**The National Evaluation of the
CHIPRA Quality Demonstration Grant Program**

Implementation Guide Number 2

Designing Care Management Entities for Youth with Complex Behavioral Health Needs

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Acknowledgments

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About This Guide

Youth with complex behavioral health needs face a range of challenges and are at risk for poor health and education outcomes. They often receive services from multiple agencies, and these agencies may not always coordinate services and care plans for these youth.

When a youth's behavioral health and psychosocial needs are not addressed in a holistic manner, families may find themselves cycling in and out of crises. Moreover, the youth themselves may end up in restrictive placements that separate them from their families and communities and increase costs for the State.

Care Management Entities (CMEs) are designed to coordinate services provided by the many State agencies that serve youth with complex behavioral health needs. By ensuring services are comprehensive but not duplicative, CMEs can improve outcomes for these youth and their families and lower costs to States.

This Implementation Guide provides information about the CME design process. We hope it will be helpful to States interested in implementing or improving CMEs for youth with complex behavioral health needs and their families. The guide may also be useful for county agencies if they are responsible for financing behavioral health or social services in the State.

To develop this Guide, we drew from the experiences of the three CHIPRA quality demonstration States that are using funds to implement or expand CMEs. Maryland and Georgia are using their CHIPRA quality demonstration funds to refine and expand their existing CMEs, which they initially developed through Substance Abuse and Mental Health Services Administration (SAMHSA) Systems of Care grants and the Medicaid Psychiatric Residential Treatment Facilities 1915(c) waiver demonstration. Wyoming is using CHIPRA quality demonstration funds to design and implement a CME for the State.

To gather information about these efforts, we conducted semi-structured interviews in the summer of 2012 and again in the spring of 2014 with State CHIPRA quality demonstration staff, CME staff, and representatives from various child-serving agencies and family advocacy organizations. We also used information from semiannual progress reports that CHIPRA quality demonstration States submitted to the Centers for Medicaid & Medicare Services (CMS). We augmented this information with a focused review of the literature on CMEs and by asking CME experts to comment on an early draft of the Guide.

This Guide consists of four parts:

- **Part 1: An Introduction to CMEs.** Read this section to learn more about CMEs and their potential for enhancing services for youth with complex behavioral health needs.

- **Part 2: Assessing State Readiness to Design and Implement CMEs.** Read this section to learn about factors that may facilitate CME implementation and to help assess State readiness to move forward with CME design.

- **Part 3: Strategies for Designing a CME.** Use the strategies in this section to help design a CME.

- **Part 4: CME Design Features.** Use this section to learn about different CME design features and the tradeoffs associated with them.

Each section draws on the experiences of the CHIPRA quality demonstration States and references additional resources.

Part 1: An Introduction to Care Management Entities (CMEs)

The Problem

Youth with complex behavioral health needs face a range of challenges and are at risk for poor health and education outcomes.[1,2] These youth are more likely to have difficulty forming friendships, drop out of high school, come in contact with the juvenile justice system, and attempt suicide than other youth.[3,4] Moreover, youth with complex behavioral health needs, especially those served in out-of-home placements such as foster care, are often taking more than one psychotropic medication, putting them at increased risk for adverse side effects, such as weight gain, high cholesterol, and diabetes.[5,6]

In addition, these youth are often served by, or come into contact with, multiple State and local agencies, such as:

- Medicaid.
- Social service agencies.
- Child welfare agencies.
- Behavioral health agencies.
- Juvenile justice systems.
- Schools and other education organizations.

These agencies may not always coordinate services and care planning for youth, due in part to poor communication channels, lack of comprehensive information, or concerns regarding confidentiality and privacy. Lack of coordination can reduce service effectiveness by agencies that inadvertently duplicate or even undermine each other's efforts.[7, 8]

When a child's behavioral health and psychosocial needs are not addressed in a holistic manner, families may find themselves cycling in and out of crises. Youth in crisis may end up in out-of-home placements such as residential treatment centers, foster care, or juvenile detention centers. These potentially avoidable and restrictive placements separate youth from their families and communities and increase costs for the State.[8]

A Potential Solution: CMEs

CMEs are designed to coordinate services provided by the many State agencies that serve youth with complex behavioral health needs. The CME model was developed and continues to be refined as a strategy for serving the highest-need, highest-cost youth with complex behavioral health concerns, such as severe or co-occurring conduct, mood, and attention disorders. CMEs are intended to improve youth and family outcomes and to reduce the cost of behavioral health and social services for States.[7, 9] They are also intended to help families better manage their children's care on their own, with the goal of gradually reducing their reliance on intensive care coordination.[10]

Child-serving agencies, such as Medicaid, child welfare, social services, and juvenile justice can establish CMEs by contracting with a variety of organizations, including other public agencies, community-based nonprofits, behavioral health provider organizations, and managed care organizations.[9] The number of CMEs States contract with varies depending on the number of youth eligible for CME services and the capacity of the CMEs.

CMEs employ or contract with care coordinators who typically support a maximum caseload of no more than 10 high-need, high-cost youth at one time. States can receive referrals for CME services from community-based organizations or child-serving agencies or analyze administrative data to identify high-cost, high-use youth. States often use a standardized screening tool, such as the Child and Adolescent Service Intensity Instrument (CASII), to determine if youth qualify for services.[7, 9]

Once youth are enrolled in the CME, the care coordinator:

- Works with the youth and his or her family to identify a care planning team that includes service providers, State or local agencies, school representatives, and other natural supports, such as clergy.

- Facilitates care planning meetings.

- Facilitates development of an individualized, cross-agency care plan for each youth in collaboration with the youth, his or her family, and other members of the care planning team.

- Manages the individualized care plan for each youth.

- Facilitates the use of home- and community-based services, parent and youth peer supports, and crisis stabilization services in place of residential and inpatient care.

- Develops the youth's and his or her family's capacity and ability to solve problems independently.

To coordinate services, CMEs follow the high fidelity wraparound care-planning model outlined by the National Wraparound Initiative.[9, 10, 11] The term "wraparound" refers to an "intensive, individualized care planning and management process."[11] The National Wraparound Initiative identified 10 principles that providers must follow to deliver high fidelity wraparound.

While all CMEs follow a similar care planning model, States can structure CME services differently. See Part 4 for more information on various CME structures.

Additional Background Resources

Brief History of CMEs (Appendix A)

Ten Principals of the Wraparound Process[11]

Ten Principles of the Wraparound Care Planning Process Outlined by the National Wraparound Initiative

1. **Family voice and choice.** Family and youth perspectives are intentionally elicited and prioritized during all phases of the wraparound process. Planning is grounded in family members' perspectives, and the team strives to provide options and choices such that the plan reflects family values and preferences.

2. **Team-based.** The wraparound team consists of individuals agreed upon by the family and committed to them through informal, formal, and community support and service relationships.

3. **Natural supports.** The team actively seeks out and encourages the full participation of team members drawn from family members' networks of interpersonal and community relationships. The wraparound plan reflects activities and interventions that draw on sources of natural support.

4. **Collaboration.** Team members work cooperatively and share responsibility for developing, implementing, monitoring, and evaluating a single wraparound plan. The plan reflects a blending of team members' perspectives, mandates, and resources. The plan guides and coordinates each team member's work towards meeting the team's goals.

