CHIPRA Quality Demonstration Grant TA Webinar Series

Financing Options for Care Management Entities
The Massachusetts Experience

Suzanne Fields, MSW, LICSW
Technical Assistance Collaborative
June 23, 2010
sfields@tacinc.org
Overview

- Massachusetts context
- Use of Medicaid
- Service array
- Financing structure and payment approaches
- Rate-setting
Rosie D. v. Patrick, a class action lawsuit filed in 2001 on behalf of children and youth with serious emotional disturbance

Alleged that MA Medicaid failed to meet obligations of the EPSDT statute

January 2006, the Court found that MA Medicaid had not provided sufficient:
- Behavioral health screening in primary care
- Behavioral health assessments
- Service coordination
- Home-based behavioral health services

Final Judgment issued June 2007 with implementation July 2009

Medicaid as the sole financer-no blending/braiding with other state systems
**MA Context - Enrollment & Managed Care**

- Approx 1.1 million Medicaid enrollees
- Approx 470,000 persons under age 21
- Approx 15,000 children in “the class”
- 5 managed care entities (MCEs)
  - one MBHO for the PCCM
  - four integrated PH & BH plans, some of which carve-out BH

- Decision to **not** enroll “the class” into one MCE
Using Medicaid

- State plan & 1115
  - MA operating under an 1115 since July 1999
  - Use of State Plan Amendment (SPA) for Targeted Case Management (TCM) was a legal strategy: well-defined terms; service level & target group approval by CMS
  - Lawsuit remedy services and TCM operate under SPA, and all other BH services operate under 1115

- Opportunities & challenges
Service Array

- MA calls its CMEs “Community Service Agencies” (CSAs)

- The role of CSAs was informed by the presence and role of the five MCEs

- Capitation, Quality Management (QM), etc., occurs at the MCE level

- CSAs bill as a provider of Intensive Care Coordination (ICC): ICC = TCM
Service Array

- There is a “package” of services that the CSAs coordinate which are not bundled, but separately defined and paid.

- The package of services can be delivered by any willing provider that meets the qualifications defined in the SPA.

- CSA is the location for TCM (ICC) and Family Partners, and where all other services are coordinated, whether or not the CSA provider, or another provider, is delivering a service or another provider is delivering a service.
Lawsuit Remedy Service Array

- CSA is expected to develop a Care Planning Team (CPT) that includes any involved providers and natural supports
- The following constitute the required package of services coordinated by the CSA but managed by the MCE, under the Rosie D. remedy:
  - Targeted Case Management (ICC)
  - Parent/Caregiver peer-to-peer support (referred to as Family Partners)
  - Behavior management monitoring
  - Behavioral management therapy
  - In-home therapy
  - Therapeutic mentoring
  - Mobile crisis intervention
Additionally, the following services are available and coordinated with the CSAs, but managed by the MCE:

- Inpatient services
- Community Support Program (CSP)
- Partial hospitalization
- Community-based acute treatment for children and adolescents
- Acute treatment services for substance abuse (ASAM 3.7)
- Clinical support services for substance abuse (ASAM 3.5)
- Psychiatric day treatment
- Structured Outpatient Addiction Program (SOAP)
- Intensive outpatient program
- Outpatient services
- Psychological testing
Financing structure and payment approaches

- MCE receives capitated payments
  - No risk for first year – added payment guaranteed
  - Reduced disincentives to authorize care

- Rate-setting process
  - Benchmarked to existing service rates
  - Public comment
  - 15-minute unit vs. bundled or case rates
  - CMS considerations
# Rate-setting Services

