State Approaches to Children’s System of Care Development

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Technical Assistance Collaborative, Inc.
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Iowa Department of Human Services
Children’s Disability Services Workgroup
# Systems of Care as System Reform

<table>
<thead>
<tr>
<th>From</th>
<th>To</th>
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</thead>
<tbody>
<tr>
<td>• Fragmented service delivery</td>
<td>• Coordinated service delivery</td>
</tr>
<tr>
<td>• Categorical programs/funding</td>
<td>• Multidisciplinary teams and blended resources</td>
</tr>
<tr>
<td>• Limited service availability</td>
<td>• Comprehensive service array</td>
</tr>
<tr>
<td>• Reactive, crisis-oriented approach</td>
<td>• Focus on prevention/early intervention</td>
</tr>
<tr>
<td>• Focus on deep end, restrictive settings</td>
<td>• Least restrictive settings</td>
</tr>
<tr>
<td>• Children out-of-home</td>
<td>• Children within families</td>
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<tr>
<td>• Centralized authority</td>
<td>• Community-based ownership</td>
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<tr>
<td>• Creation of dependency</td>
<td>• Creation of self-help and active participation</td>
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<tr>
<td>• Child-only focus</td>
<td>• Family as focus</td>
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<tr>
<td>• Needs/deficits assessments</td>
<td>• Strengths-based assessments</td>
</tr>
<tr>
<td>• Families as problems</td>
<td>• Families as partners and therapeutic allies</td>
</tr>
<tr>
<td>• Cultural blindness</td>
<td>• Cultural competence</td>
</tr>
<tr>
<td>• Highly professionalized</td>
<td>• Coordination with informal and natural supports</td>
</tr>
<tr>
<td>• Child and family must “fit” services</td>
<td>• Individualized/wraparound approach</td>
</tr>
<tr>
<td>• Input-focused accountability</td>
<td>• Outcome/results-oriented accountability</td>
</tr>
<tr>
<td>• Funding tied to program</td>
<td>• Funding tied to populations</td>
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</tbody>
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MARYLAND

State Approaches to System of Care
Mission/Vision

- Vision (Children’s Cabinet): All Maryland’s children will be successful in life.
- Vision (Gov’s Office for Children): Maryland will achieve child well-being through interagency collaboration and state/local partnerships.
- Mission: The Children’s Cabinet, led by the Executive Director of the Governor’s Office for Children, will work collaboratively to create and promote an integrated, community-based service delivery system for Maryland’s children, youth, and families. Our mission is to improve the well-being of Maryland’s children.
Maryland: Organizing structure

- Promote the vision of the State for a stable, safe, and healthy environment for youth
- Provides a forum for State agencies to meet and develop coordinated policy recommendations
- Prepares a 3 yr plan for establishing priorities
- Reviews and approves grant applications for the Children’s Cabinet Interagency Fund

- Established by Executive Order in 2005
- Responsible for developing and coordinating the delivery of interagency State govt. services to youth & families
- Led by an Executive Director (ED) appointed by the Governor
- ED serves as the Chairperson of the MD Children’s Cabinet
Maryland: Organizing structure

**Children’s Cabinet**

- Makes recommendations for integrated youth and family programs; coordinates with local govt; LMBs and private groups.

**Governor’s Office for Children (GOC)**

- Serve as the coordinators and conveners of collaboration for youth and family services on the local level. Bring together local child-serving agencies, providers, & family members. There are 24 LMBs.

**Advisory Council**

- Provides training and technical assistance
- Research and evaluation
- Certification of Wraparound practitioners
- Policy analysis

**University of MD Innovations Institute**
Maryland: Organizing structure

- **Children’s Cabinet**
  - Co-chairs Joint Committee on CYF
  - LMBs
  - Private citizens
  - Family members
  - Local agency reps

- **Governor’s Office for Children**
  - Budget and Management
  - Disabilities
  - Health & Mental Hygiene
  - Human Resources (child welfare)
  - Juvenile Services
  - Superintendent of Schools
  - Governor’s Office of Crime Control and Prevention

