to providers in managed care networks that operate under an exception and report its findings to us as part of its annual managed care program monitoring report
Proposed Regulation Medicaid Managed Care

Network Adequacy Transparency

– To promote transparency and public input for these managed care network adequacy standards, states would have to publish the network adequacy standards developed.

– States would have to make these standards available at no cost, upon request, to individuals with disabilities through alternate formats and using auxiliary aids and services.
Proposed Regulation Medicaid Managed Care

Authorizations of Care

– Require that managed care contracts adhere to the program’s reasonableness standards and use service authorization standards that are “appropriate for and do not disadvantage those individuals that have ongoing chronic conditions or needing [long term services and supports].

– The expectation is that clinical services that support individuals with ongoing chronic conditions, as well as LTSS would be authorized in a manner that reflects the beneficiary’s continual need for such services and supports,” and that limits would be consistent with an “enrollee’s current needs assessment and . . . the person-centered service plan.”
Proposed Regulation Medicaid Managed Care

Clarify the intent of care

– Contracts would also be required to incorporate the special “early” and “ameliorate” medical standard that applies to EPSDT benefits for children.
Proposed Regulation Medicaid Managed Care

Quality

– Develop and implement a Medicaid quality rating system that would reflect the type of system developed for Exchange plans, given what CMS views as the similarities between the populations.

– Use a “robust public engagement process” and to consider relative clinical quality management, plan efficiency, affordability, and member experience.

– Extend the requirement for a quality improvement strategy to all state Medicaid programs as a general state plan administration requirement and apart from a state’s use of one or more forms of managed care.

– Detailed process for developing, evaluating, and revising such strategies in order to ensure the formulation of written strategies that are continually reviewed and updated.

– Expected to consider the health of the Medicaid population, “quality of life issues,” and issues of health care use and service metrics, with specific targets and performance measurement requirements.
Proposed Regulation Medicaid Managed Care

IMD for persons 21-64

- Sets out to distinguish between short-term treatment and residential care.

- Allow MCOs to pay institutions of mental disease (IMDs) using Medicaid funds received as capitation payments to provide services to certain Medicaid eligible individuals as a Medicaid “in lieu of” service.

- The proposed rules also set requirements about how to consider utilization and costs of covered services rendered in an IMD in developing capitation rates.
Proposed Regulation Medicaid Managed Care

Permit MCOs to receive a Medicaid capitation payment from a state for an enrollee aged 21 to 64 who spends a portion of the month in an IMD so long as the facility is:

1. A hospital providing psychiatric or inpatient SUD care, or
2. A sub-acute facility providing psychiatric or SUD crisis residential services
3. The stay in the IMD is for no more than 15 days in that month
**Typical Geo-Mapping Stratifications**

<table>
<thead>
<tr>
<th>EXCERPTS:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number of Members</td>
</tr>
<tr>
<td>Total Number of Members Residing in Urban Counties</td>
</tr>
<tr>
<td>Total Number of Members Residing in Rural Counties</td>
</tr>
<tr>
<td>Percent of Members in Urban Counties Residing w/in 30 Miles of Two Outpatient Psychiatrists</td>
</tr>
<tr>
<td>Percent of Members in Rural Counties Residing w/in 75 Miles of Two Outpatient Psychiatrists</td>
</tr>
<tr>
<td>Percent of Members in Urban Counties Residing w/in 30 Miles of Two Outpatient Licensed</td>
</tr>
<tr>
<td>Chemical Dependency Counselors</td>
</tr>
<tr>
<td>Percent of Members in Rural Counties Residing w/in 75 Miles of Two Outpatient Licensed</td>
</tr>
<tr>
<td>Chemical Dependency Counselors</td>
</tr>
<tr>
<td>Percent of Members in Urban Counties Residing w/in 30 Miles of Two Outpatient Behavioral</td>
</tr>
<tr>
<td>Health Services Providers (Other)</td>
</tr>
<tr>
<td>Percent of Members in Rural Counties Residing w/in 75 Miles of Two Outpatient Behavioral</td>
</tr>
<tr>
<td>Health Services Providers (Other)</td>
</tr>
<tr>
<td>Percent of Total Members in Urban Counties Residing w/in 2 Miles of Two Pharmacies</td>
</tr>
<tr>
<td>Percent of Total Members in Suburban Counties Residing w/in 5 Miles of Two Pharmacies</td>
</tr>
<tr>
<td>Percent of Total Members in Rural Counties Residing w/in 15 Miles of Two Pharmacies</td>
</tr>
<tr>
<td>Percent of Total Members Residing w/in 75 Miles of Two 24-Hour Pharmacies</td>
</tr>
</tbody>
</table>
Network Adequacy Challenges

