Building Systems of Care

July 24-25, 2018
Washington, DC
Agenda – Day Two

8:30am  Welcome, Questions/Thoughts from Day One
        Financing
        - Worksheet and Discussion on Financing

10:00-10:15am  Break

10:15-12:15pm  Purchasing Tied to Quality Measures and Management
        - Worksheet and Discussion on Purchasing Tied to Quality Measures and Management
        Data Systems and Use of Data
        - Worksheet and Discussion on Data Systems and Use of Data
        Final Questions, Thoughts, Contributions

12:15-1:00pm  Lunch

1:00-3:00pm  System of Care “Office Hours” – Opportunity for Individual TA

3:00pm  Concludes
Financing
Strategic Financing Agenda

• Move from a mentality of “funding programs and providing grants” to “collaborative financing to support a strategic agenda”

How do you want to use your dollars to promote a unified agenda and achieve outcomes for shared populations of focus?

Strategic financing begins with cross-system and community stakeholders answering two questions:

Financing for whom???

Financing for what???
Financing for Whom?

- Identify and understand *population(s) of focus*
  - Demographics, e.g., culture/race/ethnicity, economics, etc.
  - Size
  - Strengths, issues and needs

- Analyze Data (quantitative and qualitative)


_The more you understand about your population(s) of focus, the more strategic you can be about financing._
Financing for What?

• What are the outcomes you want to achieve with respect to your identified population(s) of focus?

• This is governed by your values – is there consensus?

Financing for What?

• What outreach and engagement strategies, services and supports, and care coordination approaches will lead to effective outcomes for your identified population(s) of focus?

• Is there a common “practice approach” you want to promote? (SOC approach – strengths-based, family-driven, youth-guided, culturally and linguistically competent, individualized, effective, comprehensive)

Financing for What?

How will services/supports be organized? What is the system design?

- Customization within Medicaid delivery system?
- Changes in what child welfare, juvenile justice, schools, behavioral health systems provide?
- Specialized cross-system capacity? (e.g., Care Management Entities; Family-Run Organizations; Youth-Run Organizations; screening and assessment)

What is the administrative/system infrastructure needed to support the delivery system?

- Training and capacity development?
- IT systems?
- Cross-agency governance?
- Social marketing/strategic communications capacity?
- Quality oversight and outcomes tracking?

How Much Will the SOC Cost?

- How many children/youth can you expect to use services and supports?
- How much of what are they likely to use and for how long?
- What are the costs of the services/supports in your array and of your care coordination approaches?
- What are infrastructure costs to support the system (e.g., training, IT, governance, support for family-run organizations and youth movement)?

If You Have Answered the Questions: Financing for Whom? Financing for What?

✓ Identified your population(s) of focus
✓ Agreed on underlying values and intended outcomes
✓ Identified services/supports and practice model to achieve outcomes
✓ Identified how services/supports will be organized – system design
✓ Identified the administrative/system infrastructure needed to support delivery system
✓ Estimated costs

Then You Are Ready To Talk About Financing Strategies!

Who Controls Dollars for Your Populations of Focus?

<table>
<thead>
<tr>
<th>Medicaid</th>
<th>Child Welfare</th>
<th>Education</th>
<th>Mental Health</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medicaid Inpatient</td>
<td>• CW General Revenue</td>
<td>• ED General Revenue</td>
<td>• MH General Revenue</td>
</tr>
<tr>
<td>• Medicaid Outpatient</td>
<td>• CW Medicaid Match</td>
<td>• ED Medicaid Match</td>
<td>• MH Medicaid Match</td>
</tr>
<tr>
<td>• Medicaid Rehabilitation Services Option</td>
<td>• IV-E (Foster Care and Adoption Assistance)</td>
<td>• Student Services</td>
<td>• MH Block Grant</td>
</tr>
<tr>
<td>• Medicaid Early Periodic Screening, Diagnosis and Treatment (EPSDT)</td>
<td>• IV-B (Child Welfare Services)</td>
<td>• Federal Grants</td>
<td>• MH Block Grant</td>
</tr>
<tr>
<td>• Targeted Case Management</td>
<td>• Family Preservation/Family Support</td>
<td>• Title I</td>
<td>• MH Federal Grants</td>
</tr>
<tr>
<td>• Medicaid Waivers</td>
<td>• CBCAP</td>
<td>• Health</td>
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<tr>
<td>• Health Home option</td>
<td></td>
<td>• Maternal and Child Health</td>
<td>• MH General Revenue</td>
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<tr>
<td>• 1915 I option</td>
<td></td>
<td>• Public Health</td>
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<tr>
<td>• TEFRA Options</td>
<td></td>
<td>• Rural and community health</td>
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<thead>
<tr>
<th>Substance Abuse</th>
<th>Mental Health</th>
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<tbody>
<tr>
<td>• SA General Revenue</td>
<td>• MH General Revenue</td>
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<tr>
<td>• SA Medicaid Match</td>
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<td>• SA Block Grant</td>
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<td>• SA Prevention</td>
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<tr>
<th>Juvenile Justice</th>
<th>Other</th>
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<tbody>
<tr>
<td>• JJ General Revenue</td>
<td>• TANF</td>
</tr>
<tr>
<td>• JJ Medicaid Match</td>
<td>• Developmental Disabilities</td>
</tr>
<tr>
<td>• JJ Federal Grants</td>
<td>• Homeless Programs</td>
</tr>
</tbody>
</table>

Where to Look for Money and Other Support

Government
Federal, State, County, City

Foundations
National, Regional, Community, Family

Individuals
Contributions or Users Fees

Service Clubs
e.g., Kiwanis, Junior League, Lions

Income Generating Activities
e.g., Youth-run business

System Reform Strategic Agenda

Business
Corporate Giving Programs or Small Business; Investors

Taxes and Levies
State and County

3rd Party Reimbursement

Faith-Based Orgs.

