Customizing Health Homes for Children with Serious Behavioral Health Challenges

Prepared for:
U.S. Substance Abuse and Mental Health Services Administration

By:
Sheila A. Pires
Human Service Collaborative

March 2013

Made possible through support from the U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health Services, Child, Adolescent and Family Branch; and the Centers for Medicare & Medicaid Services through U.S. Department of Health and Human Services grant CFDA 93.767.

HSC I Human Service Collaborative

Contents

S. Pires. *Customizing Health Homes for Children with Serious Behavioral Health Challenges*, March 2013.

Purpose

Approximately one out of 10 children in the United States has a serious emotional disorder,[1] and mental health conditions represent the most costly health condition among children.[2] The health home provision of the Affordable Care Act (ACA) provides an opportunity for states to improve the quality and cost of care for these children. This resource paper provides a rationale as to why health homes under the ACA should be customized for children and youth with serious behavioral health challenges. It offers approaches to health home customization based on intensive care coordination models using high fidelity Wraparound that have emerged from systems of care in children's behavioral health care. The document outlines clear distinctions between the population of adults with serious and persistent mental illness and the population of children and youth with serious mental health conditions. Drawing on evidence-informed approaches for children with serious behavioral health challenges, the paper describes ways of designing health homes for this population that take into account federal health home requirements and the unique characteristics of these children. This resource is intended for federal and state Medicaid policymakers and system and community partners, including families and youth, to help inform planning and decision-making related to health homes under the ACA.

I. Health Homes under the Affordable Care Act: Core Provisions and Intersection with High Fidelity Wraparound Approaches

Purpose and Philosophy

Section 2703 of the Patient Protection and Affordable Care Act (ACA) adds section 1945 to the Social Security Act to allow states the option of implementing health homes under their Medicaid State plans. The health home option is intended to create health care delivery approaches that facilitate access to and coordination of physical and behavioral health (mental health and substance use) care and community-based social services and supports for both children and adults with chronic conditions. More specifically, the option allows states to choose from three types of provider arrangements: (1)"designated providers," which include various provider types, and are not limited to medical providers (e.g., behavioral health organizations); (2) "teams of health care professionals" (flexibly defined) that link to designated providers; or (3) "health teams," specifically defined in section 1945(h)(7) of the ACA to include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, doctors of chiropractic, licensed complementary and alternative care providers, and physicians' assistants.

The expectation is that health homes will result in improved quality of care and more cost efficiencies; improved experience with care on the part of beneficiaries; and reductions in the use of hospitals, emergency departments, and other expensive facility-based care. In preliminary guidance to state Medicaid directors, the Centers for Medicare & Medicaid Services (CMS) noted that health homes provide an opportunity for states "to build a person-centered system of care" utilizing a "whole-person philosophy – caring not just for an individual's physical (or behavioral health) condition, but providing linkages to long-term community services and supports, social services, and family services."[3]

The intent and values of the health home option in the ACA resonate clearly and are highly consistent with a system of care approach, which has been the major federally-supported framework for improving children's behavioral health delivery systems for over 20 years.[4] Evidence-informed innovations that have emerged from the system of care approach – in particular, care

KEY DEFINITION:
Intensive Care Coordination with High Fidelity Wraparound

Intensive care coordination models using high fidelity Wraparound:

- **Incorporate an individualized, team-based care planning process** using a structured approach that is built on key system of care values (e.g., family- and youth-driven, team-based, collaborative, and outcomes-based), and
- **Adhere to specified procedures** (e.g., engagement, individualized care planning, identifying and leveraging strengths and natural supports, and monitoring progress and process).

This approach incorporates a dedicated full-time **care coordinator** working with small numbers of children and families (e.g., 1:10) and access to **family and youth peer support**. Care coordinators engage youth and their families/caregivers to **build an individualized child and family team** to develop and monitor a strengths-based plan of care. Teams address youth and family/caregiver strengths and needs holistically across domains of physical and behavioral health, social services, and natural supports.

coordination models using high fidelity Wraparound practice with intensive care coordination at low caseload ratios – have produced quality outcomes and per capita cost savings analogous to those expected in the health home option.[5] *Wraparound* is an intensive, individualized care planning and management process that addresses the strengths and needs of children and their families holistically, seeks to build problem-solving and coping skills and self-efficacy, and to keep children in their homes and communities rather than institutions or other facilities.[6]

Health Home Eligible Populations

Health homes are intended to serve individuals with chronic conditions, described in the ACA as including: a mental health condition, a substance use disorder, asthma, diabetes, heart disease, and being overweight, with additional flexibility for states to identify other chronic conditions, with federal approval. Populations of focus for health homes must include individuals with at least two chronic conditions; one chronic condition and risk for another; or one serious and persistent mental health condition. Given the high co-occurring rates of substance use disorders in both the adult and youth populations, and the goal of a health home to provide holistic care, states may also want to specifically include individuals with co-occurring substance use disorders in their State Plan Amendments (SPAs) for individuals with serious mental health conditions.

Because the health home provision waives Medicaid's requirement that the medical assistance available to one group of individuals cannot be less in amount, duration, or scope than services made available to any other individual (known as the 'comparability requirement'), states can offer health home services that vary in amount, duration, and scope than those provided to individuals who are not in the health home population. States may focus their health home approach geographically. All categorically needy individuals (all ages) who meet the population eligibility criteria (including those eligible based on receipt of services under a 1915(c) home and community-based waiver) must be included. Under current CMS guidance, health homes cannot be directed at one age group only; thus, a state pursuing a health home option for individuals with serious mental health conditions must include both adults and children. States may submit one health home SPA for individuals with serious mental health conditions that incorporates two different health home approaches – one for adults with serious and persistent mental illness (SPMI) and one for children with serious emotional disturbance (SED) – or two separate SPAs, one for each group.

Health Home Financing

The ACA establishes an increased federal match of 90 percent for health home services during the first eight quarters that a health home SPA is in effect. The 90 percent match applies only to the health home services received by an enrollee (described in the following section). If a state submits two SPAs for persons with serious mental health conditions – one for adults and one for children – the clock for the enhanced 90 percent federal match on both starts with approval of the first. In other words, although submitted as two separate SPAs, they are considered one health home program for individuals with serious mental health conditions.

Additional periods of enhanced 90 percent federal match are allowed for new individuals served through either a geographic expansion of an existing health home program or a separate health

home for individuals with different chronic conditions. States may not receive more than one eight-quarter period of enhanced federal match for each individual health home enrollee.