• Use of “geo-mapping”
• Current standards put a premium on the number of providers in a plan’s network
• Does not address whether those in-network providers are high quality or offer expanded access
• Does not address whether contracted providers are taking new patients
• Does not capture telehealth “reach” or services provided in the home/community
• May not capture specialties and areas of expertise
Network Adequacy Approaches

Geo-mapping inclusive of:

– Satellite locations

– Certain meaningful stratifications of policy priority
  • Language, areas of expertise

– Retrospective links to service utilization
  • Telehealth, in-home

– SC: social determinants of health
South Carolina

Percent of the Population in a Hotspot

High Need Areas
- 26% No Hotspot
- 57% Child Only Hotspot
- 16% Adult Only Hotspot
- 2% Adult and Child Combined Hotspot

Rest of the State
- 71% No Hotspot
- 14% Child Only Hotspot
- 8% Adult Only Hotspot
- 8% Adult and Child Combined Hotspot

Source: http://mapping.mpr.sc.edu/healthdisparitiesmapjournal/
South Carolina

Prevalence of Select Conditions in South Carolina Medicaid Recipients, FY 2013 by County

Ring Key
- Outer Ring
  - Prevalence of Stroke
  - Prevalence of Hypertension
  - Prevalence of Diabetes
  - Prevalence of Cardiovascular Disease (CVD)

Quartile Ranking
- Low
- Medium Low
- Medium High
- High
- Prevalence for at least 1 of the Select Conditions is in the Highest Quartile

High Quartile Ranges (Prevalence per 1,000)
- CVD: 46.6 to 58.4
- Diabetes: 75.6 to 71.6
- Hypertension: 133.6 to 191.6
- Stroke: 19.7 to 27.6

Notes:
Data: SC MMS FY 2013 (June 2013 as of October 2013)

Source: http://mapping.mpr.sc.edu/healthdisparitiesmapjournal/
South Carolina

High Need Areas and Neighboring Areas Compared to the Rest of the State

Source: http://mapping.mpr.sc.edu/healthdisparitiesmapjournal/
Network Adequacy Approaches

• Ask! Ask enrollees directly whether they have adequate access to care
  - Consumer Assessment of Healthcare Providers and Systems (CAHPS®)

• Use of secret shopper reviews where faux-beneficiaries call providers to see if and how quickly they can get an appointment
Network Adequacy Approaches

• Wait time for appointments – routine, urgent, emergency
  – Enrollees will have immediate access to mobile crisis response by child trained crisis intervention specialists
  – **Health plans must demonstrate** that enrollees can get an appointment with a specialist provider within 15 business days for non-urgent services

• Office wait time
  – No more than 15 minutes beyond scheduled appointment time; offered option to reschedule at enrollee convenience

• Travel to providers – urban/suburban, rural, frontier

• Access providers by the telephone 24 hours a day and 7 days a week

• Appointments during non-typical office hours- after 5 pm and weekends – issue of amount
Network Adequacy Approaches

• Culturally and linguistically competent providers
  – Contractor shall ensure that non-English speaking Enrollees have a choice of at least two Behavioral Health Providers within each behavioral health covered service category as defined by Prevalent Languages in the Region. When such capacity does not exist, the contractor shall implement an alternative, including reimbursing for interpreter services
  – This requirement also applies to care for the LGBT population

