

**Maryland Wraparound Model**  
**Request to Amend Section 1115 Health Care**  
**Reform Demonstration**  
**(Project No. 11-W-00099/3)**

**February 13, 2006**

## **Introduction**

Maryland Medicaid seeks to amend its Medicaid section 1115 health care reform demonstration, HealthChoice (project No. 11-W-00099/3), to pilot a “wraparound” model of community-based service delivery for children with serious emotional disturbance (SED). The wraparound model is a family-driven, community-based, inter-agency cooperative model. Each child’s plan of care is tailored to that child and family’s individual needs. Under this model, a care managing entity (CME) will receive a set payment rate in exchange for delivering a specific package of specialty mental health services (i.e., “partial” capitation) to children and youth who voluntarily elect this service delivery option.

This program would serve children and youth who are determined community eligible for Medicaid or the Maryland Children’s Health Program (MCHP). This program would not expand Medicaid or MCHP eligibility. Capitation rates will be based on historical fee-for-service cost data for Medicaid-covered services. Because this population is already covered under Medicaid or MCHP, and because the capitation rates will be based on the existing benefit package, this program will be budget neutral. The population that is eligible for and elects this option would no longer access most specialty mental health services in the fee-for-service specialty mental health system, but would receive most of this care through the CME.

In addition to providing the specified package of specialty mental health services, the CME(s) may use the rate to provide non-Medicaid covered services, with the goal of preventing the need for more intensive services. The CME(s) will individualize the package of benefits to the needs of the child and to build on the strengths of the child’s family and community. The goal is to serve children in the community as opposed to institutions such as residential treatment centers (RTCs), and regional institutes for children and adolescents, (RICAs), the State-run equivalent of RTCs. Currently, lengths of stay in RTCs and RICAs are long and the costs of these settings are high.

Some of the wraparound community support services that would prevent the need for an institutional placement or facilitate a child’s transition home cannot be covered under the Medicaid State Plan. Paying the CME(s) a capitation rate to meet the mental health needs of the child will: 1) introduce flexibility to enable provision of wraparound community support services and 2) provide an incentive to the CME(s) to serve the child efficiently.

Much of the groundwork for the pilot has already been completed through a Real Choices Systems Change grant from CMS. The Mental Hygiene Administration (MHA) within the Department of Health and Mental Hygiene (DHMH) has led a steering committee composed of agency staff, provider and consumer representatives, and advocates to explore the development of this model. MHA subcontracted with the Center for Health Program Management and Development at the University of Maryland, Baltimore County (UMBC) to analyze data and design a rate system for the project.

DHMH anticipates that the CME(s) will be defined as a Prepaid Inpatient Health Plan (PIHP) according to federal rules and regulations. The State and the CME will meet all federal rules and regulations for PIHPs.

### **Experience in Other State**

#### **Wraparound Milwaukee**

Wraparound Milwaukee is a unique system of care for children with serious emotional, behavioral, and mental health needs and their families. It utilizes a wraparound philosophy and approach that focus on strength-based, individualized care. Combined with a unique organizational structure, Wraparound Milwaukee delivers a comprehensive and flexible array of services to youth and their families.

Wraparound Milwaukee has been in existence since 1995. It was designed to reduce the use of institutional-based care such as RTCs and inpatient psychiatric hospitals while providing more services in the community and in the child's home. The program also promotes more family inclusion in treatment programs along with collaboration among child welfare education, juvenile justice and mental health in the delivery of services.

A combination of several state and county agencies, including the Bureau of Milwaukee Child Welfare, the County's Delinquency and Court Services, Behavioral Health Division, and the State Division of Health Care Financing which operates Medicaid, provide funding for the system. Funds from the four agencies are pooled to create maximum flexibility and a sufficient funding source to meet the comprehensive needs of the families served. Part of the County's Behavioral Health Division, Wraparound Milwaukee oversees the management and disbursements of those funds acting as a public care management entity.

### **Program Participation**

Initially the pilot program would operate in two jurisdictions (Baltimore City and Montgomery County). DHMH anticipates that in the future the program will expand to additional jurisdictions. Individuals eligible for program participation are described as follows:

- **Population:** The target population is children in certain jurisdictions who have SED and meet RTC medical necessity criteria, as determined by MHA's administrative services organization, MAPS-MD. A standardized instrument will be used to determine level of care. Participation in the pilot program will be voluntary on the part of the child or youth's parent or legal guardian, and will be offered as an alternative to RTC placement for children who have not yet entered an RTC or have had only a short RTC stay. The child will be able to opt out of the pilot program if the parent or guardian chooses to have him/her enter the RTC instead. Initially the pilot will operate in Baltimore City and Montgomery County.
- **Financial Eligibility:** Children must already be community-eligible for Medicaid or MCHP.
- **Population Size:** The number of program slots will be limited to 750 prior to an evaluation of program efficiency.