- **Local Management Boards**
  - Local Directors of State Agencies (JJ, Education, County Agencies, Human Resources)
  - Youth
  - Community members

- **Advisory Council**
  - University of MD Innovations Institute
Maryland: Care Management Entity

- In January 2012, GOC issued an RFP to select a statewide care management entity (CME) to serve certain youth with intensive needs

<table>
<thead>
<tr>
<th>Organization/Entity</th>
<th>N of youth</th>
</tr>
</thead>
<tbody>
<tr>
<td>Department of Juvenile Services (DJS)</td>
<td>75</td>
</tr>
<tr>
<td>Department of Human Resources (DHR)</td>
<td>75</td>
</tr>
<tr>
<td>MD CARES &amp; RURAL CARES (SAMHSA SOC grants)</td>
<td>40 (will reduce over time)</td>
</tr>
<tr>
<td>1915 (c) PRTF Waiver</td>
<td>200 (will reduce over time)</td>
</tr>
<tr>
<td>Interim Case Service Account</td>
<td>5 (will reduce over time)</td>
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</tbody>
</table>
The CME will:
- Provide intensive care coordination using a Wraparound service delivery model
- Provide access to family support and youth support partners via a subcontract with family organization
- Facilitate access to community-based service and supports available through LMBs and other community resources
- Administer discretionary (flexible) funds and contract for services as needed
- Conduct assessments
- Conduct quality assurance and monitor outcomes
Services and supports

- CME facilitates linkages to and contracts (as needed) with community resources such as:
  - In-home therapy
  - Mobile crisis and stabilization
  - Behavioral aides
  - Substance use treatment
  - Respite care
  - Evidence-based treatments (FFT, BSFT, MST, SE, MTFC)
  - Individual, family, group therapy
  - Day treatment
  - Peer support
  - Medication management
  - Camp
  - Child care
  - Foster care
  - Mentoring
  - Transportation
Care Management Entity: Financing

CME is paid a case rate

- GOC (Children’s Cabinet) – general funds
- Medicaid administrative claiming for waiver enrollees
- DHR – general funds
- DJS – general funds
- SAMHSA Systems of Care grant funds
Care management for youth with SED

- Recently submitted a 1915(i) State Plan Amendment (out for public comment 9/17/13)
- Eligibility limited to Medicaid eligible youth with serious emotional disturbance with significant functional impairment
- Care coordination using Wraparound process via Care Coordination Organization (aka CME)
Care management for youth with SED

- New services under draft 1915(i) SPA that will be *coordinated* via the CCO
  - Child and Family Team (CFT) participation
  - Intensive In-Home Services
    - Must be an Evidence-based or promising practice approved by DHMH
  - Mobile Crisis Response
  - Community-Based Respite
  - Out-of-Home Respite
  - Peer-to-Peer Support (provided by a Family Support Organization)
  - Expressive and Experiential Behavioral Services
  - Mental Health Consultation to Health Care Professionals
  - Customized Goods and Services
Children’s Cabinet

Advisory Board

Dept of Health and Mental Hygiene

Core service agencies

LMBs

Care Coordination Organization (aka CME) who are TCM providers

ASO (ValueOptions)

1115 waiver

1915(i)
Maryland’s SOC Approach

• Strengths
  – Coordination of youth-serving agencies at the Governor’s Office level
  – Funding to support services at the local level available through Children’s Cabinet Interagency Fund
  – Long history of commitment to SOC values
  – Care coordination available for youth with Medicaid and non-Medicaid enrolled youth
  – Broad array of services and supports available including family and youth support
  – University of MD provides training, certification, consultation, policy analysis, research, and evaluation
Maryland’s SOC approach

• Challenges
  – Different populations of youth served in different CMEs
  – CME/CMOs are not a purchaser of services (with exception of some discretionary funds) and do not authorize care
State Approaches to System of Care

