

*Care Management Entity Quality Collaborative
Technical Assistance Webinar Series*

Care Management Entities: A Primer

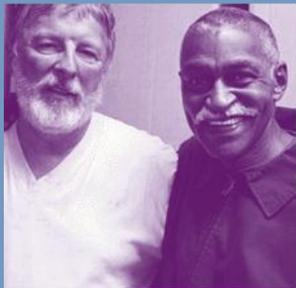
May 12, 2010, 2:00 – 3:30 p.m. ET

For audio, dial: **(866) 699-3239**

Meeting/Event Number: **716 172 870**

If you experience technical difficulties, dial 1-866-229-3239 for assistance, or click the question mark icon located in the floating toolbar at the lower right corner of your computer screen.

This webinar is made possible through support from the State of Maryland.



CHCS Mission

- To improve health care quality for low-income children and adults, people with chronic illnesses and disabilities, frail elders, and racially and ethnically diverse populations experiencing disparities in care.



CHCS Priorities

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



**Improving Quality and
Reducing Racial and Ethnic Disparities**



**Integrating Care for People with
Complex and Special Needs**



Building Medicaid Leadership and Capacity

CHIPRA Quality Demonstration Grants

- CMS awarded 10 grants to states to “establish and evaluate a national quality system for children’s health care which encompasses care provided through the Medicaid program and CHIP.”
 - ▶ Test new measures for quality of care
 - ▶ **Promote the use of HIT**
 - ▶ **Evaluate provider-based models**
 - ▶ Demonstrate impact of a model EHR format
 - ▶ Adopt/modify one – or more – of the above

Quality Demonstration Grantees

- **Children's Mental Health**
 - ▶ Maryland, Georgia and Wyoming
 - ▶ North Carolina (also, Model EHR)
- **CHIPRA Core Measures**
 - ▶ South Carolina
 - ▶ Pennsylvania (also, Model EHR)
 - ▶ Oregon, Alaska and West Virginia
 - ▶ Massachusetts
- **Model EHR/Health Information Technology**
 - ▶ Florida and Illinois
 - ▶ Utah and Idaho
- **Special Needs Populations**
 - ▶ Maine and Vermont
 - ▶ Colorado and New Mexico

Maryland, Georgia and Wyoming Collaborative Grant Project

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

Overview of Today's Webinar

- Overview of CHIPRA Quality Demonstration Grants
- Backdrop for the TA Webinar Series: *CME Quality Collaborative*
- Featured Presentation: *The CME Model: A Primer*
- Question and Answer Period

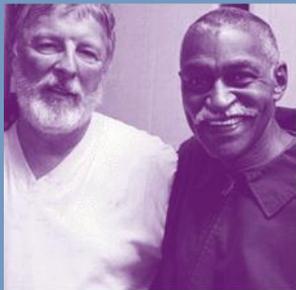
Care Management Entities: A Primer

Sheila A. Pires

Human Service Collaborative

May 12, 2010

*Care Management Entity Quality Collaborative
Technical Assistance Webinar Series*



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 for historically high-cost/poor outcome populations

Populations Focus

For CHIPRA grant, Medicaid and SCHIP populations:

- Children with serious behavioral health challenges
- Children in, on the way to PRTFs, including Family of One
- Children in other out-of-home settings such as children in therapeutic group homes
- Children in child welfare
- Children on multiple psychotropic medications
- Children in and out of psychiatric hospitalization

Other populations:

- e.g., Detention diversion, etc.

CMEs 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

CME Goals

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
- Family and youth experience with care
- Other systems' experience with care

CME Functions

- High quality Wraparound implementation
- Screening, assessment, clinical oversight
- Intensive care coordination
- Care monitoring and review
- Access to family and youth peer supports and advocacy
- Access to crisis supports
- Provider network development and management, including natural supports
- Utilization management and quality Improvement
- Outcomes management
- Information management (real time data)
- Training (e.g., CMEs, providers, families, referring entities)

Like a Medical Home, but Different

Medical home = centered around a single practice

CME = one organizing entity with multiple providers and natural supports; may also have multiple purchasers involved, e.g., Medicaid, child welfare, juvenile justice, mental health, education

Across states, CME functions are similar but there is variation in the type of entity used to perform functions and how specific CME functions are structured.