The ACA allows states considerable flexibility in designing their payment approaches for health homes. For example, states may use tiered payment methods that account for differing levels of individual severity or provider capabilities. They may use population-based case rates, and may operate within a fee-for-service or capitated structure.

The core health home services mirror those provided in high fidelity Wraparound/intensive care coordination approaches, though terminology, in some cases, may differ.

For children and youth with serious mental health conditions, intensive care coordination models incorporating high fidelity Wraparound (that have emerged from the system of care framework) often use bundled or case rate approaches, and can operate within either a fee-for-service or capitated environment. In addition, states often phase in these approaches by geographic area.

A number of states have existing statewide intensive care coordination/high fidelity Wraparound infrastructure on which to build health homes for children with serious behavioral health conditions; while in others, this infrastructure exists only in certain regions of the state and could be expanded.[7] For example, a state with a strong model of intensive care coordination using high fidelity Wraparound in one geographic area could implement its health home approach for children with serious behavioral health conditions beginning with that region. Over time, the state could expand to other geographic regions, taking advantage of the enhanced federal match for new children served in each geographic expansion area. (As noted earlier, because health home applications cannot exclude any age group, both children and adults would need to be able to enroll in any geographic area where there was a health home approach for persons with serious mental illness, though each population could be served through the particular arrangement designated for each in the health home SPA.)

Health Home Services

Core health home services, as defined in the ACA, include:

- Comprehensive care management;
- Care coordination and health promotion;
- Comprehensive transitional care from inpatient to other settings, including appropriate follow-up, and transition from pediatric to adult settings;
- Individual and family support;
- Referral to community and social support services; and
- The use of health information technology to link services.

These core health home services mirror those provided in high fidelity Wraparound/intensive care coordination approaches, though terminology, in some cases, may differ. For example, health promotion activities in a high fidelity Wraparound approach translate to activities that build on the strengths of youth and families and enhance resiliency. Comprehensive transitional care in this model covers all types of transitions and settings that are unique to children, such as

residential treatment centers, as well as transition from child-serving to adult systems. Individual and family support, a core element of high fidelity Wraparound approaches, incorporates – directly or through partnerships with family- and youth-run organizations – peer support that is provided by youth or families/caregivers with lived experience. Most states have family and youth peer support capacity on which to build for this core health home service.[8]

Health Home Provider Types

The ACA describes three types of health home provider arrangements:

- **Designated providers**, such as a community mental health center, or other type of provider entity;
- A **team of health care professionals**, which may include behavioral health professionals, social workers and others, and can be free-standing, virtual, or based at a center, hospital or other type of entity; or
- A **health team**, which must include medical specialists, nurses, pharmacists, nutritionists, dieticians, social workers, behavioral health providers, doctors of chiropractic, licensed complementary and alternative care providers, and physicians' assistants.

The first two provider arrangements are particularly flexible and include entities and personnel as deemed appropriate by the state, with federal approval. States with Care Management Entity (CME) models that use a high fidelity Wraparound approach could build on this infrastructure to establish a 'designated health home provider,' as contemplated by Massachusetts. States with high fidelity Wraparound teams embedded in community mental health centers could build on this capacity to create a 'team of health care professionals,' as Oklahoma is considering.

Health Home Quality Measures

CMS has issued guidance to state Medicaid directors on a recommended core set of quality measures for assessing the health home delivery model, which CMS intends to promulgate in the rule-making process.[9] The core measures include:

- Adult body mass index;
- Ambulatory care-sensitive condition admission (i.e., age-standardized acute care hospitalization rate for conditions where appropriate ambulatory care prevents or reduces the need for admission to the hospital);
- Care transition – transition record submitted to health care professional (all ages);
- Follow-up after hospitalization for mental illness (over age five);
- Plan-all cause readmission (over age 17);
- Screening for clinical depression and follow-up plan (over age 17);
- Initiation and engagement of alcohol and other drug dependence treatment (adolescents and adults); and
- Controlling high blood pressure (over age 17).

Most of the recommended measures are aligned with CMS' initial core set of health care quality measures for Medicaid-eligible adults.

As health homes are intended to do, intensive care coordination models using high fidelity Wraparound track quality and outcomes, though the measures are tailored specifically to the

clinical, functional, and systems quality concerns and outcomes of children and youth. Many use quality measurement tools from the Wraparound Fidelity Assessment System that measure fidelity to (and therefore the quality of) the Wraparound care planning and team process. In addition, most track clinical and functional outcomes using standardized child-oriented tools, such as the Child and Adolescent Needs and Strengths (CANS).[10] The functional outcomes that are tracked, such as school attendance, placement disruptions in child welfare, and juvenile justice recidivism, are unique to children. These are the types of child-specific measures that states may wish to incorporate in their health home SPA applications, which must include state-defined goals and associated measures, in addition to the CMS core set.

Health Homes and Medical Homes

CMS has indicated that states may expand on the patient-centered medical home (PCMH) model for health home implementation; however, there are key differences between the two. Health homes are intended for populations with chronic conditions, including those with serious behavioral health conditions, while medical homes are intended for every individual. Medical homes historically have focused on the coordination of medical care, while health homes are intended to build linkages to community and social supports and coordinate medical, behavioral and long-term care. Medical homes tend to use physician-led primary care practices as the coordinating entity or team. Health homes may use other types of entities, such as behavioral health provider organizations, and other health care professionals, such as Assertive Community Treatment (ACT) teams for adults with SPMI, and high fidelity Wraparound teams for children with serious behavioral health conditions.

Health homes are intended for populations with chronic conditions, including those with serious behavioral health conditions, while medical homes are intended for every individual.

The multiple payers supporting a PCMH often include Medicaid and commercial insurers. If health homes are to draw in multiple payers, they are more likely, initially at least, to draw the participation of other public systems, rather than commercial insurers, who historically have provided a basic behavioral health benefit. For children, likely public system co-payers may include child welfare, which spends significant dollars on children with chronic conditions. Intensive care coordination models using high fidelity Wraparound often have experience drawing in multiple public payers.[11]

While states certainly have the option of expanding on their medical home models to build a health home for children with serious mental health conditions, studies suggest that, historically, medical homes have struggled with coordinating the behavioral health care needed by this population. For example, a recent study found that "all behavioral health conditions except attention deficit hyperactivity disorder (ADHD) are associated with difficulties accessing specialty care through the medical home," with the data suggesting that "the reason why services received by children and youth with behavioral health conditions are not consistent with the medical home model has more to do with difficulty accessing specialty care than with accessing quality primary care."[12]

Some states such as Missouri are using their community mental health centers as health homes for persons with serious behavioral health conditions. For adults with SPMI, this approach often makes sense. However, in states in which the CMHCs are heavily adult-focused, other types of behavioral health providers may be more appropriate for children, or use of high fidelity Wraparound teams embedded in child-serving entities such as school-based mental health centers.