Unions

Media

Collaborative Financing

**Wide array of definitions for these terms**

<table>
<thead>
<tr>
<th>Blending/pooling</th>
<th>Braiding</th>
<th>Intentionally Coordinating</th>
</tr>
</thead>
<tbody>
<tr>
<td>• combining funds from multiple sources into one funding pool</td>
<td>• “virtually combining” funds from multiple sources that remain administratively separate</td>
<td>• agreeing across agencies to use separate funding streams for the same goals</td>
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</tbody>
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# Financing Strategies and Structures to Support Improved Outcomes for Children, Youth and Families

**REDEPLOYMENT**
- Using the money we already have
- The cost of doing nothing
- Shifting funds from high cost/poor outcome services to effective practices
- Moving across fiscal years

**REFINANCING**
- Generating new money by increasing federal claims
- The commitment to reinvest funds for families and children
- Foster Care and Adoption Assistance (Title IV-E)
- Medicaid (Title XIX)

**RAISING OTHER REVENUE TO SUPPORT FAMILIES AND CHILDREN**
- Donations
- Special taxes and taxing districts for children
- Fees & third party collections including child support
- Trust funds

**FINANCING STRUCTURES THAT SUPPORT GOALS**
- Seamless services: Financial claiming invisible to families
- Funding pools: Breaking the lock of agency ownership of funds
- Flexible Dollars: Removing the barriers to meeting the unique needs of families
- Incentives: Rewarding good practice

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Redirection

✓ Residential Treatment?
✓ Group Homes?
✓ Detention?
✓ Hospital admissions/re-admissions?
✓ Too long stays in therapeutic foster care?
✓ Inappropriate psychotropic drug use?
✓ “Cookie-cutter” psychiatric and psychological evaluations?

Where are you spending resources on high costs and/or poor outcomes?

Wraparound Milwaukee – Redirected and Pooled Funds

**Wraparound Milwaukee**

- Care Management Organization: $52M

- **Child and Family Team**
  - Plan of Care
  - Intensive Care Coordination

**Schools**
- Youth at risk for alternative placements

**Child Welfare**
- Funds thru Case Rate
  - (Budget for Institutional Care for Children-CHIPS)

**Juvenile Justice**
- (Funds budgeted for Residential Treatment for Youth w/delinquency)

**Medicaid Capitation**
- ($1923 per month per enrollee)

**Mental Health**
- Crisis Billing
- Block Grant
- HMO Commercial Insurance

**Per Participant Population Case Rates**
- From CW, JJ, and ED range from about $2000 pcpm to $4300 pcpm – tied to outcomes

**All inclusive rate (services, supports, placements, care coordination, family support)**
- $3700 pcpm
- Care coordination portion is about $780 pcpm

**Provider Network**
- 210 Providers
- 70 Services

**Families United**
- $440,000

**Mobile Response & Stabilization**
- Co-funded by schools, child welfare, Medicaid & mental health

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Wraparound Milwaukee. (2010). *What are the pooled funds?* Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch.
DAWN Project
Indianapolis, IN
Redirection and
Braided Funds

$4,088 + $166 = $4,254 PMPM

Child Welfare

Juvenile Justice

Department of Mental Health

Special Education

RAINBOWS (Family Organization)

Dawn Project Cost Allocation

DAWN Funding – Utilization

CFT and Care Coordination Structure

90% Direct Services
550 Vendors

6% Indirect Expenses

4% Administrative

2005 CHIOCES, Inc., Indianapolis, IN
Cuyahoga County (Cleveland) EX: Redirection and “Virtual” Pooled Funds


#LEADINGCHANGE
Examples of Refinancing

Milwaukee County, WI
Schools and child welfare contributed $450,000 each to expand mobile response and stabilization services (prevent placement disruptions in child welfare, prevent school expulsions)

Is a Medicaid-billable service; contributions from schools and child welfare generate $180,000 to the school contribution and $200,000 to child welfare’s in Federal Medicaid match dollars

Cuyahoga County, OH
Cross-walked Wraparound skill sets to Medicaid billing categories because Wraparound was not yet specifically covered

Raising New Revenue

- **Prop 63 in California** (1% income tax on millionaires)
- **Florida counties** – children’s trust funds
- **Jackson Co., KN** – 1.3% per $100 property tax for mental health
- **Spokane Co., WA** – 0.1% sales tax for mental health
- **Social Impact Bonds** – SC, NYC (new $100m fund)