## **Benefits**

All Medicaid-reimbursable specialty mental health services will be included in the capitated rate and will be the responsibility of the CME to provide, except for mental health prescription drugs and mental health laboratory tests and diagnostic services, which will be carved out and will continue to be paid fee-for-service.

CME specialty mental health services include:

- Inpatient and outpatient hospital services, including emergency room services, under COMAR 10.09.06
- Residential treatment centers under COMAR 10.07.04, 10.09.29, and 10.21.06
- Partial hospitalization or psychiatric day treatment under COMAR 10.210.02
- Freestanding clinic services under COMAR 10.09.09
- Psychiatrist services under COMAR 10.09.02
- Services provided by individual mental health professionals, as authorized under Health Occupations Article, Annotated Code of Maryland, including occupational therapists, social workers, psychologists, nurse psychotherapists, and professional counselors with the appropriate expertise to provide the services;
- EPSDT under COMAR 10.09.23 and 10.09.37 including therapeutic nursery programs under COMAR 10.21.18
- Mental health targeted case management under COMAR 10.09.09
- The following rehabilitation and other mental health services, under COMAR 10.09.59:
  - Mobile treatment services, under COMAR 10.21.19,
  - Outpatient mental health clinic services, under COMAR 10.21.20, and
  - Psychiatric rehabilitation programs, under COMAR 10.21.21.

Physical health services and substance abuse screening and treatment will continue to be provided through HealthChoice managed care organizations (MCOs).

Some children may require out of home placements during their period of enrollment in the program. The CME will be responsible for the length of stay in group homes or treatment foster care, equivalent to the average RTC length of stay. The capitated rate will include costs for RTC stays, and the CME will be responsible for costs of RTC care. RTC payments include a room and board component, which the CME can redirect to pay for group home or treatment foster care placements as a substitute for RTCs. This advances the goal of serving children in the community.

The CME will provide additional services to an enrollee to promote health and well-being, to help an enrollee transition from an institutional or out-of-home placement to the community, or to prevent the need for an institutional or out-of-home placement.

The CME will develop a care plan for each enrollee. The care plan will address the specialty mental health needs of the child, including a plan for responding to psychiatric emergencies.

The care plan is to be shared with the enrollee's parent or legal guardian and providers and is to be reviewed and updated on a regular basis.

## **Program Administration**

### **DHMH Structure**

DHMH is the single state Medicaid agency. The Mental Hygiene Administration (MHA) is a component of DHMH that reports to the Deputy Secretary for Public Health Services. MHA is responsible for overseeing the system for delivering specialty mental health services to Medicaid recipients.

Components of MHA include the following.

- **Core Service Agencies (CSAs)**  
The CSAs are the local mental health authorities responsible for planning, managing, and monitoring public mental health services at the local level. CSAs exist under the authority of the Secretary of the Department of Health and Mental Hygiene and also are agents of the county government, which approve their organizational structure. The functions of core service agencies are to plan, develop, and manage a full range of treatment and rehabilitation services for persons with serious mental illness in their jurisdiction as stipulated by the Health General Article, 10-10-1203, Annotated Code of Maryland.
- **MAPS-MD Administrative Services Organization**  
MAPS-MD assists the Mental Hygiene Administration and the CSAs with administering the Public Mental Health System (PMHS). As agents of MHA and the CSAs, MAPS-MD supports MHA and the CSAs by:
  - Determining whether an individual is part of the public mental health system
  - Referring the individual to qualified providers of public mental health services
  - Preauthorizing non-emergency care
  - With MHA and the CSAs, concurrently managing the care and cost of care in the public mental health system according to established protocols
  - Conducting utilization review of services to ensure quality, appropriateness, and effectiveness
  - Collecting data and submitting reports
  - Processing billing claims and remitting payments
  - Evaluating the public mental health system

The Deputy Secretary for Health Care Financing is another component of DHMH. The Deputy Secretary for Health Care Financing, along with three administrations--the Office of Health Services, the Office of Operations, Eligibility and Pharmacy, and the Office of Planning and Finance--oversees the Medicaid program.