• Special expertise
  – BHOs include child welfare providers in their networks, with assistance to CW providers to become Medicaid providers
  – Similar language applied to early childhood, SUD, peers, trauma
Network Adequacy Approaches

• Training requirements to ensure quality across the network
  – This can lead to “opening up” typical networks to expertise
  – Training in state selected EBPs/policy priorities – required hours or certification/re-certification

• Ensure availability of services to persons in their home or community setting during day, evening, weekend hours
Network Adequacy Approaches

• Spreading specialist expertise to support front-line workers/other expertise
  – MCPAP

• Exploring ways to support care delivered outside of face-to-face visits, including helping providers communicate with clients by phone and email
  – Tele behavioral health and other technologies
Network Adequacy Approaches

• Assure common benefits for Medicaid and non Medicaid covered children

• Require that the contractor continue to furnish needed services until that course of treatment is completed even if disenrolled from Medicaid or moving between Medicaid plans

• Require MOUs with child serving agencies

• Develop and maintain ongoing forums for discussion of policy issues
Network Adequacy Approaches

Combination of robust adequacy standards in contract AND additional state action targeted at monitoring and increasing access to behavioral health providers

- Investing in workforce
- Cross-system partnerships
CMS Guidance on Contract Components & Monitoring

- Contract Completeness
- Enrollment and Disenrollment
- Beneficiary Notification
- MCE Policies, Procedures, and Systems
- Providers and Provider Network
- Coverage
- Quality and Utilization Management
- Grievance and Appeals
- Program Integrity

Focus on Values-Based Contracting

• Ensure that the contract reflects system values (not a values statement) but that it *operationally* reflects values in the following areas:
  — Investing in Recovery-Oriented and Community-Based Care
  — Investing in Evidence-Based and Promising Practices
  — Provider Networks that reflect populations served; and specialized expertise
  — Data and Reporting
  — Supporting Integration (a.k.a. coordination) of Physical Health and MH/SUD at the practice/service delivery levels

• Staffing --- persons with lived experience

• Engagement of consumers and families in decision-making/oversight -- advisory council, staffing, surveys, community meetings
Focus on Values-Based Contracting

• Clear expectations on provider networks

• Quality measures/goals/benchmarks -- meaningful measures to consumers and families

• Data and reporting—transparency and availability of data, reporting to stakeholders

• Monitoring health plan performance – use of 3rd party information to monitor plan performance
Focus on Values-Based Contracting

• Focus on integration of MH, SUD, and PH takes into account the types of coordination needs that children have

• Has a PCP, accesses well-child visits, maintains periodicity schedules

• Address prevention, and health promotion vs an adult centric chronic care approach

• Communicating with PCP about therapeutic and psychotropic medication needs and issues; opportunity to participate in child and family team
Designing and Monitoring Contracts to Meet the Needs of Children & Families

- Choice
- Outreach
- Health Plan Staffing
- Provider Network
- Access
- Benefit Array & Service Descriptions
- Medical Necessity
- Quality Improvement
- Costs savings, reinvestment and rates
- Interface with State Authorities – BH, CW, JJ, PH
Contract Monitoring

• Basic Monitoring – Focuses primarily on policies and procedures, operations, and past performance; Frequency of compliance monitoring is based on priorities and past compliance

• Quality and Performance Monitoring – Focuses on high priority clinical areas and measures to what extent the health plan is successful in improving health outcomes
Payment Strategies

Value Based purchasing refers to any purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost.

Value = Quality ÷ Cost

Source: AHRQ
Payment Strategies

• Fee for service – payment for a unit of service provided

• Case rate/Bundled rates – payments to health care providers are based on the expected costs for a clinically defined episode or bundle of related health care services
  – A flat amount covers a defined service-per day, per week, per month, per episode

• Population based rates/capitation – specific capitation or case rates approaches for specified populations, e.g., child welfare, juvenile justice
  – Wraparound Milwaukee