<table>
<thead>
<tr>
<th>Service</th>
<th>Code</th>
<th>Rate: 15-min unit</th>
</tr>
</thead>
<tbody>
<tr>
<td>Intensive Care Coordination (TCM - Master’s/PhD)</td>
<td>T1017-HO</td>
<td>19.09</td>
</tr>
<tr>
<td>Intensive Care Coordination (TCM - Bachelor’s)</td>
<td>T1017-HN</td>
<td>15.72</td>
</tr>
<tr>
<td>Family Partner</td>
<td>H0038</td>
<td>13.03</td>
</tr>
<tr>
<td>Mobile Crisis Intervention (Paraprofessional)</td>
<td>H2011-HN</td>
<td>19.21</td>
</tr>
<tr>
<td>Mobile Crisis Intervention (Master’s/PhD)</td>
<td>H2011-HO</td>
<td>28.66</td>
</tr>
<tr>
<td>Behavior Management Monitoring (Bachelor’s)</td>
<td>H2014-HN</td>
<td>12.61</td>
</tr>
<tr>
<td>Behavior Management Therapy (Master’s/PhD)</td>
<td>H2014-HO</td>
<td>24.81</td>
</tr>
<tr>
<td>In-Home Therapy (Bachelor’s)</td>
<td>H2019-HN</td>
<td>12.02</td>
</tr>
<tr>
<td>In-Home Therapy (Master’s/PhD)</td>
<td>H2019-HO</td>
<td>18.60</td>
</tr>
<tr>
<td>Therapeutic Mentoring Service (Bachelor’s)</td>
<td>T1027-EP</td>
<td>12.98</td>
</tr>
</tbody>
</table>
Questions?
Financing Care Management in Maryland

Gerry Grimm
Innovations Institute
University of Maryland, Baltimore

CHIPRA Quality Demonstration Grant TA Webinar Series
June 23, 2010
Care Management Evolves

• For many years, some Maryland counties offered care coordination using Wraparound to the PRTF-eligible population, a few using a locally selected Care Management Entity (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.
  – Divided the state into three regions, each to have its own CME.
  – The Governor’s Office for Children (GOC), acting on behalf of the Children’s Cabinet, issued a Request for Proposals for CMEs.

• The RFP resulted in three contracts to not-for-profit companies to become Regional CMEs:
  – Wraparound Maryland in two regions (Baltimore City and South East regions).
  – Maryland Choices in one region (North West region)
CME Target Populations

Maryland’s CMEs work with three primary populations, each with its own funding mechanism:

- **1915(c) PRTF Medicaid Waiver population**: Youth who meet a series of technical eligibility criteria, who qualify for Community Medicaid/MCHP or are eligible for medical assistance under Family of One, and who meet medical necessity criteria (MNC) for a PRTF, but who can be safely served in the community with Wraparound.
  
  – Note: To support the Waiver, Maryland changed the MNC to say: “RTC Level of Care or Community-Based RTC Level of Care.”

- **System of Care (SOC) Grant Populations**: Maryland received two federal SOC grants for Baltimore City and the nine Eastern Shore Counties targeting foster children with SED at risk of out of home placement or placement disruption.

- **GOC Funded Youth**: Each region was allocated funds to serve 25 child welfare and 25 juvenile justice youth, targeting those who may be (a) entering the system with an identified need for group care, (b) in the system at risk for group care, or (c) already in group care but, able to be moved to a less restrictive setting.
The Challenge of Pricing Care Coordination

• Maryland chose to fund Care Coordination as an administrative expense.
  – For Waiver youth, cost became part of Medicaid Administrative Claim.
  – This permitted GOC to pay CMEs for care coordination in the same way for all populations.
• Challenge of pricing care coordination in the CME RFP:
  – Concern that uncertainty over potential CME population would discourage bidders.
  – State chose to bifurcate the financial bid into two components:
    • An overhead budget—represented an amount to be guaranteed in contracts for rent and other fixed general expenses, unrelated to the number of youth served.
    • A care coordination budget—based on a targeted number of youth, this budget covered care coordination and supervision. The budget was turned into a per diem per youth rate.
  – This resulted in a cost per youth for care coordination that is not a fixed amount, but fluctuates with the number of youth served, as overhead is spread among more youth.
Categories of Funding Available to CMEs to Support Plans of Care

- **Care Coordination** - Regional rates set by the bid process ranging from $1000 to $1400 per youth per month.
  - Variables affecting rates include travel distances and cost of living in different parts of the state.
  - For Waiver participants, the cost is paid by Medicaid; for SOC grant participants, the cost is paid by the grant; for all other populations, the care coordination is paid by State-only funds.