## **Administrative Functions Under the Waiver Amendment**

### **Relationships with Other State Agencies**

The target population often has a variety of needs and access services from multiple state agencies in addition to DHMH. Therefore it is especially important to collaborate and coordinate the efforts of state agencies, including the Department of Human Resources (DHR), the Department of Juvenile Services (DJS), the Maryland State Department of Education, (MSDE), the Maryland Department of Disabilities (MDoD), and the Governor' Office for Children (GOC). The State of Maryland has created a Local Management Board (LMB) in each jurisdiction to coordinate the delivery of State-funded services to children, youth, and families. The LMBs operate under GOC. The LMBs will be active in working with children, youth, their families, and the CME(s).

### **CME Review and Selection**

MHA with the CSAs and LMBs will select one or more CMEs to provide specialty mental health and wraparound services to the target population. The CME(s) will be selected through a competitive bidding process. Proposals responding to the RFP will be reviewed for the following.

- CME capacity and network adequacy
- Data systems
- Clinical and care coordination expertise
- Expertise in the principles of wraparound
- Human resource expertise
- Financial and administrative systems
- Quality assurance systems
- Compliance with federal requirements

### **CME Quality Oversight**

Oversight of the quality of care provided by the CME(s) will be the responsibility of MHA in partnership with the CSAs and LMBs. Specific quality oversight activities include the following.

- Establish and regularly update clinical standards
- Analyze encounter data and assess CME clinical performance
- Perform focused studies to assess performance in areas that cannot be evaluated using encounter data, or to assess performance at the beginning of the program before encounter data are available
- Operate an enrollee hotline, and oversee appeals process
- Conduct enrollee satisfaction surveys
- Operate a provider hotline

### **Administrative and Financial Monitoring of CMEs**

Monitoring the administrative and financial functioning of the CME(s) will be the responsibility of MHA, with support from the CSAs and LMBS as well as Medicaid . Specific activities include:

- Rate setting. Initial CME rates will be set as a percentage of current Medicaid fee for service payments (the fee for service equivalency). UMBC is developing the risk adjustment methodology and capitation rates for the waiver. UMBC will procure the services of an actuary for consulting services to assure actuarially sound rates. UMBC will also work with DHMH to update rates annually.
- Solvency standards. MHA will monitor the financial performance of the CME.
- Financial Reports. The CME(s) will submit periodic financial reports, e.g., quarterly, on their financial expenses. These reports should provide enough detail to assist with future rate setting calculations as well as to provide DHMH with timely data regarding what is driving certain expenditure trends by service type, eligibility group, or geographical area

### **Eligibility, Outreach, and Enrollment**

MHA, Medicaid OOE, and DHR will share responsibility for this function.

- Eligibility determinations. DHMH and the Department of Human Resources currently share responsibilities for determining eligibility for Medicaid and MCHP. MHA will be responsible for determining whether a Medicaid or MCHP eligible individual meets RTC level of care and can therefore elect to enroll with the CME program.
- Recipient Education and Outreach. The CSAs and LMBs will provide recipient education and outreach to the target population.
- Recipient enrollment. BMHS or MHA will enroll individuals, load enrollment data into their information systems, and notify CME within several business days. BMHS will enter individual's information into the MAPS-MD Care Connections or another information system, which will flag enrollees.

### **Management Information and Data Systems**

The successful implementation and management of the waiver requires sophisticated data and systems support. MAPS-MD will:

- Make monthly capitation payments to the CME.
- Process capitation payments through MMIS.
- Edit their information systems to block fee-for-service payments for the enrolled population.
- Process CME encounter data.
- Validate CME encounter data submissions on an ongoing basis.

Data will be warehoused and analyzed. The encounter data that will be submitted will be used for various functions, such as analysis of program performance, and future development of capitation rates. To assure that these activities are done in a timely manner, using consistent and reliable data, a central data warehouse with analytic capacity will be developed.

### **Delivery System**

#### **Organizations Qualifying as CMEs**

Organizations that can qualify as CMEs must be health maintenance organizations that hold a certificate of authority from the Maryland Insurance Administration (MIA) or managed care systems that are authorized to receive medical assistance pre-paid capitation payments and enroll

only Medicaid recipients. Both types of organizations must meet the same standards relating to quality, access, and data in order to qualify as CMEs.

