Exploring Medicaid Health Homes
Developing Health Homes for Children with Serious Emotional Disturbance: Considerations and Opportunities

February 25, 2014; 1:00 – 2:00PM (ET)

For more information or technical assistance in developing health homes, visit http://www.Medicaid.gov.

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Kathy Moses

Senior Program Officer

Center for Health Care Strategies

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Health Home Information Resource Center

- Established by CMS to help states develop health home models for beneficiaries with complex needs
- Technical assistance includes:
  - One-on-one technical support to states
  - Group discussions and learning activities
  - Webinars
  - Online library of hands-on tools and resources, including:
    - Matrix of approved health home SPAs
    - Map of state health home activity
    - New draft of SPA template

    http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html

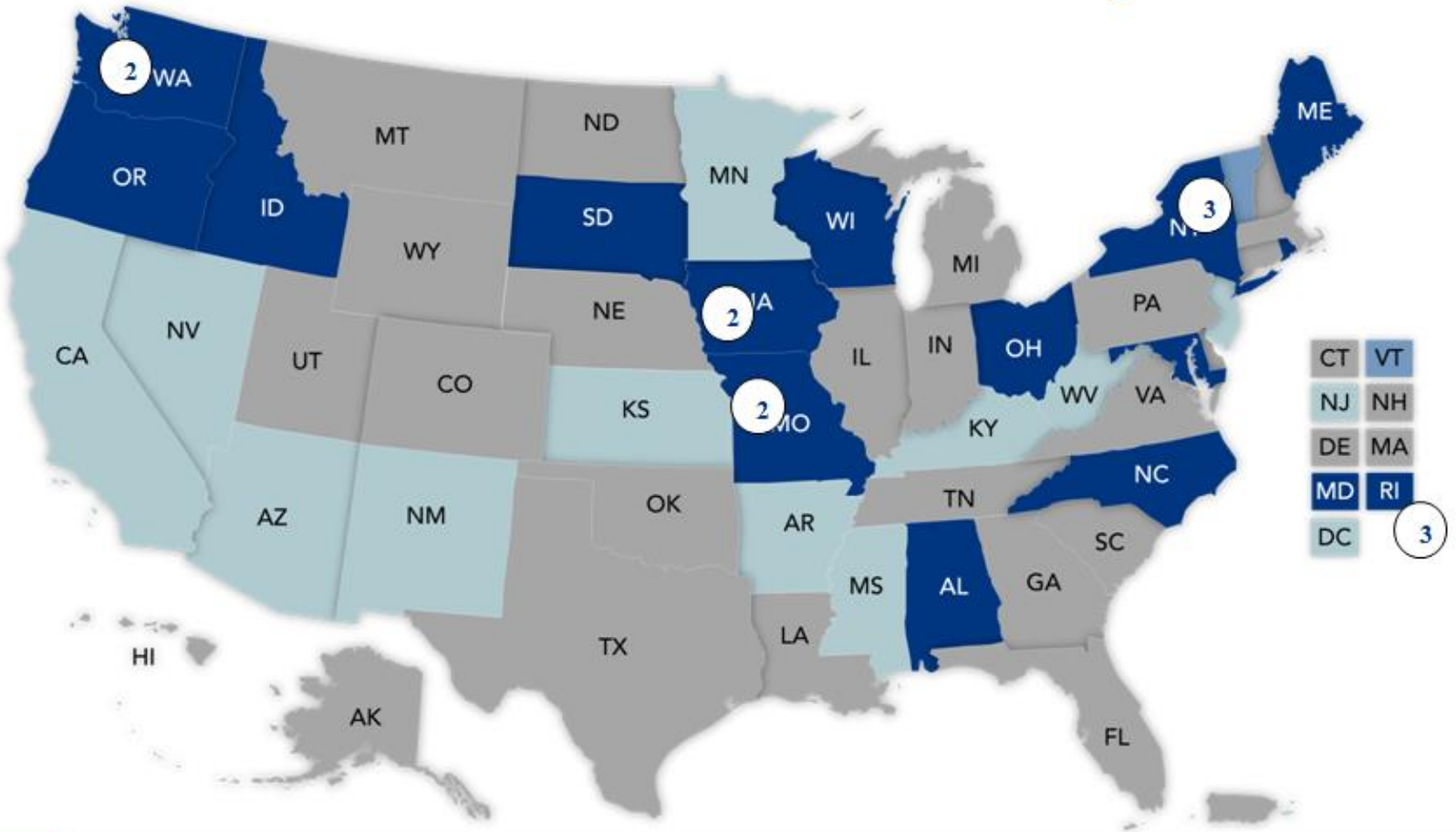
Exploring Medicaid Health Homes Webinar Series

- Provides a forum for states to share models, elements of their SPAs, and successes or challenges in their development process
- Creates an opportunity for CMS to engage in conversation with states considering and/or designing health home programs
- Disseminates existing knowledge useful to health home planning
- Open to any state considering or pursuing health homes