MASSACHUSETTS
Legal action as change agent

- *Rosie D. v. Patrick*, a class action lawsuit filed in 2001 on behalf of children and youth with serious emotional disturbance
- Alleged that MA Medicaid failed to meet obligations of the EPSDT statute
- January 2006, the Court found that MA Medicaid had not provided sufficient:
  - Behavioral health screening in primary care
  - Behavioral health assessments
  - Service coordination
  - Home-based behavioral health services
- Final judgment issued June 2007, with implementation of care coordination and home-based services beginning July 2009
- Medicaid as the sole financer-no blending/braiding with other state systems
Legal action as change agent

- Medicaid as the sole financer-no blending/braiding with other state systems
- Final judgment issued June 2007, with implementation of care coordination and home-based services beginning July 2009
  - Intensive care coordination (Wraparound)
  - Family support and training (Family Partners)
  - Mobile crisis intervention
  - In-home therapy
  - In-home behavioral therapy
  - Therapeutic mentoring
Children’s Behavioral Health Initiative Governance

- Staff positions created at Executive Office of Health and Human Services level to:
  - Coordinate interagency (child welfare, mental health, public health, juvenile justice, education) activities
    - Develop referral and collaboration protocols
  - Facilitate compliance with state’s remedial plan and serve as the liaison for the federal court monitor
  - Collaborate with MassHealth Office of Behavioral Health and other stakeholders

- Children’s Behavioral Health Advisory Council
  - Established via statute
  - Membership consists of Commissioners of child-serving state agencies, education, providers, family members, trade organization reps, academics, and managed care reps
  - Required to submit an annual report, with legislative and regulatory recommendations to the governor, secretary of health and human services, the commissioner of early education and care, the commissioner of elementary and secondary education, the child advocate and the general court
MassHealth Organizational Chart

MassHealth
MA Medicaid Program

MassHealth Managed Care
- Under 65
- No other insurance
- Not institutionalized

MassHealth (Not Managed Care)
- Over 65
- Other insurance
- Institutionalized

Primary Care Clinician (PCC) Plan

Managed Care Organization (MCO) Program

MBHP

Neighborhood Health Plan
Fallon
BMCHP
Network Health
Health New England

Beacon Health Strategies
Community Service Agencies

- Managed care entities contract with 32 CSAs -- one for each service area (29) and three culturally- and linguistically-focused CSAs
- Deliver Intensive Care Coordination and Family Support and Training using the Wraparound care coordination model
- Convene and staff the local System of Care Committee
  - Local state agency reps (e.g. mental health, child welfare, JJ)
  - Local service providers
  - Community organizations and businesses
  - Family and youth
<table>
<thead>
<tr>
<th>Care Coordination for youth with varying needs: Clinical Hubs</th>
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<tr>
<td><strong>Intensive Care Coordination</strong> (Wraparound)</td>
</tr>
<tr>
<td>• Clinical Assessment inc. CANS</td>
</tr>
<tr>
<td>• SED determination for eligibility</td>
</tr>
<tr>
<td>• Medical Necessity determination</td>
</tr>
<tr>
<td>• Care coordination</td>
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</tbody>
</table>

| **In-Home Therapy**                                         |
| • Clinical Assessment inc. CANS                              |
| • Medical necessity determination                           |
| • Care coordination available                               |

| **Outpatient Therapy**                                      |
| • Clinical Assessment inc. CANS                              |
| • Medical necessity determination                           |
| • Care coordination available                               |
Care Coordination

Intensive Care Coordination (Wraparound)
- Clinical Assessment inc. CANS
- SED determination for eligibility
- Medical Necessity determination
- Care coordination

In-Home Therapy
- Clinical Assessment inc. CANS
- Medical necessity determination
- Care coordination available

Outpatient Therapy
- Clinical Assessment inc. CANS
- Medical necessity determination
- Care coordination available

Child may have 1, 2, or all 3 core services
Care coordination provided by most intensive service received.

