MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION
CHILDREN'S MENTAL HEALTH SERVICES

WRAPAROUND MILWAUKEE

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MEMO

Date: June 4, 2007

To: Alice Galloway
Janice Gratton
Lynn Saxton
Mitch Anderson

From: Bruce Kamradt, Director, Wraparound Milwaukee and Financing Consultant

Re: ***Financing Models for Systems of Care***

As I discussed with you, here are some brief summaries of seven system of care models with innovative funding schemes that could be models for the statewide Oregon Wraparound Program – particularly around financing. Some are state operated models including New Jersey, Massachusetts, Pennsylvania and Arizona and other are locally developed systems including Wraparound Milwaukee and the DAWN Project in Indianapolis. There are funding diagrams for several models to help visualize how funds flow into and out of the various models. There are probably other models to look at, but these are generally considered among the best.

There are several aspects of each of these plans that I think are worth noting in the design of a system of care and financing model in Oregon.

I think the Massachusetts Rosie D versus Romney is interesting because it mandates universal screening (and screening tool) for behavioral health across pediatrician's offices, public health and child-serving system and than mandates a comprehensive assessment for youth requiring further mental health assessment based on the screen. Massachusetts would also require that every child needing more than regular outpatient services would get a coordinated services team (wraparound child and family team) and a care manager provided through a statewide system of Community Services Providers. It also sets up two levels of care management depending on the intensity of need of the child.

Pennsylvania's model uses county MCOs, much like Oregon currently does, but requires interagency service planning teams for all children with serious emotional and mental health needs. It also has a broad benefit plan and has loosened the requirements for, and developed "family-friendly" medical necessity criteria.

The Integrated Services Programs in Wisconsin (for counties other than Wraparound Milwaukee with the HMO model) is an example of more of a braided funding model. But the language for the required coordinated services team, development of the Coordinated Services Plan, responsibilities of each service system for services and funding contribution is written in statutory language. It also has required local coordinating committees to oversee each program and help determine needed funding support and arrangements.

Arizona's Child and Family Team model also requires statewide implementation of child and family teams for all youth with serious emotional and mental health needs. It also utilizes a very broad benefit plan.

New Jersey, Wraparound Milwaukee and DAWN offer the best examples of blending funding to meet the needs of youth with serious emotional and behavioral problems. All three programs serve youth and their families who are Medicaid or non-Medicaid eligible. New Jersey and Wraparound Milwaukee maximize the use of Child Welfare and Juvenile Justice funds (and DAWN with education funds) to support the broadest and most flexible array of mental health, substance abuse and even social services. Both have been able to use the pooling of funds to maximize other federal monies for the funding pool.

New Jersey pools the funds at the State level and creates local Care Management Organizations to provide care coordination/case management services and facilitate child and family teams. Like Milwaukee and DAWN, New Jersey has strong parent participation and advocacy through local based parent partner agencies. In New Jersey, local Providers bill the State MCO/Value Options directly to provide payment for services.

Wraparound Milwaukee (and DAWN) are County based. Wraparound Milwaukee has the most comprehensive funding and benefit plan. It relies on case rates and fixed funding to obtain funds from system partners including Child Welfare and Juvenile Justice and a capitated arrangement to obtain funds through Medicaid.

All three systems utilize care managers with very similar ratios for care managers to families (about 1:8 to 1:10). All three systems have heavily invested in very good (IT) information systems to manage and support their program operations.

Many of the features of these systems I discussed when I was in Oregon last week, but this will provide further reference information for those who either attended the finance sub-committee meeting or have an interest in fiscal models for Oregon.