National Landscape to Date

- 21 approved State Plan Amendments in 14 states: AL, IA, ID, MD, ME, MO, NC, NY, OH, OR, RI, SD, WA and WI
- Over 750,000 health home enrollees
- Number of states in discussion with CMS
- Many other states exploring the opportunity to develop health homes

State Health Home Activity



	Approved Health Home State Plan Amendment (SPA) (where (#) = number of approved SPAs if more than one exists)	Alabama, Idaho, Iowa, Maine, Maryland, Missouri, New York, North Carolina, Ohio, Oregon, Rhode Island, South Dakota, Washington, Wisconsin
	Health Home SPA "On the Clock" (officially submitted to CMS)	Iowa (3rd SPA), Maine (2nd SPA), Ohio (2nd SPA), Vermont, Wisconsin (2nd SPA)
	Approved Health Home Planning Request	Alabama, Arizona, Arkansas, California, District of Columbia, Idaho, Kansas, Kentucky, Maine, Maryland, Minnesota, Mississippi, Nevada, New Jersey, New Mexico, North Carolina, Washington, West Virginia, Wisconsin
	No Proposed SPA Submitted to CMS*	Alaska, Colorado, Connecticut, Delaware, Florida, Georgia, Hawaii, Illinois, Indiana, Louisiana, Massachusetts, Michigan, Montana, Nebraska, New Hampshire, North Dakota, Oklahoma, Pennsylvania, South Carolina, Tennessee, Texas, Utah, Virginia, Wyoming

Health Home Basics

- New state plan option created under ACA Section 2703
- Overall goal: improve integration across physical health, behavioral health and long-term services and supports
- Opportunity to pay for “difficult-to-reimburse” services (e.g., care management, care coordination)
- Flexibility for states to develop models that address an array of policy goals
- Significant state interest in evidence-based models to improve outcomes and reduce costs
- States receive an enhanced 90/10 federal match for the first eight fiscal quarters of the health home benefit

What Are Health Home Services?

- Comprehensive care management
- Care coordination
- Health promotion
- Comprehensive transitional care/follow-up
- Individual and family support
- Referral to community and social support services

Information technology used to link all services

What Are Health Home Services?

- All six services must be provided
- Do not include medical/direct treatment services
- Do not need to be provided “within the walls”
- Not limited to primary care

Targeting Health Home Populations

Targeting Do's

- Condition
- Geography
- Severity/risk
- Certain eligibility categories

Targeting Don'ts

- Age
- Delivery system
- Dual-eligibility status

Who Can Receive Services?

- Two or more chronic conditions
- One condition and risk of a second
- Serious mental illness

Developing Health Homes for Children with SED - Considerations

- States cannot target by age, thus cannot build a health home for only children or only adults; however…
- States may tailor the health home approach to meet the specific needs of adults and children, e.g.:
  - How the population is identified;
  - How provider standards are developed; and
  - How services are defined.

Developing Health Homes for Children with SED - Opportunities

- Leverage a program or care model built for children with SED
  - Intensive care coordination
  - Care Management Entities (CME)
- Avoid duplication of services
  - Convert duplicative services to health home
  - Member chooses between the two services
  - Adequately differentiate between services

Speakers

Presenter:

- Sheila Pires, Partner, Human Service Collaborative

Panelists:

- Mary Pat Farkas, Technical Director for Health Homes, Centers for Medicare & Medicaid Services (CMS)
- Trina Dutta, Public Health Advisor, Substance Abuse and Mental Health Services Administration (SAMHSA)

Tailoring Behavioral Health Homes to Children with Serious Behavioral Health Challenges

Sheila A. Pires
Human Service Collaborative

February 25, 2014

Mental Health: Costliest Health Conditions of Childhood (annual costs)

- Infectious diseases: $2.9 Billion
- Acute bronchitis: $3.1 Billion
- Trauma-related conditions: $6.1 Billion
- Asthma: $8 Billion
- Mental health disorders: $8.9 Billion

Source: Soni, 2009 (AHRQ Research Brief #242)

Children in Medicaid Using Behavioral Health Care Are an Expensive Population

- Have mean Medicaid expenditures (physical and behavioral health care) of $8,520 per year – nearly 5x higher than for Medicaid children in general ($1,729 per year)
  - TANF children – nearly 3x higher
  - Foster care – 7x higher
  - SSI/Disabled – nearly 9x higher
- Expenditures are driven more by behavioral health service use than by physical health service use, except for children on SSI/Disabled, for whom mean physical health expenditures are slightly higher
- 9.6 % of children using behavioral health care account for an estimated 38% of all spending in Medicaid for children