5. **Community-based.** The wraparound team implements service and support strategies that take place in the most inclusive, most responsive, most accessible, and least restrictive settings possible, and that safely promote child and family integration into home and community life.

6. **Culturally competent.** The wraparound process demonstrates respect for and builds on the values, preferences, beliefs, culture, and identity of the youth and family and their community.

7. **Individualized.** To achieve the goals laid out in the wraparound plan, the team develops and implements a customized set of strategies, supports, and services.

8. **Strengths-based.** The wraparound process and the wraparound plan identify, build on, and enhance the capabilities, knowledge, skills, and assets of the child and family, their community, and other team members.

9. **Persistence.** Despite challenges, the team persists in working toward the goals included in the wraparound plan until the team reaches agreement that a formal wraparound process is no longer required.

10. **Outcomes-based.** The team ties the goals and strategies of the wraparound plan to observable or measurable indicators of success, monitors progress in terms of these indicators, and revises the plan accordingly.

Source: Ten Principles of the Wraparound Process[11]

CMEs Impact Youth Outcomes and Costs

Youth outcomes

CMS and SAMHSA identified high fidelity wraparound as a promising model for serving youth with significant behavioral health concerns in the community.[12] Research on the effects of CMEs or other similar wraparound service programs have tracked outcomes for youth receiving wraparound services over time or compared their outcomes to youth receiving different services.[13,14,15,16,17,18,19] These studies found youth receiving wraparound services:

- Experienced less severe symptoms and improved clinical functioning.
- Were less likely to miss school.
- Were less likely to come into contact with the juvenile justice system.
- Experienced fewer days as runaways.
- Were less likely to change foster care homes.
- Spent fewer days incarcerated.

While promising, many available studies are limited by small sample sizes, short followup periods, and nonequivalent comparison groups. In addition, some studies concluded that CME-like wraparound services have limited benefits. For example, several studies found that wraparound services are more beneficial for some youth, such as those with the highest level of need, than others.[18,19] In addition, a study of a predecessor to the CME model found that although youth and their families were satisfied with demonstration services, clinical outcomes for youth did not improve.[20,21]

Cost

As with research on youth outcomes, research on the cost implications of CMEs is still evolving and relies largely on information reported by programs as opposed to rigorous independent evaluations. According to Maine's wraparound initiative, total treatment costs 1 year after youth enrolled in the program were lower than costs for the year prior to enrollment.[22] Other States and counties with CMEs have indicated that the average monthly cost per youth served is lower than the average monthly cost per youth served in an inpatient hospital, residential care, or a juvenile correctional facility.[13, 16, 17, 19, 23]

In contrast, an early wraparound study showed that behavioral health service use and costs were higher for youth in the demonstration than for youth receiving traditional services, though the study did not take into account potential savings to other child-serving agencies.[20] Overall, cost outcomes have been difficult to assess because CMEs may produce measurable effects on such outcomes only after the relatively short followup periods covered in previous studies, and many cost studies do not include comparison groups.

Part 2: Assessing State Readiness to Design and Implement CMEs

Deciding whether and how to adopt, expand, or improve a CME structure to serve youth with complex behavioral needs is, like any change to the health care delivery system, a major undertaking for a State. We analyzed interview data from the CHIPRA quality demonstration States and identified the following four factors that contributed to their readiness to undertake CME design:

- A high-level CME champion.
- Support for interagency cooperation.
- A group of engaged and supportive stakeholders.
- Data for decision support.

Use Table 1 to assess State readiness to undertake CME design and identify next steps that can help address any weaknesses. After assessing readiness, States can use the subsequent sections of this guide to (1) help further prepare for CME design activities, (2) start the CME design process, or (3) improve existing CMEs.

Table 1: Assessing State Readiness for CME Design and Implementation

Key Questions	What do States need?	Why is it important?	How can States prepare?
Does the State have a **high-level CME champion(s)**?	One or more leaders in the State, such as the governor or director of a child-serving agency (for example, a Medicaid Medical Director), who strongly supports the CME concept and champions its implementation.	One child-serving agency often initiates the CME design process. High-level buy-in for the CME model at that agency can facilitate: • Advancing new strategic directions. • Securing funding for CME services. • Promoting cross-agency coordination. • Promoting a unified vision of CME design in the State. • Explaining how CMEs align with State and agency missions. • Keeping project directors and staff motivated.	Consider having State leaders meet with national CME experts to develop their understanding and support of CMEs before initiating the CME design process (see "Consult CME Experts" in Part 3).
Does the State **support interagency cooperation**?	Interest in and support for interagency collaboration. For example, a State could have: • A history of collaboration to improve the coordination of services and financing across agencies. • An interagency policy and planning body, especially one with cross-agency funding.	Support for interagency cooperation: • Facilitates building consensus to adopt or expand CMEs. • Facilitates cross-agency service planning once the CME is implemented or expanded. • May provide an infrastructure for the complex CME planning and design process. • May provide resources to help fund CME planning and implementation.	Consider establishing an interagency workgroup or assign new duties to a workgroup formed for some other purpose (see "Work with Stakeholders" in Part 3. Consider applying for grants to support interagency work (for example, SAMHSA System of Care grants).
Can the State assemble a group of **engaged and supportive stakeholders**?	Child-serving agencies, youth, families, and the provider community in the State meaningfully engage in and support CME design.	Engaged stakeholders can facilitate: • Developing consensus around the CME design that is most appropriate for youth in the State. • Establishing cross-agency funding strategies for CMEs. • Encouraging community referrals to CMEs and uptake of services by families and youth. • Building a network of home and community-based support services for youth served in the CME.	Establish a stakeholder engagement process (see "Work with Stakeholders" in Part 3).
Does the State have **data for decision support**?	Capacity to obtain and analyze demographic, cost, and service utilization data from multiple child-serving agencies.	Analyzing data from multiple child-serving agencies facilitates: • Understanding how the State currently allocates resources to serve youth with complex behavioral health needs and assessing opportunities for improvement. • Identifying a target population for a new or expanded CME. • Determining CME provider payments. • Evaluating the CME once implemented or expanded.	Develop internal data capacity or consider hiring consultants (see "Use Data to Drive Decisions" in Part 3).

Part 3: Strategies for Designing a CME

The CME design process is a creative, complex effort that requires careful consideration of how a State could structure a CME. Depending on a State's readiness for implementation, the CME design process can take between 1 and 3 years or more (use Part 2 of this guide to assess State readiness).

As indicated in Figure 1, States can use the three strategies highlighted in this section to help prepare for CME design activities and to think through important CME design decisions. States can apply each strategy outlined here to help prepare for CME implementation and to facilitate design of the seven CME design features listed in the center of Figure 1 and described in more detail in Part 4. Throughout the Guide, please refer to the side bar for additional resources on CME design and implementation.