Variation in Types of CME Entities

- **Public agency as CME**
 - Wraparound Milwaukee
- **New non profit organization** with no other role
 - New Jersey Care Management Organizations
- **Existing non profit organization** with other direct service capability
 - Massachusetts Community Service Agencies
- **Hybrid** - Non profit organization with other direct service capability in formal partnership with neighborhood organization
 - Cuyahoga County, OH Coordinated Care Partnerships
- **Non profit HMO**
 - Mental Health Services Program for Youth

Variation in How CME Functions are Structured

Wraparound and Care Coordination

- CME may do these functions itself (many do – e.g., Massachusetts, New Jersey, Maryland)
- CME may contract out for these functions – Wraparound Milwaukee

Access to Family and Youth Peer Supports and Advocacy

- CME may hire its own peer support staff, contract with a family-run organization, utilize peer supports as a billable service, combination

Variation in How CME Functions are Structured

Access to Crisis Supports

- CME may operate its own mobile response and stabilization service – Wraparound Milwaukee
- CME may utilize mobile response and stabilization capacity contracted by the State – New Jersey
- CME may utilize crisis capacity in Medicaid managed care networks – Massachusetts

Variation in How CME Functions are Structured

Provider network development and management

- CME controls provider network directly – Wraparound Milwaukee
- State (sometimes working with a statewide ASO) develops and manages provider network; role of CME is to provide local oversight and management, identify gaps, develop natural supports and community resources – New Jersey
- Medicaid managed care organizations develop and manage provider network; role of CME is to identify gaps, develop natural supports and community resources – Massachusetts

Variation in How CME Functions are Structured

Utilization Management (UM)

- CME solely responsible for UM – Wraparound Milwaukee
- Statewide ASO has formal UM responsibility; CME role is to monitor utilization at child/family level, ensure plans of care meet quality and cost goals – NJ
- Medicaid managed care organizations have formal UM responsibilities; CME role is to monitor utilization at child/family level, ensure plans of care meet quality and cost goals – MA

Variation in How CME Functions are Structured

Quality Improvement and Outcomes Management

- A shared function among purchasers, CMEs and other statewide management entities such as ASOs where they are playing a role, but CME plays critical role at child/family level

Training

- CME is responsible for training
e.g. Wraparound Milwaukee
- State and CME share training responsibilities
e.g. New Jersey, Maryland

Variation in How CME Functions are Structured

Information Management

- CME has its own Internet-based IT system
e.g., Wraparound Milwaukee, Cuyahoga County, OH,
and Maryland
- CME is tied into statewide ASO IT system
e.g., New Jersey

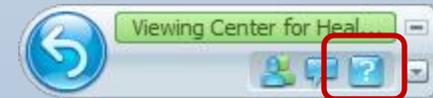
Communications Technology

- Hand-held communications devices for care coordinators; videoconferencing, telemental health, etc.

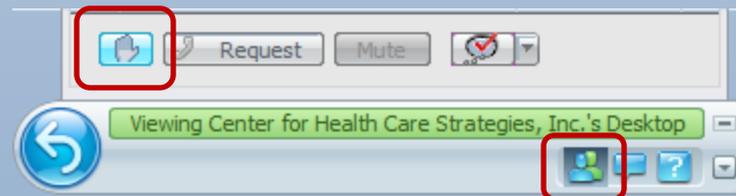
Questions?

To submit a question please use one of the following options:

• **Ask a Question Online:** Click the **Q&A** icon located in the floating toolbar at the lower right side of your screen.



• **Ask a Question via Phone:** Click the **Participant** icon located in the floating toolbar at the lower right side of your screen, then click the **Raise Hand** icon to notify the operator that you would like to ask a question.



Slides and a video archive of this event will be available on our website, at www.chcs.org.

Questions?

To submit a question please use one of the following options:

• ***Ask a Question Online***: Click the **Q&A** icon located in the floating toolbar at the lower right side of your screen.



• ***Ask a Question via Phone***: Phone lines will now be un-muted.

Slides and a video archive of this event will be available on our website, at www.chcs.org.

