CHCS
Center for
Health Care Strategies, Inc.

FACT SHEET

Care Management Entities: A Primer

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Children and adolescents with complex behavioral health conditions often receive fragmented care through multiple service systems, resulting in poor outcomes and unnecessarily high costs.[1,2] Improved care coordination and increased access to home- and community-based services and peer supports offer substantial opportunities to improve health outcomes, increase resiliency among youth and their families/caregivers, and, ultimately, decrease spending for this population. Reduced costs result from: 1) decreased use of emergency room care; 2) decreased use of inappropriate out-of home placements; and 3) reduced duplication of effort across agencies and providers.

A number of states and regions have begun to demonstrate significant cost savings and improved clinical and functional outcomes for children and youth with behavioral health issues through the use of the Care Management Entity (CME) Model.[3] The CME approach promotes health home concepts and supports a comprehensive Systems of Care framework.[4]

IN BRIEF

Care Management Entities offer a centralized vehicle for coordinating the full array of needs for children and adolescents with complex behavioral health issues. This fact sheet outlines the core characteristics of this promising new approach.

What is a Care Management Entity?

A CME is an organizational entity that serves as a centralized accountable hub to coordinate all care for youth with complex behavioral health challenges who are involved in multiple systems, and their families. As described below, a CME provides: (1) a youth guided and family-family driven, strengths-based approach that is coordinated across agencies and providers; (2) intensive care coordination; (3) home- and community-based services and peer supports as alternatives to costly residential and hospital care for children and adolescents with severe behavioral health challenges.

Goals of a CME

The underlying goals of a CME are to: (1) improve clinical and functional outcomes; (2) enhance system efficiencies, and control costs; and (3) foster resiliency in families and youth. To achieve these objectives, a CME works to:

- Improve access to appropriate services and supports;
- Reduce unnecessary use of costly services (e.g., out-of-home placements and lengths of stay);
- Employ health information technology to support service decision making; and
- Engage youth and their families as partners in care decisions to improve their experience with care.

Populations of Focus

The CME is designed for populations with historically high health care costs and poor health and social outcomes. Beneficiaries who can benefit from CMEs include Medicaid and SCHIP-enrolled youth and others:

- With severe behavioral health challenges;
- In (or at risk of being placed in) psychiatric residential treatment facilities;
- In other out-of-home settings such as therapeutic group homes;
- On multiple psychotropic medications;
- In child welfare; and/or

This fact sheet is based on *Care Management Entities: A Primer*, a presentation by Sheila A. Pires, Human Service Collaborative, May 12, 2010, for the Care Management Entity Quality Improvement Collaborative Technical Assistance Webinar Series. For more information, visit http://www.chcs.org/info-url3966/info-url_list.htm?cat_id=2335

CME Functions

CMEs typically include the following functions:

- High-quality wraparound[5] implementation
- Screening, assessment, and clinical oversight
- Intensive care coordination
- Information management, including real-time data
- Access to family and youth supports and advocacy
- Access to crisis supports
- Development and management of provider networks, including natural supports
- Utilization management and quality improvement
- Outcomes management
- Training for CME staff, providers, families, and referring entities
- Care monitoring and review

CMEs and Health Homes

The goals of CMEs are consistent with those of health homes, as described in the Affordable Care Act.[6] As such, CMEs may be conceptualized as customized health homes for children and youth with severe behavioral health needs. Similar to CMEs, health home functions include:

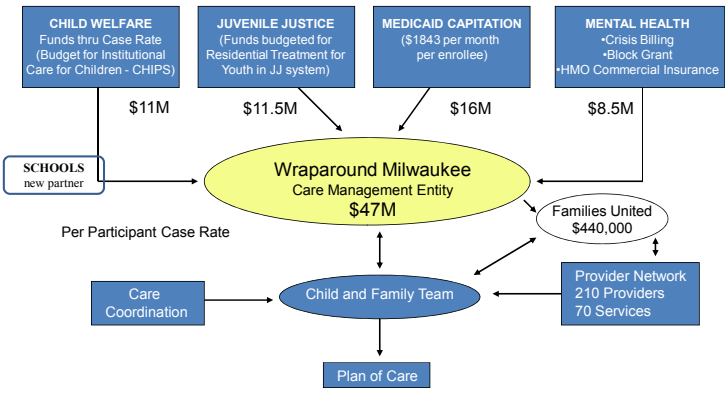
- Comprehensive care management
- Care coordination and health/behavioral health promotion
- Transition care across multiple settings
- Individual and family support services
- Linkage to social supports and community resources.

Health homes focus on improving the quality and cost of care for populations with serious and persistent mental illness and those with chronic conditions. These are also the goals of CMEs.

Variations in CME Organization Type and Delivery

While the underlying functions of CMEs are similar across states, there is variation in how these functions are structured and the type of entity employed to perform them. See Figures 1 and 2 for graphic depictions of a local CME (Wraparound Milwaukee) and a statewide delivery system that incorporates CMEs (New Jersey).