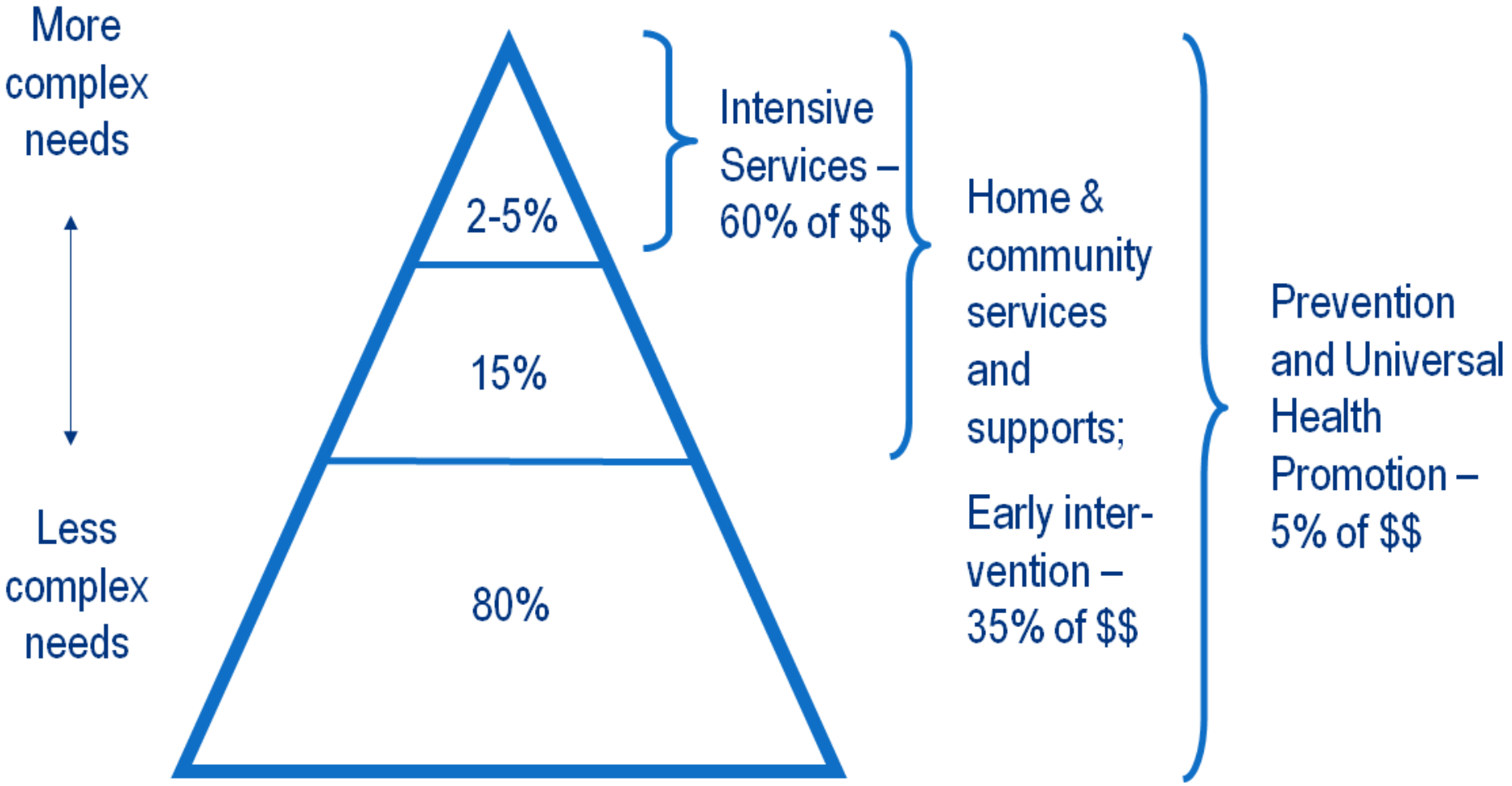
Source: Pires, SA, Grimes, KE, Allen, KD, Gilmer, T, Mahadevan, RM. Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures. Center for Health Care Strategies, December, 2013. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261588#.UqsNZMRDvmc

Three Highest Expenditure Medicaid Services for Children with Behavioral Health Use

1. Residential treatment and therapeutic group homes: 19.2% of all expenditures for 3.6% of children using behavioral health services
2. Outpatient treatment: 6.5% of all expenditures for 53.1% of children using behavioral health services
    - "Based on current evidence of the effectiveness of interventions in community mental health settings, there is no reason to assume that the outpatient mental health services provided to foster children are effective in improving outcome" (James, S., Landsverk, J., Slymen, D. and Leslie, L. Predictors of Outpatient Mental Health Service Use—The Role of Foster Care Placement Change Ment Health Serv Res. 2004 September; 6(3): 127–141
3. Psychotropic medications: 13.5% of all expenditures for 43.8% of children using behavioral health services
    - Total Medicaid expense for child and adolescent psychotropic medication use in 2005 was $1.6B, with 42% of expense represented by anti-psychotic use
    - Children in foster care have highest rate of psychotropic med use (higher than children on SSI/disability – 27% vs 23%; TANF=4%

Source: Pires, SA, Grimes, KE, Allen, KD, Gilmer, T, Mahadevan, RM. Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures. Center for Health Care Strategies, December, 2013. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261588#.UqsNZMRDvmc

Prevalence/Utilization Triangle



Source: Pires, S. 2006. Human Service Collaborative. Washington, D.C.

Why, absent reform, are outcomes poor and costs high?