CME Financing

Often, CMEs use Case Rates or Bundled Rates

What is the rate? Depends on what's in the rate – i.e., how functions are structured

Variation in CME Rates

All-inclusive case rate:

- Covers all services and supports, placements and administrative functions
 - Wraparound Milwaukee: average of \$3,900/pmpm (compares to \$8,500 per month for RTC, for example)

Variation in CME Rates

Partial Case/Bundled Rates:

- Rate covers Wraparound, intensive care coordination, outcomes management, shared role in QI and UM at the child/family level, access to (but not payment of) peer supports and crisis supports, community resource development
 - NJ : Medicaid rate of \$1,034.12 per child per month plus state BH contract of \$53,693 per month, including flex funds (assumes CME serves 200 children a month)
 - MD: Average rate of \$14,500 per child per year
 - Cuyahoga County, OH: Medicaid rate of \$1,602 per child per month

Variation in CME Rates

Partial Case Rates:

- Rate includes care coordination, placements, support services, funding for family organization for peer supports and advocacy; Medicaid services are outside of the rate

Example: Nebraska's Integrated Care Coordination Units:
\$2,137 per child per month

Variation in CME Rates

Example: Choices, Inc. (a CME operating in multiple states)

- Case rate tiers range:
 - \$6,500 (pmpm for highest complexity)
 - \$4,290 (very high risk for out of home placement)
 - \$2,780 (community based care, no placement costs)
 - \$1,565 (Care Coordination and Wraparound)

Sometimes there is no case rate or bundled rate

Example: Massachusetts

- 15-minute billing increments for Targeted Case Management
 - \$19.09 for Masters level care manager
 - \$15.72 for Bachelor's level care manager
- Rate includes: Home-based assessment; Wraparound; care coordination, monitoring and review; access to peer supports and advocacy; access to crisis supports; outcomes management and documentation; clinical oversight; training; translation; participation in system of care community meetings

