Care Management Entities: A Model to Support Youth with Serious Behavioral Health Problems and their Families in the Community

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Children and Youth with Behavioral Health Problems: A Unique Population of Youth with Special Health Care Needs

- Children with mental health and substance abuse disorders represent less than 10% of the overall Medicaid child population but an estimated 38% of the total Medicaid child expenditures.*
- Children with serious behavioral health problems are often involved with multiple systems: child welfare, juvenile justice, education, and the courts.
- Integrated primary and behavioral health care models designed for adult populations often fail to adequately incorporate the complex multi-system service and fiscal coordination required to effectively and efficiently serve children with complex behavioral health needs and their families.

*Source: Pires, S.A., Grimes, K., Allen, K., Mahadevan, R. (2012). Forthcoming Center for Health Care Strategies Behavioral Health Utilization and Expenditure Study; based on 1.2M children, with fee-for-service expenditure data applied to children in capitated managed care arrangements.

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

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

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

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

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

Source: Pires, S.A., Grimes, K., Allen, K., Mahadevan, R. (2012). Forthcoming Center for Health Care Strategies Behavioral Health Utilization and Expenditure Study

What are Care Management Entities?

- An organizational entity – such as a non profit organization or public agency – 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, outcomes, and cost of care for populations historically experiencing high-costs and/or poor outcomes

What are Care Management Entities?

- At the Service Level, CMEs provide:
  - Child and family team facilitation using high quality Wraparound practice model*
  - Screening, assessment, clinical oversight
  - Intensive care coordination
  - Access to peer support partners, mobile crisis, and other home- and community-based services (including individualized services)
  - Promotion of natural supports

* For more information on Wraparound, please visit the National Wraparound Initiative's website: http://www.nwi.pdx.edu

What are Care Management Entities?

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

Child and Youth Populations Typically Served by CMEs

- Children & adolescents with serious emotional & behavioral challenges at risk of out-of-home placement in residential treatment, group homes and other institutional settings
- Youth at risk of incarceration or placement in juvenile correctional facilities
- Children in child welfare
- Children & adolescents returning from institutional placements in residential treatment, correctional facilities or other out-of-home setting
- Children & adolescents at risk of or returning from psychiatric inpatient settings
- Detention diversion and alternatives to formal court processing for juveniles
- Other populations (e.g., youth at risk for alternative school placements)

Source: Pires, S. (2010). Human Service Collaborative.

Care Management Entities Are Values-Based*

Care is:

- Youth-guided and family-driven
- Individualized
- Strengths-based, resiliency focused
- Culturally and linguistically competent
- Community-based, integrated with natural supports
- Coordinated across providers and systems
- Solution focused
- Data-driven, evidence-informed

*Values draw on system of care values

Source: Pires, S. (2010). Human Service Collaborative.

Care Management Entity Goals

To Improve:

- Clinical and functional outcomes
- System-level outcomes (e.g., reduction in use of out-of-home placements and lengths of stay)
- Cost of care
- Community safety (e.g., reduction in recidivism rates or offense patterns)
- Child safety and permanency
- Educational outcomes (e.g., improved school attendance, reduction in school suspensions)
- Family and youth experience with care
- Other systems' experience with care

Source: Pires, S. (2010). Human Service Collaborative.

Examples of Outcomes in Other States

- Wraparound Milwaukee
  - Reduction in placement disruption rate in child welfare from 65% to 30%
  - School attendance for child welfare-involved children improved from 71% days attended to 86% days attended
  - 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
  - Decrease in average daily population in residential treatment centers from 375 to 50
  - Reduction in psychiatric inpatient days from 5,000 days per year to less than 200 days per year
  - Average monthly cost of $4,200 (compared to $7,200 for RTC, $6,000 for juvenile detention, $18,000 for psychiatric hospitalization)

Source: Milwaukee County Bureau of Children's Behavioral Health. 2010)

Examples of Outcomes in Other States

- New Jersey: Estimates the State has saved $30 million in psychiatric inpatient expenditures alone over last three years (Hancock, B. NJ Division of Child Behavioral Health, 2010).
- Maine: Experienced 30% net reductions in Medicaid spending, comprised of decreases in PRTF and inpatient psychiatric hospitalizations with increases in targeted case management and home and community-based services (Bruns, E., 2011)

Source: Pires, S. (2011). Human Service Collaborative.

CMEs in Maryland

Systems of care have been in development for more than 30 years in Maryland. For many years, some Maryland counties offered care coordination using Wraparound to the Psychiatric Residential Treatment Facility (PRTF)-eligible population, a few using a locally selected CME.

- 2007: Maryland is a 1915(c) PRTF Demonstration Waiver State, using the CMEs to provide intensive care coordination to all Waiver participants.
- 2009: Maryland's Children's Cabinet decides to develop CME capacity across the state, in part to support implementation of the 1915(c) PRTF Medicaid Waiver.
- 2012: The current contract period is coming to an end, as is the PRTF Demonstration. GOC issued a new RFP for a single, statewide CME to serve multiple populations of youth. The Department of Health and Mental Hygiene is actively pursuing a 1915(i) State Plan Amendment to support the PRTF population using the CME model once the PRTF Demonstration comes to a conclusion on September 30, 2012.

Initial Findings in Maryland

- The home- and community-based service array has expanded with Medicaid reimbursement.
- Family Voice and Choice: On average, 82% of youth and 80% of caregivers have had an overall positive perception (a.k.a. “were satisfied with Wraparound”) of the services they received through the CME.
- Of the 500 youth who were ever enrolled in the CME (December 29, 2009-June 30, 2011),
  - 63% continue to be successfully served in the community and 7% were discharged from the CME due to their improved functioning;
  - Only 4% were discharged into a PRTF and 0.8% discharged due to incarceration/placement in a juvenile justice facility.

Source: University of Maryland (October 26, 2011)

Maryland: Costs of Care

- Youth enrolled in the PRTF Demonstration Grant and served by the CME had an average per member, per year cost of care of $32,987 (Medicaid costs only; n=174).
- Youth enrolled in a PRTF during the same time (not served by the CME) had an average per member, per year cost of care of $153,417 (Medicaid costs only; n=1,119).
- These costs include the capitated MCO rate, medications, inpatient hospitalizations, oral health care, home health services and all services covered by Medicaid.

Time Period: September 30, 2009-June 30, 2011 (claims paid through 10/31/11)

Source: Medicaid claims data provided by The Hilltop Institute to the University of Maryland under the CHIPRA Quality Demonstration Grant (November 2011).

Looking Ahead: CMEs in the Context of Health Care Reform

- CMEs have the potential to serve as health homes; they provide:
  - Comprehensive care management
  - Care coordination and health/mental health promotion
  - Transition care across multiple settings
  - Individual and family support services
  - Linkage to social supports and community resources
  - Focus on improving the quality and cost of care for populations with
    - Co-occurring chronic conditions
    - Serious behavioral health challenges, including children at risk
- In considering how to improve the quality and cost of care for children with behavioral health needs, it is important to think of them as a specialty population within the category of youth with special health care needs.
- For more information about the CME model, go to http://www.chcs.org,Child Health Quality Program, CHIPRA Care Management Entity Quality Collaborative.