



Spotlight on Maryland

July 2015

This brief highlights the major strategies, lessons learned, and outcomes from Maryland's experience during the first 5 years of 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 is leading the evaluation of the program.

Maryland expanded and improved care management entity (CME) services

CMEs use intensive care coordination to help orchestrate the many services needed by youth with complex behavioral health needs.¹ Having implemented CME services in 2006, Maryland used its CHIPRA quality demonstration funding to expand access to and improve the quality of these services. With support from the CHIPRA quality demonstration, Maryland—

- **Developed training for CME care coordinators in oral and physical health and wellness.** To identify gaps in services, Maryland contracted with a family advocacy organization to conduct focus groups with families of children and youth served in the CMEs. The State found that the youth had unmet oral and physical health service needs that were often overshadowed by their behavioral health needs. In response, the State incorporated information on oral and physical health into the CME care plan to help CMEs identify gaps in recommended preventive services and treatment for chronic physical health conditions. The State also developed publically available, Web-based training that teaches CME providers how to discuss oral and physical health needs and resources with families.²

Maryland's Goals: Improve the quality and reduce the cost of care for children with serious behavioral health challenges by—

- Refining care management entities to improve coordination across child-serving agencies.
- Enhancing the accessibility and quality of services and supports for youth and their families.

Partner States: Georgia and Wyoming implemented similar projects and met quarterly with Maryland to discuss lessons learned.

- **Worked to improve CME quality monitoring.** After developing an extensive list of quality measures used by experienced States to monitor CMEs, Maryland refined the list so that it balances the State's needs to effectively monitor quality and minimize reporting burden. Maryland also customized an electronic system that CMEs and child-serving agencies can use to report and track quality measures. In addition, the State trained CMEs and referral providers to use standardized tools not only to determine whether youth are eligible for CME services but also to track youth outcomes.³
- **Identified a sustainable funding stream for CME services.** Historically, Maryland used a patchwork of federally funded demonstrations and grants as well as its own funds to support CME services. The State weighed various options for more sustainable funding and decided to modify its targeted case management program for children and adolescents, referred to as care coordination organizations (CCOs). Under a new State plan amendment developed with demonstration funds, CCOs now provide CME services as a third tier of service intensity. While the State still uses its own funds and Federal grant funds to support CME services, it is now able to serve more youth. Most CCOs needed State-provided training in order to offer the intensive level of care coordination required for the CME model.

- **Analyzed data across agencies to identify ways to improve CME services.** Maryland contracted with a team of researchers to analyze data to support CME quality improvement, including data submitted by CMEs as well as administrative data from Medicaid and from the child welfare and juvenile justice systems. The researchers also helped child-serving agencies and CMEs establish data-sharing agreements, reduce cross-system variation in the structure of service records, and improve data consistency. Although addressing these challenges delayed the researchers' work, Maryland was able to assess the total cost of care across child-serving agencies and to begin identifying service gaps, opportunities for better care coordination, and incidences of psychotropic drug misuse or overuse.

“The grant provided us with a lot of capacity. We were able to more fully assess the costs and quality of services and really think about how CMEs could be improved.”

— Maryland CHIPRA Demonstration Staff, May 2014

Maryland identified funding for crisis response and family support

Youth served by CMEs and their families rely on crisis response and family support services. The former include mobile crisis teams and mental health urgent care centers, which give youth an alternative to emergency rooms. Through family support programs, trained families of youth with complex behavioral health needs provide emotional support to other families and help them identify and connect with community resources. Maryland sought to improve access to and the quality of these services. The State—

- **Pursued stakeholder input on crisis response and family support services.** Maryland partnered with family advocacy organizations, surveyed behavioral health providers, and conducted focus groups with families to catalog existing services, understand family

experiences related to these services, and identify gaps in service availability. These stakeholders indicated that while they value the services overall, they are not always available or do not meet their individual needs. Stakeholders, for example, indicated that the unmet needs for family support result from low reimbursement, staff turnover, and poor organizational infrastructure. Additionally, Maryland demonstration staff visited States and cities with well-developed crisis systems (New Jersey and Milwaukee) and family support programs (Georgia) to learn from their experiences.

- **Identified sustainable funding for crisis response and family support.** The State determined an appropriate reimbursement rate for mobile response, stabilization, and family support and included these services in its new state plan amendment.
- **Identified and disseminated best practices for crisis response.** Maryland developed a report outlining best practices for crisis response and disseminated it to local agencies that contract for and organize these services.

Key demonstration takeaways

- Given the opportunity to assess and think critically about how to improve services provided to youth with complex behavioral health needs, Maryland developed various strategies for improving care. These included obtaining sustainable funding for CMEs, integrating oral and physical health into CME services, and developing materials on best practices for crisis response.
- The State required providers to deliver new CME services and implement new tools to monitor quality. Maryland developed and implemented training programs to prepare CME leaders and staff to assume the additional responsibilities.
- While challenges in analyzing agency data caused significant delays, Maryland expects to benefit from its new capacity to evaluate service cost and use across child-serving agencies.

Endnotes

1. CMEs follow the high-fidelity wraparound care–planning model outlined by the National Wraparound Initiative. For more information, visit <http://nwi.pdx.edu/>.
2. Maryland’s training in preventive physical and oral health services is available at <https://theinstitute.umaryland.edu/training/onlinetraining.cfm>.
3. Maryland trained providers to use the Child and Adolescent Service Intensity Instrument (CASII), Early Childhood Service Intensity Instrument (ECSII), and the Child and Adolescent Needs and Strengths Tool to identify youth who qualify for CME services.

Continuing Efforts in Maryland

Maryland will continue to pursue its CHIPRA quality demonstration activities until February 2016 under a grant extension approved by CMS. Moving forward, the State will—

- Continue to use its own funds and Federal grants to support CMEs and implement its State plan amendment to expand service capacity.
- Conduct additional training and technical assistance for CME providers, including CCOs.
- Complete its analysis of cost and use of services, as well as prescribing patterns for psychotropic medicines to inform future programs.
- Continue to engage family and youth in service planning and identify funding to support initiatives that improve the quality of CME, crisis, and family support services.

LEARN MORE

Maryland’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/md.html>.

The following products highlight Maryland’s experiences—

- *Implementation Guide No. 2: Designing Care Management Entities for Youth with Complex Behavioral Health Needs.*
- *Evaluation Highlight No. 4: How the CHIPRA quality demonstration elevated children on State health policy agendas*
- *Evaluation Highlight No. 6: How are CHIPRA quality demonstration States working together to improve the quality of health care for children?*
- *Evaluation Highlight No. 7: How are CHIPRA quality demonstration States designing and implementing caregiver peer support programs?*
- *Reports from States: Maryland published an analysis of psychotropic medication use and produced a report on the State’s crisis response system.*

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

The following staff from Mathematica Policy Research contributed to data collection or the development of this summary: Grace Anglin and Adam Swinburn.