Variation in Use of Medicaid Options for CME

1915 a

- Wraparound Milwaukee; Cuyahoga County, OH

Targeted Case Management

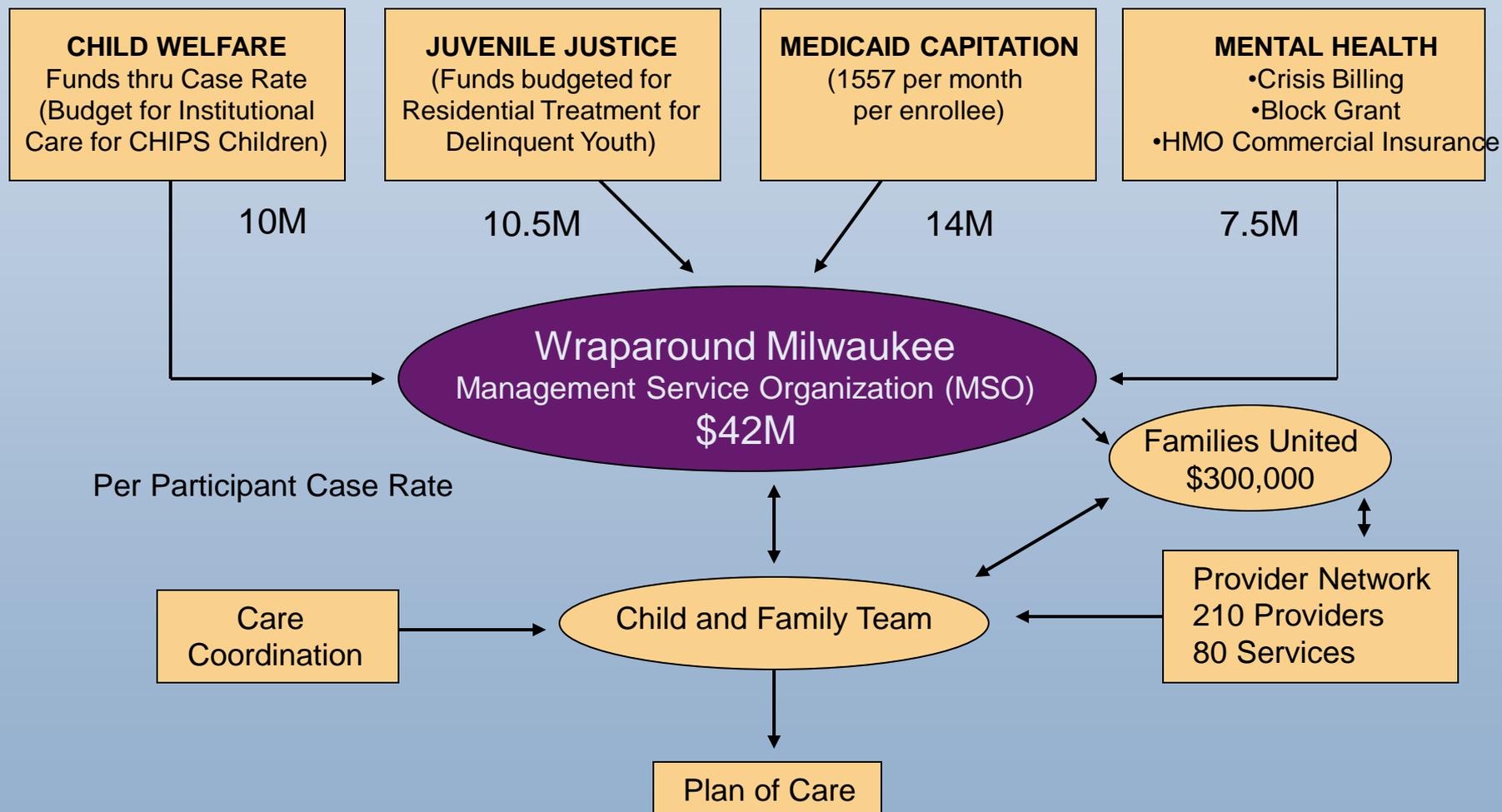
- Massachusetts; New Jersey

Administrative Case Management; 1915 c