Emergency Services
Mobile Crisis Intervention

Families decide on most appropriate initial service independently or in consultation with helping professions such as:
- primary care,
- mental health clinicians
- schools
- case workers
- community orgs
- faith leaders
- others

Additional Services
- Behavior Management Therapy & Monitoring
- Family Support and Training (Family Partners)
- Therapeutic Mentoring
- Partial hospital
- Inpatient hospital
- Inpatient diversion
MassHealth Managed Care Entities’ Networks of Providers

Care Planning Team
(Individual Care Plan)

- Other Services, incl. primary care
- In Home Behavioral Services
- Mobile Crisis Intervention
- In Home Therapy Services
- Therapeutic Mentoring
- Family Support and Training
- Outpatient care
- 24-hour acute Care (IP, CBAT)
- Informal Supports

Provider Network
Massachusetts SOC approach

• Strengths
  – Use of evidence-based care coordination model in Wraparound
  – Care coordination available for youth with different intensities of need
  – Strong array of Medicaid behavioral health services and supports
  – Sustainable funding stream through Medicaid state plan
  – “No wrong door” entry for youth
  – Statewide service access
  – Common assessment used across all service providers
Massachusetts SOC approach

• Challenges
  – No access to state financed flexible dollars to support supports identified in a plan of care for a youth
  – Care coordination for non-Medicaid enrolled youth is fragmented across state agencies
  – Neither CSAs (nor the MCEs) purchase or authorize non-Medicaid services or supports making it difficult to leverage these supports on behalf of youth
  – Six MCEs with differing authorization and billing practices places administrative burden on providers
  – Continuity of care can be a challenge when a youth loses MassHealth
State Approaches to System of Care

NEW JERSEY
Governance

• Department of Children and Families
  – Child Protection and Permanency
  – Children’s System of Care
  – Family and Community Partnerships
  – Women
  – Adolescent Services
  – Advocacy
  – Education
  – Licensing
  – Performance Management and Accountability
  – Institutional Abuse Investigation Unit
Division of Children’s System of Care

• Serves youth with:
  – Emotional and behavioral health care challenges
  – Developmental and intellectual disabilities
    • Responsible for determining eligibility for developmental disability services of children under age 18.
  – Serves Medicaid and non-Medicaid eligible youth
University of Medicine & Dentistry of NJ
Behavioral Health Research & Training Institute

- Develop SOC curriculum
- Training & TA
- Certification on assessment tools

Work with families who need care coordination to assist with advocacy and promote family voice in service planning

Family support org (15 county-based)
(expense based contract)

- Single point of entry to obtain behavioral health and IDD services
- Authorize, monitor, and coordinate care and service outcomes
- Publish reports
- Maintain IT system
- Quality management
- Manage the single payer system – process claims to Medicaid

Contracted System Administrator (ASO)
PerformCare
/admin fee

Care management orgs (15 county-based)
(case rate + flex funds)

Medicaid

Community providers

Pays claims
Adj. claim
FFS claim

Modeled on diagram created by Bruce Kamradt
Services and supports

• In addition to care coordination
  – Mobile crisis response
  – Intensive in-home therapy
  – Therapeutic foster care
  – Functional family therapy
  – Behavioral aides
  – Multi-systemic therapy
  – Group homes
  – Residential care
  – Flexible funding available to pay for good and services identified in a plan of care for a youth
Financing

- Mental health
- Child welfare
- Developmental disabilities
- Medicaid
  - Administrative funds
  - Rehab Option
  - EPSDT
  - Targeted Case Management
Single payer system

• CMOs and Mobile Crisis Response providers can make Medicaid presumptive eligibility determinations
• Blended funding from DCF to Medicaid to administer and pay claims
• Created a Medicaid “look-alike” program to cover services for non-Medicaid enrolled youth
• Providers reimbursed at same rate for Medicaid and non-Medicaid youth
• Providers submit all claims to the CSA (ASO)
NJ SOC approach

• Strengths
  – Single payer system
  – Single point of entry
  – Services available to Medicaid and non-Medicaid enrolled youth
  – Training and research infrastructure to support best practice service delivery
  – Training and technical assistance infrastructure
  – Flexible funding available to support needs identified in a youth’s plan of care
NJ SOC approach

• Challenges
  – FSOs disconnected with service delivery -- serving as advocates as opposed to a peer support service
  – Heavy reliance on Medicaid funding makes it challenging to focus on other “non-billable” activities such as training, quality improvement, etc.
Contact Us

Technical Assistance Collaborative, Inc. – TAC

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