# Examples of Medicaid Options

<table>
<thead>
<tr>
<th>Medicaid Option</th>
<th>Advantages</th>
<th>Issues</th>
<th>Example</th>
</tr>
</thead>
<tbody>
<tr>
<td>Rehabilitation Services Option</td>
<td>• Flexibility to cover a broad array of services and supports provided in different settings (e.g., home, school)</td>
<td>• Service definitions often adult-oriented</td>
<td>• Most states</td>
</tr>
<tr>
<td>Managed Care Demos and Waivers - 1115 and 1915 (b)</td>
<td>• Accountability and management of cost through risk structuring/sharing • Flexibility to cover wide range of services and populations</td>
<td>• Managed care not without risks/challenges • Federal waiver process can be challenging • Cost neutrality issues</td>
<td>• Most states</td>
</tr>
<tr>
<td>Home and Community-Based Waivers - 1915 (c)</td>
<td>• Flexibility, broader coverage, waiver of income limits and comparability</td>
<td>• Alternative to hospital-level of care, but residential treatment may be issue • Cost and management concerns so limited to small number</td>
<td>• KS, NY, VT, IN, WI, LA – have HCBS Waivers • AK, FL, GA, IN, KN, MD, MS, MT, SC, VA – had community alternatives to psychiatric residential treatment facilities demonstration grant</td>
</tr>
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### Examples of Medicaid Options

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</table>
| Early and Periodic Screening, Diagnosis and Treatment - EPSDT | • Broadest entitlement  
• Supports integrated physical and behavioral assessments and services  
• No waiver or state plan amendment requirements | • Management mechanism critical because of cost concerns  
• Oriented more to physical health in practice  
• EPSDT BH lawsuits | • All states |
| Targeted Case Management                            | • Can be focused on high need populations  
• Supports small case load focus (e.g., 1-10) - Wraparound | • Not sufficient without other services  
• Must avoid duplication of care coordination functions | • MA  
• NJ |
| Medicaid Administrative Dollars                     | • Ability to cover basic case management services to support enrollment access  
• System navigation, outreach | • Not sufficient without other services | • NJ – covering some activities of family-run organizations  
• PA BHOs in some counties paying for Wraparound |
### Examples of Medicaid Options

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<tr>
<td>Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA)</td>
<td>• Avenue to eligibility to community-based services for children who meet SSI disability criteria – allows disregard of family income</td>
<td>• SSI criteria not easy to meet for children with SED • Does not expand types of covered services • Cost issues, so generally small program</td>
<td>• MN • WI</td>
</tr>
<tr>
<td>Medicaid as Part of a Blended or Braided Funding Approach (with or without a waiver)</td>
<td>• Holistic, integrated (across systems) financing, supports broad array of services, natural supports and individualized care</td>
<td>• Involves significant restructuring</td>
<td>• Milwaukee Wraparound • Massachusetts Mental Health Services Program for Youth • New Jersey Partnership</td>
</tr>
</tbody>
</table>
Flex Funds: Customized Goods and Services

• Purchase non-recurring set-up expenses (furniture, bedding, clothing)

• One-time payment of utilities, rent or other expenses as long as the youth and family demonstrate the ability to pay future expenses

• Academic coaching, memberships to local girls or boys clubs, etc.

• Particularly useful when a youth is transitioning from residential treatment setting to family or independent living

• Available to individuals participating in various Medicaid waivers and/or the 1915(i) program
Relationship between Medicaid Service Definition (Allowable Activities) and Rate

Example: Peer Support

- Does the service definition allow for ---
  - Telephone time?
  - Transportation? Meals? Lodging?
  - Documentation time?
  - Supervision/coaching?
  - Training?

- How many hours of service (per day, per week, per month, per year) are allowed?
- What are the requirements for who can provide the service?
- Is training required? Certification?
- Does rate reflect all the activities involved?

Pires, S. 2017, National TA Network for Children’s Behavioral Health webinar
New Jersey Federal Funding Mechanisms

- Medicaid Rehab Option: In-home services, EBPs, Mobile Response and Stabilization, Therapeutic Foster Care
- Targeted Case Management: Care Management Entities
- Medicaid Health Home State Plan Amendment: Wellness, Primary Care Integration
- Medicaid 1115 Research and Demonstration Waiver: SUD services, transportation
Financing Family- and Youth-Run Organizations

- State or county contracts with government agencies such as mental health, juvenile justice, child welfare, etc.
- Subcontracts with larger organization initiatives (e.g. TA Network and FREDLA)
- Medicaid reimbursement for covered services (peer support)
- Medicaid managed care organizations – reinvestment funds, “in lieu of” funds, admin dollars
- Accountable Care Organizations – system navigation, outreach, peer support, care coordination
- Private foundations
- Public awareness fundraising activities: annual campaigns, events, and donors/sponsor relationships
- Federal grants (e.g., SAMHSA Initiatives, Statewide Family Network grants, Child welfare etc.)

Parent Support Network of Rhode Island Funding

• SAMHSA – Mental Health Block Grant
• CBCAP Funds
• Title IV-B

• State Service Contracts:
  • Department of Children, Youth & Families
  • Department of Health
  • Department of Education
  • Department of Behavioral Healthcare, Developmental Disabilities & Hospitals

Conlan, L. 2018. Parent Support Network of Rhode island
Family Involvement Center
Maricopa County, AZ

✓ Contract with State mental health agency
✓ Medicaid MCO “administrative functions” contract
✓ Medicaid MCO contract as provider in network
✓ Contract with State child welfare agency

Financed initially by State legislative appropriation; now financed by:

- State general revenue (Mental Health)
- Tobacco settlement
- Federal Mental Health block grant
- Federal discretionary grant
- Medicaid billable services
- Child welfare (General Revenue and IV-E waiver)

Cost Efficiency: Adopting Culturally Competent Systems

• Using funds efficiently – Keeping track of population data and needs helps use funds for real (rather than assumed) needs

• Reducing errors and decreasing costs – Effective care can help avoid lower adherence to treatment, poorer health outcomes and unnecessary diagnostic services

• Improving the effectiveness of treatment plans and creating more timely recovery – Language barriers can cause treatment to take 25-50% longer for individuals with limited English proficiency

• Avoiding legal and regulatory risks – Complying with CLAS can help avoid lawsuits related to inadequate informed consent and violations of federal laws (e.g., Title VI and the Americans with Disabilities Act).