Non-HMO CMEs will still be required to meet solvency requirements for MCOs established jointly by DHMH and MIA. Any regulations established by MIA that apply to MCOs will also apply to the CME.

### **Federal Definition—PIHP**

From a federal perspective, DHMH anticipates that the CME(s) will be defined as a Prepaid Inpatient Health Plan (PIHP) according to federal rules and regulations. The CME will assume risk for the cost of services covered and incur loss if the cost of furnishing services exceeds capitated payments. Consistent with federal rules, the CMS Regional Office will review and approve CME contracts.

### **CME Youth and Family Advisory Board**

MHA and GOC will establish an advisory committee that will meet on a regular basis to monitor the care provided by the CME(s). In addition to youth and families, the committee will include representatives from the CME(s), DHMH and the CSAs representative, providers, and other state agencies.

### **Enrollment and Disenrollment Processes**

#### **Enrollment**

Enrollment will operate as follows:

- A child/youth will be referred to MHA or its designee to determine if they satisfy the clinical criteria for RTC level of care.
- All children/youth that satisfy the medical necessity criteria will be given the option of participating in the program or placement in an RTC. These enrollment choices will be explained to the child by MHA or its designee.
- All children that choose the program will get enrollment brochures for the provider(s) in their jurisdiction. The child may select the CME. Each CME must accept all children/youth selecting them. CMEs will not discriminate for any reason (e.g., health status, need, demographics) and will accept all applicants who are eligible for Medicaid and the wraparound program, up to the capped number of slots.
- The selected provider will enroll the child/youth within a reasonable timeframe and contact the child/youth within a reasonable timeframe to begin delivering specialty mental health care. The CME's capitation payment will be effective the date of enrollment.

Children and youth will enroll in the pilot program for no longer than 18 to 24 months. After 18 to 24 months they will disenroll to receive specialty mental health services on a fee-for-service basis. Analysis of claims data shows that in the years after the RTC stay, children's average service costs decrease. DHMH interprets this to mean that in many cases the need for intensive services reduces dramatically over time.

Enrollees will remain in the program even if they require placement in an RTC. The CME will be responsible for paying the costs of the RTC from the capitation payments. This will provide the maximum incentive for the CME to serve the child or youth in the community when possible.

### **Disenrollment and Transition Planning**

Reasons for disenrollment include end of 24 months of enrollment, loss of Medicaid or MCHP eligibility, change of residence outside of the service area, or voluntary disenrollment by the child or youth's parent or legal guardian.

Prior to disenrollment at 24 months, the CME will develop a transition plan for the child/youth. The child/youth may be placed in an after care program if offered by the program or other community mental and social programs that serve their area.

This transition planning process should be part of the plan of care development throughout the course of the child's enrollment.

### **Enrollee Rights**

The State and the CME will comply with all federal and state rules and regulations to protect the rights of enrollees of prepaid inpatient health plans (PIHPS)

### **Access Standards**

Each CME must meet DHMH's standards for the following:

- Appropriate range of qualified providers in network
- Adequate ratios of providers to enrollees
- Geographic access to providers (i.e., time/distance to providers)
- Clear policies and procedures regarding referrals and prior authorization
- Availability of medically necessary emergency care 24 hours a day, seven days a week.

### **Quality**

MHA will monitor the quality of care delivered by CMEs, and each CME will have a written quality assurance and performance improvement program. These activities will ensure:

- Delivery of medically necessary services to enrollees
- Quality of health care service rendered meets professionally recognized standards
- Performance improvement over time
- Compliance with federal and State law and regulation

Through a systematic process of periodic reviews of managed care organizations' operations and provider services, MHA will monitor and identify problems and trends in service delivery on a timely basis. Monitoring efforts will include:

- Review of CME application and qualifications, including an on-site review

- Conducting an annual quality of care audit conducted by an external quality review organization (EQRO)
- Assessing CME infrastructure, including complaint and appeal processes
- Collecting and evaluating certain standardized performance measures
- Conducting performance improvement projects focusing on clinical or non-clinical areas as determined by the Department
- Administering provider and enrollee satisfaction surveys
- Conducting annual financial audits by an independent external auditor
- Initiating ad hoc performance reports using encounter data
- Oversight by a quality improvement committee

### **Complaints and Appeals**

Enrollees and providers will have access to hotlines at the CME as well as at MHA or its designee, and will be able to file complaints and appeals with the CME as well as with MHA. Each CME will have written complaint policies, and procedures for appealing denials, reductions, or terminations of service. These policies and procedures will include standards for timely handling of complaints and appeals. An enrollee does not have to exhaust the CME procedures, but can file an appeal with MHA at any time.

