Financing Systems of Care: An Overview of Funding and Resources to Maximize Sustainability

Presented by
Bruce Kamradt and Elizabeth Manley
Wraparound Milwaukee—Innovative Funding through Pooling Funds

Presented by Bruce Kamradt, MSW, Retired Director of Wraparound Milwaukee
What is Wraparound Milwaukee

- Created in 1995, it is a unique system of care for Milwaukee County children and adolescents with serious emotional, mental health and behavioral needs that cross child serving systems (e.g., mental health, juvenile justice, child welfare) who are at imminent risk of institutional type placements.

- 1,700 youth/families served annually (1,200 daily census)

- Operated by Milwaukee County government as a unique Care Management Entity (CME) under the 1915(a) provision of Social Security Act, it acts as a type of behavioral health HMO.
What is Wraparound Milwaukee (cont’d)

- Pools funds across child serving systems ($54 million for 2016) to increase flexibility and availability of funding – Wraparound Milwaukee is single payer
- One service plan and one care manager
- 42% of youth served are from juvenile justice system and 25% are referred from child welfare system, 30% non-court involvement
Rationale for the Creation of Wraparound Milwaukee

- Over utilization of out of home care for youth involved in the juvenile justice and child welfare systems including group/residential treatment, juvenile correctional placements, and psychiatric in-patient care – Too many youth being placed and for too long
- High cost of out of home care expenditures was causing serious deficits in juvenile justice/child welfare budget in Milwaukee County
- Poor outcomes for youth coming out of institutional placements concerned court, advocates and juvenile justice/child welfare officials
What is a Care Management Entity (CME)?

- An organizational entity that serves as the “locus of accountability” for defined populations of youth with complex challenges across service systems
- Without a good CME model, wraparound approaches are not as effective for high risk populations
- Is accountable for improving the quality, outcomes and cost of care for historically high-cost/poor outcomes populations
Wraparound Milwaukee Functions

<table>
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<tr>
<th>Administration</th>
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<td>▪ Assessment</td>
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<td>▪ Enrollment</td>
<td>▪ Care Coordination</td>
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<td>▪ Finance – claims processing and payment of providers</td>
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<td>▪ Liaison with courts</td>
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<td>▪ Dispute resolution</td>
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Our Philosophical and Treatment Approach

• We utilize a “high-fidelity” wraparound approach with highly individualized, strength-based, family directed care.

• Care coordinators facilitate the care planning teams with families having access to family advocates and educational advocates through Families United of Milwaukee.

• Ratio of care coordinators to families is 1:8.

• Care coordinators have unique legal roles in Wraparound Milwaukee and prepare reports, testify in court, prepare legal documents.

• Participation in Wraparound Milwaukee for youth adjudicated delinquent or children in need of protection or services is part of the court order (flex orders).
Pooling of System Dollars
Wraparound Milwaukee Funding Pool

1. To create flexibility, adequacy so that youth and families could really get all the services and supports needed and prevent "cost shifting", funds were pooled by using capitation, case rates, some fixed and fee for service funding methods.

2. Wraparound designated as "single payor" of care ($53 million pool for 1400 families).

3. Monies get de-categorized and follow the needs of the family and not the system.
How We Pool Funds

**Welfare**
- **Child Welfare**: $114.00 per day, Case Rate (Budget for Institutional Care for Chips Children)

**Juvenile Justice**
- **Funds Budgeted for Residential Treatment and Juvenile Corrections Placements**

**Medicaid Capitation**
- **$1893 per Month per Enrollee**

**Mental Health**
- **Crisis Billing**
- **HTI Grant**
- **HMO Commercial Insur**

**Wraparound Milwaukee Care Management Organization (CMO)**
- **$53.0M**

**Care Management Organization**
- **Child & Family Team or Transition Team**
- **Plan of Care or Futures Plan**
- **Families United $525,000**
- **Provider Network 150 Providers, 60 Services**

**Care Coordination or Transitional Specialist**
Why We Pool Funds?
Pooling funds across systems can create “win-win” scenarios

Wraparound Milwaukee Pooled Funding Model

- **Child Welfare**
  Alternative to out-of-home care or to stabilize & preserve foster care placements

- **Juvenile Justice**
  Alternative to detention, incarceration of youth with mental health issues, high cost/poor outcomes

- **Mental Health**
  Alternative to IP/ER costs, improve coordination between primary care & behavioral care

- **Education**
  Alternative to alternative school placement, unnecessary school suspensions/expulsion and poor school attendance