From Making CLAS Happen (2013) Commonwealth of Massachusetts, Dept. of Public Health
Cross-Agency Analysis of Expenditures and Utilization

Expenditure and Utilization Questions

1. Which state and/or county agencies spend dollars on your population(s) of focus?
2. How much do they spend? In total and by service type?
3. What types of dollars are spent (e.g., entitlement, general revenue, block grant)?
4. How many children and youth use services? In total and by service type?
5. How much service do they use? What is average length of stay/tenure by service type?
6. What are the characteristics of these children and youth (e.g., by age, gender, race/ethnicity, diagnosis, region)?

Using Financial Analysis Data

Example: What Drives Costs (and often poor outcomes) for Youth with Behavioral Health Challenges?

- Use of Residential Treatment, Group Homes, Psychiatric Inpatient (and Day Treatment)
- Inappropriate use of psychotropic medications
- Use of traditional outpatient therapies – lack of evidence of benefit
- Psychosocial rehab services – are they built for adults? Or encompass effective practices for children and youth?
- Duplication of Services, e.g., multiple assessments and care coordinators

### Using Data: Medicaid Enrollment and Behavioral Health Service Use by Race/Ethnicity

<table>
<thead>
<tr>
<th>Race/Ethnicity</th>
<th>Percentage</th>
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<tbody>
<tr>
<td>NH/PI</td>
<td>0.5%</td>
</tr>
<tr>
<td>AI/AN</td>
<td>1.2%</td>
</tr>
<tr>
<td>Asian</td>
<td>2.4%</td>
</tr>
<tr>
<td>NH/PI</td>
<td>0.2%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>1.4%</td>
</tr>
<tr>
<td>Asian</td>
<td>0.7%</td>
</tr>
</tbody>
</table>

#### All Children in Medicaid*

- **8%** Other/Unknown
- **23%** Native Hawaiian or Pacific Islander
- **23%** American Indian or Alaska Native
- **37%** Asian
- **47%** Hispanic or Latino
- **28%** Black or African American
- **23%** White/Caucasian

#### Behavioral Health Service Users**

- **11%** Other/Unknown
- **23%** Native Hawaiian or Pacific Islander
- **17%** American Indian or Alaska Native
- **23%** Asian
- **47%** Hispanic or Latino
- **20%** Black or African American
- **20%** White/Caucasian

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Summary of Financing Strategies for Systems of Care

- Maximize Medicaid
- Blend, braid or intentionally coordinate funding streams across systems
- Redirect spending from high cost and/or poor outcome services to effective practices
- Manage dollars through managed care arrangements that are tied to values and goals
- Risk adjust payment for complex populations of children (e.g., risk-adjusted capitation rates to MCOs; case rates to providers)
- Finance:
  - Locus of care coordination accountability, e.g., intensive care coordination with fidelity Wraparound for youth with most complex, cross-system challenges
  - Family and youth partnerships at policy, management and service levels
  - Training, capacity building, quality and outcomes monitoring
  - Broad, flexible array of services and supports

Break
Purchasing Tied to Quality
Examples of Incentives to Providers

• Decent rates
• Flexibility and control
• Timely reimbursements
• Back up support for difficult administrative and clinical challenges
• Access to training and staff development
• Capacity building grants
• Less paperwork

Value-Based Purchasing

Performance-Based Payment Structures

Value Based purchasing refers to any purchasing practices aimed at improving the value of health care services, where value is a function of both quality and cost... (Source: Agency for Healthcare Research and Quality)

Incentive Payments – Providers are rewarded (bonuses, share in savings) or penalized (reductions in payments) based on meeting pre-established targets or benchmarks for measures of quality and/or efficiency and/or outcomes.

| CT: enhanced FFS payments to BH clinics for weekend/off-hours | MI: payments over and above the capitation rates for Medicaid-enrolled children involved with child welfare who have serious mental health conditions | Choices, Inc and Wraparound Milwaukee – population case rates with shared savings and risk for reducing use of residential treatment and psych inpatient |

Payment Approaches

- **Fee for service** - payment for a unit of service provided
- **Capitation rates** – fixed per member per month rate for every eligible user
- **Population case rates** – fixed per member per month for every actual user for all costs or for some costs
  - In fidelity intensive care coordination/Wraparound approaches, all-inclusive cost of care (e.g., admin, care coord, placements, clinical treatment, informal supports) averages $3700-$4200 pmpm – compare to $9,000 pmpm in PRTFs, higher in psych inpatient
- **Bundled episodes of care or bundled service rates** – based on expected costs for a clinically defined episode or bundle of related health care services
- **Bundled care coordination rates** – per member per month rate
  - Intensive care coordination rates for youth with complex BH needs range from $780 pmpm to $1300 pmpm (CHCS Matrix)
- **Enhanced fee-for-service rates**