• Separate BH and PH capitation rates
Payment Strategies

• Incentive payments – providers are rewarded (bonuses) or penalized (reductions in payments) based on meeting pre-established targets or benchmarks for measures of quality and/or efficiency
  – CT: enhanced payments for weekend/off-hours
  – MA: prioritized policy areas
  – MI: payments over and above the capitation rates for Medicaid children involved with CW who have serious mental health conditions
Innovations in Payment Strategies

• Coordinate Care Organizations (CCOs)
  Pooled Incentive Payments

  – While it includes more traditional (and limited) measures of BH Quality, BH is included as part of the pooled incentive payment, incenting BH to be front and center with PH to improve health and wellness
Discussion: Current Efforts and Challenges
State Teams Break-Out Groups: Apply Lessons Learned to the Work Plan
State Teams Break-Out Groups: Room Assignments

• Harbor II (stay in this room)
  – Arkansas
  – North Carolina
  – Colorado
  – New Mexico

• McHenry (up the stairs next to the elevator and on your left)
  – Illinois
  – Kentucky
  – New York
  – Ohio
  – Tennessee
Panel Presentation and Discussion:
Care Coordination Approaches

Colorado, Illinois, Tennessee, Sheila A. Pires
Colorado

CMP                      Wraparound                           COE

Care Management Entity Pilot REACH
## Colorado FY2010-11 High Intensity Services

<table>
<thead>
<tr>
<th>Funding Agency</th>
<th>Number of Children</th>
<th>Agency Expenditure</th>
<th>Additional Medicaid Contribution</th>
<th>Total</th>
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</thead>
<tbody>
<tr>
<td>Child Welfare</td>
<td>2,063</td>
<td>$51,719,376</td>
<td>$5,922,691</td>
<td>$57,642,068</td>
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<tr>
<td>Medicaid – BHO, Inpatient and Residential Treatment</td>
<td>1,749</td>
<td>$17,339,065</td>
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<tr>
<td>DYC</td>
<td>577</td>
<td>$12,960,211</td>
<td>$1,495,839</td>
<td>$14,456,050</td>
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<td>Colorado Mental Health Institutes (Ft. Logan and Pueblo)</td>
<td>132</td>
<td>$5,041,972</td>
<td>N/A</td>
<td>$5,041,972</td>
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<tr>
<td>Office of Behavioral Health (non-Medicaid)</td>
<td>31</td>
<td>$656,148</td>
<td>$147,845.69</td>
<td>$803,993</td>
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<td><strong>Total</strong></td>
<td>4,552</td>
<td>$87,716,773</td>
<td>$7,566,376</td>
<td>$95,283,149</td>
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</tbody>
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4,022 Unique Individuals, 488 had services paid by more than one agency
Colorado

Care coordinators, health navigators, system navigators, caseworkers, community health workers, wraparound facilitators, case managers

ACCO-RCCOs 7 regions combined BHO/RCCO Rebid Process

“One size does not fit all”
Illinois

Care Coordination Efforts
• Mandatory Managed Care
  • MCOs / MCCN
  • CCEs
  • ACEs
• Choices
  • CCE => CME
• Stratification Model

<table>
<thead>
<tr>
<th></th>
<th>Intensive</th>
<th>Intervention</th>
<th>Early Intervention</th>
<th>Prevention</th>
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<tr>
<td>Model:</td>
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<td>CFT</td>
<td>CFT</td>
<td>Telephonic</td>
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<tr>
<td>CANS Rate:</td>
<td>90 days</td>
<td>90 days</td>
<td>180 days</td>
<td>Annually</td>
</tr>
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</table>
Illinois

Link:
http://www2.illinois.gov/hfs/SiteCollectionDocuments/CCExpansionMap.pdf
Illinois

Medicaid Structure
• Medicaid Capitation
• PCCM Payments – Case Rates
• Fee-for-Service Payments

Still workin’ on it...
Illinois

Environmental Challenges
• Illinois Budget;
• *NB v. Norwood*;
• Illinois Managed Care Implementation;
• Illinois’ Legacy Service Delivery Model

Needs and Challenges
• Inclusion of Child Welfare in Integrated Managed Care;
• Inclusion of Other State Partners (DJJ, Substance Use, DD, etc.);
• *NB Remedy*
Illinois

Outstanding Questions

How are States handling Systems of Care values and principles in the face of Integrated Managed Care?