- Child and family needs are complex
  - Youth with serious behavioral health challenges typically have multiple and overlapping problem areas that need attention
  - Families often have unmet basic needs
  - Traditional services don't attend to health, mental health, substance abuse, and basic needs holistically -- or even know how or have time to prioritize what to work on
- Families are often not fully engaged in services
  - They don't feel that the system is working for them
  - Leads to treatment dropouts and missed opportunities
- Systems are in "silos"
  - Systems don't work together well for individual families unless there is a way to bring them together
  - Youth get passed from one system to another as problems get worse
  - Families relinquish custody to get help; Children are placed out of home

Source: Adapted from Bruns, E. 2012. University of Washington.

Children and Youth with Serious Behavioral Health Conditions Are a Distinct Population from Adults with Serious and Persistent Mental Illness

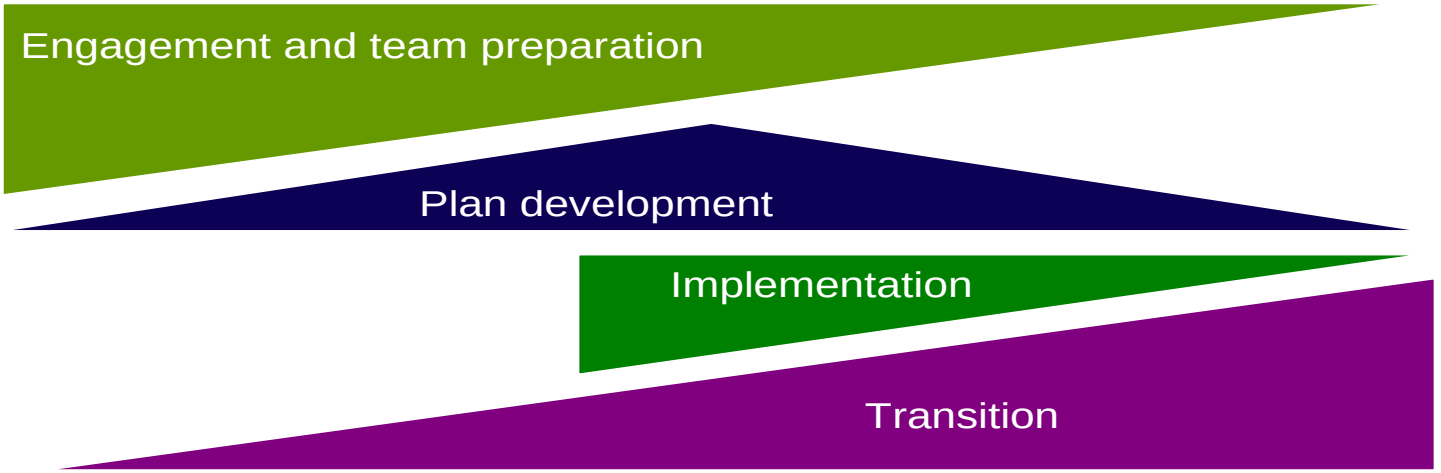
- Children with SED do not have the same high rates of co-morbid physical health conditions as adults with SPMI
- Children, for the most part, have different mental health diagnoses from adults with SPMI (ADHD, conduct disorders, anxiety; not so much schizophrenia, psychosis, bipolar as in adults), and diagnoses change often
- Among children with serious behavioral health challenges, two-thirds typically are involved with child welfare and/or juvenile justice systems and 60% may be in special education – systems governed by legal mandates
- Coordination with other children's systems – child welfare, juvenile justice, schools – and among behavioral health providers consumes most of care coordinator's time, not coordination with primary care
- To improve cost and quality of care, focus must be on child and family/caregiver(s) – takes time

Source: Pires, S. Customizing Health Homes for Children with Serious Behavioral Health Challenges .Human Service Collaborative, March 2013.

Customized Care Coordination Approaches: Intensive Care Coordination with Fidelity Wraparound