II. Distinguishing Children with Serious Behavioral Health Conditions from Adults with Serious and Persistent Mental Illness

Chronicity and Long Term Care

The ACA and CMS recognize that the service utilization patterns and costs of children with serious behavioral health conditions render them an appropriate population for health homes. However, the health home language of "chronicity" and "long term care" applied to adults with SPMI does not resonate well with respect to child and youth populations. There is a fundamental understanding with respect to children that they are still developing, and that even serious behavioral health conditions identified early in childhood and treated appropriately, often can be resolved. While there is certainly an important subset of the child population that transitions to adult mental health systems, most children served by public mental health and Medicaid agencies do not suffer from the types of chronic disorders (e.g., bipolar disorder and schizophrenia) that characterize the adult population served by these systems.[13] In addition, health homes for adults with SPMI who typically have comorbid physical health conditions can be conceptualized as lifetime homes. In contrast, the average length of stay for children served through intensive care coordination models using high quality Wraparound is 16-18 months.[14]

Comorbid Physical Health Conditions

Children with serious behavioral health challenges do not have the same high rates of expensive comorbid physical health conditions as found in adults with SPMI. Recent estimates suggest that about one-third of Medicaid-enrolled children who use behavioral health care have serious medical conditions, principally asthma.[15] In contrast, it is estimated that over two-thirds of adults with SPMI have comorbid physical health conditions such as diabetes, heart disease and chronic obstructive pulmonary disease, which are far more expensive to treat and manage.[16] Furthermore, Medicaid expenditures for children who use behavioral health care – even the most expensive of these children – are driven more by behavioral health service use than by use of physical health care – again, in contrast to the adult population.[17] State officials in Missouri, the first state to implement a health home for persons with serious mental illness, recently corroborated that behavioral health use is driving

Medicaid expenditures for children who use behavioral health care – even the most expensive of these children – are driven more by behavioral health service use than by use of physical health care, in contrast to the adult population.

expenditures for children in the health home, in contrast to adults with SPMI, where use of medical care is the cost driver.[18]

While children with serious behavioral health challenges do not have the same high rate of co-occurring physical health conditions as adults with SPMI, it is important to note that these children use more physical health care than Medicaid-enrolled children in general.[19] Intensive care coordination approaches using high fidelity Wraparound ensure that these children have a designated primary care provider, that EPSDT screens and well-child visits are conducted, that there is appropriate metabolic monitoring for children on psychotropic medications, and that there is coordination between medical and behavioral health providers.[20]

Diagnostic Differences

Identifying the population of children with serious behavioral health challenges requires a different approach from that used to identify adults with SPMI, for whom diagnosis is a more reliable indicator.

Children with serious behavioral health conditions tend to have diagnoses different from those of adults with SPMI. The most common diagnosis among children who use behavioral health care in Medicaid is ADHD, followed by conduct disorder and anxiety. These are different from the types of diagnoses such as schizophrenia, psychosis or bipolar disorder that characterize the adult population with SPMI. In contrast to adults, only about four percent of children enrolled in Medicaid who use behavioral health care have a diagnosis of psychosis, for example.[21]

In addition, it has been argued that mental health diagnoses in children, which must be considered in the context of a child's specific developmental stage, are not as reliable as diagnoses in adults.[22] Children with serious behavioral health challenges often have multiple behavioral health diagnoses, and their problems (and diagnoses) often shift during treatment.[23] For a state planning a health home, identification of the appropriate child population using diagnoses alone is unlikely to be sufficient. Identifying the population of children with serious behavioral health challenges requires a different approach from that used to identify adults with SPMI, for whom diagnosis is a more reliable indicator. States must also consider the cost and types of services used by children with serious behavioral health needs. Intensive care coordination approaches using high fidelity Wraparound rarely rely solely on diagnoses to identify children with serious behavioral health challenges; instead, they use a combination of standardized tools that measure clinical and functional impairment, such as the Child and Adolescent Service Intensity Instrument (CASII) or the Child and Adolescent Needs and Strengths (CANS) tool; the type of service a child is using or is at risk for using (e.g., residential treatment); involvement with multiple child-serving systems; and cost.

Systems Involvement

A significant percentage of children in Medicaid with serious behavioral health challenges are also involved with the child welfare and/or juvenile justice systems, as well as special education. It is estimated that roughly two-thirds of children served in intensive care coordination models using high quality Wraparound are involved in child welfare and/or juvenile justice, and 60

percent are involved with special education.[24] These systems have legal mandates governing the care of children, including physical and behavioral health care. Most states, for instance, have requirements that when children enter foster care, they must receive health and behavioral health screens within certain expedited timeframes. For court-involved children, judges often play a role in determining care; and special education plans specify the services a child will receive. Based on the experience of intensive care coordination models using high quality Wraparound, it is the coordination among these systems, as well as among behavioral health providers, that consumes care coordinators' time, rather than the interface with primary care. The systems involvement experienced by children with serious behavioral health challenges and the legal role of these systems in determining care differs considerably from that of adults with SPMI.

Family/Caregiver Involvement and Peer Supports

To improve the quality and reduce the cost of care provided to children, health homes will have to focus on both the child *and* his/her family/caregivers. Unlike most adults with SPMI, children under the age of 18 (with a few exceptions) are not able to make legal decisions on their own. Even in states with assent policies for youth, parents and legal guardians play a critical role in consent for services. Even more compelling is that most children live in families, whether birth families, kinship arrangements or foster families, and family dynamics and involvement play a key role with respect to mental health conditions in children. A family-driven, youth-guided system of care is central to effective service delivery for children.[25] These concepts, while philosophically similar to the concept of "person-centered care" in the ACA health home language, also specifically recognize that a focus only on the individual child without a focus on his/her family is insufficient to improve outcomes for children.