Figure 1: Thinking Through CME Program Design—Strategies to Use and Features to Consider in CME design
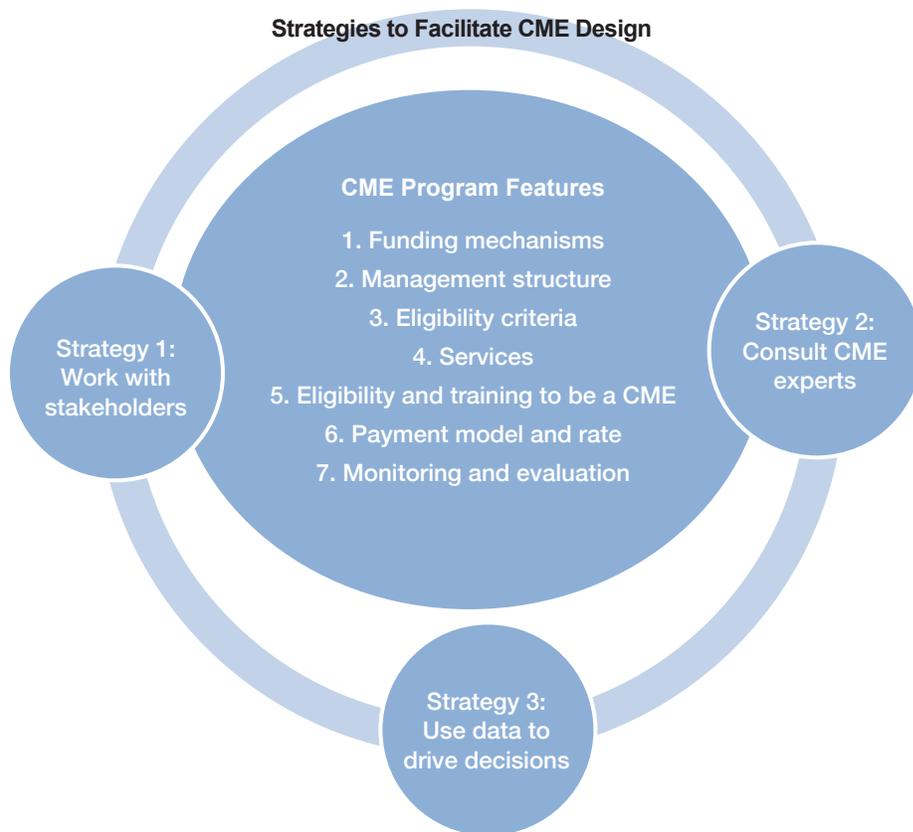
Strategies to Facilitate CME Design

CME Program Features

1. Funding mechanisms
2. Management structure
3. Eligibility criteria
4. Services
5. Eligibility and training to be a CME
6. Payment model and rate
7. Monitoring and evaluation

Strategy 1: Work with stakeholders

Strategy 2: Consult CME experts

Strategy 3: Use data to drive decisions

We begin the discussion with a review of three core strategies for CME design that can assist States in the process.

Strategy 1: Work with Stakeholders

Broad stakeholder involvement is critical because CMEs require cross-agency coordination and extensive youth, family, and provider involvement to operate effectively and enhance outcomes. Stakeholders should be involved in all of the design decisions.

Selecting and Engaging Stakeholders

This section provides guidance on how States should engage stakeholders in the CME design process.

Form Collaborative Cross-Agency Partnerships

States should invite agencies representing Medicaid, child welfare, behavioral health services, juvenile justice, social services, and education to collaborate on the CME design process. Cross-agency partnerships are imperative when multiple agencies are contributing funding to the CME. States should also consider fostering partnerships with non-funding agencies, since local agency staff (such as behavioral health providers, social workers, probation officers, and educators) should be invited to participate in care planning meetings regardless of who funds the CME services.

For each agency, States should consider recruiting:

- High-level decisionmakers whose buy-in and approval are needed for key design decisions such as: (1) what services the agency is interested in having CMEs coordinate and (2) the level of funding agencies contribute to CMEs.

- Program staff at State and local agencies who can help determine which youth the CME should serve and ensure the CME fits into the local service delivery environment.

CHIPRA Quality Demonstration State Experiences: Stakeholder Engagement

Maryland and Georgia obtained executive input from existing director-level cross-agency committees, while staff who work directly with families addressed design details in a CME-specific stakeholder group.

Engage Other Stakeholders

The participating agencies should also involve the following stakeholder groups in CME design discussions:

- **Youth and families.** Input from youth and their families can help a State understand how a CME could improve the existing service system from a consumer's point of view.

- **Provider community.** Behavioral and physical health providers, social service providers, court representatives, and others who work closely

with youth can provide unique insight into how services are currently structured and paid for and how to improve service delivery. These groups can also help a State avoid potential pitfalls in CME design that might reduce provider acceptance of the model and limit referrals.

- **Utilization management organizations.** Include organizations that work with agencies to authorize, oversee, or finance behavioral health or social services for youth, including Medicaid Managed Care Organizations. These groups can provide insight on improving care delivery. In addition, engaging utilization management organizations in the design process can facilitate a productive working relationship between them and the CME once it is operational.

Strategies for Working with Stakeholders

States can encourage continuous stakeholder participation by:

- **Educating stakeholders on CME goals and outcomes.** States will need to provide basic information at the beginning of the stakeholder engagement process to build shared understanding about CMEs, especially if high fidelity wraparound is a new concept in the State. Stakeholder education throughout the process helps integrate new stakeholders and minimize disruption.

- **Giving voice to all stakeholders.** The State can foster constructive input from all parties by recognizing different stakeholder perspectives.

  - **Strategies for child-serving agencies.** Participating agencies can select a neutral organization to convene cross-agency meetings as one means to ensure that design decisions are not dominated by one agency, which could prompt other agencies to disengage from the process.

  - **Strategies for youth and families.** Youth and families in particular should feel that their inclusion in the CME design process is more than a token gesture. Strategies for engaging youth and families include hosting youth and parent conferences, conducting focus groups, and covering child care and travel expenses so a family representative can attend all stakeholder meetings as a core team member.

CME Resource to Share with Stakeholders

Care Management Entities: A Primer[9]

CHIPRA Quality Demonstration State Experiences: Change in Child-Serving Agency Stakeholders

Wyoming and Georgia experienced turnover at the agency director and program staff levels. Both States found that educating new stakeholders about CMEs and integrating them into the design process was labor intensive and time consuming, resulting in project delays.

For more information on stakeholder engagement, consult the first implementation guide in this series: *Engaging Stakeholders to Improve the Quality of Children's Health Care.*[27]

Strategy 2: Consult CME Experts

For help deciding among the complex array of CME design options, States could consult either with other States that have implemented a CME or with organizations that provide technical assistance in CME design and implementation. As with stakeholder engagement, this strategy can be particularly helpful if a State has limited experience with CMEs. Options for learning from others include:

- Arranging conference calls with experienced States.

- Participating in a learning collaborative with other States.

- Observing how services are actually structured and provided by visiting another State.

- Asking staff in experienced States to help train State agency staff new to CME concepts on the wraparound model.

- Contracting with technical assistance organizations to provide advice on complex problems such as CME financing and program evaluation or to help facilitate cross-State learning.