- Maryland

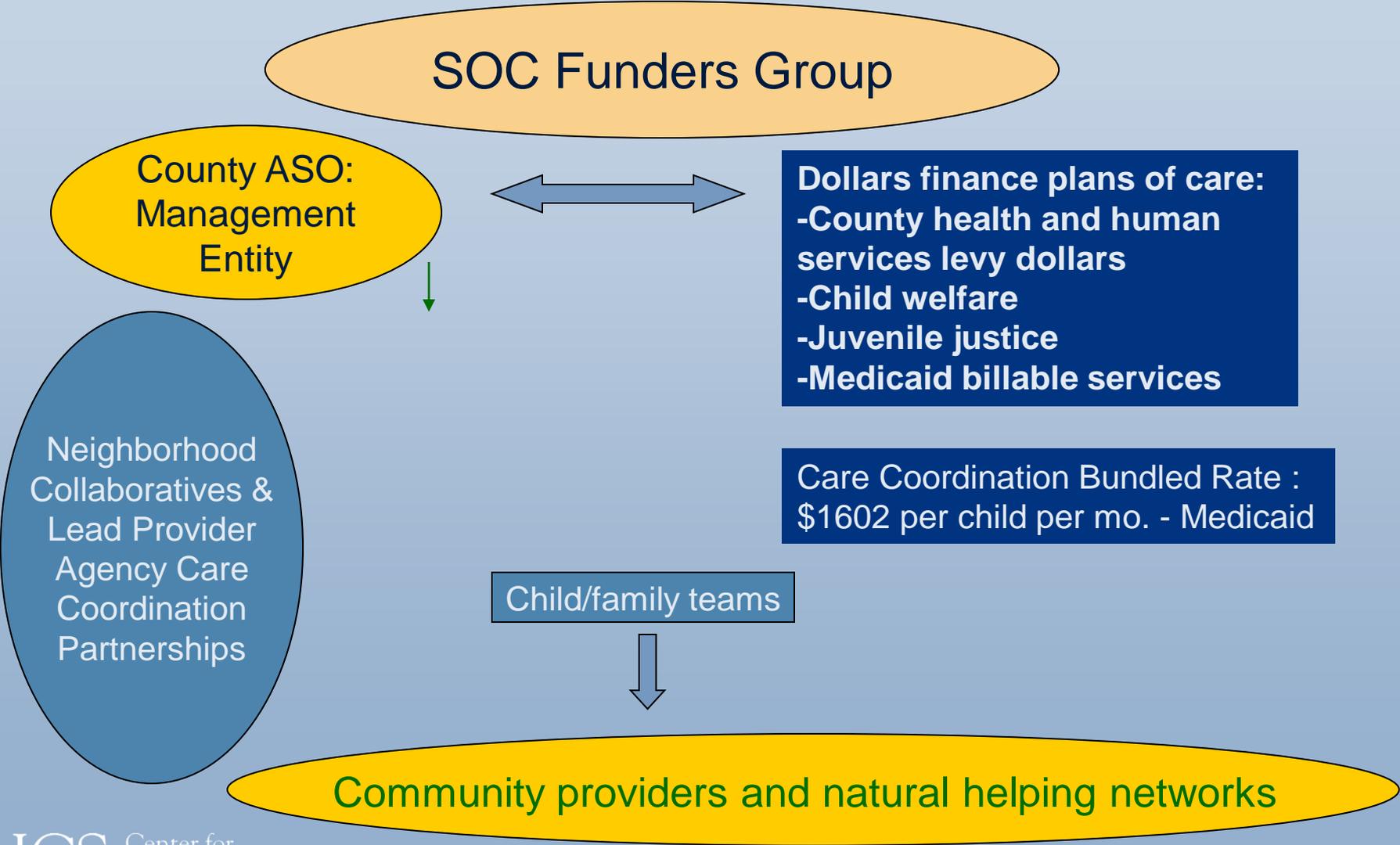
Variation in Financing Sources

Wraparound Milwaukee



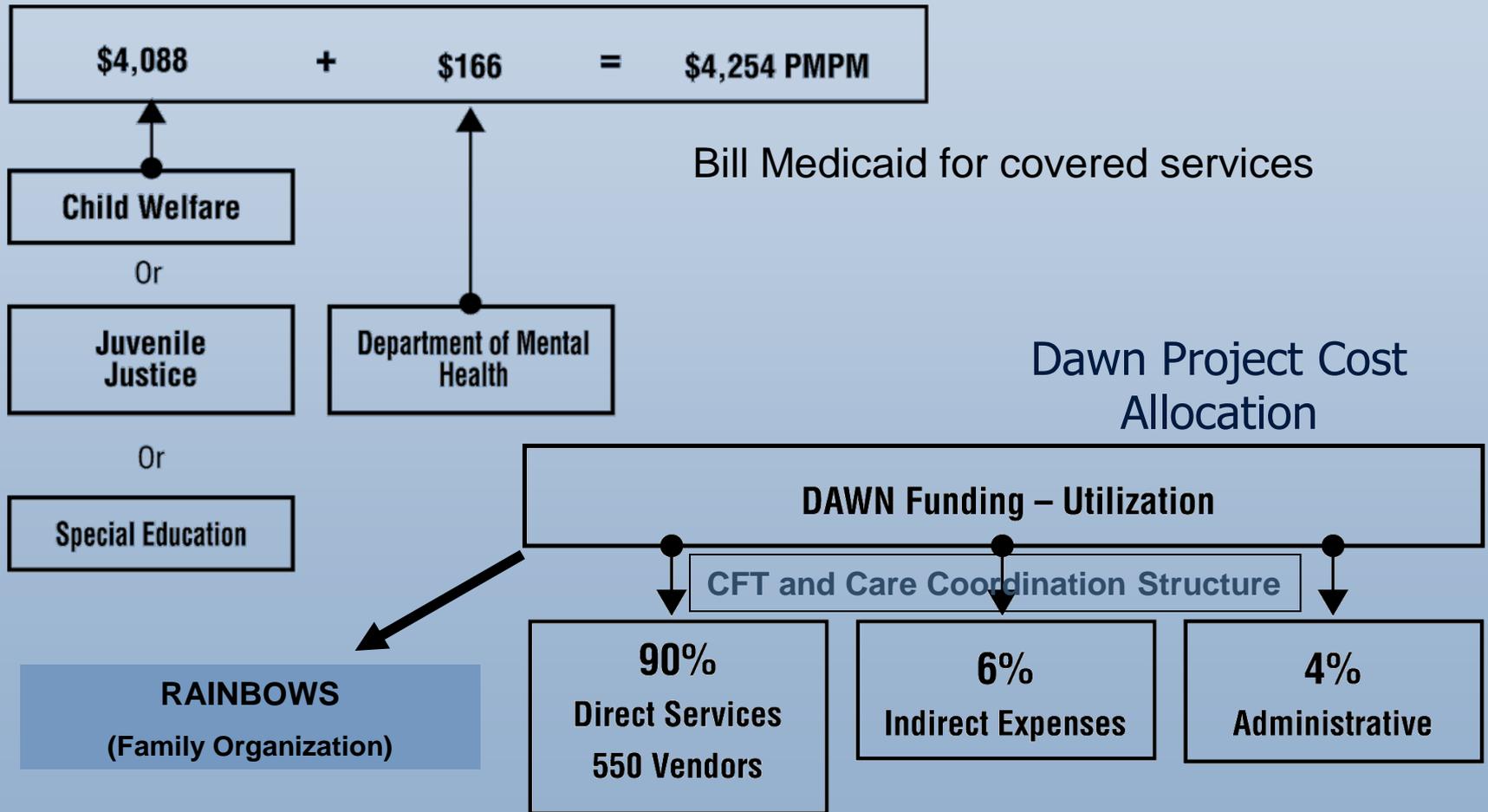
Variation in Financing Sources

Cuyahoga County (Cleveland)