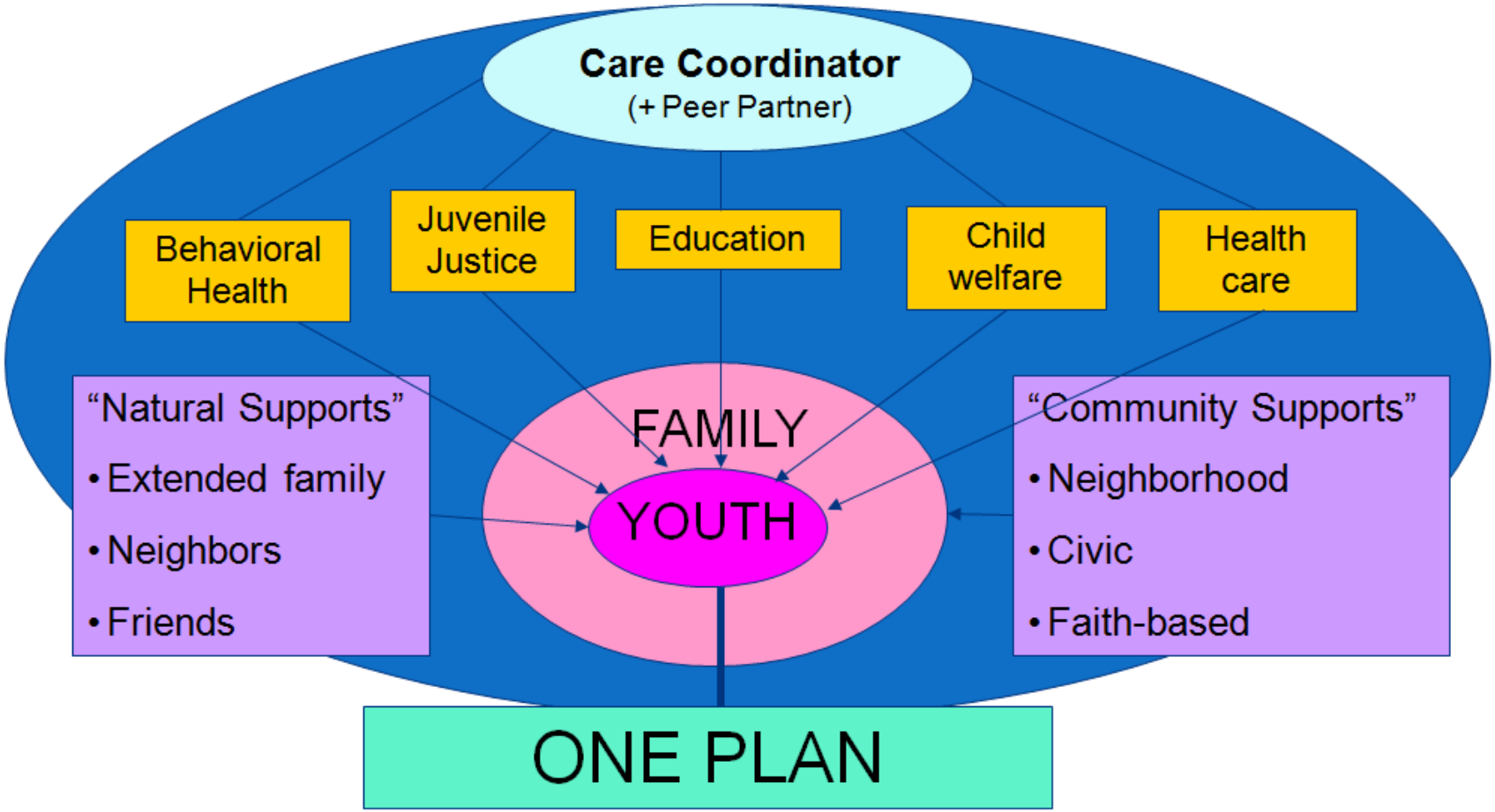
- Care Management Entities: Provide intensive care coordination at low ratios (1:10) using high quality Wraparound approach
- High Quality Wraparound Teams: Provide intensive care coordination at low ratios embedded in supportive organization, such as CMHC, FQHC or school-based mental health center

Wraparound is “a definable service planning and care coordination process that results in a unique set of community services and natural supports that are individualized for a child and family to achieve a positive set of outcomes.”



Source: Adapted from Bruns, B. & Hoagwood, K. (Eds.) Community-Based Interventions for Children and Families. Oxford: Oxford University Press and National Wraparound Initiative.

In wraparound, a care coordinator coordinates the work of system partners, providers and other natural helpers so there is one coordinated plan of care



Source: Adapted from Laura Burger Lucas, ohana coaching, 2009.

Important points about the wraparound process

- Wraparound is a defined, team-based service planning and coordination process
- The Wraparound process ensures that there is one coordinated plan of care and one care coordinator
- Wraparound is not a service per se, it is a structured approach to service planning and care coordination
- The ultimate goal is both to improve outcomes and per capita costs of care