Jurisdictions with CME Experience

- Cuyahoga County, OH
- Georgia
- Louisiana
- Maine
- Massachusetts
- Maryland
- Milwaukee County, WI
- New Jersey
- New York
- Wyoming

Additional Resources on Consulting Experts

How Are the CHIPRA Quality Demonstration States Working Together to Improve the Quality of Health Care for Children?[28]

Choosing a Consultant to Support Your Wraparound Project[29]

National Technical Assistance Center for Children's Mental Health

Additional Resources from the CHIPRA Quality Demonstration

Maryland, Georgia, and Wyoming used CHIPRA quality demonstration funds to work with the Center for Health Care Strategies. For resources on CMEs developed under the grant, visit the Center's Web site.

Strategy 3: Use Data to Drive Decisions

The right information is essential for a State to understand how youth with complex behavioral health needs receive services currently, which in turn can inform many CME design decisions.

Data derived from surveys, interviews, focus groups, content analysis of program materials, and program or participant observation can shed light on the strengths and weaknesses of the State's existing system of service delivery and potentially identify duplicative services and unmet needs. Consider:

- Discussing potential sources of this type of information during stakeholder meetings.
- Interviewing key representatives from child-serving agencies, family advocacy groups, and provider associations.
- Reviewing child-serving agency operational plans that discuss cross-agency coordination, out-of-home placements, and services for youth with complex behavioral health needs.
- Reviewing materials created by local family advocacy groups, such as the local chapter of the National Federation of Families for Children's Mental Health.

Analysis of administrative data (for example, enrollment, utilization, and claims data) can yield insights on:

- Numbers and characteristics of youth who could benefit from more intensive care management.
- Geographic utilization patterns of current services.
- Availability and geographic distribution of behavioral health providers and community services.
- Historical and baseline costs for services.
- An appropriate payment rate for CME services.

Potential Sources of Administrative Data to Analyze
- Medicaid and CHIP claims and enrollment data
- Public behavioral health data
- Foster care and adoption data
- Juvenile justice data

Additional Resource on Using Data

Putting the Pieces Together: Guidebook for Fact-Based Decision Making to Improve Outcomes for Children and Families[30]

Because CMEs coordinate services across child-serving agencies, analyzing data on service use, cost, and eligibility from multiple agencies is especially valuable. However, even States with sophisticated, robust data systems may not have access to the required information across all affected agencies. Common data issues faced by States include:

- Poor data quality (for example, missing data or out-of-date information).
- Different administrative data systems across agencies, which may not be linked or compatible.
- Privacy concerns that limit the ability of agencies to share sensitive information, such as data on substance abuse treatment.

A State can mitigate or overcome these challenges by keeping the following strategies in mind:

- Budgeting resources to obtain and analyze data.
- Developing interagency data-sharing agreements early in the design process to avoid delays in making data-driven decisions.
- Seeking short-term technical assistance from other agencies or firms that specialize in data analysis.
- Investing resources in improving and aligning existing data systems over the long term.

In addition to facilitating CME design, improving access to data across agencies will help a State monitor and refine its CME over time (see "CME Monitoring and Evaluation" in Part 4 for more information).

CHIPRA Quality Demonstration State Experiences: Data Analysis

- Maryland contracted with a data analytics firm to link data sets and do exhaustive exploratory analysis to improve its CME design
- Maryland also created a single, integrated database for most of it's social service programs to allow for real time data exchange.

Part 4: CME Design Features

States can use this section to learn more about the seven CME features shown in Figure 1. For each feature, the guide describes decision points and tradeoffs identified by the CHIPRA quality demonstration States (see Appendix B for a description of the specific design features that Maryland, Georgia, and Wyoming selected for their CMEs).

Design Feature 1: Funding Mechanisms

CMEs can be funded by one or more child-serving agencies. Agency directors typically decide if they will help fund CME services, although political leaders (for example, the governor) or court mandates can also direct agencies to participate. Child-serving agencies initiating the CME design process can use strategies outlined in Part 3 of this guide to encourage other agencies to contribute funding.

- CMEs funded by multiple agencies often can serve a larger number of youth, provide more support to youth they serve, or both. Moreover, agencies contributing funding are more likely to engage actively in the CME design process, and the additional funding may help with long term CME sustainability.

- However, when multiple agencies contribute funding, the CME management structure can be complex (see section on "Management Structure").

To augment State-only funding, agencies can also seek Federal dollars to help support CME services. Federal funding sources include programs with matching Federal dollars (for example, Medicaid in which the Federal government pays for a percent of program expenditures), Federal block grant dollars (such as mental health block grants), and other Federal grant programs (for example, SAMHSA System of Care grants).

- Seeking Federal funding may increase the number of youth a State is able to serve or the type of services the CME would be able to provide with State funding alone. For example, the Federal share of Medicaid funding would permit a State to free up State-only dollars to serve youth who do not qualify for Medicaid or to cover support services not funded by Medicaid.

- Using Federal funding to cover CME services, however, can limit CME design flexibility. The State should consider very carefully what Federal funding mechanisms are most appropriate because each option will affect how the CME can be structured. Specifically, the funding mechanism selected may affect:

  - Who is eligible to be served by the CME.
  - What services are available through the CME.
  - How many providers and what types of providers are eligible to be a CME.
  - The ability to pilot a CME with a limited number of youth or in a specific geographic location.

Design Feature 2: Management Structure

States will need to determine (1) the type of organization that will contract for and oversee CME services, (2) the level of management, and (3) the flow of funding from multiple agencies to the CME, if relevant.

Type of Organization Managing CMEs

Different organizations can contract for and oversee CME services, including:

- Child-serving State or local agencies.
- Medicaid managed care organizations.
- Cross-agency committees or purchasing collaboratives.

The type of organization responsible for contracting and oversight is closely related to how funding flows from the agencies to the CME.

If **one agency** is the **only** funding agency, it will typically use the same procedures in place for contracting with and overseeing other behavioral health or social services. For example, a Medicaid agency may contract directly with the CME, or it may leave contracting to Medicaid managed care organizations if behavioral health services are provided under a managed care arrangement.

If **multiple agencies** are funding a State's CME, the State should consider selecting a cross-agency committee to oversee CME services. The advantage here is twofold: the managing organization represents all the agencies, thereby making them comfortable with how their funds are spent, and it is the single entity to which a CME reports, thereby simplifying the administrative logistics related to accountability. For administrative ease, the committee may choose to designate one agency to oversee day-to-day CME operations.

CHIPRA Quality Demonstration State Experiences: CME Management and Oversight

- Maryland's statewide CME funded by multiple agencies is managed by the Children's Cabinet, at the Governor's Office for Children, a group with high-level representation from all child-serving agencies.
- Maryland's Medicaid-funded CMEs will be managed at the county level to increase local control.

Level of CME Management: State or Local.

CMEs can be managed at the State or local level.

- By centralizing CME management at the State level (for example, by State agency offices), States may reduce administrative costs, simplify the referral and utilization review process, and decrease disruptions when youth move across the State. CMEs managed at the State-level, however, may face challenges overseeing care coordinators spread throughout the State and may be less familiar with local needs and available resources. To address these concerns, a State can (1) contract with multiple CMEs

that specialize in different regions, (2) require CMEs to establish regional or local offices and hire local staff, and (3) facilitate meetings with the CME and local community members (for example, case workers, county attorneys, and community behavioral health providers).