Capitation and Case Rate Distinctions

**Capitation**
Pays MCOs or providers a fixed rate per *eligible* user

*Incentive:*
1) Prevent eligible users from becoming actual users (e.g., make it difficult to access services; engage in prevention)
2) Control the type and volume of services used

**Case Rate**
Pays MCOs or providers a fixed rate per *actual* user

*Incentive:*
1) Control the type and volume of services used

Purchasing/Contracting Options

Pre-Approved Provider Lists:
+ Flexibility for system of care
+ Choice for families
- Could disadvantage small indigenous providers
- Could create overload on some providers

Risk-Based Contracts
+ Flexibility for providers
+ Individualized care for families
- Potential for under-service
- Potential for overpaying for services

Fixed Price/Service Contracts
+ Predictability and stability for providers
- Inflexible—families have to “fit” what is available

Which Payment Models To Use

1. Fee-for-service – depends on high volume, low rates
2. FFS with performance incentives and enhanced rate
   • Negotiate higher rates for desired outcomes, e.g., EBP, ready access, more challenging populations
3. Population management – more flexibility, higher risk
   • Bundled care coordination rate
   • Population case rate
   • Shared savings/risk

Progression of Financial Risk by Purchasing Arrangement

<table>
<thead>
<tr>
<th>RISK TO SYSTEM OF CARE</th>
<th>RISK TO PROVIDER</th>
<th>TYPE OF CONTRACTING ARRANGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>HIGHEST RISK</td>
<td>LOWEST RISK</td>
<td>• Grant</td>
</tr>
<tr>
<td></td>
<td>LOWEST RISK</td>
<td>• Fee-for-Service</td>
</tr>
<tr>
<td></td>
<td>HIGHEST RISK</td>
<td>• Case Rate</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Capitation</td>
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Wraparound Milwaukee – Population Case Rates and Capitation Tied to Outcomes

Per Participant Population Case Rates from CW, JJ and ED range from about $2000 pcpm to $4300 pcpm – tied to outcomes

All inclusive rate (services, supports, placements, care coordination, family support) of $3700 pcpm; care coordination portion is about $780 pcpm

Use CANS

Wraparound Milwaukee, (2010). *What are the pooled funds?* Milwaukee, WI: Milwaukee County Mental Health Division, Child and Adolescent Services Branch.
## Performance Incentives Tied to Quality and Outcomes Measures

<table>
<thead>
<tr>
<th>Type of Measure</th>
<th>Measure</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BH Utilization and Expenditures by population characteristics</strong></td>
<td>• Race, ethnicity, gender, age cohorts- children, youth and young adults, zip code/community; and aid category</td>
</tr>
<tr>
<td><strong>Structural Measures</strong></td>
<td>• Provider network adequacy (e.g., % of EBPs, racially/ethnically/linguistically diverse providers; geographic distribution)</td>
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<tr>
<td></td>
<td>• Rate of children/adolescents per 1,000 of the eligible population diagnosed with mental health or substance use disorders that have received mental health or SUD treatment</td>
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<tr>
<td></td>
<td>• Number of behavioral health providers with training in early childhood issues per child enrollee under age six</td>
</tr>
<tr>
<td></td>
<td>• Care coordinator caseload size</td>
</tr>
<tr>
<td><strong>Process Measures</strong></td>
<td>• Fidelity to EBPs</td>
</tr>
<tr>
<td></td>
<td>• Wait times for services</td>
</tr>
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<td></td>
<td>• Timely provider payments</td>
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<td></td>
<td>• Time to mobile crisis response</td>
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</tbody>
</table>
## Outcome Measures

**Functioning:**
- Percent of children/adolescent in behavioral health services who have improved, maintained, or reduced levels of need/symptoms

**Community:**
- Compares enrollment entry adjudications and formal charges to number of adjudications and formal charges during enrollment
- Percent of enrolled school age children/adolescents whose unexcused absences have decreased while receiving services
- Compares total number of school days possible to total number of school days attended – at monthly intervals
- Compares days in the community vs days in out of home

**Family and youth satisfaction:**
With a minimal threshold established of 4.0 out of 1-5 scale; compiled and reported 2x/year

**Costs:** moving beyond descriptive utilization totals
- Costs of all services and supports provided compared to costs of diverted care (hospital, detention, and residential)

**Numbers of children on 2, 3, 4 plus psychotropic meds; on specific classes of meds**

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Performance Measures Tied to Payment

Connecticut
- Enhanced Clinic Payment for OP services with a focus on Access
  - Targets for routine, urgent and emergent care
  - Requires MOUs with primary care
  - Weekend and evening hours
  - Screening targets for co-occurring conditions

Oregon Coordinated Care Organizations
- Seventeen measures used, the following are specific to BH or relevant to BH
  - Satisfaction with care
  - Screening for clinical depression and follow-up
  - Adolescent Well-Care visits
  - Follow-up care for children prescribed ADHD medication
  - Access to Care
  - Alcohol or other substance misuse screening
  - ED utilization
  - Developmental screening in first 36 months

Oklahoma Enhanced Tier Payment System

- Oklahoma Department of Mental Health and Substance Abuse Services (ODMHSAS) designed a performance outcomes payment plan with an overarching goal to proactively increase the recovery of Oklahomans from mental illness and substance abuse.