• Model: Entity or Provider
• Deliverables: Specialty Population
• Financing: Subcap vs. Case Rate vs. Other

“No Carve Outs” in Integrated Care
Tennessee community mental health intensive, in-home pilot modeled on the system of care

Home Based Treatment (HBT)
- Care coordinator, therapist, medication manager, and primary care provider
- A minimum:
  - 3 face-to-face sessions must occur per week.
  - 2 sessions per week are required by therapist with a minimum of 1 individual therapy session and 1 family therapy sessions.
  - 1 session is required by the care coordinator per week.

Mental Health Care Coordination (MHCC)
- Led by a Care Coordinator and must involve all community providers and stakeholders.
- A minimum:
  - 3 face-to-face contacts must occur per month
  - 1 must involve direct caregiver/parent contact.
Tennessee

bundled case rate set by state Medicaid agency for each service

Home Based Treatment (HBT)

- T1024
- Services included: Care coordination, family or individual therapy, and if applicable, family support services
- Other services that may be billed FFS: 90792, 99201-99205; 99211-99215, 90833, 90836, 90838, 90785

Mental Health Care Coordination (MHCC)

- H2022
- Services included: Care coordination including family care conferences; collateral contacts
- Other services that may be billed FFS:
  - all other professional codes if provided to the member during their enrollment in MHCC.
Tennessee

delivering high quality, cost-effective care that results in improved health and quality of life for eligible Tennesseans

Evaluate results:
• What does it take for successful delivery?
  – Providers accountable for all aspects of activity so that true assessment of what it takes can be accomplished
• Universal outcome measures
  – Have we made a difference?

Hopes for the service:
– Discern best candidates for the models: what works for whom?
– Identify challenges for adequately staffing the services and identify opportunities to address challenges and gaps
– Discover true costs of each model
– Fine tune team case conference models
– Discern best contracting methodology (e.g., P4P)
– Get provider and family/member feedback
State Mini-Poster Presentations:
State Goals and Plans to Date
Wrap-Up and Planning for Day 2

- Instructions for Day 2 Affinity Groups
Leveraging Managed Care Approaches to Promote Children’s Behavioral Health: Day 2

Wednesday July 22, 2015
The Holiday Inn Inner Harbor Baltimore
<table>
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<th>Day 2 Agenda</th>
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<td><strong>Welcome, Overview of Day 1 and Plans for Day 2</strong></td>
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<td><strong>Data, Quality Measurement, Reporting, and Data Sharing</strong></td>
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<td><strong>Affinity Groups: Specialized Technical Assistance</strong></td>
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<td>Break</td>
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<td><strong>State Teams Break-Out Groups: Apply Lessons Learned to the Work Plan</strong></td>
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<td>Lunch</td>
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<td><strong>Panel Presentation and Discussion: Everything but the Kitchen Sink</strong></td>
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<td><strong>Peer Lessons Learned and Next Steps</strong></td>
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<td><strong>Closing and Next Steps</strong></td>
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Data, Quality Measurement, Reporting, and Data Sharing

Suzanne Fields, University of Maryland
What Is Quality?

The Institute of Medicine defines health care quality as "the degree to which health care services for individuals and populations increase the likelihood of desired health outcomes and are consistent with current professional knowledge."
What is Quality?

“Oops! I just deleted all your files. Can you repeat everything you’ve ever told me?”
Quality is Contextual
Approaches to Measurement

- **Structure** – assesses features of delivery organizations, the capabilities of their professionals and staff, and the policy environment in which health care is delivered

- **Process** – assesses the activities carried out by health care professionals to deliver services

- **Outcome** – includes health states, mortality, laboratory test results, patient reported health states

Measures For Providers To Collect

- Characteristics of people
  - Race, ethnicity, gender, age cohorts - children, youth and young adults, zip code/community

- Structure
  - Caseload size
  - % of informal supports in plans of care
  - Staff tenure/departures
  - Number of substantiated complaints
Measures For Providers To Collect

Process

– Fidelity to EBPs
– Time between referral and completed visit
– Time spent in waiting rooms
– Time to mobile crisis response
– Numbers of children on 2, 3, 4 plus psychotropic meds; on specific classes of meds
Measures For Providers To Collect

Outcome

• Functioning:
  – Percent of children/adolescent in behavioral health services who have improved, maintained, or reduced levels of need/symptoms.