- **Medicaid Services** – Medicaid-eligible youth can access the fee-for-service Public Mental Health System, and Waiver youth can access the extra services provided by the Waiver.

- **Flex Funds** - Discretionary general funds allocated per youth per day to support components of the Plan of Care not otherwise funded. (All State-only funds)
  - Waiver youth: $7 per day
  - Non-Waiver youth: $20 per day

- **Residential Services**
  - Medicaid funds inpatient or Residential Treatment Center (RTC) stays.
  - Custodial agency funds group home or foster care placement.
  - GOC funds group or foster care for non-custodial youth.
1915(c) PRTF Medicaid Waiver

Maryland is in the third year of implementation of the PRTF Waiver.

• Eligible Populations
  – Youth who meet MNC for RTC or Community-Based RTC Level of Care; and
  – Youth who can be safely served in the community; and
  – Youth who are community Medicaid eligible or eligible as a family of one; and
  – Youth who meet specific technical criteria (i.e. age, choose to participate in the Waiver, etc).

• Waiver state match
  – Maryland Medicaid and Mental Hygiene Administration required that the state match funds for the Waiver be identified from existing budgets. This resulted in the Waiver being limited to 215 youth going into Year 4.
  – Sources of state match:
    • GOC-general funds budgeted for RTC return and diversion;
    • MHA-general funds budgeted for RTC diversion; and
    • Local funds identified by counties to become state match
PRTF Waiver-Service Array

Waiver participants are eligible to receive seven new Medicaid mental health services:

• Expressive Behavioral Services: art, drama, dance, equine, music, and horticultural therapies.
• Caregiver Peer-to-Peer Support: provided by current or previous caregivers of a child or youth with emotional, behavioral, or mental health challenges.
• Youth Peer-to-Peer Support: provided by a youth 18-26 who has or had emotional and/or behavioral health challenges.
• Family and Youth Training: provided by either a parent or youth with experience in the system.
• Crisis and Stabilization: mobile supports to youth/families in psychiatric crisis.
• In-Home Respite Care: provided where the youth resides or in the community.
• Out-of-Home Respite Care: provided in the community overnight.
Rate Setting

• 1915(c) RTC Waiver Rates
  – Consulted existing rates for similar services (e.g., Expressive Services)
  – Bundled rates based on estimated usage of components of service (e.g., Crisis Stabilization)
  – Created a rate using salary, caseload size, contact duration and frequency and overhead data (e.g., Peer Support)

• Flex Funds
  – Evaluated historical Maryland spending data
  – Consulted with other states for their experiences with flex fund usage

• Residential Programs
  – Maryland has an Interagency Rates Committee, with staff, that uses a negotiated rates process with congregate care and treatment foster care providers that sets rates for all payers

• Care Coordination
  – Competitive bid process, as described previously
Waiver Cost Neutrality/CME Savings

• Maryland’s 1915(c) Waiver application establishes the average cost for a youth to be served in an RTC, without the Waiver. In Year 3 of the Waiver, this cost is $128,000 per RTC episode.

• This is compared to the cost of serving a youth in the Waiver:
  – Estimated Public Mental Health System Cost $18,500
  – Estimated cost for Waiver services $18,100
  – Average Health Choice capitated rate for somatic care $6,100
  – Care coordination average annual cost $14,500
  – Flex funds $2,500
  Total without residential $59,700

Out-of-home cost is the “great unknown” in Maryland, without usage history.