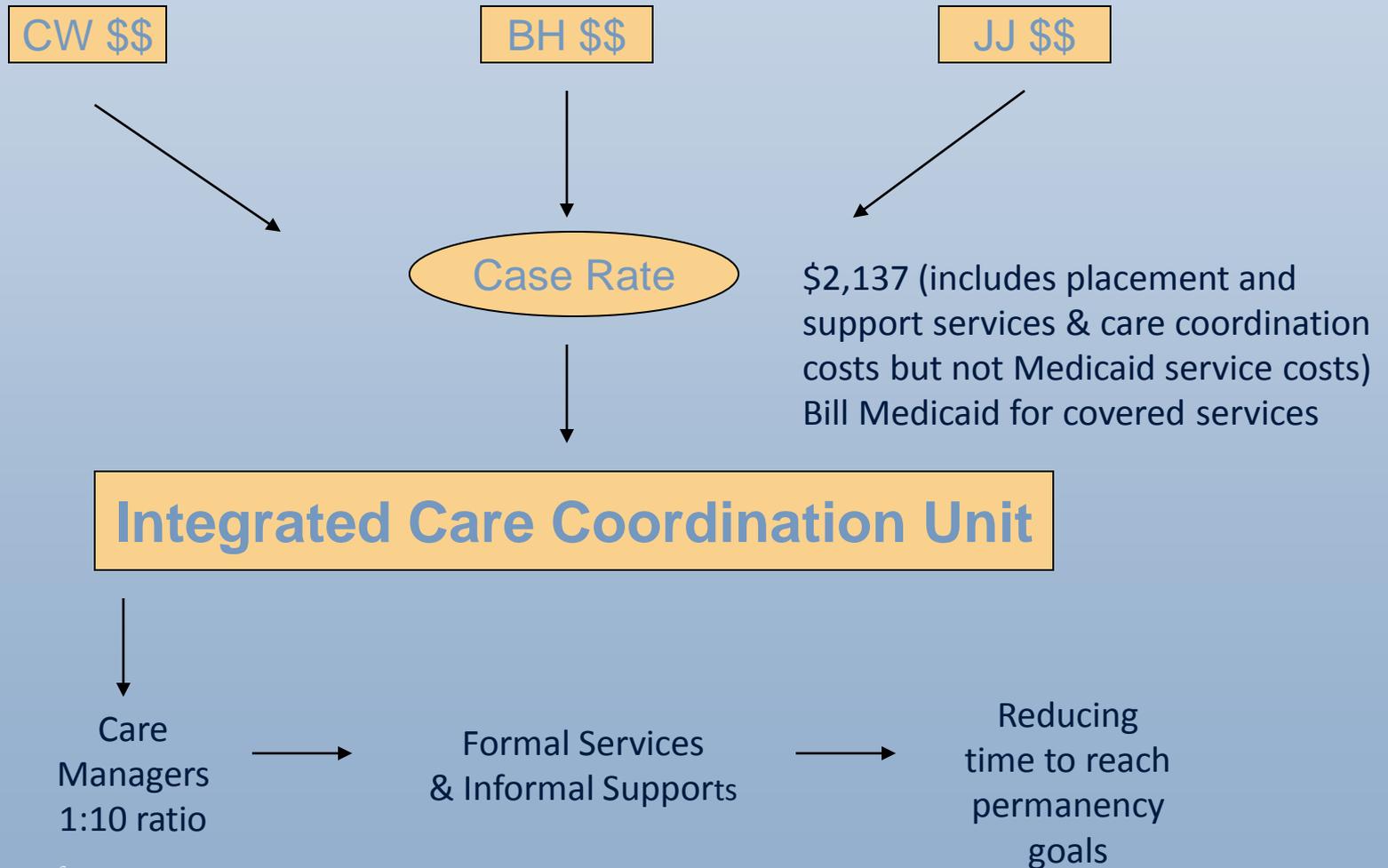
Variation in Financing Sources

DAWN Project - Indianapolis, IN



Variation in Financing Sources

Nebraska Region Three (22 Rural Counties)



