# SYSTEMS OF CARE
# FINANCING MODEL

## OREGON – STATEWIDE APPROACH
## UTILIZING BOTH MEDICAID AND NON-MEDICAID FUNDS

Target Group – Children and youth birth to 18 who have emotional and behavioral health problems and who touch at least two systems. This population includes children and youth who are at risk as well as those who already have a diagnosed problem.

Presumptive Eligibility – Financial Eligibility – All children who meet clinical and programmatic criteria – across payer sources

Funding Approach – Blend all resources at the state level for the necessary services and supports for the target population.

- Mental health
- Addictions
- Child welfare behavioral health services and supports and foster care
- Education – state and local for behavioral health services and supports
- Medicaid
- Public Health behavioral health services and supports
- Juvenile Justice
- Local investments
- Oregon Youth Authority – community behavioral health services and supports
- Commission on Children and Families – behavioral health services and supports
- Early childhood – education, childcare
- Commission for Children and Families

Comment: Interim steps may be necessary – e.g., state or local braiding. Develop future relationships with private insurers.

Administration of Funding – Statewide Purchasing Collaborative – Government Entity vs. Private Entity – driven by common policies for

- service definitions
- rates
- credential requirements



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- administer payments in standard manner
- report on federal funding requirements administration, data, outcomes, evaluation

Comment: Local or regional services could be financed through either risk based managed care contracts, administrative service organizations or fee-for-service strategies. More discussion of these options is necessary prior to formalizing a recommendation.

Administration of Benefits to be done locally using common definitions, outcomes, data reporting requirements, etc., risk based or non-risk based

Provider Network – Statewide policy standards for providers, certified or licensed providers and "non-traditional" providers, need to be part of the system. Each eligible child/family has a care coordinator.

Youth, Young Adult and Family Involvement -- Family Support Organizations (FSOs) – should be broaden to include youth and young adults.

- Involved in statewide policy making oversight of statewide purchasing collaborative.
- Locally involved in administration of local delivery system – policy oversight.
- Is part of provider networks as family advocates, navigators, etc.

Benefit Plan – Universal screening leading to comprehensive assessment when needed and done in natural settings. Inclusive of care management, broad array of substance abuse, mental health assessment and treatment services (inpatient, outpatient, day treatment, residential and broad array of flexible services, treatment foster care, home based, school based, seldom office based, respite, independent living, etc.) Appropriate services for behavioral health issues seen in juvenile justice system, including sex offender treatment, and other treatment geared to juvenile offenders. Financial incentives for breadth of services, evidence-based practice accountability parameters in delivery of services. Appropriate for all age groups.

Screening and Assessment – Universal screening from earliest age. Comprehensive assessment – yielding coordinated service plan

- Effective Risk Assessment for juvenile justice clients

Care Management –

- Critical
- Locally-based
- Inclusive of all needs
- Fidelity to recognized wraparound model – caseload size
- Accountable to systems and family

Outcomes – Method of tracking core outcomes must be built into care plan. Youth should be at home, in school, with friends, and out of trouble. Outcomes to include education, child welfare, and juvenile justice. Performance based contracts with incentives and requirement to report to feds (NOMS).

Quality Assurance, Quality Improvement – Active monitoring of client outcomes through formal QA/QI program. Monitoring of clinical outcomes on standardized tools; reduction in restrictiveness of living, improved school attendance/performance, reduction in recidivism rates for delinquent behavior, family satisfaction with service and overall reduction in cost of Wraparound versus institutional care.

Info Systems – Management Information System and Payment System –

- Real time authorization of services
- Tracks outcomes state, regional, local
- Electronic medical records – internet operated
- Ability to meet federal reporting requirements.

Work Force Changes –

- Develop family support for addictions
- Continue to develop, grow, family support and youth involvement
- Comprehensive plan for work force development
  - Administrators
  - Culture change
  - Supervision/Clinical change
  - Clinical delivery change
- Include judges, juvenile justice, parole, probation, county commissioners
- Physicians – education, information sharing
- Educators – information sharing
- Develop universal language – change way we think about and show respect for children and families with or at risk for complex problems.



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