Rate examples:
  – Treatment Foster Care $40,000-$50,000 per year
  – Group Home $60,000-$80,000 per year
  – Therapeutic Group Home $80,000-$90,000 per year
Maryland has blended a variety of funding sources to support the CMEs:

<table>
<thead>
<tr>
<th>Source</th>
<th>Services and Supports Financed</th>
</tr>
</thead>
</table>
| GOC (Children’s Cabinet)     | - General funds budgeted for RTC youth  
|                               | - Rehab option funds available when Maryland chose to use Medicaid to pay for group home health care                                                         |
| Federal Medicaid              | - Match for Public Mental Health System services and PRTF Waiver services  
|                               | - Match for administrative funding for care coordination                                                                                                    |
| Title IV-E                    | Federal matching funds for placement cost for eligible youth                                                                                                |
| Dept. of Human Resources      | Child Welfare general fund share of placement cost                                                                                                          |
| Dept. of Juvenile Services    | Juvenile Justice general funds share of placement cost                                                                                                       |
| System of Care Grants         | Federal funds awarded to Maryland to carry out specific proposed projects                                                                                   |
Maryland’s CHIPRA Goals

• Maryland aspires to “grow up to be like our older sibling,” Wraparound Milwaukee, by establishing
  – A case rate incorporating all funds supporting CME youth;
  – A single-payer system;
  – ‘One youth, one care manager and one plan’ model;
  – Financial risk with the CMEs; and
  – Provider Incentives

• Maryland will use its CHIPRA grant to develop the case rate and the mechanisms to implement it.
Questions?

For further information contact
Gerry Grimm
Innovations Institute,
University of Maryland, Baltimore
410-706-2564
ggrimm@psych.umaryland.edu
Overview

- System funding sources
- Federal reimbursement sources
- Non-eligible populations
- Rate-setting methodology
NJ System of Care Funding Streams

- State appropriations:
  - Mental Health
  - Child Welfare
  - Medicaid

- Federal revenue sources
  - Medicaid/SCHIP
Federal Funding Mechanics

- Rehab Option: In-home Services, EBPs, Mobile Response, Group Homes/Therapeutic Foster Care

- TCM: Care Management, Youth Case Management

- Cost Allocation Plan: Family Support, Administrative Services Contract, State Services
Non-Eligible Children

- Medicaid “look-alike” program
  - All providers reimbursed at same rates as Medicaid program
  - Providers submit claims through same process
  - Provides single payment structure for all children receiving services
CME Financing

- Use a deficit-funded contract with revenue targets
- Provide contract funding for costs not eligible for Medicaid reimbursement (e.g., Flex Funds)
- Monthly Inclusive Rate is set using cost-based methodology including all allowable costs
- Rate strongly determined by ratio of care managers to children
Rate-Setting Methodology

- Market-based methodology using transparent inputs to arrive at rate
- Requires collaboration with providers around true cost of care
- Requires clear modeling of staffing and service-level requirements
Financing Benefits

- Reduced use of acute inpatient services saved more than $30 million in last three years alone

- Residential treatment budget reduced by 15% over last three years

- Total federal revenue increased 5x since 2000, while state costs grew 2x
Figure 7.
Comparison of Original Estimated Spending per Capita and Need Index

- Total Children's Initiative Costs per Child in Poverty
- Need Level

Costs Per Capita

Need Level Scores

Children = Ages 0 through 17
Figure 8.
Comparison of 2005 Consolidated Children’s Mental Health Spending per Capita and Need Index

Children = Ages 0 through 17
Comparison of FY ‘08 Consolidated Per Capita Spending to Needs Index by County

Per Capita
Need Index

Cape May
Cumberland
Camden
Salem
Mercer
Atlantic
Passaic
Essex
Monmouth
Ocean
Union
Gloucester
Burlington
Hudson
Warren
Bergen
Somerset
Sussex
Middlesex
Morris
Hunterdon

Per Capita Need Index
Questions?
Options for Financing Care Management Entities:

Wraparound Milwaukee’s Pooled Funding Model

Bruce Kamradt, MSW
Director, Wraparound Milwaukee
June 23, 2010

CHIPRA Care Management Entity Quality Collaborative Technical Assistance Webinar Series
What is Wraparound Milwaukee?