Examples of Outcomes

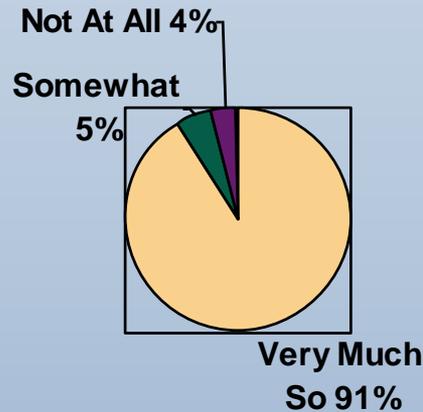
Wraparound Milwaukee

- Reduction in placement disruption rate 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 RTC population from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days to less than 200 days per year
- Average monthly cost of \$4,200 – all inclusive cost (compared to \$7,200 for RTC, \$6,000 for juvenile detention, \$18,000 for psychiatric hospitalization)

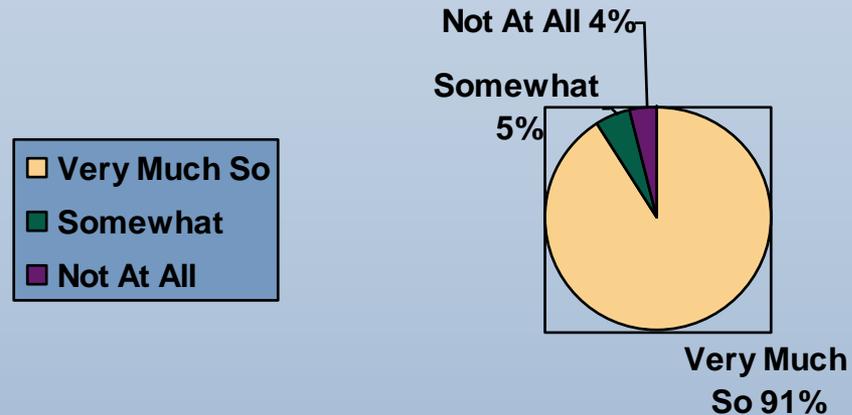
Examples of Outcomes

Wraparound Milwaukee

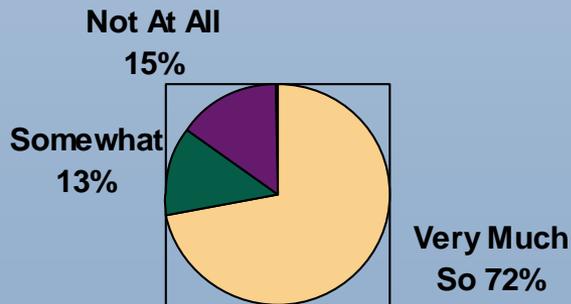
91% felt they and their child were treated with respect (n=191)



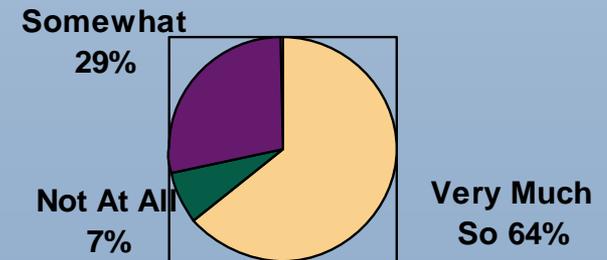
91% felt staff were sensitive to their cultural, ethnic and religious needs (n=189)



72% felt there was an adequate crisis/safety plan in place (n=172)



64% reported Wrap Milwaukee empowered them to handle challenging situations in the future (n=188)



Examples of Outcomes

Nebraska Region III

- At enrollment, 35.8% of children were in group or residential care
- At disenrollment, 5.4% were in group or residential care
- At enrollment, 2.3% of children were living in psychiatric hospitals
- At disenrollment, no children were living in psychiatric hospitals
- At enrollment, 7% of youth were in juvenile detention or corrections
- At disenrollment, no youth were in detention or corrections
- At enrollment, 41.4% of children were living in the community
- At disenrollment, 87.1% of children were living in the community
- Improvement in CAFAS scores
- Generation of \$900,000 in cost savings