An increasing number of states now cover peer support provided by families and youth with lived experience, either in their Medicaid State Plans or through Medicaid waivers – just as many states cover peer support for adult consumers. There is growing recognition that peer supports are a cost effective approach to engaging individuals with chronic health and behavioral health conditions in treatment and a potentially powerful addition to the health home team.[26] However, there are differences in the organization of peer support for children and families, including: who may provide peer support; the training and supervision peer support specialists receive; and certification standards. Intensive care coordination approaches using high fidelity Wraparound incorporate family and youth peer support as a core component. Many states using Wraparound have developed family and youth peer support capacity reinforced by training curricula and certification at the state level, and may also be accessing national certification for Parent Support Providers developed by the National Federation of Families for Children's Mental Health.[27]

Differences in Care Coordination

The extensive systems involvement that characterizes children with serious behavioral health conditions, as well as the need to work closely with families/caregivers in addition to the individual child, creates a complexity to the care coordination required by this population that differs from that of adults with SPMI. This added complexity has implications for care coordination staffing ratios, reimbursement rates, and care coordinator qualifications. Care coordination staff ratios for the adult population tend to be much higher than for children. In the Missouri health home model for persons with serious mental health conditions, the nurse care manager-to-recipient ratio is 1:250.[28] In intensive care coordination approaches using high

fidelity Wraparound, the care coordinator-to-child/family ratio typically does not exceed 1:10. Previous studies that have examined case management approaches for children with serious behavioral health conditions, in which care coordinators have large caseloads or perform additional functions (such as clinical therapy), have found quality outcomes to be minimal, particularly in comparison to intensive care coordination approaches using high quality Wraparound with dedicated full-time care coordinators working with small numbers of children and families.[29]

Similarly, care coordination payment rates for the adult population tend to be much lower than for children with complex needs. In Missouri, the health home per member per month (PMPM) rate is $78. A recent national scan of care coordination rates in intensive care coordination approaches with high quality Wraparound shows a range of $780-$1,300 PMPM.[30] While these rates for children may seem high, the reality is that this intensive care coordination approach focuses on children whose Medicaid costs run, on average, five times higher than that of Medicaid children in general, and in the case of the most expensive 10 percent of these children, Medicaid costs are 25 times higher. It is estimated that children in Medicaid who use behavioral health care use 38 percent of overall Medicaid child expenditures, and the largest percentage of their total expenditures goes to residential treatment centers and therapeutic group care.[31] From a cost standpoint, children with serious behavioral health conditions in the Medicaid population are a prime population for a health home approach. Data from the CMS Psychiatric Residential Treatment Facility Waiver Demonstration focusing on these children found that states in the demonstration that were using a high quality Wraparound approach experienced an average per capita savings ranging from $20,000 to $40,000 per year.[32]

In intensive care coordination approaches using high fidelity Wraparound, care coordinators … spend considerable time in face-to-face interactions with youth and families, supporting child and family teams to plan for and revise services and supports as needed, monitoring, assessing, helping families navigate systems, and providing crisis intervention.

There are also differences in the types of staff who provide care coordination. In health home approaches for adults with SPMI, nurse practitioners often serve as care coordinators, in recognition of the comorbid physical health conditions of the adult population. As noted earlier, it is not physical health issues that predominate in the care coordination needed by children with significant mental health conditions; rather, it is coordinating the behavioral health, social services and family issues that require most of a care coordinator's time. In intensive care coordination approaches using high fidelity Wraparound, care coordinators tend to be bachelor's level staff with experience working with children involved in public systems, and they receive close behavioral health clinical supervision and coaching. They spend considerable time in face-to-face interactions with youth and families, supporting child and family teams to plan for and revise services and supports as needed, monitoring, assessing, helping families navigate systems, and providing crisis intervention.

In effect, the model of care coordination that is effective for children with significant behavioral health challenges, requiring more intensive, face-to-face interactions with the child and family/caregivers, and with other system partners like schools, is quite different from the approach typically used for adults with SPMI. For adults, care coordinators have a larger number of individuals to manage, and thus care coordination activities are typically telephonic or via e-mail and not as frequently conducted face-to-face. For children, in intensive care coordination approaches using Wraparound, care coordinators work closely with youth and their families/caregivers, typically with requirements for a specific number of hours per week of face-to-face interaction. This expectation of frequent, in-person contact with youth and families is a key explanation for why the cost of care coordination for children is appreciably higher than for adults. However, as discussed more fully below, investment in this model of intensive care coordination, even at the higher rate, results in per capita cost savings through reduced use of expensive facility-based care (e.g., inpatient psychiatric hospitalization, residential treatment, emergency room use, etc.).

Services and Supports

A key function of health homes is facilitating access to appropriate services and supports. The services and supports needed by children and their families differ from those needed by adults with SPMI. A more comprehensive range of services is needed for children as well as approaches that include parents/caregivers. For example, intensive in-home services, behavioral management consultation, and respite, which focus on the individual child and his or her family/caregivers, are often critical in helping children avoid residential treatment; these are not services typically used by adults with SPMI.

Core health home services, such as identification and screening activities, are also operationalized differently for children. Unlike adults with SPMI, children with serious behavioral health challenges are often first identified in school settings or by their pediatricians. Child-specific tools, like the Pediatric Symptoms Checklist, CANS or CASII-II, can assist in screening and assessing children for serious behavioral health conditions and, thus, for health home eligibility.

Providing transitional care across settings – another core health home service – also entails considerations for children that are different from adults. Transitional care for children must encompass not only inpatient hospitalization, but residential treatment, therapeutic group care and therapeutic foster homes. Indeed, for children, residential treatment has supplanted inpatient psychiatric hospitalization in its cost to Medicaid.[33] Transitional care also must encompass transitions for the subset of youth who move into adult behavioral health systems, and these transition issues may be complicated by a youth's transition at the same time out of foster care, special education or the juvenile justice system.

For adults with SPMI, effective linkage to social supports and community resources, another core health home service, often entails assistance with maintaining eligibility for disability benefits, access to housing and transportation, and legal services. While children may also need this type of assistance – especially youth who transition to adult systems – more often, the linkages required are to child-specific community activities, after school programs, sports, music

and arts activities, youth groups affiliated with faith-based organizations, and similar resources that create a normalized community environment and help to build resiliency.