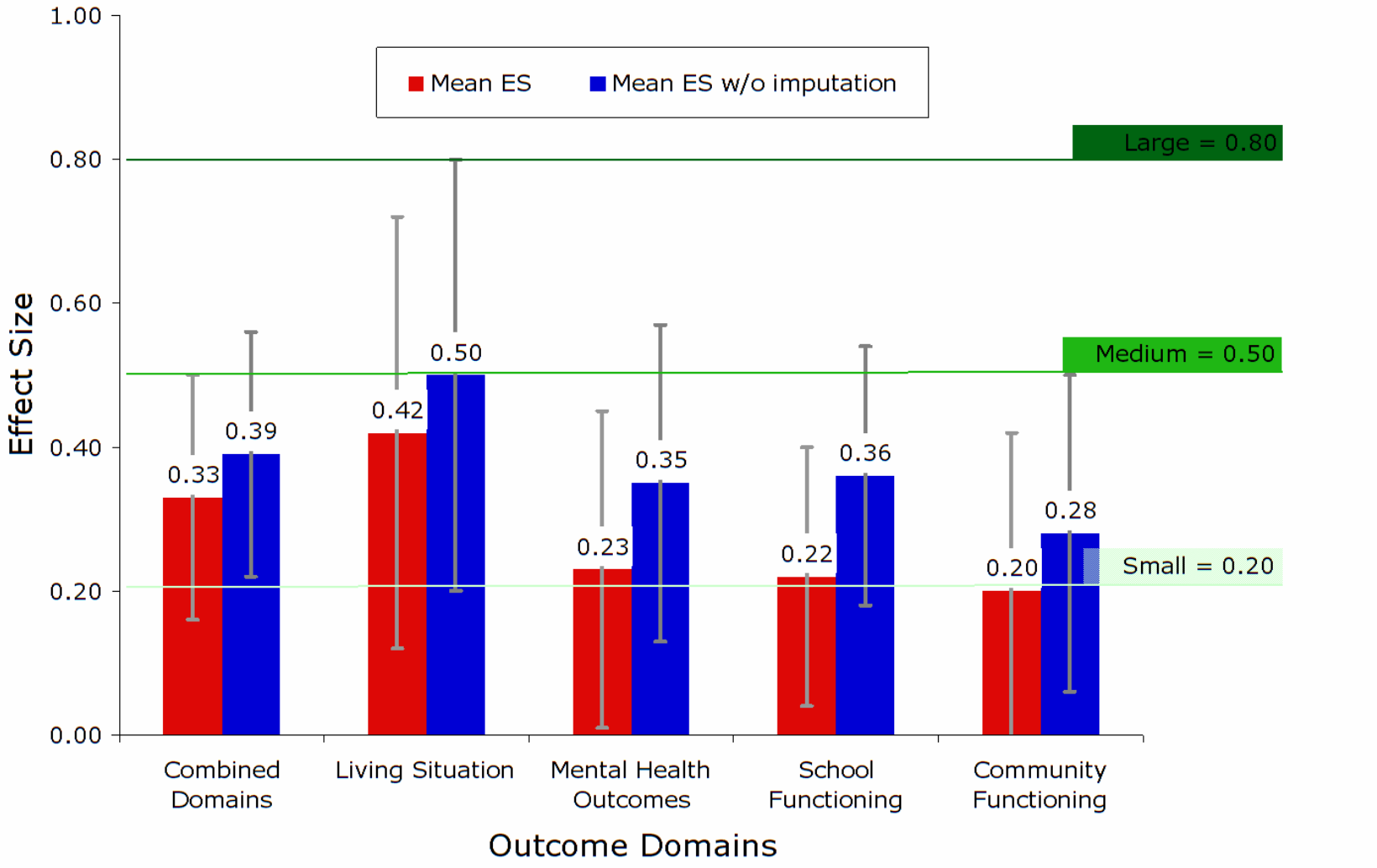
Source: National Wraparound Initiative at nwi.org.

What's Different in Wraparound?

- High quality Teamwork
  - Collaborative activity
  - Brainstorming options
  - Goal setting and progress monitoring
- The plan and the team process is driven by and "owned" by the family and youth
- Taking a strengths based approach
- The plan focuses on the priority needs as identified by the youth and family
- A whole youth and family focus
- A focus on developing optimism and self-efficacy
- A focus on developing enduring social supports

Source: National Wraparound Initiative at nwi.org.

Effects of Wraparound are Significant



Reduced Costs and Out-of-Home Placements

Wraparound Milwaukee

- Reduction in placement disruption rate in child welfare from 65% to 30%
- School attendance for child welfare-involved children improved from 71% days attended to 86% days attended
- 60% reduction in recidivism rates for delinquent youth from one year prior to enrollment to one year post enrollment
- Decrease in average daily pop. in residential treatment centers from 375 to 50
- Reduction in psychiatric inpatient days from 5,000 days per year to <200
- Average monthly cost of $4,200 (compared to $7,200 for RTC, $6,000 for juvenile detention, $18,000 for psychiatric hospitalization)

New Jersey

- Savings of $40 million from 2007 to 2010 by reducing the use of acute inpatient psychiatric services
- Residential treatment budget was reduced by 15% during the same time period, and length of stay in residential treatment centers decreased by 25%

Maine

- Experienced 30% net reductions in Medicaid spending, comprised of decreases in PRTF and inpatient psychiatric with increases in targeted case management and home- and community-based services

Sources: Milwaukee County Bureau of Children's Behavioral Health. 2010; Hancock, B. (2010); New Jersey System of Care Financing Overview. CHIPRA Quality Demonstration Grant TA Webinar Series. June 23, 2010. Guenzel, J. (2012). System of Care Expansion in New Jersey. Presentation at Georgetown University Training Institutes. July 23, 2012, Orlando, FL; Bruns, E. 2011.