• Community:
  – Compares enrollment entry adjudications and formal charges to number of adjudications and formal charges during enrollment
  – Percent of enrolled school age children/adolescents whose unexcused absences have decreased while receiving services
  – Compares total number of school days possible to total number of school days attended – at monthly intervals
  – Compares days in the community vs days in out of home

• Family and youth satisfaction:
  – With a minimal threshold established of 4.0 out of 1-5 scale; compiled and reported 2x/year

• Costs:
  – Costs of all services and supports provided compared to costs of diverted care (hospital, detention and residential)
Measures for a Plan and/or State Purchaser to Collect

- Characteristics of Populations
  - Race, ethnicity, gender, age cohorts- children, youth and young adults, zip code/community

- Structures
  - Provider network adequacy (e.g., % of EBPs, racially/ethnically/linguistically diverse providers; geographic distribution)
  - Rate of children/adolescents per 1,000 of the eligible population diagnosed with mental health or substance use disorders that have received both mental health and alcohol-drug treatment
  - Number of behavioral health providers with training in early childhood issues per child enrollee under age six
  - Numbers of children on 2, 3, 4 plus psychotropic meds
Measures for a Plan and/or State Purchaser to Collect

Process

– Fidelity to EBPs
– Wait times for services
– Timely provider payments
– Time to mobile crisis response
– Numbers of children on 2, 3, 4 plus psychototropic meds; on specific classes of meds
Measures for a Plan and/or State Purchaser to Collect

Outcome

• Functioning:
  – Percent of children/adolescent in behavioral health services who have improved, maintained, or reduced levels of need/symptoms

• Community:
  – Compares enrollment entry adjudications and formal charges to number of adjudications and formal charges during enrollment
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  – Compares days in the community vs days in out of home

• Family and youth satisfaction:
  – With a minimal threshold established of 4.0 out of 1-5 scale; compiled and reported 2x/year

• Costs: moving beyond descriptive utilization totals
  – Costs of all services and supports provided compared to costs of diverted care (hospital, detention, and residential)
Emerging Approaches

Rhode Island Lifespan Behavioral Health Measures
- Linking population data to identify others for screening and/or intervention
Multi-Agency Data Collaborative at the University of Maryland (LINKs - Linking Information to eNhanace Knowledge)

The LINKs data collaborative is designed to be fully compliant with HIPAA, FERPA, and all agency regulations.

1. Agency identifying information is loaded onto a secure machine not connected to the internet. A Unique LINKs ID is assigned to replace identifying information. Only required linking data is maintained on the secure machine (1). De-identified Analysis data is maintained on the LINKs server (2).

2. LINKs Data Collaborative at the University of Maryland Baltimore (de-identified linked data) Agency data, stripped of personal identifiers, are linked by the Unique ID and maintained on a secure data server.

LINKS Review Board¹: A representative from each agency in the collaborative, with the capacity and authority to review research proposals and make decisions related to the merit of the proposal and data usage, will review all proposals involving LINKS. Agencies can decide not to allow their data to be used for a study.