- Performance payment is based on the number of members attributed to the provider and agency performance on each measure (meaning providers can earn a bonus for individual measures as opposed to “all or nothing”).
  - Facilities are divided into four tiers based upon their relative performance.
  - Those in the lowest tier earn zero incentive dollars; those in the next lowest tier earn 50% of their allotment; those in the next tier earn 100% of their allotment; and, those in the highest tier earn 150% of their allotment.
### Oklahoma Measures

<table>
<thead>
<tr>
<th>Measure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Outpatient Crisis Service Follow-up within 8 Days</td>
<td>Follow-up within 8 Days</td>
</tr>
<tr>
<td>Inpatient/Crisis Unit Follow-up within 7 Days</td>
<td>Follow-up within 7 Days</td>
</tr>
<tr>
<td>Medication Visit within 14 Days of Admission</td>
<td>Medication Visit within 14 Days of Admission</td>
</tr>
<tr>
<td>Access to Treatment - Adults</td>
<td>Access to Treatment - Adults</td>
</tr>
<tr>
<td>Improvement in CAR Score: Self Care/Basic Needs Domain</td>
<td>Improvement in CAR Score: Self Care/Basic Needs Domain</td>
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<tr>
<td>Improvement in CAR Score: Medical/Physical Domain</td>
<td>Improvement in CAR Score: Medical/Physical Domain</td>
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<tr>
<td>Improvement in CAR Score: Interpersonal Domain</td>
<td>Improvement in CAR Score: Interpersonal Domain</td>
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<tr>
<td>Improvement in CAR Score: Self Care/Basic Needs Domain</td>
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</tr>
<tr>
<td>Inpatient/Crisis Unit Community Tenure of 180 Days</td>
<td>Inpatient/Crisis Unit Community Tenure of 180 Days</td>
</tr>
<tr>
<td>Peer Support: % of Clients Who Receive a Peer Support Service</td>
<td>Peer Support: % of Clients Who Receive a Peer Support Service</td>
</tr>
<tr>
<td>Access to Treatment – Children: The interval between initial contact and receipt of treatment services</td>
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</tr>
</tbody>
</table>

#### Access to Treatment – Children:

- **Bonus**: See clinician for screening in 0-3 days
- **2 pts.**: Come in within 4-5 days and will see clinician
- **1 pt.**: Come in for paperwork 1-5 days, but won’t see clinician
- **0 pts.**: Anything else
Optum-Multiple States

- Enhanced payment to Outpatient Providers
- Ratings focus on quality and cost targets:
  - One star for defined quality metric targets
  - One star for cost targets
- Separation of targets allows providers to gain from meeting quality targets even if can’t meet cost; and protects against exclusive focus on cost by requiring those who meet cost targets to also meet quality targets
Wraparound Milwaukee Quality and Outcome Measures

1) **Care Coordinator Productivity** – time spent per month per family providing service to family/youth or engaging in communication with child/family team members; standard is 14 hours per month per family; can include up to 8 hours of Medicaid-billable crisis time; reported 2x/yr on Care Coordination Agency Performance Report

2) **Face-to-Face Contacts** – standard is one face-to-face contact per week; reported 2x/yr on Care Coordination Agency Performance Report

3) **Child/Family Team Meeting** – standard is first one must be held within 30 days; then monthly after

4) **Number of Successful Disenrollments** – 75% or greater for: parent and youth perception of change (disenrollment survey); needs being met (Needs Ranking Scoring); permanency plan achieved

5) **Informal Supports** – standard is 100% of plans of care include at least 50% of the supports being informal

6) **Family Activities** – family and youth engagement activities for all families/youth served offered 1x/month

7) **Care Coordinator Productivity** – time spent per month per family providing service to family/youth or engaging in communication with child/family team members; standard is 14 hours per month per family; can include up to 8 hours of Medicaid-billable crisis time; reported 2x/yr on
Wraparound Milwaukee Quality and Outcome Measures

8) Care Coordination Agency Performance Report

9) *Face-to-Face Contacts* – standard is one face-to-face contact per week; reported 2x/yr on Care Coordination Agency Performance Report

10) *Child/Family Team Meeting* – standard is first one must be held within 30 days; then monthly after

11) *Number of Successful Disenrollments* – 75% or greater for: parent and youth perception of change (disenrollment survey); needs being met (Needs Ranking Scoring); permanency plan achieved

12) *Informal Supports* – standard is 100% of plans of care include at least 50% of the supports being informal

13) *Family Activities* – family and youth engagement activities for all families/youth served offered 1x/month

14) *Functioning* – uses CANS to assess

15) *Living Environment* - compares % of days in a restrictive setting (inpatient, RTC, detention, group home, shelter facility to % of days in a community-based setting (home, foster care, living with relative, independent living) - 2x/year
Wraparound Milwaukee Quality and Outcome Measures

16) **Functioning** – uses CANS to assess

17) **Living Environment** - compares % of days in a restrictive setting (inpatient, RTC, detention, group home, shelter facility to % of days in a community-based setting (home, foster care, living with relative, independent living) - 2x/year

18) **Community Safety** – compares enrollment entry adjudications and formal charges to number of adjudications and formal charges during enrollment

19) **School attendance** – compares total number of school days possible to total number of school days attended – at monthly intervals

20) **Family and youth satisfaction with care coordination** – surveys mailed to every family and youth at 1 month, 6, 12, disenrollment; threshold is average score of 4.0 out of 1-5 scale; compiled and reported 2x/year on care coordination agency performance report

21) **Family and youth satisfaction with provider network services** – surveys mailed to every family and youth at 4 and 9 mos; threshold is 4.0 out of 1-5 scale; results provided to providers with request to respond to negative comments and results reported in 2x/year QI report
New Jersey Quality Improvement Plan

- Data
- Rigorous Debrief
- Training and Workforce Development
- Systems Review
- Local Feedback Loops
Data

“If we have data, let’s look at data. If all we have are opinions, let’s go with mine.”