Reduced Costs and Out-of-Home Placements

Maryland

- Cost of serving PRTF Waiver youth in the CME is 35% of the cost of serving youth in PRTFs

Georgia

- Medicaid annual average cost for a CME youth is $44,008 less than average annual cost for PRTF youth (CME = $34,398, PRTF =$78,406)
- Comparing youth out-of-home placements in the 6 months pre-CME engagement to the 3-8 months post-CME engagement showed:
- 86% reduction in inpatient hospitalization for CME youth meeting PRTF waiver criteria
- 89% reduction in inpatient hospitalization for other high need youth enrolled in CME
- 73% reduction in PRTF stays for CME youth meeting PRTF waiver criteria
- 62% reduction in PRTF stays for other high need youth enrolled in CME

Source: Pires, S. 2013 Human Service Collaborative: Washington D.C.

Costs and Residential Outcomes are Robust

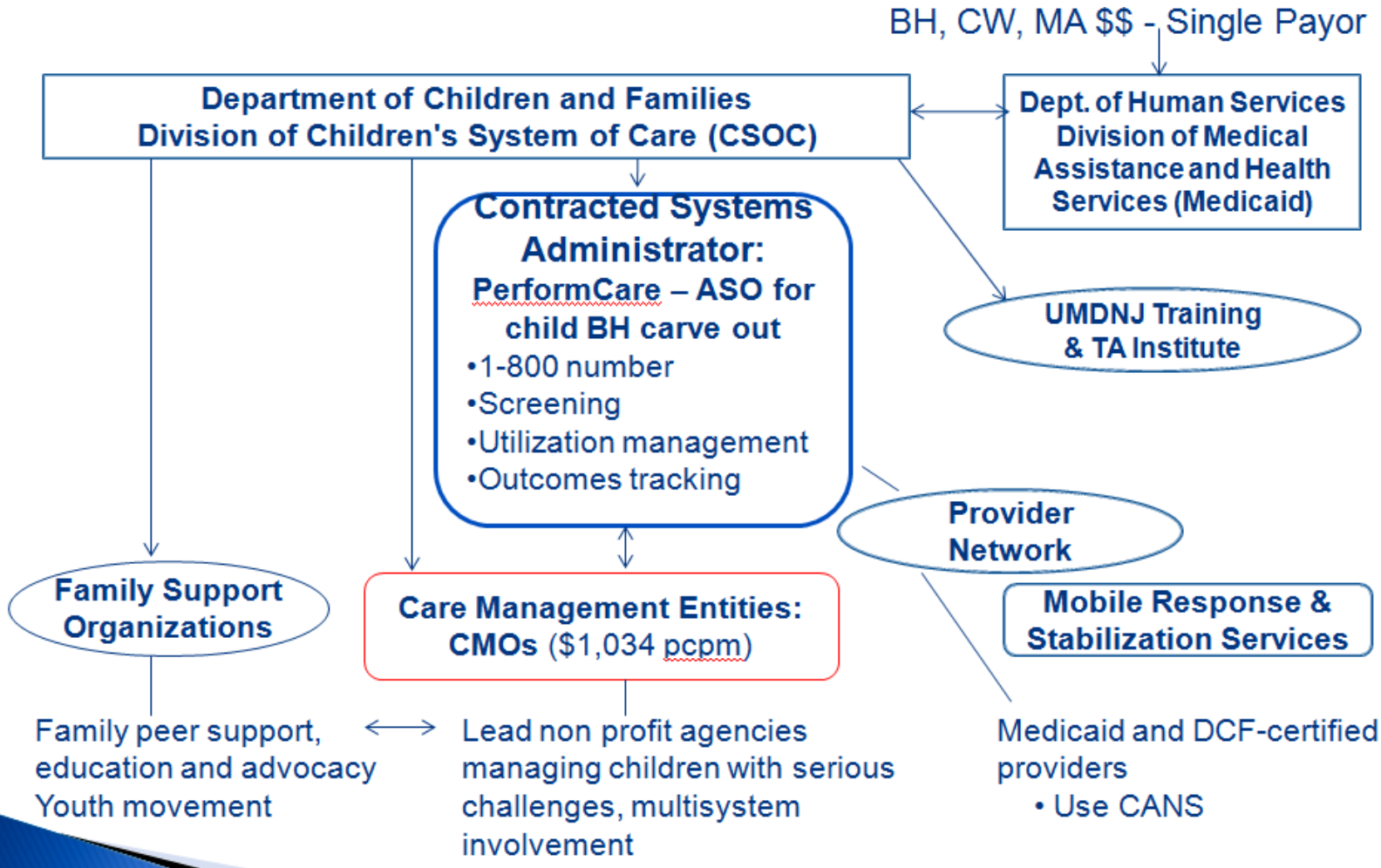
- Controlled study of Mental Health Services Program for Youth in Massachusetts (Grimes, 2011)
  - 32% lower emergency room expenses
  - 74% lower inpatient expenses than matched youths
- CMS Psychiatric Residential Treatment Facility (PRTF) Waiver Demonstration project (Urdapilleta et al., 2011)
  - Average per capita saving by state ranged from $20,000 to $40,000
- Los Angeles County Department of Social Services
  - Found 12-month placement costs were $10,800 for Wraparound-discharged youths compared to $27,400 for matched group of RTC youths

Source: Pires, S. 2013 Human Service Collaborative: Washington D.C.