### **Financing**

#### **Capitation Rate**

Financial risk will reside with the CME. The federal government will match the State's contribution to the capitated rate at the usual 50% or 65% FFP level, depending on whether the child/youth is eligible for Medicaid or MCHP.

As noted above, initial CME rates will be set as a percentage of current Medicaid fee for service payments (the fee for service equivalency). UMBC is developing the risk adjustment methodology and capitation rates for the waiver. UMBC will procure the services of an actuary for consulting services to assure actuarially sound rates. UMBC will also work with DHMH to update rates annually.

#### **CME Claims Processing System**

The CMEs must have a HIPAA compliant claims processing systems in place to make payments to their provider networks. The system must be able to identify those claims that qualify for payment and determine the correct payment amount. The system must also contain a reporting module that will permit the CME to monitor and report on the payments that they have made. Clean Claims that do not involve other insurers must be paid within 30 days of receipt.

The system must contain a series of edits to ensure that accurate payments are made. The system must be able to identify those services that are covered in the benefit package and those services that are excluded. The editing procedure must also be able to identify the recipients that are enrolled in the CME and the periods of time when they were enrolled. In order to qualify for participation in the program, the CME must include an explanation of the features of their claims processing system, including a description of the editing procedures and examples of the management reports generated by the system.

## **Encounter Data**

The provider must submit an encounter for each service provided to each child/youth. The provider must submit the encounters to MAPS-MD or the Maryland MMIS, to be determined. Encounters must be submitted electronically and in a HIPAA compliant format.

The encounter must include the following information;

- Medicaid ID for the recipient
- Provider ID for the provider of service
- Date the service was received
- Diagnosis codes describing the recipient's condition
- Procedure codes describing the services that were rendered

Encounters should be submitted within two weeks following the payment of the claim for the service. The CME must monitor the volume of encounters submitted to the MMIS system and the volume of encounters accepted by the system. The CME system must have the ability to receive encounters rejected by the MMIS system, correct deficiencies identified by the MMIS system, and resubmit corrected encounters.

The CME must reconcile their encounter data with their financial reports on a quarterly basis to ensure that the volume of accepted encounters is consistent with the volume of paid claims.

## **Payments and Funding**

The CME must submit quarterly and annual reports so that the State can monitor their financial position. The financial reports will also serve to evaluate the adequacy of the capitation rates. Timely and accurate financial reporting is essential in order for a provider to participate in the program

The CME must submit financial reports on a quarterly basis stating their revenues and expenditures for the previous quarter. Quarterly reports must be submitted within three months following the end of each quarter. The quarterly report will detail the premium payments received by the provider during the quarter and the total value of claims paid by the provider during the quarter. The provider will report claims separately for the major category of services included in the benefit package. The provider will report the value of claims paid for services rendered during the current service year, and the value of claims for services provided during prior service periods.

On an annual basis the provider will submit a complete financial report detailing all of their revenues, expenditures for the service year. The annual report must be submitted within six months following the end of the service year. The financial report must detail paid claims, claims received but not paid, and services incurred for which a claim has not been received. An independent auditor must certify this report.

### **Budget Neutrality**

The wraparound program will be budget neutral. Children and youth who will be eligible to participate in this program are already eligible for Medicaid or MCHP in the community; this waiver is not an expansion of Medicaid or MCHP eligibility. Moreover, the CME will be paid a capitation rate that is slightly less than the fee-for-service rate of specialty mental health services that are covered under the Medicaid State Plan. Therefore we expect no budgetary impact from this program.

### **Program Evaluation**

DHMH will evaluate how the pilot programs affect clinical outcomes and costs. This program may be cost-effective in the long term by providing an individualized package of community-based services to children to prevent them from entering institutions.

The types of indicators to be included in the evaluation include:

- Restrictiveness of service settings;
- Improvements in functioning;
- School attendance, performance, and/or participation in vocational activities;
- Adjudication of offenses;
- Child/youth, family, and caregiver satisfaction with services; and
- Access to appropriate health care services.

### **Waivers**

DHMH requests that CMS waive the federal requirement for statewideness and allow the State to serve a limited number of children who have serious emotional disturbance.