- In contrast, **local entities**, such as county behavioral health offices, have a working knowledge of local needs and resources. Local entities may be better able to (1) identify youth who could benefit from CME services, (2) coordinate local home- and community-based providers, and (3) foster trust with youth, their families, and the community. However, under local contracting arrangements, a State may struggle to maintain fidelity to a single CME design, and as a result, it may need to implement a rigorous quality monitoring process. Moreover, localities with relatively few youth who qualify for CME services may need to pool together and create regional CMEs for the service to be financially viable.

Flow of funding from multiple agencies

If multiple agencies are funding CME services, States have two options for managing the flow of funds:

Braided funding. In braided funding, each contributing agency pays the CME individually. The agencies can put limits on how their dollars are used and can track how they are spent. A given agency might pay for a subset of children receiving CME services. For example, Medicaid could pay for Medicaid-eligible youth, and juvenile justice could pay for youth not eligible for Medicaid. Or, one agency would pay for particular services provided by the CME (for example, Medicaid could pay for Medicaid-reimbursable services, and social service funding could be used to cover additional services).

Blended funding. In blended funding, agencies contribute funding to a single "bucket," and then all of the funds are paid to the CME. The CME can use the dollars to cover any service for any youth served by the CME.

- Agencies relying on *braided funding* have more control over how their respective funds are used and should be able to account for how their funds are spent. However, funds are typically designated for particular youth or certain services, so CMEs have less flexibility to spend available funds to cover any services required.

- In contrast, CMEs funded through a *blended funding* approach have more control over how funds are spent. However, agencies using a blended funding approach may face more administrative challenges in linking the source of funds and the services delivered and therefore may want to institute more intensive monitoring processes.

Design Feature 3: Eligibility Criteria

CMEs typically enroll youth who are served by at least one of the CME funding agencies. These agencies often target youth with complex behavioral health needs who would otherwise be served in out-of-home placements.[9] For example, if Medicaid is funding the CME, it generally targets youth who are eligible for care in a hospital or residential treatment center. Juvenile justice funding, as another example, may be used to serve youth who would otherwise be placed in juvenile detention centers.

In addition, a State could open up enrollment to other youth at risk for greater system involvement or with high costs or high service needs. These youth could include, for example, individuals with frequent emergency room use for behavioral health concerns, those using multiple psychotropic medications, or youth in alternative school settings.

- **Limiting CME services** to youth who qualify for out-of-home placements is administratively straightforward, assuming a State has an effective process in place for identifying and screening these youth. In addition, by substituting CME services for out-of-home care, the State is most likely to demonstrate cost savings for this population.

- **Expanding the criteria for entry into a CME** increases the number of youth in the State who can receive CME services and may prevent out-of-home placements or other adverse outcomes. However, expanding the eligiblity criteria may reduce the cost effectiveness of CMEs. States can analyze utilization data and work with stakeholders to determine additional populations that may benefit from CME services. Before expanding the CME population, a State should consider the capacity its CME has avaliable to serve more youth and any additional training CMEs may need to serve new populations.

CHIPRA Quality Demonstration State Experiences: CME Participant Identification

- Maryland and Wyoming use The Child and Adolescent Service Intensity Instrument (CASII) and the Early Childhood Service Intensity Instrument (ECSII) to identify youth who qualify for or are at risk for residential treatment.

- In addition, Maryland is providing CME services to youth identified by schools as at risk for greater system involvement based on an ongoing history of expulsions, suspensions, absences, and poor academic performance.

After selecting the eligibility criteria for CME services, the State will need to establish a process to identify and refer youth to CMEs. States can rely on referrals from the community, use administrative data to identify eligible youth, or both.

- *Community referrals* can come from a variety of organizations including physical and behavioral health providers, case workers, courts, family advocacy organizations, and schools. In some States, families and youth can also self-refer for CME services. Once a youth is referred, an organization (such as a State agency or a utilization review vendor) determines if the youth qualifies for services. To help ensure an accurate referral process, States should consider using a standard assessment tool administered by an organization other than the CME and its vendors. In addition, States may need to educate potential referral organizations about the CME so they understand and trust the model; otherwise they may be hesitant to refer youth for services, or they may refer youth who are not eligible for CME services.

- States can also use *administrative data* to identify youth who may qualify for CME services based on prior service use. This strategy may help States identify the first cohort of youth to target for CME enrollment. However, this method may be ineffective if service-use data and contact information are out of date or inaccurate or if families are not receptive to "cold calls" from the CME.

CHIPRA Quality Demonstration State Experiences: Referral Process

Community providers in Georgia use a standard form to refer youth for CME services.

Design Feature 4: Services

As noted in Part 2, all CMEs provide intensive care coordination for youth. The National Wraparound Initiative sets standards for high fidelity wraparound, such as the frequency of child and family care team meetings and the composition of child and family care. States can require CMEs to follow the standards outlined in that model.

For CMEs to effectively deliver this model, a State needs (1) a sufficient network of home- and community-based service providers and family and youth supports and (2) an established utilization management process to help ensure youth receive these services over more costly or less effective options.[24] State agencies, the CME, or another utilization management organization can take on responsibility for developing, managing, and paying for these services. Specifically, States can make CMEs responsible for:

- Identifying gaps in service availability and encouraging providers to offer new services.

- Managing a discretionary fund that can be used to support a variety of youth and family needs by helping families pay for household necessities, modest recreational activities, or services otherwise not covered by their insurance.[a]

- Contracting and paying for a limited number of services, such as crisis response or family support.

- Taking on financial risk for some or all behavioral health and social services provided by CME funding agencies.

CHIPRA Quality Demonstration States Experiences: Additional Service Requirements

In the second year of their contract, the CME in Wyoming will take on financial risk and be required to coordinate, administer, and reimburse all behavioral health services with the exception of pharmacy. The State decided to not require the CME to take on financial risk in the first year so the CME had time to develop its network and start enrolling youth.

There are benefits and drawbacks to asking CMEs to take on one or more of these additional services.

- CMEs may be better positioned to take on these responsibilities than the State or another organization because they are more familiar with the service needs of the enrolled youth, and their staff work closely with community providers.

- CMEs assigned these additional responsibilities have more accountability for the full range of service needs and can exert more control over service delivery. With more control, CMEs may more easily coordinate services,

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[a]Depending on the CME funding agencies, CMEs can cover youth with private or public insurance or uninsured youth. Discretionary funds can be used to cover services included in the youth's care plan that are not otherwise covered by their insurance policy.

potentially improving outcomes while decreasing costs to the State. However, the State may have to increase its monitoring and oversight efforts to ensure the CME does not shift costs from CME funding agencies to agencies that do not contribute funding.

- Requiring CMEs to provide other services may limit the pool of CME providers, since not all organizations qualified to provide high fidelity wraparound have the capacity to take on additional responsibilities. States could consider helping CMEs build capacity to take on these responsibilities, phase in increased responsibilities over time, or both.

Design Feature 5: Eligibility and Training to be a CME

CME Eligibility

Different types of organizations can serve as CMEs, including managed care organizations, community-based nonprofits, and behavioral health provider organizations. The number of CME contracts a State holds can vary widely, depending on the size of the geographic area covered, the number of youth in the area who qualify for services, and the number of youth CMEs can serve. In consultation with stakeholders, States can determine how many CMEs to contract with, set minimum requirements for CMEs, and define selection criteria for participation.