III. Customizing Health Homes Using Intensive Care Coordination with High Fidelity Wraparound

Care Management Entities as Designated Health Home Providers

As part of the Children's Health Insurance Program Reauthorization Act (CHIPRA) Quality Demonstration Grants, CMS is funding a five-year demonstration project in three states to implement and/or expand CMEs as a specialty provider approach to improve the quality and better control the cost of care for children with serious behavioral health challenges enrolled in Medicaid or the Children's Health Insurance Program. CMEs are typically nonprofit behavioral health organizations that manage care for children with complex challenges who are involved with multiple systems and providers. One of the oldest examples is Wraparound Milwaukee, recipient of Harvard University's 2009 Innovations in American Government Award. Several states are implementing this approach statewide, including: New Jersey, Louisiana, Maryland and Massachusetts. Georgia has regional capacity in place, and others such as Ohio, Indiana and Wisconsin have CME models in several counties.[34]

CMEs use a high quality Wraparound approach. Wraparound is an individualized, team-based care planning process intended to improve outcomes for children and youth with complex behavioral health challenges and their families. Wraparound is not a service per se; it is a structured approach to service planning and care coordination that is built on key system of care values (e.g., family- and youth-driven, team-based, collaborative, and outcomes-based) and adheres to specified procedures (e.g., engagement, individualized care planning, identifying and leveraging strengths and natural supports, and monitoring progress and process). [35] The Wraparound approach incorporates a dedicated full-time care coordinator working with small numbers of children and families (e.g., 1:10) and access to family and youth peer support. Care coordinators engage youth and their families/caregivers to build an individualized child and family team to develop and monitor a strengths-based plan of care. Teams address youth and family/caregiver strengths and needs holistically across domains of physical and behavioral health, social services, natural supports, etc. CMEs also utilize information technology to create an electronic clinical record and to support utilization management, care coordination, continuous quality improvement and outcomes tracking.[36]

The functions and goals of CMEs align closely with those of health homes, as illustrated in Table 1 below. Massachusetts is planning a health home application for persons with serious mental health conditions and is considering building on its CME infrastructure for the health home approach for children.

The Center for Health Care Strategies (CHCS) developed a resource for states that contains sample language for State Plan Amendment development using a CME approach as a designated health home provider for children with serious behavioral health conditions, and is in the process of developing a second resource using a Wraparound team as a team of health care professionals, the approach described below.[37]

High Quality Wraparound Team as 'Team of Health Care Professionals'

Some states do not have CMEs but may have Wraparound teams embedded in supportive structures such as community mental health centers, school-based mental health centers, or even Federally Qualified Health Centers (FQHCs). These Wraparound teams could serve as the 'team of health care professionals' described in ACA as an allowable health home arrangement. Oklahoma is an example of a state that is planning this approach, using Wraparound teams within their community mental health centers as the 'team of health care professionals' for children with serious mental health conditions. If states are to embed Wraparound teams into non-behavioral health entities such as FQHCs, it is important that care coordinators have access to behavioral health clinical supervision and coaching and psychiatric consultation.

Table 1 – Comparison of Health Home Provider Standards and Care Management Entity Activities

Health Home Provider Standards	Care Management Entity Activities
Provide quality-driven, cost-effective, culturally appropriate, and person-and family centered health home services	Provide family-driven, youth-guided, culturally and linguistically competent care that is community-based, flexible and individualized
Coordinate and provide access to high-quality health care services informed by evidence-based practice guidelines	Employ the evidence-based *Wraparound* model of care planning and care management to coordinate all services and supports needed by the youth.
Coordinate and provide access to preventive and health promotion services, including prevention of mental illness and substance use disorders	Build resiliency in youth and families by promoting connections with behavioral health prevention and wellness services
Coordinate and provide access to mental health and substance abuse services	Coordinate and provide access to mental health and substance abuse services
Coordinate and provide access to comprehensive care management, care coordination, and transitional care across settings.	Coordinate and provide access to comprehensive care coordination services using the *Wraparound* model of care planning
Coordinate and provide access to chronic disease management, including self-management support to individuals and their families	Foster connections to natural supports and services that can help youth and families be successful at home, school, and in the community.
Coordinate and provide access to individual and family supports, including referral to community, social support, and recovery services	Provide access to peer and family support services to help youth and families successfully navigate multiple service systems
Coordinate and provide access to long-term care supports and services	Coordinate and provide access to needed supports and services across all domains of the youth's life including school, home, and community
Develop a person-centered plan of care for each individual that coordinates and integrates all of his or her clinical and non-clinical health-care related needs and services	Create a plan of care that serves as a guide to the youth's clinical and non-clinical health care and social services needs
Demonstrate a capacity to use HIT to link services, facilitate communication among team members and between the health team and individual and family caregivers, and provide feedback to practices	Employ HIT to support data-driven decision making , facilitate communication among team members, including with youth and family caregivers, and provide feedback to providers
Establish a continuous quality improvement program, and collect and report on data that permits an evaluation	Participate in quality improvement activities and collect and report on data.

Fields, S. 2011. Boston, MA: Technical Assistance Collaborative

Evidence Base for Intensive Care Coordination Using High Quality Wraparound

To date, there have been nine controlled published studies of Wraparound, seven of which found consistent and significant outcomes in favor of Wraparound compared to control groups across outcomes domains – most prominently residential placement, along with symptoms, recidivism, and community and school functioning .[38] The influential Washington State Institute for Public Policy has recently included full fidelity Wraparound in its inventory of evidence-based practices

for prevention and intervention services for children and youth in the child welfare, juvenile justice, and mental health systems.

There are also cost and outcome data available from individual states and localities implementing intensive care coordination approaches using high quality Wraparound that are relevant to health homes. Wraparound Milwaukee reduced total child population use of psychiatric hospitalization from an average of 5,000 to less than 200 days annually and reduced its average daily residential treatment facility population from 375 to 50. The average all-inclusive cost (i.e., all services, supports, care coordination, etc.) for a child in Wraparound Milwaukee is $3,900 PMPM, compared to $8,600 per month in residential treatment or $1,600 per day in inpatient psychiatric hospital care. Wraparound Milwaukee's care coordination rate is about $780 PMPM, included within the all-inclusive cost of $3,900 PMPM.[39] Wraparound Milwaukee also has ensured that every child has a medical home and has reduced inappropriate use of psychotropic medications.[40] A 2011 policy study by the State of Maine found a 28 percent reduction in total net Medicaid spending among youth served in its Wraparound Maine initiative, even as use of home- and community-based services increased. The reduction of expenditures for youth enrolled in Wraparound Maine was driven by a 43 percent reduction in the use of psychiatric inpatient treatment and a 29 percent reduction in the use of residential treatment.[41] Finally, New Jersey estimates that the state has saved over $30 million in inpatient psychiatric expenditures over the last three years through its system of care approach to children with behavioral health needs, including a CME model for children with serious disorders.[42]

