

Spotlight on Wyoming

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This brief highlights the major strategies, lessons learned, and outcomes from Wyoming's experience from February 2010 to February 2016 with the quality demonstration funded by the Centers for Medicare & Medicaid Services (CMS) through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). For this demonstration, CMS awarded 10 grants that supported efforts in 18 States to identify effective, replicable strategies for enhancing the quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) led the evaluation of the program.

Wyoming designed and implemented a care management entity (CME)

With support from State agencies serving youth with complex behavioral health needs, CMEs help to orchestrate the many services needed by these youth and their families.¹ Wyoming Medicaid used the CHIPRA quality demonstration to develop and implement its first CME. Wyoming Medicaid—

- **Engaged staff from various child-serving agencies in the CME design process.** Wyoming formed a workgroup that brought together staff from Medicaid, mental health, child welfare, and juvenile justice agencies to design and implement the CME pilot. At the outset, most staff in the agencies were unfamiliar with the CME concept. According to the CHIPRA quality demonstration staff, although educating these and other stakeholders about the model took longer than expected, the collaboration ultimately helped to break down barriers to communication among agencies.
- **Designed a model for CME services.** Wyoming found that CME development was a complex and iterative process. It took the State nearly three years to identify funding for CME services, select the CME's target

Wyoming's Goals: Improve services for children with complex behavioral needs by—

- Piloting a care management entity (CME) to improve coordination across child-serving agencies.
- Integrating CME services with other health information technology initiatives in the State.

Partner States: Maryland and Georgia implemented similar projects and met with Wyoming and the Center for Health Care Strategies to engage in peer learning through a quality collaborative.

population, and outline the services to be provided. The State faced several design challenges, including agencies' competing priorities and stakeholders' steep learning curve. On the other hand, Wyoming made three insightful decisions that helped it understand the design options. The State analyzed data from prior pilot projects in behavioral health to gain insight into how to improve services, dedicated specific staff to lead CME development, and consulted both with a contractor that had CME expertise and with experienced States, including its CHIPRA quality demonstration partners Maryland and Georgia.

Key Features of Wyoming's CME

Wyoming Medicaid funded and managed the CME, which—

- Started in a seven-county pilot area and then launched statewide.
- Served youth ages 4 to 21 who had a serious qualifying mental health diagnosis or who qualified for services at a residential treatment center.
- Contracted with behavioral health providers and community-based nonprofits to deliver:
 - Intensive care coordination according to the National Wraparound Initiative's model.¹
 - Family support services.

- **Piloted the CME model in a seven-county area.**

Wyoming Medicaid awarded the CME contract to a managed care organization with behavioral health experience, the only organization to respond to the State's request for proposals. Since this organization was headquartered out of State, it had to contract with behavioral health providers and community-based nonprofit organizations in Wyoming to deliver coordination and family support services. Wyoming helped to train these organizations in the CME model. Enrollment in the CME pilot was initially slow because referral providers in the community did not understand and, in some cases, did not trust the CME model. In response, Wyoming improved the referral process by facilitating outreach activities between the CME and other providers. From June 2013 to January 2015, the CME served 142 youth and their families, surpassing the State's goal of serving 100 youth during the pilot period.

"We haven't yet worked with many children, but we have seen individual successes. We had one kid go from being on lots of psychotropic medications and struggling in school to getting off all their medications and preparing to graduate."

— CHIPRA Demonstration Staff, April 2014

- **Expanded the CME model statewide in July 2015.**

The State adapted its CME model to reflect lessons learned from the pilot before implementing the model statewide. Changes included the following: forming regional quality committees that involved families as well as agencies that serve children, requiring the CME to implement quality improvement projects and step up their community outreach to referral organizations and families, providing the CME and its staff with additional training, making the CME credentialing process more stringent, and establishing a pay-for-performance model under which the CME is given payment incentives or withholds based on its performance on process and

outcome measures (for example, staff fidelity to the wraparound model and participants' length of stay in residential settings). Wyoming noted several challenges to expanding the program statewide. For one, there was not enough family support staff in the State to provide the level of youth and family peer support targeted by the State. In addition, identifying funding to continue CME services beyond the pilot took longer than anticipated. The State indicated that the process could have been expedited if it had involved regional CMS leaders responsible for approving funding changes in discussions when the demonstration began.

Wyoming integrated health IT into the CME

Wyoming integrated its existing health information technology (IT) efforts into CME activities. The health IT included, for example, a telehealth network and a total health record that allows multiple providers to see more complete health information online. During the first few years of the demonstration, the State focused less on integrating CME activities with these non-demonstration health IT efforts because of the complexity of CME design and the competing priorities for health IT resources. Towards the end of the grant, however, CHIPRA demonstration staff leveraged the State's health IT initiatives to do the following—

- **Make the total health record useful for CME providers.** The State added fields for CME data to the total health record, including care coordination plans. The State also trained CME staff to use the total health record to identify service gaps or the duplication of services. Although technical difficulties limited the record's usability, Wyoming reported that CME staff did use the tool to ensure that participants received pediatric preventive care services in a timely manner.
- **Required the CME to use telehealth services.** Wyoming reported that the statewide CME used telehealth services to increase access to the services needed by youth in remote areas of the State, where physical and behavioral health services are limited.

Key demonstration takeaways

- Cross-agency collaboration in Wyoming helped to break down communication barriers among child-serving agencies, thereby promoting a more coordinated model of care.
- The design of Wyoming's CME, a new service delivery model for the State, was a complex and lengthy undertaking. The State relied on advice and assistance from experienced States and a contractor to develop and implement the pilot.
- Wyoming and the CME had to conduct outreach and education in order to encourage providers to refer youth to the CME.
- Piloting the CME in a seven-county region allowed the State to evaluate and refine the model before implementing it statewide.
- CME providers used health IT to improve services. Specifically, they used the total health record to identify participants' needs, and they used telehealth to improve participants' access to care.

Continuing Efforts in Wyoming

After Wyoming's CHIPRA quality demonstration ended in February 2016, the State planned to—

- Continue to operate the CME for youth with complex behavioral health needs.
- Work to improve the quality of CME services. Most notably, Wyoming planned to expand the network of peer support staff.
- Continue encouraging cross-agency collaboration on CME design and monitoring. The State planned to look for new CME funding mechanisms that would involve resources from several agencies.
- Continue to improve the functionality of health IT and to educate CME providers about health IT to increase its use.

Endnote

1. CMEs follow the high-fidelity wraparound care planning model outlined by the National Wraparound Initiative. For more information, visit <http://nwi.pdx.edu/>.

LEARN MORE

Wyoming's CHIPRA quality demonstration experiences are described in more detail on the national evaluation Web site available at <http://www.ahrq.gov/policymakers/chipra/demoeval/demostates/wy.html>.

The following products highlight Wyoming's experiences—

- *Implementation Guide No. 2: Designing Care Management Entities for Youth with Complex Behavioral Health Needs.*
- *Evaluation Highlight No. 6: How are CHIPRA quality demonstration States working together to improve the quality of health care for children?*

The information in this brief draws on interviews conducted with staff at Wyoming agencies, CMEs, and family advocacy organizations and a review of project reports submitted by Wyoming to CMS.

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