FIGURE 1: CME Example -- Wraparound Milwaukee

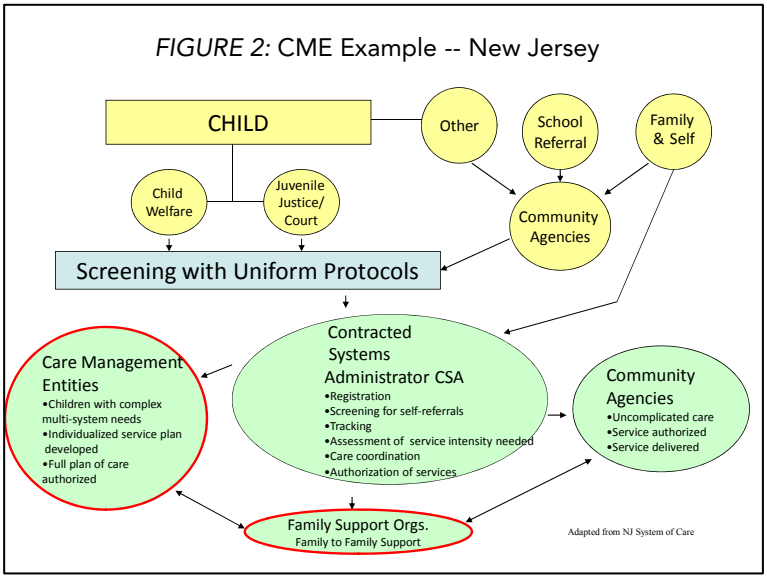


Wraparound Milwaukee. (2010). *What are the pooled funds?* Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch.

Types of CMEs

The following can serve as CMEs:

1. Public agencies (e.g., Wraparound Milwaukee);
2. New nonprofit organizations with no other role (as in New Jersey);
3. Existing nonprofit organizations that deliver other direct services (as in Massachusetts);
4. Nonprofit HMOs (e.g., the Mental Health Services Program for Youth[7]); or
5. Nonprofit organizations with direct service delivery capability that formally partner with a community organization (e.g., Coordinated Care Partnerships in Cuyahoga County, Ohio[8]).



Structures for CME Function Delivery

Each CME function can be structured in a variety of ways, as described below:

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

Financing of CMEs

Financing structures and use of Medicaid for CMEs can vary significantly, depending on existing / available resources, politics, and culture. Typically, however, CMEs use case rates, draw on multiple funding streams, and seek to redirect dollars from "high cost/poor outcome" services to more appropriate home and community-based care. Financing structures include:

Type of Rate	Services Covered
All-Inclusive Case Rate	All services, supports, placements, and administrative functions.
Partial Case/Bundled Rate	Wraparound, intensive care coordination, outcomes management, shared role in quality improvement and utilization management at the child/family level, access to (but not payment of) peer and crisis supports, and community resource development.
Partial Case Rate	Intensive care coordination, placements, support services, and funding for family organization for peer supports and advocacy.
Fee-for-Service Structure	Services billed discretely, in 15-minute increments, at an established rate.

Financing streams include:

- Medicaid options, including: (1) 1915 a (a provision of the Medicaid statute that allows creation of a voluntary managed care – or care management – entity), used in Milwaukee and Ohio; (2) Medicaid targeted case management, used in Massachusetts and New Jersey; (3) Medicaid administrative case management, used in New Jersey; (4) 1915 b and c waivers, used in Maryland; (5) use of the Rehabilitation Services Option, as in all states employing a CME model;
- Child welfare;
- Juvenile justice;
- Mental health and substance abuse;
- Education; and
- Others.

CHCS Role in CHIPRA Quality Demonstration Grant

The Center for Health Care Strategies (CHCS) is the coordinating entity for a five-year, three-state Quality Demonstration Grant project funded by the Centers for Medicare & Medicaid Services through the Children's Health Insurance Program Reauthorization (CHIPRA) Act of 2009. The multi-state grant is supporting lead-state Maryland, and partner states Georgia and Wyoming, in implementing or expanding a CME approach to improve clinical and functional outcomes, reduce costs, increase access to home- and community-based services, and increase resiliency for high-utilizing Medicaid- and CHIP-enrolled children and youth with serious behavioral health challenges. CHCS is leading the project's Quality Learning Collaborative, through which the states will develop, implement, and/or expand their use of a CME model. Throughout the course of the project, the states will participate in the federal National Evaluation of the Quality Demonstration Grant program. The CHCS Quality Improvement framework serves as the main component and central construct of the independent evaluation for the three-state Quality Collaborative. Visit **www.chcs.org** for more information.

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Endnotes

[1] U .S. Public Health Service, Report of the Surgeon General's Conference on Children's Mental Health: A National Action Agenda. Department of Health and Human Services, 2000.
[2] C.A. Fontanella, S.J. Zuravin, and C.L. Burry. The Effect of a Medicaid Managed Care
Program on Patterns of Psychiatric Readmission Among Adolescents: Evidence from Maryland. The Journal of Behavioral Health Services and Research, 2006 Jan;33(1):39-52.
[3] Stroul, B.A., Pires, S.A., Armstrong, M.I et. al. (2009). Effective financing strategies for systems of care: Examples from the field. Tampa, FL: University of South Florida. Also see one of earliest examples of a CME approach, Wraparound Milwaukee, at (www.county.milwaukee.gov/WraparoundMilwaukee.htm)
[4] Pires, S.A. (2010) Building systems of care: A primer, 2nd edition. Washington, DC: Georgetown University Child Development Center, National Technical Assistance Center for Children's Mental Health.
[5] Note: "Wraparound" refers to a collaborative, team-based approach to service and support planning and delivery, rooted in Systems of Care principles, that employs the use of child and family teams.
[6] Public Law 111-148, "Patient Protection and Affordable Care Act" (Sec. 2703).
[7] For more information, visit: http://www.mhspy.org/.
[8] For more information, visit: http://www.cuyahogatapestry.org/.