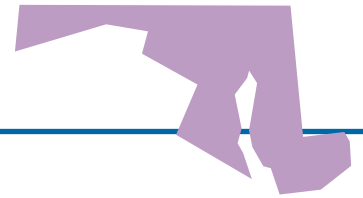

Spotlight on Maryland

January 2018

This brief highlights the major strategies, lessons learned, and outcomes from Maryland's experience from February 2010 to February 2016 with the quality demonstration funded by the Centers for Medicare & Medicaid Services (CMS) through the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). For this demonstration, CMS awarded 10 grants that supported efforts in 18 States to identify effective, replicable strategies for enhancing the quality of health care for children. With funding from CMS, the Agency for Healthcare Research and Quality (AHRQ) led the evaluation of the program.

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

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

Partner States: Georgia and Wyoming implemented similar projects and met quarterly with Maryland and the Center for Health Care Strategies to engage in peer learning through a quality collaborative.

Maryland expanded and improved care management entity (CME) services

CMEs employ intensive care coordination using a Wraparound practice model to help coordinate the many services and supports needed by youth with complex behavioral health needs and their families with a family- and youth-driven, individualized, and strengths-based approach.[1] Having implemented CME services in 2006, Maryland used its CHIPRA quality demonstration funding to expand access to and improve the quality of these services. With support from the CHIPRA quality demonstration, Maryland—

- **Developed training for CME care coordinators in oral and physical health and wellness.** To identify gaps in services, Maryland contracted with a family-run organization to conduct focus groups with families of children and youth served in the CMEs. The State found that the youth had unmet oral and physical health service needs that were often overshadowed by their behavioral health needs. In response, the State incorporated information on oral and physical health into the CME care plan to help CMEs identify gaps in recommended preventive services and treatment for chronic physical health conditions. The State also developed publicly available, Web-based training that teaches CME providers how to discuss oral and physical health needs and resources with families.[2]
- **Worked to improve CME quality monitoring.** After developing an extensive list of quality measures used by experienced States to monitor CMEs, Maryland refined the list so that it balanced the State's needs to effectively monitor quality and minimize reporting burden. Maryland also customized an electronic system that CMEs and child-serving agencies can use to report and track quality measures. In addition, the State trained CMEs and referral providers to use standardized tools, not only to determine whether youth are eligible for CME services but also to track youth outcomes.[3]
- **Identified a sustainable funding stream for CME services.** Historically, Maryland used a patchwork of federally funded demonstrations and grants along with its own funds to support CME services. The State weighed various options for more sustainable funding and decided to modify its targeted case management program for children and adolescents, referred to as care coordination organizations (CCOs). Under a new 1915(b) State Plan Amendment developed with demonstration funds and approved by CMS in October 2014, CCOs started providing CME services, referred to as intensive care coordination, as a third tier of service intensity. While the State still used its own funds and Federal grant funds to support some CME services, it was able to serve more youth through the CCOs. Most CCOs needed State-provided training in order to offer the intensive level of care coordination required for the CME model.

AHRQ Agency for Healthcare Research and Quality
Advancing Excellence in Health Care • www.ahrq.gov

- **Analyzed data across agencies to identify ways to improve CME services.** Maryland analyzed data to support CME quality improvement, including data submitted by CMEs as well as administrative data from Medicaid and from the child welfare and juvenile justice systems. The researchers also helped child-serving agencies and CMEs establish data-sharing agreements, reduce cross-system variation in the structure of service records, and improve data consistency. Although addressing these data challenges caused some delays, the researchers were able to analyze data across child-serving agencies to assess the services used by CME participants, how service use evolved over time, and the total cost of care for youth served by CMEs.

> "The grant provided us with a lot of capacity. We were able to more fully assess the costs and quality of services and really think about how CMEs could be improved."
>
> — Maryland CHIPRA Demonstration Staff, May 2014

Maryland identified funding for crisis response and family support

Youth served by CMEs and their families rely on crisis response and family support services. The former include mobile crisis teams and mental health urgent care centers, which give youth an alternative to emergency rooms. Through family support programs, trained families of youth with complex behavioral health needs provide support to other families and help them navigate community resources and develop the necessary skills and knowledge to feel comfortable with and participate fully as a member of their child's team for care planning. Maryland sought to improve access to and the quality of these services. The State—

- **Pursued stakeholder input on crisis response and family support services.** Maryland partnered with family-run organizations, surveyed behavioral health providers, and conducted focus groups with families to catalog existing services, understand family experiences related to these services, and identify gaps in service availability. These stakeholders indicated that, while they value the services overall, the services were not always available or did not meet their individual needs. Stakeholders, for example, indicated that the unmet needs for family support result from low reimbursement, staff turnover, and poor organizational infrastructure. Additionally, Maryland demonstration staff visited States and cities with well-developed crisis systems (New Jersey and Milwaukee) and family support programs (Georgia) to learn from their experiences.
- **Identified sustainable funding for crisis response and family support.** The State determined an appropriate reimbursement rate for mobile response and stabilization services and family peer support and included these services in its 1915(i) State Plan Amendment, approved in October 2014.
- **Identified and disseminated best practices for crisis response.** Maryland developed a report outlining best practices for crisis response systems and disseminated it to local agencies that contract for and organize these services.

Key demonstration takeaways

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

Endnotes

1. Care coordinators within the CMEs were trained and certified in Wraparound by the National Wraparound Implementation Center. For more information, visit http://www.nwic.org/ and http://nwi.pdx.edu/.
2. Maryland's training in preventive physical and oral health services is available at https://theinstitute.umaryland.edu/training/onlinetraining.cfm.
3. Maryland trained providers to use the Child and Adolescent Service Intensity Instrument (CASII), Early Childhood Service Intensity Instrument (ECSII), and the Child and Adolescent Needs and Strengths Tool to identify youth who qualify for CME services. CANS training was already in existence in Maryland prior to the CHIPRA Quality Demonstration Grant, but it was continued and integrated with the other related assessment and care planning activities.

Continuing Efforts in Maryland

After Maryland's CHIPRA quality demonstration grant ended in February 2016, the State planned to—

- Continue providing CME services as well as mobile response and stabilization and peer support services under the service delivery and financing structures developed under the grant.
- Use Substance Abuse and Mental Health Services Administration system of care grants, received in 2015, to continue to improve the quality of CME, crisis, and family support services.
- Continue training CMEs on oral and physical health and wellness as part of the National Wraparound Implementation Center's standardized training curriculum.
- Disseminate lessons learned about serving youth with complex behavioral health needs to stakeholders in Maryland and across the nation.
- Continue analysis of the use and cost of services as well as prescribing patterns for psychotropic medicines to inform future programs.

LEARN MORE

Maryland's CHIPRA quality demonstration experiences are described in more detail on the national evaluation Web site available at **http://www.ahrq.gov/policymakers/chipra/demoeval/demostates/md.html.**

The following products highlight Maryland's experiences—

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

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

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