¹ The LINKs Review Board will not replace the University or Agency IRB processes, only add another layer of protection.
² The MSDE participation is project specific based on an examination of Kindergarten readiness.
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<tr>
<th>Department of Family Services</th>
<th>Date Feed Name</th>
<th>Status</th>
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<td>WY Caps</td>
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<td>Family Records</td>
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<td>Current* (missing 11/06 – 6/07)</td>
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<td>Employment and training for Self Sufficiency</td>
<td>ETSS Invoices, Grants, Trainees, Expenditures</td>
<td>Active</td>
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<td>Workforce Development Training Fund</td>
<td>Training Records</td>
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<td>Unemployment Insurance</td>
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<td>Current</td>
<td>Quarterly</td>
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<td>Workers’ Compensation Payments</td>
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<td></td>
<td>Workers’ Compensation Medical Bill Records</td>
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<td>Department of Corrections</td>
<td>DOC Offender records and Demos Recs</td>
<td>Active</td>
<td>Current</td>
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<td>Department of Corrections</td>
<td></td>
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Wyoming WHIN Integrated Agency Pareto Analysis
Total Population: 07/01/10 - 06/30/11

**Total Claimants:** 146,064 (-2.3%)
**Average Cost:** $5,754 (+0.3%)

**Future High-Risk Migration**
- Multiple Program Utilization
- Demographic
- Health/Disease

**Migration From High-Risk To Low-Risk**

**Quintile Breakdown:**
- **Quintile 1** (N=113,213)
- **Quintile 2** (N=19,172)
- **Quintile 3** (N=8,488)
- **Quintile 4** (N=3,657)
- **Quintile 5** (N=1,534)

**Average Annual Cost per Claimant:**
- Medicaid Medical
- Medicaid Drug
- WC Total
- SNAP
- POWER
- CHILD CARE
- WIA
- VOC Rehab
- UI

**Time Period:** 07/01/10 - 06/30/11
Wyoming Healthy Families Succeed
Clinical Prevention Service Model

Executive Leadership Team

WHIN/HCMS Risk Analysis

Clinical Prevention Service
- Enrollment
- Health as Human Capital Assessment
- Inform, Educate, Decision Support
- Evaluation

Health Services
- Public Health Services
- Medical Services
- Mental Health Services
- Workers’ Compensation

Administrative Services
- Compensation Assistance
- Case/Disease Management
- Job Training

Medical Services
- State Agency Services
- Clinical Prevention Service
- Person Family
- Other Community Activities

Education

Other Community Activities
- Workplace
- Recreation
- Religious
- Nonprofit Services
Hawaii Data Sharing 7 System Accountability Language

- Objective review of system performance data
- Establish a mechanism for problem solving discussions
- Review system and joint performance
- Recommend strategies to address system and joint interagency issues impacting quality
- Monitor improvement

Source: Language abbreviated from Hawaii's Interagency MOU on Quality Assurance
Discussion: Current Efforts and Challenges
Affinity Groups: Specialized Technical Assistance
Purpose of Affinity Group Discussions

- Faculty facilitated peer to peer exchange on 1 of 4 topic areas
- Opportunity for state teams to divide up to discuss range of topics and meet others
Affinity Groups Room Assignments

• Care Coordination
  – TBD
• Managed Care Rate Setting
  – TBD
• Managed Care Contracting
  – TBD
• Quality and Data Metrics
  – TBD
State Teams Break-Out Groups: Apply Lessons Learned to the Work Plan
State Teams Break-Out Groups: Room Assignments

• **Harbor II** (*stay in this room*)
  – Arkansas
  – North Carolina
  – Colorado
  – New Mexico

• **McHenry** (*up the stairs next to the elevator and on your left*)
  – Illinois
  – Kentucky
  – New York
  – Ohio
  – Tennessee
Panel Presentation and Discussion: Everything but the Kitchen Sink

Hawaii, Kentucky, New York, Suzanne Fields
Hawaii: Quality Management
Hawaii: Health Care Reform & Models of Quality Assurance (QA)

- Established QA procedures originating in physical health care systems
- The importance of clinical oversight
- Consistent case management practice throughout the system assures better quality.
Hawaii