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Positive Outcomes do Matter
Reduction in Utilization (Cost & Usage) of Residential Treatment by Milwaukee County Youth

• Wraparound Milwaukee is designed to provide community-based alternatives to residential treatment

• In 1995, the first year Wraparound Milwaukee targeted serving youth in residential treatment centers, there were 375 Milwaukee youth in residential treatment placements

• Wraparound Milwaukee utilized a strategy to enroll all youth in RTC’s and those identified at risk for residential treatment placement over a 2 year period with a goal to reduce the need for such placements
Reduction in Utilization (Cost & Usage) of Residential Treatment by Milwaukee County Youth – cont’d

• System Stakeholders were interested from the start in whether Wraparound Milwaukee could reduce RTC use. Today there are 110 youth in residential treatment centers with a reduction in average stay from 14 months to 4 months.

• Wraparound Milwaukee continues to pay for and manage nearly all residential treatment placements of Milwaukee County youth and so we continue to monitor utilization for our system stakeholders.

• As the graph on the following slide shows, over the past four years the utilization of residential treatment services has declined each year since 2010 from 25.5% of total enrollees to 17.3% in 2013 and the cost per month per child (PCPM) has decreased from $1,110 to $910 in 2013 (through first six months of 2013).
Average Utilization Trends (Cost and Usage) of Residential Treatment by Wraparound Milwaukee Enrollees (2010-2013)*

*2013 (year-to-date)
Cost Effectiveness of Wraparound Milwaukee Versus All Types of Institutional Care

• Since Wraparound Milwaukee serves all Milwaukee County youth with serious emotional and mental health needs and is the single payor of care, one of our first studies was to compare the costs of WAM to institutional care.
• For the past 5 years, the average monthly cost of care for a youth in Wraparound Milwaukee has consistently been less than the average cost for institutional care.
• 6 year average monthly cost comparison:
  - Wraparound Milwaukee: $3,263
  - Group Home: $5,998
  - Correctional Facility: $8,374
  - Residential Treatment: $9,116
  - Psychiatric Hospital Stay (30 days): $38,130
Cost Effectiveness
Wraparound Milwaukee vs. Institutional Placements
Over Past Six Years
(average monthly cost of service)
Other Outcomes

- 40% increase in school attendance from time of enrollment to disenrollment
- 87% of youth achieved permanency upon disenrollment
- Improved clinical status based on CBCL and YSR
Questions? More Information?

- Go to wraparoundmke.com
The NJ Children’s System of Care

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STATE OF NEW JERSEY
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THE CHILDREN'S INITIATIVE
CONCEPT PAPER

A System of Care for Children with Emotional and Behavioral Disturbances and Their Families

Christine Todd Whitman
Governor

Michele K. Guhl
Commissioner

January, 2000
Summary of Children’s Initiative Concept Paper

In summary, the Children’s Initiative concept operates on the following abiding principles:

• The system for delivering care to children must be restructured and expanded
• There should be a single point of entry and a common screening tool for all troubled children
• Greater emphasis must be placed on providing services to children in the most natural setting, at home or in their communities, if possible
• Families must play a more active role in planning for their children
• Non-risk-based care and utilization management methodologies must be used to coordinate financing and delivery of services
Service Array Expansion to Reduce Use of Deep End Services

Prior to Children’s System of Care Initiative

Out of Home

Low Intensity Services

Out of Home

Intensive In-Community
- Wraparound – CMO
- Behavioral Assistance
- Intensive In-Community

Lower Intensity Services
- Outpatient
- Partial Care
- After School Programs
- Therapeutic Nursery

Today

Out of Home

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The NJ Children’s System of Care Serves:

- Behavioral health: Youth with moderate and complex needs, entire NJ population
- Behavioral Health Home – youth with chronic medical conditions in coordination with behavioral health
- Child welfare: Youth with child welfare involvement and a treatment need
- Developmental disabilities: Youth eligible for services based on regulatory definition of functional impairment
- Substance use: Youth who are underinsured and have a treatment need
Language Is Important

Client
Case
Placement
Department of Children and Families
Division of Children's System of Care (CSOC)

- Trauma Informed SOC, Utilizes an Integrated Approach to Care
  - Embedded in System of Care Approach (values and principles)
  - Policy Authority, Funding Agency
  - Approves and manages the Provider Network (BH carve out; Providers bill on fee for service basis)