CHIPRA Quality Demonstration State Experiences: CME Provider Eligibility

Georgia Medicaid required CMEs to have experience as a community service board, the representative group of the Georgia mental health safety net. Some stakeholders were disappointed that the requirement narrowed the potential field of providers to two located in the northern region of the State.

Prior experience or certification. States can require providers to have experience, specialized training, or certification delivering high fidelity wraparound or other care management services, such as targeted case management.

- Having CMEs with previous experience providing intensive care coordination reduces the need for initial training and allows CMEs to get up and running faster. This may save time and costs. However, certain requirements (for example, requiring CMEs to have prior experience coordinating care across all child-serving agencies) may limit the pool of potential CMEs.

- Without the requirement of prior experience or certification, a State will likely have to make additional investments—both short term and long term—in training and capacity building to ensure CMEs are prepared to deliver services according to the high fidelity wraparound model.

Provision of direct services. To minimize the risk of providing unwarranted services, States could exclude organizations that provide direct services, such as mental health counseling, from consideration as CME vendors.

- CMEs that only provide high fidelity wraparound may be better positioned to build trust with community providers because they will not be viewed as competition. In addition, these CMEs may have a more balanced view of available services and will not have a financial incentive to authorize more direct clinical services or encourage families to use their services over those of another provider.

- However, if a State has a limited supply of direct service providers that can treat youth, inclusion of CMEs with this capacity may actually improve timely access to treatment. If CMEs are allowed to provide direct services, a State should consider increased oversight and monitoring of CME service delivery patterns and costs — either directly or through a utilization review vendor.

CHIPRA Quality Demonstration State Experiences: Contracting for CME Services

Requests for Proposals and Statements of Need for CME services in CHIPRA quality demonstration States are available at the national evaluation web site.

Local versus out of State organizations. States may consider contracting with an out-of-State vendor for CME services, especially if the State has limited prior experience with high fidelity wraparound and State regulations allow it to contract with such vendors.

- An organization already operating within a State is likely to have experience with the service delivery system and have relationships with local providers. However, if a State has limited experience with high fidelity wraparound, organizations in the State may not meet other CME eligibility criteria.

- Although out-of-State organizations may have less direct experience with local providers and the service delivery system, they can bring their expertise as CMEs and help build capacity within the State's system of care. To ensure that out-of-State organizations are successfully integrated with local providers, a State may require CMEs to establish an in-State office, contract with local vendors for care coordination services (as opposed to hiring care coordinators directly), or develop local advisory boards. These requirements can add administrative complexity and may increase initial costs to set up the CME.

CHIPRA Quality Demonstration State Experiences: Out-of-State CME Providers

Wyoming contracted with an out-of-State organization for CME services because no local organizations responded to their request for proposals. Some community providers were initially reluctant to refer youth for services. The CME and State are holding local-level stakeholder meetings to build trust in the community.

Training CME Care Coordinators

Regardless of a CME provider organization's experience serving youth with complex behavioral health needs, States should expect to offer at least some initial and ongoing training to CMEs and care coordinators.

High fidelity wraparound training should include a fairly in-depth introduction to its key components. Potential training modules include:

- Intensive care coordination.
- Integration of primary and behavioral health care.
- Working with the courts and social workers.
- Youth and family engagement.
- Referral to crisis services.
- Quality improvement and assurance.
- Administrative and technology systems.
- Financial management and controls.

As a State monitors CMEs (described under Design Feature 7), it can adjust the training curricula as needed to address emerging service gaps or quality issues.

State agencies involved in funding or managing CMEs can (1) develop and coordinate the training themselves; (2) collaborate with a local organization, such as a university; or (3) seek training services from a more experienced State or organization.

States that coordinate the training themselves or collaborate with a local organization may have more flexibility to adapt the CME training to meet evolving needs in the State. However, States may want to seek external assistance if CMEs or the high fidelity wraparound care planning model are new in the State. One way to leverage the experience of others while building internal training capacity is to consider a "train the trainer" approach. Under this approach, trainers with experience in other States train a cohort of individuals who then train and coach other care coordinators in the State.

Additional Resources on CME Staff Training

Training, Coaching, and Supervision for Wraparound Facilitators: Guidelines from the National Wraparound Initiative[33]

CHIPRA Quality Demonstration State Experiences: Training

- Maryland is introducing CME services as the highest tier of service offered by existing targeted case management providers. While these organizations are experienced at providing care coordination, the State is requiring intensive high fidelity wraparound training so they are prepared to deliver this approach to care coordination.

- The State collaborates with the Institute for Innovation & Implementation at the University of Maryland's School of Social Work to develop and provide CME training. In addition, the Institute has helped train providers in other States.

Design Feature 6: Payment Model and Rate

All CMEs are reimbursed for intensive care coordination services. CMEs may also be reimbursed for other behavioral health or social services if they are responsible for contracting for and managing those services. In addition, States often provide CMEs a limited discretionary fund that can be used to help families pay for household necessities, modest recreational activities, and behavioral health services not covered by insurance.

Payment model

States can align the CME reimbursement model with the prevailing reimbursement models in the State or use a different model. States can:

- Use a fee-for-service (FFS) model and reimburse CMEs for the time they spend providing services (for example, in 15 minute units for care coordination or family support services).

- Use a case rate under which the CME will receive a set payment for each youth enrolled and receiving services from the CME regardless of the time or resources they spend on services. The payments can be made daily, weekly, or monthly. CMEs that are responsible for managing and paying for behavioral health or social services are typically paid using this approach.

- Use a combined approach in which some services (such as care coordination) are included in a case rate and other services (such as family support) are reimbursed on a fee-for-service basis.

There are tradeoffs to these different reimbursement approaches.

- Under the FFS model, a State can more easily track what services are provided. In addition, a State can incentivize the use of preferred home- and community-based providers by, for example, offering a higher reimbursement rate for services that follow evidence-based practices. This reimbursement model, however, can be less flexible than case rates. If using the FFS model, a State should carefully consider what services need to be reimbursed to allow the CME to operate effectively. For example, a State may want to offer reimbursement for both in-person and telephonic care coordination so the CME can provide the most appropriate service.

- In contrast, case rates provide CMEs more flexibility. Case rates also increase a State's ability to predict and manage total program costs and utilization. However, the State may lose the ability to drill down in their data to analyze service utilization. Additionally, States using case rates should consider implementing additional reporting and quality controls to ensure that beneficiaries receive clinically appropriate services and to confirm the adequacy of the case rate.

Payment rate

The payment rate for CME services will depend on the characteristics of the target populations and the services covered by the CME. The rates for intensive care coordination and family support services will depend on the time required to provide these services and the providers' salaries. States can set different rates for different populations based on their levels of need. The reimbursement rates for youth with the highest need who meet eligibility criteria for out-of-home placements are typically much higher than other care coordination rates in the State, but they are generally lower than the cost of out-of-home placements.[34] Engaging agency leadership and other stakeholders (for example, managed care organizations) in the CME design process may help avoid stakeholders questioning the appropriateness of the rate after the CME is implemented.