Costs of Services Procured

Millions

$44.2  $46.2  $43.6  $38.7  $32.1  $31.0  $32.1  $31.1

Fiscal Year

2007  2008  2009  2010  2011  2012  2013  2014
Hawaii

Youth Served & Days in Service: CBRIII, FY2009-FY2014

Days

60000
50000
40000
30000
20000
10000
0

Fiscal Year

2009
2010
2011
2012
2013
2014

Youth

250
200
150
100
50
0

Units
Youth
Hawaii

Youth Served & Days in Service: HBR, FY2009-FY2014

Fiscal Year

Days

Youth

2009 2010 2011 2012 2013 2014

Units Youth
Hawaii
Hawaii: QA & Utilization Review

- Reorganization to assure clinical oversight
- QA has had a direct effect on Length of Stay (LOS)
- Data to show diminishing returns over time
- The importance of longitudinal outcomes measures for each case
Hawaii: Better Care With Lower Costs – the Promised Land

• Savings in Length of Stay while moving to less restrictive settings
• The changing role of parent partners as a reimbursable part of the treatment team
Hawaii: Challenges for Further Progress

• More reliable and detailed data sets
• Acceptance of routine QA and financial data by care coordinators and providers
• Building real-time data sets into the EHR for both line staff and supervisors and using data for day-to-day decision making
• Culture change to accept clinical oversight
Kentucky: Cross-Agency Collaboration
Kentucky: Collaborative Activities

- Establishment of a communication plan
  - Medical Directors
  - Operations
  - Behavioral Health Directors
- Bright Spots
  - MCO Performance Improvement Plans addressing psychotropic medication use among children
  - Bringing our children home
Kentucky: Lessons Learned

• “Rome wasn’t built in a day but... managed care was implemented in KY in 3 months” – the rush to implement

• “If you’re not at the table, you might be on the menu” – getting the right people to the table

• “Get everyone on the same page” – uniform yet flexible MCO contracts

• Address systemic issues in joint meetings with all MCOs
Kentucky: Needs and Challenges

- Upcoming administration change
- Divisiveness regarding ACA
- Alignment of federal and state plans, regulations, and systems
- Keeping state agency staff engaged in sustained hard work
- Remaining vigilant with MCOs
- System readiness to support credible data
- Constant change for the provider community
New York: Health Homes
New York – Health Homes

- What innovative activities related to Health Homes is New York participating in and where is the state trying to get to?
  - Children: Tailoring Health Home model for the enrollment of children (January 2016)
    - HH eligibility criteria – recognizing Complex Trauma in children and adolescents as chronic condition
    - Integrate systems of care that impact children in Health Home (education, child welfare, juvenile justice)
    - Demonstration to test in the integration of High Fidelity Wrap care management approach in Health Homes serving children
    - Ensuring services are available to assist Health Home in developing plans of care for children with chronic conditions and complex needs (expanded State plan services and Home and Community Based Services (HCBS))
    - Navigating laws around consent and sharing of information, including educational information
New York – Health Homes

• What innovative activities related to Health Homes is New York participating in and where is the state trying to get to?
  • Adults:
    ✓ Outreach efforts for “hard to serve” members with behavioral health issues
    ✓ Transition of Behavioral Health benefit to Managed Care
      • Health and Recovery Plans (HARP) members will be enrolled in Health Home
      • HARP members eligible for Home and Community Based Services
  • Adults and Children:
    ✓ Medicaid Analytics Performance Portal (MAPP)
      • Tracking and Performance Management
      • Referral Mechanism for Children (consent)
New York – Health Homes

- What are some of your lessons learned?
  - Include all players in development of design (Health Homes, Managed Care Plans, Care Managers)
  - Balance between Standards and Flexibility to most effectively operationalize overall model
  - Share best practices
  - Communication between Plans and Health Homes (e.g., operational procedures, performance management)
  - To extent possible, Have data systems and infrastructure in place at rollout
  - Consider functional/clinical indicators in rate/ PMPM setting (not just claims and encounter based acuity)
  - Carefully consider how consent and data sharing will impact operations
New York – Health Homes

What do you see as the needs and challenges you will need to overcome moving forward?

- Ensuring a smooth transition to Managed Care and improving rates of Health Home enrollment
- Providing continuity of care during the transition from existing children’s waiver and TCM providers/programs into Health Home
- Transitioning to the MAPP
Suzanne Fields, University of Maryland

Peer Lessons Learned and Next Steps