Contracted System Administrator (ASO+)
- Single Point of Entry and Access to Care 24/7
- Triage, Utilization Management
- Care Coordination
- Authorizes Services
- Non risk based
- Hosts CSOC’s MIS (EHR and Data)

Family Support Organizations
- Family-led peer support and advocacy for parents/caregivers and youth group

Mobile Response & Stabilization Services
- Crisis response and planning; 24/7/365 within 1 hour

Care Management Organization
- Utilizes wraparound model to serve youth and families with moderate and complex needs; designated health home entity

Children’s Interagency Coordinating Council (CIACC)-One per county (21)-local planning bodies

Other Authorized Services includes but is not limited to:
- Biopsychosocial Assessments
- In home Clinical/Therapeutic
- Out of Home Care (OOH)
- Partial Hospitalization/Partial Care
- Substance Use Services
- In home Behavioral for I/DD youth
- Family Support Services for I/DD Youth
- Non Medical Transportation
- Interpreter Services
- Outpatient
- Assistive Technology

1115 Waiver-Children’s Supports Waiver, I/DD and SED
State Plan Amendments
- Targeted Case Management-CMO
- Psych under 21 Benefit-OOH Programs
- Rehabilitative Option-MRSS, IIC/BA, Out of Home
State Option to Provide Health Homes
- Flex Funds

Populations served are youth (and their families) with one or more of the following:
- Behavioral health challenges
- Substance use challenges
- Intellectual/developmental disabilities
- Autism
- Youth with multisystem involvement: child welfare and/or juvenile justice

**Youth with multisystem involvement:
- Child welfare
- Juvenile justice

Dept. of Human Services
Division of Medical Assistance and Health Services (Medicaid)

Dept. of Human Services
Division of Mental Health and Addiction Services

Dept. of Human Services
Division of Developmental Disabilities

Rutgers UBHC Training and Technical Assistance

- Trains All System Partners, Families

CANS ASSESSMENT TOOL
- Utilized in Triage, for Treatment Planning and Outcomes Tracking

State and Federal Appropriation

Title XIX and Title XXI

Children's Interagency Coordinating Council (CIACC)-One per county (21)-local planning bodies
1999
NJ wins a federal system of care grant that allowed us to develop a system of care.

2000 - 2001
NJ restructures the funding system that serves children. Through Medicaid and the contracted system administrator, children no longer need to enter the child welfare system to receive behavioral health care services.

2006
The Department of Children and Families (DCF) becomes the first cabinet-level department exclusively dedicated to children and families [P.L. 2006, Chapter 47].

2007 – 2012
The number of youth in out-of-state behavioral health care goes from more than 300 to three.*

July 2012
Intellectual/developmental disability (I/DD) services for youth and young adults under age 21 is transitioned from the Department of Human Services (DHS) Division of Developmental Disabilities to the DCF Children’s System of Care (CSOC).

July 2013
Substance use treatment services for youth under age 18 is transitioned from DHS, Division of Mental Health and Addiction Services, to DCF/CSOC.

July 2015
NJ is awarded a Federal SAMHSA Grant System of Care - Expansion and Sustainability.

May 2013
Unification of care management, under CMO, is completed statewide.

December 2014
Integration of Physical and Behavioral Health is piloted in Bergen and Mercer County with expected Statewide rollout.

*How did we do this? Careful individualized planning and the development of in-state options (based on research about what kids need) using resources that were previously going out of state.
NJ Structure – Who Does What?

- Division of Mental Health and Addiction Services
- Licensing for Hospitals
- Probation
- Family Court
- Training School
- Juvenile Detention Alternative Initiative
- Children’s System of Care
- Division of Child Protection and Permanency
- Division of Medical Assistance and Health Services – Medicaid
- Division of Developmental Disabilities
- Department of Children and Families
- Department of Human Services
- Administrative Office of the Courts and Juvenile Justice Commission
- Department of Health
- Division of Mental Health and Addiction Services
- Licensing for Hospitals

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Financing
Title XIX Funding
- Rehab Option
- Targeted Case Management
Child Welfare
Juvenile Justice
1915 like (i) or (c)
1115 Waiver
CHIP/SCHIP
State Funds

Environment
Political Perspectives of Leaders
Lawsuits/Settlements
Crisis/Tragedy
Mandates
Community Will
Economy

Priorities
Increase Access to Care
Addressing Urgency
Evidence Informed Care
Care Management
System Coordination
Reduce Institutional Care
Meet the Needs of Particular Populations