- A unique system of care for families and children who have serious emotional, mental health or behavioral needs that:
  - Cross two or more child-serving systems;
  - Have persisted for six months or more;
  - Cause some functional impairment at home, school or in the community; and
  - Place them at risk for out-of-home placement in residential treatment, juvenile correctional care, a psychiatric hospital, or other facility

- Operated by the Milwaukee County Behavioral Health Division, Wraparound Milwaukee functions as its own managed care entity, pooling funding across systems and managing the care of all children in the target group regardless of the system they came from

- Serves 1500 youth annually
Administrative and Service Structures of Wraparound Milwaukee – What Does It Need to Do

- Screening /assessment of youth
- Enrollment
- Care coordination
- Development and maintenance of a provider network
- Crisis intervention
- Clinical oversight
- Development of informal community supports
- Quality Assurance
  - Utilization Management
  - Evaluation
- Finance
  - Service Authorization/Claim Processing
  - Reports
- IT
- Contracting with other systems
- Developing and supporting family advocacy organization
- Liaison with court system
Wraparound Milwaukee Organizational Chart

Wraparound Milwaukee
Bruce Kamradt, Director

MEDICAL DIRECTOR
D. Kozel, M.D.

FAMILY ADVOCACY
FAMILIES UNITED OF MILWAUKEE
Margaret Jefferson, Director

INTERNAL OPERATIONS
Admin. Coord.

DEPUTY DIRECTOR
M. J. Meyers, M.S.

WRAPAROUND MILWAUKEE

INTERNATIONAL
Coord.

FISCAL SERVICES
Admin. Coord.
- Verifications
- Invoicing/Provider
- Provider Logs
- Accounts Receivable
- Synthesis Software Application

MANAGEMENT INFORMATION
Consultant

QUALITY ASSURANCE
Coordinator
- 2 Staff
- 220 Plus Agencies
  80 Services

PROVIDER NETWORK
Network Coord.

MOBILE URGENT TREATMENT TEAM
Director
- 2 Clinical Psych.
- 1 Reg. Nurse

CHILDREN'S COURT LIAISONS
3 Staff

ENROLLMENTS & DISENROLLMENTS
Clinical Coord.
- 3 Assessment Staff

8 CARE COORDINATION AGENCIES
8 Supervisors
100 Care Coordinators
Background for Development of Wraparound Milwaukee

- Initiated in 1995 under SAMHSA grant

- Focused on target population of youth due to:
  - Over-utilization of residential treatment (375 youth in residential treatment)
  - Budget deficits for Milwaukee County
  - Poor outcomes for youth returning from institutional care

- Pilot project in 1995-96: “25-Kid Project” showed that Wraparound-based system of care could be successful in effectively and safely returning youth to their home and community

- Funding structures, including contract with Medicaid as special managed care entity, put in place in 1996-1997
Key Child-Serving Agencies Contracting With Wraparound Milwaukee

- Bureau of Milwaukee Child Welfare
  - State-Administered / Privately Operated

- Milwaukee County Children’s Court
  - Delinquency Services

- Division of Health Care Financing
  - State Agency Operating Medicaid

- Milwaukee County Behavioral Health Division
Wraparound Milwaukee

Funding
Creating “Win-Win” Scenarios

- Child Welfare
  - Alternative to out-of-home care
  - Reduce high-cost/poor outcomes
- Medicaid
  - Alternative to inpatient and ER
  - Reduce high cost
- Juvenile Justice
  - Alternative to detention
  - Reduce high-cost/poor outcomes
- Special Education
  - Alternative to out-of-school placement
  - Reduce high cost
Wraparound Milwaukee’s Funding Model

- **Blended Funding Pool**
  - Medicaid: capitated rate and fee-for-service for crisis services
  - Child Welfare: case rate agreement with Department of Children and Family Services
  - Delinquency Services: fixed annual funding and case rate for diversions from juvenile corrections

- **Principal approach is to re-direct money from institutional to community-based care**

- **Contract with Medicaid as a special, publically operated managed care entity**

- **Under 1915(a) authority**

- **Wraparound Milwaukee is the single payor for all services for enrolled youth and is at risk for service costs**

- **Wraparound Milwaukee utilizes a provider network, pays providers on a fee-for-service basis and sets rates it pays providers**

- **All care coordination agencies, mental health and support service providers are on Wraparound Milwaukee’s Synthesis IT system**
  - Services are authorized, claims processed and providers paid electronically
What are Pooled Funds?