Jim Barksdale, former CEO, Netscape
The Importance of Data

Understanding the data = Understanding opportunities to improve the quality and cost of care

Big Data

Information generated across a number of varied sources (e.g., multiple agencies) leading to large, complex, diverse data sets versus Information from a single data source (single agency), though that data also can be large and complex

Big Data Analytic Factors

- Volume
- Velocity (generation and accessibility speed)
- Variety (diverse types of data)
- Veracity (accuracy)
- Value (is it worthwhile data, worth the time and effort)

Data Infrastructure

A. Service System Silos
   Little information sharing

B. Service System Silos
   Some cross-system sharing

C. Integrated Silos
   Cross-system sharing utilizing an external structure

D. Integrated System
   Information sharing through consistent infrastructure

Cross-system sharing using an external data warehouse

- Memoranda of Understanding across child-serving Agencies: FL Dept of Children and Families, FL Dept of Juvenile Justice, Miami-Dade Public Schools

- Confidentiality and data sharing agreements
Montgomery County, Maryland Department of Health and Human Services “No Wrong Door”

Integrated System Information sharing through consistent infrastructure

- Confidentiality and data sharing agreements – took 18 months
- Common face sheet to identify needs and allow immediate electronic referral

Wraparound Milwaukee Information Technology System

• One electronic health record and single information system links all care coordinators, providers and system purchasing partners

• *Synthesis* IT system developed by Wraparound Milwaukee has now been purchased by other communities and states

Gathering Data

- Questionnaires
- Surveys
- Interviews
- Focus groups
- Clinical outcome data
- Claims/administrative data

- Participatory action research
- Network analyses
- Financial analyses
- Chart reviews

How Data Are Used in Systems of Care

• Planning & Decision Support
• Utilization Management
• Continuous Quality Improvement
• Cost & Outcomes Monitoring
• Research & Evaluation
• Social Marketing
• Accountability
• Education & Advocacy

Using Data to Inform Utilization Management

Who is using services?
What services are being used?
How much service is being used?
What is the cost of the services being used?
What effect are the services having on those using them? (i.e., are clinical/functional outcomes improving? Are families and youth satisfied?)

Using Data to Inform Quality: Michigan Example

Uses data on child/family outcomes (CAFAS) to:

- Focus on quality statewide and by site
- Identify effective local programs and practices
- Identify types of youth served and practices associated with good outcomes (and practices associated with bad outcomes)
- Inform use of evidence-based practices (e.g., CBT for depression)
- Support providers with training informed by data
- Inform performance-based contracting

QI Initiative designed and implemented as a partnership among State, University and Family Organization

Using Data to Track Access by Diverse Families

THE MIRROR PROJECT, Jacksonville System of Care Initiative

- Organizational Values
- Governance, Planning, Monitoring & Evaluation
- Communication & Language Assistance (illustrated)
- Training & Staff Development
- Family/Youth Participation
- Service Delivery (N=5)

For more information contact: Selena Webster-Bass, MPH, selenawb@coj.net, Jacksonville System of Care Initiative
Using Data to Track Progress: Evaluation of a Natural Helper Program - EQUIPO

Using Data to Track Progress: Evaluation of a Natural Helper Program - EQUIPO

Using Evaluation Data: Attitude & Knowledge Shifts

<table>
<thead>
<tr>
<th>Measures [N=107]</th>
<th>PRE Mean</th>
<th>POST Mean</th>
<th>Change</th>
</tr>
</thead>
<tbody>
<tr>
<td>“My comfort level with people perceived as gay, lesbian, or bisexual is:” 1=Very Uncomfortable, 2=Somewhat Uncomfortable, 3=Unsure, 4=Fairly Comfortable, 5=Very Comfortable</td>
<td>4.1</td>
<td>4.4</td>
<td>+ 0.3</td>
</tr>
<tr>
<td>“My comfort level with people perceived as transgender is:” 1=Very Uncomfortable, 2=Somewhat Uncomfortable, 3=Unsure, 4=Fairly Comfortable, 5=Very Comfortable</td>
<td>3.8</td>
<td>4.4</td>
<td>+ 0.6</td>
</tr>
<tr>
<td>“When possible, I will speak up when someone is bullied with gender-based or anti-gay slurs:” 1=Never, 2=Very Rarely, 3=Sometimes, 4=Often, 5=Always</td>
<td>3.4</td>
<td>4.4</td>
<td>+ 1.0</td>
</tr>
<tr>
<td>“I feel equipped to handle a situation that could arise regarding gender or orientation.” 1=Strongly Disagree, 2=Disagree, 3=Unsure, 4=Agree, 5=Strongly Agree</td>
<td>3.5</td>
<td>4.2</td>
<td>+ 0.7</td>
</tr>
<tr>
<td>“I am knowledgeable of the specific challenges facing youth and families regarding gender &amp; orientation:” 1=Strongly Disagree, 2=Disagree, 3=Unsure, 4=Agree, 5=Strongly Agree</td>
<td>3.9</td>
<td>4.2</td>
<td>+ 0.3</td>
</tr>
</tbody>
</table>
New Jersey Tracking Evidence of Progress