CMS' Psychiatric Residential Treatment Facility Waiver Demonstration compared home- and community-based services (implemented using the Wraparound approach) for children to treatment in psychiatric residential treatment facilities (PRTFs). The PRTF waiver demonstration evaluation report concluded that, across all state grantees over the first three waiver years, youth maintained or improved their functional status while services cost substantially less than institutional alternatives. In most cases, waiver costs were around 20 percent of the average per capita total Medicaid costs for services in institutions from which enrolled youths were diverted, representing average per capita savings of $20,000 to $40,000.[43]

IV. Coordinating with Primary Care in a Wraparound Approach

Integration of Physical and Behavioral Health Care

A key objective of health homes is integration of physical and behavioral health care, which has several meanings and may be operationalized in different ways. In some cases, it means literally combining physical and behavioral health Medicaid financing and administration within one provider or managed care entity. Within large-scale Medicaid managed care arrangements using this type of integrated financing approach, results have not been favorable for children with serious behavioral health conditions because physical health care consumes most of the focus and the dollars, and there is insufficient behavioral health customization for children with serious conditions.[44] A pilot initiative within a nonprofit health maintenance organization in Massachusetts, however, produced positive results by customizing an integrated financing approach for children with serious behavioral health conditions using a high fidelity Wraparound/intensive care coordination model. Among the findings was that, by improving

coordination of behavioral health care and social supports, not only were better cost and quality outcomes achieved on the behavioral health side, there were reduced costs for physical health care as well.[45]

Integration may also refer to the co-location of physical and behavioral health providers without integration of financing, and it may also refer to enhanced coordination between physical and behavioral health care providers without actually co-locating providers. Wraparound Milwaukee, for instance, does not co-locate behavioral and physical health providers. However, it has ensured that every child has a medical home through an agreement with a local FQHC, which serves as the medical home for children who do not have a primary care provider (PCP) upon enrollment.

Requirements Related to Coordination with Primary Care

Many states already have a patient-centered medical home (PCMH) approach in place, and it is important to ensure coordination between the behavioral health home and the PCMH. Oklahoma, for example, has PCMHs and is planning a health home approach for children with serious behavioral health conditions using a high fidelity Wraparound/intensive care coordination team embedded in community mental health centers. Oklahoma is planning to incorporate specific requirements for the health home to coordinate with primary care, including:

- Ensuring that every child enrolled in the health home has an identified PCP, including development of memoranda of understanding with the PCP for communication and consultation;
- Ensuring that every child enrolled in the health home receives all required EPSDT screens on schedule, including behavioral health screens;
- Tracking "outlier" psychotropic medication use among children enrolled in the health home (e.g., polypharmacy, antipsychotic medication use particularly among young children, etc.), consultation to the PCP on psychotropic medication use particularly related to metabolic monitoring of risk issues related to psychotropic medication use (e.g., obesity, diabetes); and
- Incorporating wellness goals into plans of care.

V. Avoiding Duplication with Other Care Management Structures

CMS Guidance

In its initial guidance to state Medicaid directors on health homes, CMS recognizes that many states have existing care coordination entities in place and encourages the states to design their health home approaches to complement (rather than duplicate) these existing entities.[46] In addition to medical homes, states may also have Medicaid managed care entities and Targeted Case Management providers in place, which also have care coordination functions. Health home functions cannot duplicate those of other care management entities. States have to ensure that they are not billing the same services for the same enrollees performed by two different care coordination entities. For states planning health homes, a useful exercise is to develop matrices

Health home functions cannot duplicate those of other care management entities. States have to ensure that they are not billing the same services for the same enrollees performed by two different care coordination entities.

that clearly show the differences between the services performed by their different care coordination entities. The Integrated Care Resource Center has developed a resource paper on avoiding duplication of services across entities.[47]

Managed Care Entity Functions versus Health Home

Health homes or teams of healthcare professionals are (or are linked to) provider entities, which, in turn, may be part of a state's larger Medicaid managed care network. A managed care organization (MCO) may be well-positioned to perform certain health home functions that support a health home provider or team, for example, identifying eligible children or supporting health information technology (HIT) requirements. In Massachusetts, CMEs (called Community Services Agencies), which the state is considering utilizing for health homes for children with serious behavioral health conditions, are supported by the HIT infrastructure of the state's MCOs. If states plan to use existing Medicaid-financed MCO capacity for certain health home functions, they cannot incorporate these functions into the rates that would be paid to the health home provider entity or team as it would constitute double-billing.

Patient-Centered Medical Home Functions versus Health Home

PCMHs are typically paid a small enhanced rate to coordinate medical care. For states using a high quality Wraparound/intensive care coordination approach as their health home for children with serious behavioral health conditions, the PCMH would continue to coordinate medical care. The health home care coordination rate would encompass coordination of behavioral health, family and social services, supports in the community, and coordination with the PCP, but not coordination of physical health services *per se.* As noted earlier, PCMHs are often best suited to coordinate medical care but typically do not have the capacity to perform the intensive care coordination involving the extensive non-medical systems issues and behavioral health needs of children with significant behavioral health conditions.

Targeted Case Management Providers

For children with serious behavioral health conditions, the interface between health homes and Targeted Case Management (TCM) providers may be the most critical – and perhaps difficult – one to clarify. States may have TCM in place for children with serious emotional disorders and/or for children involved in child welfare systems and would need to ensure that health home functions do not duplicate those provided through TCM. Recognizing that CMS has not provided guidance to states specific to TCM and health homes, the following are offered as potential options for states to consider to avoid duplication between health homes and TCM providers for children with serious behavioral health conditions.

- **Option A**: States could replace TCM with their health home approach altogether. This option might make sense for states that have concerns about the quality and cost effectiveness of their existing TCM capacity or for states with complete overlap between the population served in TCM and that designated for health homes.