- **CHILD WELFARE**
  Funds thru Case Rate
  (Budget for Institutional Care for Chips Children)
  $10.0M

- **JUVENILE JUSTICE**
  Funds Budgeted for Residential Treatment and Juvenile Corrections Placements)
  $10.5 M

- **MEDICAID CAPITATION**
  (1825 per Month per Enrollee)
  $14.0 M

- **MENTAL HEALTH**
  - CRISIS BILLING
  - BLOCK GRANT
  - HMO COMMERCIAL INSUR
  $7.5 M

**WRAPAROUND MILWAUKEE CARE MANAGEMENT ORGANIZATION (CMO)**
$42 M

**CARE COORDINATION**

**CHILD AND FAMILY TEAM**

**PLAN OF CARE**

**PROVIDER NETWORK**
  210 Providers
  80 Services
Advantages of Blended or Pooled Funding

- Flexibility
- Adequacy
- De-categorization of funds
- Responsiveness to changing needs
- Lends itself to managed care approaches
- De-politicizes allocation and awarding of funds
List of Available Services in Social/Mental Health Plan

- Case Management
- Referral Assessment
- Medication Management
- Outpatient
- Individual/Family
- Outpatient - Group
- Outpatient - AODA
- Psychiatric Assessment
- Psychological Evaluation
- Mental Health
- Assessment/Evaluation
- Inpatient Psychiatric
- Nursing Assessment/Management
- Consultation with Other Professionals
- Daily Living Skills - Individual
- Daily Living Skills - Group
- Parent Aide
- Child Care
- Housekeeping
- Mentoring
- Tutor
- Life Coach
- Recreation
- After-School Programming
- Specialized Camps
- Discretionary Funds
- Supported Work Environment
- Group Home Care
- Respite
- Respite - Foster Care
- Respite - Residential
- Crisis Bed - RTC
- Crisis Home
- Foster Care
- Treatment Foster Care
- In-Home Treatment (Case Aide)
- Day Treatment
- Residential Treatment
- Transportation
SERVICE STRUCTURES

Delivery of Wraparound Approach & Processes
Mobile Crisis Team

- Available 24/7
- Mobile Crisis gatekeeps inpatient care
- Crisis is defined as a situation in which a child’s behaviors threaten removal from school, home, etc.
- M.U.T.T. assesses situation, identifies alternative to hospitalization and makes referrals as needed to:
  - Crisis intervention
  - Short-term case management
  - Intensive case management - 30 Days
  - Family preservation services - 60 Days
  - Crisis group home
Care Coordination Services

- Meet the child and family
- Strength-based inventory
- Convene child and family team to develop the Wraparound Plan
- Establish goals
- Identify and prioritize needs
  - Formal services from a provider network
  - Informal services within family’s support system
- Obtain commitments to implement plan
- Evaluate and modify plan as needed
Provider Network

- 80 Services
- No formal contracting -- services purchased on a fee-for-service basis -- rates established by Wraparound Milwaukee
- Extensive quality assurance/quality monitoring
- Residential treatment vendors were asked to re-engineer institutional services to community-based services
- Consumer choice of providers
- All providers and care managers linked through internet-based IT system for authorizations, plan submission, invoicing, etc.
Family Advocacy Component
Families United of Milwaukee

- Advocacy
- Support groups & activities
- Family & system education
- Satisfaction surveys
- Serve on committees, boards, etc.
- Train care coordinators
- Crisis intervention
- Resource development
- Develop newsletter, brochures, other info
Program

Outcomes
Outcomes - Program

- Average daily residential treatment population reduced from 375 placements to 80 placements (FOCUS Project: 15-20)
- Psychiatric inpatient utilization reduced from 5000 days per year to less than 200 days (avg. length of stay of 2.3 days)
- Reduction in Juvenile Correctional commitments from 385 to 185 per year
Outcomes - Financial

- Wraparound Milwaukee’s average monthly cost is $3900 per child per month, versus
  - $8600 per child per month for residential treatment
  - $8000 per child per month for a correctional placement
  - $1600 per day for psychiatric inpatient care
Questions?