Wraparound is Increasingly Considered "Evidence-Based"

- State of Oregon Inventory of Evidence-Based Practices (EBPs)
- California Clearinghouse for Effective Child Welfare Practices
- Washington Institute for Public Policy: "Full fidelity wraparound" is a research-based practice

New Jersey (Rehab Option and TCM)



Source: Adapted from State of New Jersey 2010

High Quality Wraparound Team as Health Team Oklahoma

Community Mental Health Center

- Wraparound facilitator
- Intensive care coordinator
- Family and youth peer support

Coordination with Primary Care in a Wraparound Approach

For children with complex behavioral health challenges enrolled in Health Home - Care Management Entity or Wraparound Team of Health Care Professionals:

- Ensures child has an identified primary care provider (PCP)
- Tracks whether child receives EPSDT screens on schedule
- Ensures child has an annual well-child visit (more frequent if on psychotropic medications or chronic health condition identified)
- Communicates with PCP opportunity to participate in child and family team and ensures PCP has child's plan of care and is informed of changes
- Ensures PCP has information about child's psychotropic medication and that PCP monitors for metabolic issues such as obesity and diabetes

Source: Pires, S. 2012. Human Service Collaborative

Customizing Health Home Approaches for Children with Serious Behavioral Health Challenges Using High Quality Wraparound and Intensive Care Coordination

- Ensures child has an identified primary care provider (PCP)
- State may submit one health home SPA that incorporates distinct approaches for adults with SMI and for children with SED, or
- State may submit two separate health home SPAs – one for adults with SMI and one for children with SED – but they must have the same effective date

Core Health Home Services

- Comprehensive care management
  - Identifying, screening and assessing children appropriate for health home
  - Youth and family engagement
  - Mobilizing child and family team
  - Development and updating of coordinated plan of care
  - Monitoring of clinical and functional status
- Care coordination and health/mental health promotion
  - Ensure coordinated implementation of plan of care
  - Support youth and family to make and keep appointments and to achieve goals
  - Facilitate linkages for youth and family and among providers and systems
  - Ensure communication across providers, systems and with youth and families

Core Health Home Services (continued)

- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up
  - For children, other out-of-home treatment settings, e.g. residential treatment
- Individual and family support services
  - Family and youth peer support (families/youth with lived experience)
- Linkage to social supports and community resources

Important to Ensure:

- Health home services do not duplicate those of other management entities – for example, patient-centered medical homes, managed care organizations, targeted case management providers
  - Develop matrices that show distinct functions of each and interface between health home and these other entities
- Sufficiency of rate
  - In Care Management Entity approaches nationally, care coordination rate ranges from about $780 PMPM to about $1300 PMPM

Other Lessons

- Establish much closer connections from the outset between the organizations responsible for case management and provider organizations
- Address data sharing issues and needs
- Ensure reimbursement for location and enrollment of high risk, high cost enrollees
- Extensive education required to build good relationships with other organizations, be clear on roles, build consistent communication mechanisms
- “Given the intensity of the job, it was difficult to hire the right people to do community-based case management with clients, and there was considerable turnover…Need workforce training that prepares case managers to provide coordinated patient-centered care… and a particular emphasis on training peer support specialists”

Source: New York’s Chronic Illness Demonstration Project: Lessons for Medicaid Health Homes. Center for Health Care Strategies, December 2012.

Federal Medicaid Guidance

7/11/13 State Medicaid Director's Tri-Agency Letter on Trauma-Informed Treatment
http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/SMD-13-07-11.pdf

5/7/13 Informational Bulletin on Coverage of Behavioral Health Services for Children, Youth and Young Adults with Significant Mental Health Conditions
http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-05-07-2013.pdf

3/27/13 Informational Bulletin on Prevention and Early Identification of Mental Health and Substance use Conditions
http://www.medicaid.gov/federal-policy-guidance/downloads/CIB-03-27-2013.pdf

8/24/12 Informational Bulletin on Resources Strengthening the Management of Psychotropic Medications for Vulnerable Populations
http://www.medicaid.gov/Federal-Policy-Guidance/Downloads/CIB-08-24-12.pdf

11/21/11 State Medicaid Directors Tri-Agency Letter on Appropriate Use of Psychotropic Medications Among Children in Foster Care
http://www.medicaid.gov/federal-policy-guidance/downloads/SMD-11-23-11.pdf

Websites

- Health Home Information Resource Center http://www.medicaid.gov/State-Resource-Center/Medicaid-State-Technical-Assistance/Health-Homes-Technical-Assistance/Health-Home-Information-Resource-Center.html

- SAMHSA consultation process and guidance document are available at: http://beta.samhsa.gov/health-reform/health-care-integration/health-homes/establishing-health-home

For More Information

- Download practical resources to improve the quality and cost-effectiveness of Medicaid services.
- Subscribe to e-mail updates to learn about new programs and resources.
- Learn about cutting-edge efforts to improve care for Medicaid's highest-need, highest-cost beneficiaries.

healthhomes@cms.hhs.gov