- **Option B:** States could distinguish between their health home and TCM populations. For example, states could define their health home population as children with very serious behavioral health challenges who meet a specified high acuity level on standardized screening and assessment tools and who meet (or are anticipated to meet) a certain high cost threshold. States could retain their TCM for children who are at high risk for very serious behavioral health challenges and use of high-cost services. In this approach, states would have to be clear about their population definitions, and care coordination ratios and rates would need to reflect differences between the intensity of effort required. States might also designate TCM for children with more severe behavioral health conditions and use health homes for more at risk populations. This approach might make sense for states that are not using a customized health home approach for children, such as high fidelity Wraparound with intensive care coordination, but are instead planning the health home for adults and children as an "add-on" for medical homes or community mental health centers, for example.

- **Option C**: Arguably, states could use their TCM providers as health homes for children with serious behavioral health conditions. States would have to be very clear as to what was being billed as TCM and what was being billed as a health home service in order to avoid duplication. One potential scenario might include, for example, that intensive care coordination continue to be billed through TCM, and other health home services (i.e., health promotion, HIT, identification and screening, individual and family support) might be billed through the health home provision. This option, which could be conceptualized as an enhancement of existing TCM capacity, could conceivably pose a significant challenge in documentation to sufficiently and convincingly ensure that there would not be duplication of functions between the health home and TCM.

VI. Lessons Learned from an Adult Demonstration

A recent Center for Health Care Strategies publication described "lessons for Medicaid health homes" that emerged from New York State's Chronic Illness Demonstration Project (CIDP), a three-year initiative to improve the quality and cost of care for adult Medicaid beneficiaries with chronic physical and behavioral health conditions.[48] While this project focused on adults, these lessons are useful for child-focused health homes as well and, in fact, tend to mirror lessons that have emerged from intensive care coordination approaches using high quality Wraparound.[49] The CIDP lessons include:

Training and coaching for care coordinators and peer specialists are hallmarks of a high quality Wraparound approach.

- Establish much closer connections from the outset between the organizations responsible for care management and provider organizations delivering treatment and other services,
    - Massachusetts, for example, requires its CMEs to create local "system of care" committees to ensure ongoing communication across providers and other stakeholders in the local community;

- Address data sharing issues and needs,
    - Wraparound Milwaukee has data sharing agreements in place with its providers and child-serving systems such as child welfare;
- Ensure reimbursement for identification and enrollment of high-risk, high cost enrollees;
- Recognize that extensive education is required to build good relationships with other organizations, be clear on roles, and build consistent communications mechanisms; and
- Recognize the need for workforce training that prepares care managers to provide coordinated patient-centered care, with a particular emphasis on training peer support specialists,
    - Training and coaching for care coordinators and peer specialists are hallmarks of a high quality Wraparound approach, with states like Massachusetts developing training curricula and requirements and Maryland creating a university-based "center of excellence" to develop this specialized workforce.[50]

VII. Conclusion

In light of their history of experiencing poor quality and outcomes in traditional approaches, children with serious behavioral health conditions are a population that could benefit enormously from an effective health home approach. Based on the utilization and cost patterns of this population, Medicaid agencies would also benefit from an effective approach. Other children's systems, particularly child welfare, juvenile justice and the schools, which spend significant resources on children with serious behavioral health challenges, also stand to benefit. The challenge for states is to develop an approach that will indeed be effective for children and contain costs.

Intensive care coordination models using high fidelity Wraparound have demonstrated better quality, clinical/functional, and cost outcomes for this population of children and their families and have been promoted for many years by the U.S. Substance Abuse and Mental Health Services Administration. State Medicaid agencies would benefit from familiarizing themselves with this approach as they consider potential health home designs. By the same token, families, youth, child advocates, and other children's systems, which often have spent years developing and implementing high quality Wraparound models, must become knowledgeable about the ACA's health home provision as a potential avenue to incorporate this evidence-informed, system of care approach into the larger Medicaid delivery system. Together, all stakeholders may be able to craft health homes that, in keeping with CMS' objectives, truly produce better outcomes for children and improve health care quality and costs.

Endnotes

[1] U.S. Substance Abuse and Mental Health Services Administration (2008). *Child and Adolescent Mental Health*. Available at http://mentalhealth.samhsa.gov/publications/allpubs/CA-0004/default.asp.
[2] A. Soni (2009). *Statistical Brief #242: The Five Most Costly Children's Conditions, 2006: Estimates for the U.S. Civilian Noninstitutionalized Children, Ages 0-17.* Agency for Healthcare Research and Quality, U.S. Department of Health and Human Services. Available at: http://meps.ahrq.gov/data_stats/Pub_ProdResults_Details.jsp?pt=Statistical%20Brief&opt=2&id=903.