Factors That impact Design

NJ CSOC
Final System of Care Design
Values & Principles

Structure
Government
State and County
Existing Reality
Envisioned Ideal
Medicaid Agency
Locus of Control
Leadership Structure
NJ Model for Providing Care

- Public Health Approach
- Single Point of Access – With a focus on Cultural Linguistic Competence
- Individualized Planning as a Driver to Care
- Family Driven
- Youth Guided
- Focus on Community Engagement
NJ Governance Structure

- NJ Department of Family and Children Children’s System of Care
  - Children, Youth and Young Adults and their Parents and Caregivers
  - Children’s Interagency Coordinating Councils – Community Planning Table

Division of Medical Assistance – the Single Medicaid Authority

System Partners-CMO, FSO, MRSS, OOH, IIC, CIACC Members

Community Members

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Evidence Based and Informed Approaches in NJ

- The Nurtured Heart Approach Large Scale Adoption
- Wraparound for youth with Moderate and Complex Needs with Behavioral Health, Substance Use, Intellectual/Developmental Disabilities
- Functional Family Therapy for youth engaged with Juvenile Justice and Child Welfare Systems
- Multisystemic Therapy specific for youth engaged with Family Court
NJ Evidenced Informed Services Used within Wraparound

Behavioral Health
- Intensive In Community with focus on TF-CBT, NHA, DBT
- Social Emotional Learning

IDD and Autism
- Applied Behavioral Analysis (ABA)
- DIR/Floortime (in process)
- Individual Supports
- Respite

Substance Use
- Trauma Focused CBT
- Motivational Interview
- Dialectal Behavioral Therapy
- Medication Assistance Treatment
Out of Home Treatment Interventions in a System of Care

✓ Home Like Environment
✓ Trauma Informed
✓ Goal is for the child to feel better
✓ No breaks for the team when the youth is in an out of treatment intervention
✓ There are diminishing returns on long lengths of stay
Promising Path to Success System of Care Expansion Grant

✩ Reduce the percentage of youth in the system of care who require multiple episodes of Out of Home (OOH) treatment

✩ Reduce the percentage of youth who re-enter treatment after discharge from an initial treatment episode

✩ Reduce the average length of stay for youth in OOH treatment from 11.5 to 9 months

✩ Analyze and understand the impact of each type of system involvement to aid in making resource allocation decisions
Key Components of Each Phase

**Kick Off**
- Local Kick Offs

**Training**
- Six Core Strategies (6CS) for OOH, CMO, FSO, MRSS & CIACC Leadership
- Nurtured Heart Approach (NHA) for OOH, CMO & FSO staff

**Sustainability**
- Coaching for OOH on 6CS implementation
- Nurtured Heart Approach (NHA) Super User Group
The CANS is a tool that is used with youth for all levels of care:

- Additional Assessment are used as appropriate
- Independent Needs Assessment
- Mobile Response and Stabilization uses the Crisis Assessment Tool
- Care Management and Behavioral Health Home use the CANS every 90 days for every youth engaged with in Care Management
NJ Center for Excellence and Workforce Development

Center for Excellence

Roles for Each Partner

- NJ CSOC sets the vision, policy, budget and manages the provider pool.

- The CSA, PerformCare is the single point of access, provides utilization management, has the electronic record, and connects to Medicaid.

- Rutgers Training Partners train the workforce and communities and has responsibility for the certification process for CANS, Care Management, Family Support, MRSS and Behavioral Assistance, provides coaching and technical assistance.

- Boggs Center responsible for training and consultation specific to youth with IDD.

- Autism NJ responsible for the training and consultation specific to Autism.
NJ Communication Strategies

- Newsletters
- Data Dashboards
- Resource Nets – www.monmouthresourcenet.org
- Meet the Director Events
- Face to Face Meetings with all System Partners
- Face to Face Meetings with Associations
- Social Media such as Facebook
- Written Materials
- Training
- Learning Collaborative
NJ Quality Improvement Plan

- Data
- Rigorous Debrief
- Training and Workforce Development
- Systems Review
- Local Feedback Loops
Some Evidence of Success

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

ROI Analysis of the CSOC Expansion

21-42 months

Baseline ROI Analysis and Refine Analysis Plans

*Months 13-20*

Prepare Data for ROI Analysis

*Months 7-12*

Develop ROI Analysis Plan

*Months 1-6*
For more information...

Children’s System of Care

http://www.state.nj.us/dcf/families/csc/

PerformCare Member Services 877-652-7624
www.performcarenj.org

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Questions?