CHCS Care Management Quality Framework

□ Applied at planning level

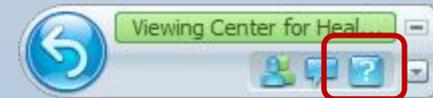
□ Applied at operational level

Care Management Quality Components	Definition	Tools/Strategies
Identification Stratification Prioritization	<p>Identification, stratification, and prioritization should be used to identify children at the highest risk who offer the greatest potential for improvements in clinical and functional, and quality and cost, outcomes. Programs should incorporate clinical and non-clinical sources of information to identify children who will most benefit from a Care Management Entity (CME) approach.</p>	<ul style="list-style-type: none"> • Expenditure and utilization data • Predictive models (algorithm-driven model that uses multiple inputs to predict high-risk opportunities for care management) • Surveys • Case finding (e.g., chart reviews, surveys) • Referrals from families, providers, other systems (e.g., child welfare), and community
Outreach and Engagement	<p>Outreach and engagement efforts should be tailored to providers, families, youth, and referring agencies (such as child welfare) to clarify the CME approach, conduct training in the CME approach, and change referral patterns as needed.</p>	<ul style="list-style-type: none"> • Provider forums • Family -to-family education • Youth-to-youth education • Mapping of referral pathways • Web-based communications • Training and coaching
Intervention	<p>CME Interventions should be tailored to meet individual child and family needs, respecting the role of the youth and family to be decision makers in the care planning process. Interventions should be designed to draw on youth and family strengths and natural supports, be multi-faceted and culturally and linguistically competent, improve quality and cost effectiveness, and ensure coordination of care.</p>	<ul style="list-style-type: none"> • High quality Wraparound • Evidence-informed practices • Child and Family teams • Interactive care plan, developed based on youth- and family-set priorities • “Go to” person, i.e. dedicated care manager • Integration of health, behavioral health, and social supports • Youth and family engagement (e.g., behavioral management training, family and youth peer support, and education) • Crisis and safety plans
Evaluation	<p>Evaluation should include systematic measurement, testing, and analysis to ensure that tailored interventions improve quality, efficiency, and effectiveness. Careful and consistent evaluation will build the evidence base in terms of what works for complex and special needs populations.</p>	<ul style="list-style-type: none"> • Program evaluations • Rapid-cycle micro experiments (e.g., continuous quality improvement, testing, and program adjustments) • Representative measures of quality • Representative measures of cost (e.g., ROI calculations)
Payment/Financing	<p>Payment/Financing should be aligned to support improvements in quality and cost outcomes by allowing flexibility and establishing accountability for quality and cost.</p>	<ul style="list-style-type: none"> • Case rates • Pay for performance • Share in program savings (gainsharing)

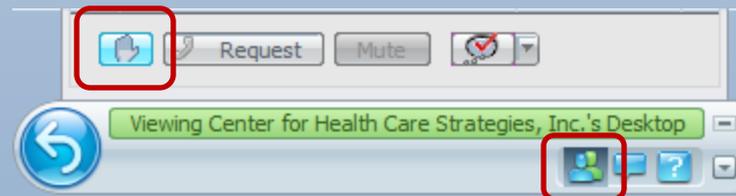
Questions?

To submit a question please use one of the following options:

• **Ask a Question Online:** Click the **Q&A** icon located in the floating toolbar at the lower right side of your screen.



• **Ask a Question via Phone:** Click the **Participant** icon located in the floating toolbar at the lower right side of your screen, then click the **Raise Hand** icon to notify the operator that you would like to ask a question.

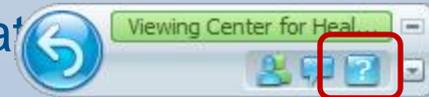


Questions which could not be answered due to time constraints will be answered and posted online as soon as they are available. You may also send additional question to Sheila Pires via email at sapires@aol.com.

Questions?

To submit a question please use one of the following options:

- ***Ask a Question Online***: Click the **Q&A** icon located in the toolbar at the lower right side of your screen.



- ***Ask a Question via Phone***: Phone lines will now be un-muted.

Slides and a video archive of this event will be available on our website, at www.chcs.org.

Questions which could not be answered due to time constraints will be answered and posted online as soon as they are available.

You may also send additional question to Sheila Pires via email at sapires@aol.com.

Visit [CHCS.org](http://www.chcs.org) to ...

- **Download** practical resources to help improve the quality and efficiency of Medicaid services.
- **Subscribe** to *CHCS eMail Updates* to be notified about new programs and resources.
- **Learn** about cutting-edge state/health plan efforts to improve care for high-risk, high-cost beneficiaries.

www.chcs.org