Setting the reimbursement rate is more complicated if the State uses a case rate that includes behavioral health and social services. The State can hold the CME accountable for any services overseen and paid for by agencies funding the CME. The State can set the case rate by reviewing the target population's historical costs for the services managed by the CME. CME payment rates may include:

- Home- and community-based support services.
- Outpatient and inpatient behavioral health services.
- Psychotropic medications.
- Residential stays at psychiatric facilities.
- Services provided at juvenile detention centers.
- Foster care placements.
- Family and youth peer support services.

States may choose to include all services managed by a given funding agency in the case rate or carve out some services. States may want to carve out services that (1) fall outside the direct purview of the CME (for example, specialty physical health services), (2) are managed by a different organization (for example, family advocacy organizations may manage peer support services), (3) are billed through separate administrative data systems and therefore can be difficult to distinguish using real time administrative data (for example, psychotropic medications), or (4) a State wants to closely track (often easier to do with separate fee-for-service claims).

In addition to direct services, CMEs will need to be reimbursed for reasonable general and administrative or overhead expenses, such as training costs and office rental. These expenses can either be embedded in the payment rate or paid to the CME separately. A newly contracted CME may initially have higher overhead expenses since it will need to build an infrastructure to provide services, and it will likely start off serving a smaller population. Over time, a State may consider reducing reimbursement for overhead expenses as efficiency increases.

Design Feature 7: Quality Monitoring and Evaluation

In addition to using data to help design the CME (see Part 3), States should plan how to use data to monitor and evaluate the CME once it is operational. This section provides guidance on (1) what data to collect on CMEs, (2) how to use the data to drive quality improvement, (3) how to use the data to evaluate impact, and (4) who can do the work.

Data Collection on CMEs

States should consider measuring model fidelity (how well the CME delivers services according to the National Wraparound Initiative model), youth and family outcomes, and service costs (Table 2).

Table 2: CME Quality Monitoring and Evaluation – Example Measures, Methods, and Tools used by CHIPRA Quality Demonstration States

Area to track	Example measures	Example data collection methods	Example tools
Model fidelity	• Care coordinator qualifications and certifications. • Frequency of care team meetings. • Composition of care team. • Quality of care plans.	• Administer fidelity monitoring tool. • Collect and analyze data from CME records. • Conduct CME chart and care plan reviews.	• Wrap Fidelity Index (measures fidelity to National Wraparound Initiative principles).
Youth and family outcomes	• Youth and family functioning. • Youth and family empowerment. • Youth resiliency. • Contact with juvenile justice system. • Use of out-of-home placements or restrictive services. • Appropriate and inappropriate use of psychotropic medications. • School attendance and grades.	• Administer youth and family surveys. • Hold youth and family focus groups. • Conduct chart and care plan reviews. • Analyze administrative data from multiple child-serving agencies (for example, track outcomes for youth enrolled in the CME over time or compare them to a comparison group or State projections).	• Columbia Impairment Scale- Parent. • Columbia Impairment Scale-Youth. • Family Empowerment Scale. • California Healthy Kids Survey. • Child and Adolescent Functional Assessment Scale. • Child and Adolescent Needs and Strengths (CANS).
Costs	• Cost of CME care coordination and family support. • Costs for out-of-home placements. • Costs for outpatient behavioral health services. • Costs for home- and community-based services and social supports. • Total cost of services.	• Analyze administrative data from multiple child-serving agencies (for example, track costs for youth enrolled in the CME over time or compare them to a comparison group or State projections).	

Source: Interviews with staff in CHIPRA quality demonstration States.

As highlighted in Table 2, States may collect and analyze data from CME records, surveys and focus groups with youth and their families, and multiple administrative systems.

- **CME Records.** CMEs submit process data to the State. States can require CMEs to use an electronic system to collect and submit this information or allow the CME to manually report. Electronic reporting can be more accurate and timely than manual reporting, but implementing an electronic system can be time consuming and costly for the CME. In either case, the State will need to work closely with the CME to review data submissions, identify data gaps or inaccuracies, and work to improve data entry and transmissions.

CHIPRA Quality Demonstration State Experiences: CME Record Data

Maryland is working to adapt and implement WrapTMS, an electronic system to track care coordination services and authorize services coordinated by the CME.

- **Youth and Families.** Youth and families are the only source of data for several important quality metrics. To minimize the cost and potential burden of data collection, States may:
  - Carefully consider how often the State collects data from families and youth, weighing the need for ongoing followup data against the burden and expense of collecting it.
  - Provide incentives to youth and their families for participating in surveys and focus groups. Make reauthorization of services dependent on completion of critical surveys (for example, youth functioning assessments).
- **Administrative systems.** Refer to Part 3 of this guide for strategies for improving administrative data systems.

Using Data to Drive Quality Improvement

CMEs and the organizations managing and overseeing their services can use data to improve quality and operational efficiency. The organization overseeing CME quality should work collaboratively with the CMEs in the State to identify what measures and strategies are most useful for improving quality. Using a collaborative strategy to drive improvement may encourage CMEs to participate actively in the process and make positive changes. The State can consider several strategies to drive quality improvement including:

- Providing feedback reports to CMEs that cover model fidelity, youth and family outcomes, and costs. The feedback reports can track outcomes over time and benchmark CMEs against national wraparound standards or, if relevant, other CMEs in the State. A State should aim to provide timely feedback at regular intervals so it and the CME can quickly identify opportunities for improvement and assess the effectiveness of quality improvement strategies.

Additional Resource on Measuring Outcomes and Improving Quality

Continuous Quality Improvement Toolkit[36]

- Holding regular, frequent quality improvement meetings with CME leadership. During these meetings, the State and the CME can discuss challenging cases, policy developments, data issues, and training needs.

- Providing incentive payments to CMEs that demonstrate improvement on quality metrics. (States may also consider punitive action if CMEs consistently perform poorly.)

- Holding refresher courses or developing new training modules to address identified quality difficulties.

- Hosting learning collaborative sessions or other forums to encourage CMEs to learn from each other, if more than one CME exists in the State.

CHIPRA Quality Demonstration State Experiences: Quality Improvement

Georgia used CHIPRA quality demonstration funds to develop a new CME quality improvement process that involves regular quality feedback to CMEs and quality council meetings between the CME, State agencies, and staff at Georgia State University who monitor CME quality.

Using Data to Evaluate Impact

States can also use data to demonstrate CME impacts. One way to approach and help focus evaluation planning is to identify the information needs and expectations of the key stakeholders in the State, such as policymakers and agency leadership who decide if CMEs should be continued or expanded. To that end, a State could use the stakeholder engagement strategies (described in Part 3) to help determine what program evaluation questions stakeholders have and how they might use or act on any answers they receive.

States can compare actual performance with past or projected performance. If stakeholders need to be able to make inferences about cause and effect with a high degree of confidence, the State might also consider using an experimental or quasi-experimental design. This requires a comparison group to estimate the difference between the outcomes for youths referred to CME services and the outcomes for youth referred to alternative services. Specifically, the evaluator might seek data on the population of youth served by CMEs and compare their experiences, utilization, and costs to a similar population of youth not served by a CME.

