## Wyoming Medicaid Care Management Entity Facts and Figures

Since July 1, 2015, the Wyoming Medicaid Care Management Entity (CME) program has provided the only evidence-based and community-based alternative to institutional care for Medicaid-covered youth (4-20 years of age) experiencing serious emotional disturbance/serious mental illness (SED/SMI). The state uses authority granted under the Medicaid 1915 (b) & (c) waivers to contract with a single CME to provide an evidence-based intensive care coordination model called "high fidelity wraparound" (HFW) to help youth stay in home, in school, and out of trouble. HFW is also recognized by the Family First Prevention Service Act (FFPSA) as an evidence-based practice that meets FFPSA funding requirements for states to receive federal Title IV-E funds.

The CME serves qualifying Medicaid-enrolled children and youth as well as children who qualify for Medicaid under the Medicaid Children's Mental Health Waiver (CMHW). Before the CMHW was in place, families with children who had complex behavioral health needs were faced with relinquishing custody of their children to the state in an effort to obtain services and supports not covered by private insurance or other funding sources.

- While High Fidelity Wraparound is an evidence-based practice, it isn't currently covered by traditional insurance plans although the federal Centers for Medicare and Medicaid Services (CMS) recognize it as an advantageous practice for children and youth with SED/SMI to assist them to remain in the community.
- Although the youth served by the CME meet at least one Medicaid inpatient psychiatric admission criteria, CME-enrolled youth's overall Medicaid costs are much lower than youth served by Psychiatric Residential Treatment Facilities (PRTFs).

Per Medicaid outcomes data (WDH/HCF CME Health Stat documents), the CME reduces the rate of admissions, lengths of stay, and readmissions to inpatient and residential psychiatric institutions, detention, and juvenile justice placements for youth served. The overall cost of care for CME-enrolled youth is provided at a dramatically lower cost to the State than costs to Medicaid for non-participating Medicaid youth with SED/SMI. Every youth enrolled in the CME meets at least one Medicaid criteria for admission to inpatient psychiatric services at the time of enrollment but are deemed by qualified mental health professionals to be able to be safely served in the community with the right mix of community-based services and supports in place.

| Service Type | Enrollment | SFY16 | SFY17 | SFY18 | SFY19 | SFY20 |
|---|---|---|---|---|---|---|
| # CME youth served/total Medicaid cost per youth | All CME youth served | 328<br>$55,175 | 431<br>$26,960 | 494<br>$23,640 | 402<br>$20,072 | 402*<br>$21,482 |
| | CME youth served 6+ months | 196<br>$39,663 | 233<br>$21,165 | 230<br>$24,856 | 167<br>$24,647 | 174<br>$27,619 |
| | Graduated CME youth[1] | 40<br>$42,275 | 56<br>$11,914 | 107<br>$14,898 | 89<br>$11,445 | 79<br>$15,309 |
| # Psychiatric Residential Treatment Facility (PRTF) served youth who had no CME involvement/ total Medicaid cost per PRTF-served youth (non-CME) | | 236<br>$55,197 | 228<br>$57,265 | 228<br>$58,027 | 243<br>$48,892 | 173<br>$47,045 |

*While the number of CME youth served above details the number of enrolled youth who received high fidelity wraparound services, it doesn't capture the numbers of others involved in this team based process. For every enrolled youth there are teams of caregivers, other family members/siblings, and community members whose numbers aren't captured by the enrollment data, who also benefit from the skills learned and services provided.

- PRTF admission data for CME-served youth up to six months after discharge from the CME:

| % and # of CME youth served 6+ months or > who admitted to a PRTF within 6 months after CME discharge | SFY16 | SFY17 | SFY18 | SFY19 |
|---|---|---|---|---|
| | 0.5%<br>(1/196) | 0%<br>(0/233) | 0%<br>(0/230) | 0.5%<br>(1/167) |

[1] "Graduated youth" is defined as those youth who have successfully transitioned from the CME program meeting all of their goals.

- The CME currently employs over one hundred (100) Wyoming residents with lived experience related to children and youth with SED/SMI to serve Wyoming children, youth and their families through it's program support staff, statewide network of care coordination, peer support and respite providers.
- Parents, guardians, and youth (18-26 y/o) who are alumni of the CME program are able to apply and become credentialed to provide CME services.
- Each CME-involved family is asked to identify a primary care resource or is helped by the CME to locate appropriate primary care resources and address any barriers to accessing primary care services ensuring CME youth and families have access to primary care resources.
- CME services have prevented children/youth from entering DFS custody and also helped return children in DFS custody to families and communities who are better prepared to meet their needs.
- The CME program serves youth with co-occurring complex behavioral health and development challenges which assists families and provides tools and support that helps youth with co-occurring needs remain in the community while waiting for DD waiver services. This additional support is especially important with the long waitlist times for access to the Children's DD (Supports and Comp) waiver.
- Satisfaction and fidelity-related surveys are sent to each CME Care coordination provider, parent, and CME-enrolled youth at their six month enrollment mark. This data is sent to a national database that evaluates all evidence-based high fidelity wraparound programs to assess fidelity to the HFW model. The national average HFW program fidelity score is 72% while the Wyoming Medicaid CME program's score is >75%. This level of fidelity to the model contributes to the success of the program and families/youth served.
- Wraparound got started several decades ago as a response to what was obviously **not** working well for children and youth with serious mental health or behavioral challenges, and their families. At that time, the kinds of intensive and helpful services and supports that children and families needed were often simply not available in their communities. And as for the services that *were* available, they were often focused on what the systems or providers wanted families and children to do, and not focused on what children and families needed in order to thrive. This meant that children and families would be involved with multiple systems and providers, with each one developing a separate plan telling the child and family what to do. Not surprisingly, outcomes from this situation were not good. Many children ended up placed in residential treatment far away from their families and communities, often for very long periods of time. After being out of home, it was hard for children to come back and do well in their home communities and schools. In contrast, Wraparound programs are able to keep children in their communities, producing better outcomes at lower cost.