[3]Center for Medicare & Medicaid Services. State Medicaid Director Letter #10-024, November 16, 2010. Available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.
[4] J.A. Wotring and B.A. Stroul (2011).*The Intersect of Health Reform and Systems of Care for Children with Mental Health and Substance Use Disorders and Their Families*. Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health. Available at: http://gucchdtacenter.georgetown.edu/publications/SOC_Brief_Series1_BL.pdf
[5] National Wraparound Initiative. *Research Update.* http://www.nwi.pdx.edu/wraparoundresearch.shtml
[6] National Wraparound Initiative (2012) *What Is Wraparound? Available at: www.nwi.org*
[7] S.A. Pires (2010). *Building Systems of Care: A Primer, 2nd Edition.* Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.
[8] Center for Health Care Strategies (2012). *Medicaid Financing for Family and Youth Peer Support: A Scan of State Programs.* Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261373
[9] Centers for Medicare & Medicaid Services. State Medicaid Director Letter #13-001, January 15, 2013. Available at: http://www.medicaid.gov/Federal-Policy-Guidance/downloads/SMD-13-001.pdf.
[10] A. Slather, E.J. Burns, and S. Hensley (2012). Pilot test of the Wraparound Fidelity Index, Brief version (WFI-EZ). National Wraparound Initiative. Available at: http://www.nwi.pdx.edu/pdf/WFI-EZ-summary-of-initial-results.pdf.
[11] B.A. Stroul, S.A. Pires, M.I. Armstrong, J. McCarthy, K. Pizagatti, and G. Wood (2009). *Effective financing strategies for systems of care: Examples from the field – A resource compendium for financing systems of care: Second edition (RTC study 3: Financing structures and strategies to support effective systems of care, FMHI pub #235-03).* Research and Training Center for Children's Mental Health, Florida Mental Health Institute, University of South Florida.
[12] R.C. Sheldrick and E.C. Perrin. "Medical home services for children with behavioral health conditions." *Journal of Developmental Pediatrics,* 31 no.2 (2012): 92-9.
[13] S.A. Pires, K.E. Grimes, K.D. Allen, T. Gilmer, R.M. Mahadevan. *Faces of Medicaid: Examining Children's Behavioral Health Service Utilization and Expenditures*. Center for Health Care Strategies. Forthcoming, 2013.
[14] Center for Health Care Strategies (2011). *Care Management Entities: A Primer*. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261240.
[15] Pires et al., op cit.
[16] C. Boyd, B. Leff, C. Weiss, J. Wolff, A. Hamblin, and L. Martin. *Clarifying Multimorbidity Patterns to Improve Targeting and Delivery of Clinical Services for Medicaid Populations*. Center for Health Care Strategies. December 2010. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261201.
[17] Pires et al., op cit.
[18] L. Alexander, B. Druss, and J. Parks. "A (Health) Home Run: Operationalizing Behavioral Health Homes." Webinar, Center for Integrated Health Solutions, U.S. Substance Abuse and Mental Health Services Administration, January 2013.
[19] Pires et al., op cit.
[20] K. Allen, S. Pires, and R. Mahadevan. *Improving Outcomes for Children in Child Welfare: A Medicaid Managed Care Toolkit.* Center for Health Care Strategies. February 2012. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261349.
[21] Pires et al., op cit.
[22] S. Kirk. "Are children's DSM diagnoses accurate?" *Brief Treatment and Crisis Intervention*, 4 no.3 (2004): 255-70.
[23] American Psychological Association Task Force on Evidence-Based Practice for Children and Adolescents (2008). "Disseminating Evidence-Based Practice for Children and Adolescents: A Systems Approach to Enhancing Care." Available at: www.apa.org/practice/resources/evidence/children-report.pdf.
[24] Pires, op cit.
[25] B. Stroul, S. Goldman, S. Pires, and B. Manteuffel (2012). *Expanding Systems of Care: Improving the Lives of Children, Youth and Families.* Georgetown University Center for Child and Human Development, National Technical Assistance Center for Children's Mental Health.
[26] D. Sells, L. Davidson, C. Jewell, P. Falzer, and M. Rowe. "The treatment relationship in peer-based and regular case management services for clients with severe mental illness." *Psychiatric Services*, 57 no.8 (2006): 1179-1184.
[27] Center for Health Care Strategies. "Family and Youth Peer Support in Care Management Entities." Presentation given via Center for Health Care Strategies webinar, September 2011. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261289.
[28] Alexander et al., op cit.
[29] M. Evans and M. Armstrong. "What is case management?" In B. Burns and K. Hoagwood (Eds.), *Community Treatment for Youth: Evidence-Based Interventions for Severe Emotional and Behavioral Disorders*. (New York: Oxford University Press, 2002), Chapter 3.
[30] Center for Health Care Strategies (2012). *Case Rate Scan for Care Management Entities*. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261434#.USurEKLCaSo.
[31] Pires et al., op cit.
[32] O. Urdapilleta, G. Kim, Y. Wang, J. Howard, R. Varghese, G. Waterman, S. Busam, and C. Palmisano (2012). *National evaluation of the Medicaid demonstration waiver home and community based alternatives to psychiatric residential treatment facilities.* IMPAQ International Columbia. Available at: http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Delivery-Systems/Downloads/CBA-Evaluation-Final.pdf.
[33] Pires et al., op cit.
[34] For resources related to the CHIPRA Care Management Entity demonstration and information about particular states and counties using this approach, see: http://www.chcs.org/info-url_nocat3961/info-url_nocat_show.htm?doc_id=1250388.
[35] E. Bruns and J. Walker. "The Wraparound Process: An Overview of Implementation Essentials." In E.J. Bruns and J.S. Walker (Eds.), *The Resource Guide to Wraparound.* (Portland, OR: National Wraparound Initiative, 2011), Chapter 5a2.
[36] Center for Health Care Strategies (2011). *Care Management Entities: A Primer*. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261240.
[37] Center for Health Care Strategies (2012). Using Care Management Entities for Behavioral Health Home Providers: Sample Language for State Plan Amendment Development. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261441.
[38] E. Bruns and J. Suter. "Summary of the Wraparound Evidence Base." In E.J. Bruns and J.S. Walker (Eds.), *The Resource Guide to Wraparound.* (Portland, OR: National Wraparound Initiative, 2011), Chapter 3.5.
[39] B. Kamradt (2009). *Overview of Wraparound Milwaukee: Serving emotionally disturbed youth.* Harvard University Kennedy School of Government.
[40] Allen et al., op cit.

[41] Maine Department of Health and Human Services, Office of Continuous Quality Improvement Services (2011). "Wraparound Maine: A Mental Health Service Use and Cost Study."QI Data Snapshot. Vol 3, Issue 3. Available at: http://www.maine.gov/dhhs/ocfs/wraparound/july_qi_data_snapshot_v3_I3.pdf.
[42] B. Hancock. "Financing Options for Care Management Entities: New Jersey System of Care Financing Overview." Presentation given via Center for Health Care Strategies webinar, June 2010.
[43] Urdapilleta et al., op cit.
[44] A series of publications and issue briefs documenting these findings published by the Health Care Reform Tracking Project can be found at: http://www.fmhi.usf.edu/cfs/stateandlocal/hctrking/hctrkprod.htm
[45] K.E. Grimes, P.E. Kapunan and B. Mullin. "Children's Health Services in a "System of Care:" Patterns of Mental Health, Primary and Specialty Use." *Public Health Reports*, 121 no.3 (2006):311-323.
[46] Center for Medicare & Medicaid Services. State Medicaid Director Letter #10-024, November 16, 2010. Available at: http://downloads.cms.gov/cmsgov/archived-downloads/SMDL/downloads/SMD10024.pdf.
[47] Center for Health Care Strategies. (December 2012) *Avoiding Duplication of Services in Health Homes.* Available at: www.integratedcareresourcecenter.com
[48] Center for Health Care Strategies (2012). *New York's Chronic Illness Demonstration Project: Lessons for Medicaid Health Homes*. Available at: http://www.chcs.org/publications3960/publications_show.htm?doc_id=1261469#.USuzY6LCaSo.
[49] Bruns and Walker, op cit.
[50] P. Miles, N. Brown, and The National Wraparound Initiative Implementation Work Group (2011). *The Wraparound Implementation Guide: A Handbook for Administrators and Managers*. National Wraparound Initiative. Available at: http://nwi.pdx.edu/NWI-book/index.shtml.