- Increase in Access to Care
- Decrease in over reliance in out of home treatment
- Decrease in over reliance on detention with 9 centers closing
- Decrease by 70% the population of youth who are on Probation
- The only state hospital has closed
- Have brought all children with behavioral health challenges home to NJ
- Decrease in use of restraint, seclusion and coercion in all out of home treatment interventions.
New Jersey Return on Investment

ROI Analysis of the CSOC Expansion

21-42 months

Baseline ROI Analysis and Refine Analysis Plans
Months 13-20

Prepare Data for ROI Analysis
Months 7-12

Develop ROI Analysis Plan
Months 1-6
New Jersey Tracking Progress

Youth in Behavioral Health Out of Home Treatment Settings
2010 - October 2017

Section 4: Page 7
Why Analyze Medicaid Data

- Medicaid is the largest funder of behavioral health care for children and youth
- To be effective and sustainable, system of care reforms must impact Medicaid delivery systems
- Understanding child behavioral health utilization and expense in Medicaid can guide quality improvement efforts affecting most children and youth involved with systems of care

Why Analyze Medicaid Data

- Can Identify Opportunities to:
  
  Maximize Medicaid and re-direct spending from high-cost, poor outcome spending – e.g. from facility-based care to home and community-based services, peer support and effective care coordination using fidelity Wraparound

  Address appropriate use of psychotropic medications

  Address disparities and disproportionality in access, in type of service used, in psychotropic medication rate and use - based on gender, age, race and ethnicity, aid category (TANF, Foster Care, SSI/Disabled) and geography

Why Analyze Medicaid Data

- Can project number of children with co-morbidities by examining physical health use and expense among children who use behavioral health care
- Can identify children with top 10% most expensive use to project numbers for health homes and intensive care coordination using Wraparound
- Can compare your State’s utilization and expenditures to national child behavioral health use and expense
- Can establish benchmarks related to system of care goals (e.g., access, reduced disparities, increased use of home and community based services and peer support, reduced use of facility-based care)

New York State Medicaid Managed Care Organization Data Requirements

**New York State Children’s Health and Behavioral Health Benefit**

New requirements and standards for Medicaid Managed Care Organizations related to Children’s System Transformation

MCO BH QM must review and analyze data and develop/approve interventions related to:

- Under and over utilization of BH services and cost data
- Inpatient admission and readmission rates, trends and ALOS
- Inpatient and outpatient civil commitments
- Follow-up after discharge from MH inpatient, SUD inpatient and residential
- SUD initiation and engagement
- ER and crisis service use
- BH prior auth/denial and notices of action
- Psychotropic medication use with a separate analysis for foster care
- Rates of initiation and engagement of individuals with FEP
- Addiction medication use
- Transition issues for 18-23 yr olds, focusing on continuity of care

#LEADINGCHANGE
New York State Medicaid Managed Care Organization Data Requirements

New York State Children’s Health and Behavioral Health Benefit
New requirements and standards for Medicaid Managed Care Organizations related to Children’s System Transformation

For children eligible for home and community-based services:
• Use of crisis and crisis diversion services
• Prior auth/denial and notices of action
• HCBS utilization
• HCBS quality assurance performance measures as determined by the State and pending CMS requirements
• Enrollment in Health Home
Faces of Medicaid: Examples of Promising Findings

- Penetration rates ↑ overall
- Greater access by most racial/ethnic groups
- Greater access by girls
- Greater access by 0-5 population
- Use of broader range of home and community-based services

Faces of Medicaid: Examples of Concerning Findings

- 8% penetration rate for use of BH services (while up), remains well below prevalence estimates of need
- Disproportionately low rates of use for Hispanic/Latino, Asian, and Native Hawaiian/Pacific Islander children
- Disproportionately low utilization rates for girls
- Disproportionately low rates of use for 0-5 population
- Residential treatment ↑
- Inpatient psychiatric ↑
- Persistently high rates of residential treatment and inpatient psych use for foster care population
- Rate of psychotropic medication use ↑, and close to half of children on meds did not receive accompanying behavioral health services
- Utilization rates of peer support, MST, Wraparound (while up) remain very low

Faces of Medicaid: Types of Questions/Issues Raised by Data

- Most frequent diagnosis for 0-5 population was Conduct Disorder – May mask learning problems? Trauma?
- Rate of PTSD diagnosis at 6% may be low?
- ADHD remains most frequent diagnosis – are children being over-diagnosed?
- Black/African American children most likely to receive ADHD diagnosis and least likely to receive diagnoses of Mood Disorder, Anxiety and PTSD – are these children being misdiagnosed?
- Children in Medicaid using BH care are 11% of the Medicaid child population and consume 36% of all Medicaid child expenditures, and their mean expense is over 4x that of children who do not use BH care – what are the best value-based strategies for improving the cost and quality of care for these children?

Final Thoughts before Lunch and Individual TA
“Office Hours” Post-Lunch
Individual TA