If a State is implementing a CME for the first time, it may consider piloting the program. Evaluating the impacts of the program on youth in a specific geographical area (for example, city, county, or region) or limited population will allow the State to test the CME approach and refine it before going statewide.

CHIPRA Quality Demonstration State Experiences: Piloting CMEs

In the first year of implementation, Wyoming piloted their CME in a seven county region. It plans to refine and then expand the model statewide.

Who Monitors Quality and Conducts the Evaluation

States can develop and implement the quality monitoring and evaluation processes or contract with an external organization, such as a family advocacy organization or university, for some or all of these services.

- If a State has access to both data and analytic expertise, it may want to consider using State resources. These resources can be located in agencies funding or managing the CME or in other agencies. State staff may have a more complete understanding of CME implementation and may be able to provide more timely feedback that reflects State priorities.

- Alternatively, using an outside organization can augment analytic capacity and provide additional credibility for some stakeholders. Since external evaluators are not involved with CME implementation or invested in its success, external audiences may be more likely to trust their findings. Moreover, external evaluators may feel more comfortable sharing and discussing findings with the project team that show no impact or unintended negative consequences of the CME.

CHIPRA Quality Demonstration State Experiences: Evaluation

- The Center for Health Care Strategies helped design an evaluation plan for each of the demonstration States. The plans include measuring the key outcomes or results of CME adoption or expansion, as well as measuring care processes to support quality improvement.

- Georgia and Maryland are working with State universities to monitor and improve CME quality. In addition, Maryland contracts with a family advocacy organization to conduct family and youth focus groups.

Conclusion

CMEs are a promising model for serving high-cost, high-need youth with serious behavioral health concerns. Designing and implementing a CME, however, can be a large undertaking. Some States may be well positioned to undertake the challenge. Others may need to build capacity for CME design by, for example, facilitating high-level support for CMEs, fostering interagency collaboration, engaging stakeholders, or developing internal data analysis capabilities. Before a State moves forward with CME design, it should carefully consider the resources required to build CME capacity, weighing the potential benefits of CMEs against other priorities in the State.

A State that decides to move forward has considerable flexibility in how it designs CMEs. As noted throughout this guide, many CME design features are linked, and decisions on one design component can influence the options available for other aspects of the CME. For example, the funding mechanisms identified for a CME may directly influence the CME management structure, target population, and available services. As another example, if a State requires CMEs to oversee and finance behavioral health or social services, it may be restricted to selecting large organizations with sophisticated administrative capabilities to provide those services.

Given the complexity and interrelatedness of design features, a State should review the full implications of each design decision before moving forward. Engaging stakeholders, consulting experts, and analyzing data can help a State determine which approach is most appropriate for its context.

Appendix A: Brief History of CMEs

Although CMEs were developed specifically to serve youth with complex behavioral health needs, the concept is rooted in the broader historical transition from residential care to community-based care for individuals with complex health needs, typically individuals with serious and persistent mental illness or developmental disabilities.[10, 25, 37]

In 1984, the National Institute of Mental Health within the U.S. Department of Health and Human Services initiated the Child and Adolescent Service System Program (CASSP).[25] The program provided funding and assistance to all States to increase interagency collaboration around providing services for youth with complex behavioral health needs. A few years later, Congress mandated that States develop plans for serving adults and youth in the community, as opposed to those in residential settings. From that time on, a wave of congressional mandates and programs, as well as foundation-funded initiatives, have encouraged interagency collaboration and spurred the creation of community-based models for serving individuals with complex needs.[25]

CMEs were developed to serve youth whose needs were not met by traditional managed care organizations or organizations providing adult home- and community-based services, both of which lack experience in cross-agency service coordination.[9, 25,38,39] Early CME efforts provided the building blocks for the CHIPRA quality demonstration projects described in this document.

Appendix B: Key CME Design Features in CHIPRA Quality Demonstration States, as of June 2014

	Maryland[a]		Georgia	Wyoming
Funding mechanisms	• State general funds. • SAMHSA System of Care grants. • Medicaid 1915 (c) waiver.	• Medicaid 1915 (i) waiver. • State Plan Amendment (adding as third tier of targeted case management).	• Medicaid 1915 (c) waiver. • Money Follows the Person. • Balancing Incentives Program.[b] • SAMHSA State Mental Health Block grants.	• Currently using Medicaid 1915(i) waiver. • State is planning to use a Medicaid 1915(a) waiver.
Management structure	Governor's Office for Children in the Children's Cabinet (interagency State-level organization).	Counties or groups of counties.	State Medicaid office and managed care organization.	State Medicaid office.
Eligibility criteria for services	Different funding mechanisms use different eligibility criteria. Example criteria: • Youth with serious emotional disability who qualify for or are at risk for out-of-home placement by child welfare or juvenile justice. • Youth in foster care who receive a serious mental health diagnosis. • Youth who have multiple expulsions or suspensions, high absentee rate, and poor academic record.	Medicaid-eligible youth with a serious mental health diagnosis that meets established thresholds on the Child and Adolescent Service Intensity Instrument or the Early Childhood Service Intensive Instrument.[c]	Youth already served by CMEs or with a 90-day stay in a residential treatment facility with at least 1 day paid by Medicaid.	Youth age 4-21 with a serious mental health diagnosis that meet established thresholds on the Child and Adolescent Service Intensity Instrument or the Early Childhood Service Intensive Instrument,[c] have conditions that can be expected to improve with appropriate treatment, and live in the seven-county area served by the CME.
Services	• Providing intensive care coordination. • Managing a discretionary fund.	• Providing intensive care coordination.	• Providing intensive care coordination. • Contracting and paying for family support services. • Managing a discretionary fund.	• Providing intensive care coordination. • Contracting and paying for family support services. • Will assume financial risk for behavioral health services.
Provider type (selected contractor)	Local nonprofit organization (Choices, Inc.).	Local targeted case management providers (to be determined).	Local community service boards[d] (Viewpoint Health and Lookout Mountain).	Managed care organization (Colorado Access operating in Wyoming as Wyoming Access).
Provider training	Training developed and delivered by State university.	Training developed and delivered by State university.	Current training developed and delivered by University of Maryland; transitioning to training developed and delivered by State.	Current training developed by Wraparound Milwaukee and delivered by State; transitioning to training delivered by CME and overseen by State.
Payment model	• Daily case rate for care coordination. • Limited discretionary fund.	• Fee-for-service reimbursement for care coordination.	• Monthly case rate for care coordination. • Hourly reimbursement for family support. • Limited discretionary fund.	• Current monthly case rate for care coordination and family support. • Transitioning to also include all other Medicaid-financed behavioral health services with the exception of pharmacy.

Source: Interviews with CHIPRA quality demonstration staff and State semiannual progress reports to the Center for Medicare & Medicaid Services

Notes:

[a]Maryland plans to operate two CME models.

[b]Money Follows the Person and the Balancing Incentives Program are Medicaid programs to increase use of home- and community-based services for individuals otherwise served in long-term care facilities.

[c]Child and Adolescent Service Intensity Instrument (CASII) and the Early Childhood Service Intensive Instrument (ECSII) link clinical assessments with appropriate levels of care.

[d] Community service boards oversee the public mental health system.

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