A Building Bridges Initiative Leadership Series Document

Innovative Fiscal Practices Employed by Wraparound Milwaukee: A 20-Year Perspective on Promoting Community-Based Services and Short-Term Residential Interventions that Support Better Long-Term Outcomes for Youth and Families

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Introduction

Bruce Kamradt had the good fortune to serve as director of Wraparound Milwaukee, recognized nationally as one of the best systems of care for children and adolescents (hereafter most often referred to as "youth") with serious emotional and behavioral health needs and their families, since its inception in 1995. When Bruce left his position in 2015, Wraparound Milwaukee had expanded from serving 25 children per year to serving more than 1,700 families per year. Most youth and families served are racially and ethnically diverse, with approximately 65 percent African-American, 24 percent White, 10 percent Hispanic/Latino and 1 percent Native American or Asian. Wraparound Milwaukee has won several awards, including being named as an exemplary model in children's mental health by President George W. Bush's New Freedom Commission on Mental Health in 2004 and earning the Harvard University Kennedy School of Government's Best Innovation in American Government Award in 2009.

In bestowing these accolades, the award bodies made references about the innovative fiscal approaches used to fund the Wraparound Milwaukee (WM) model; the flexibility in how WM arranged, paid for, and delivered services to children and their families; and the reduction in the use of institutional care, including residential treatment, psychiatric inpatient hospitalization, and juvenile correctional placements. The award bodies also highlighted the positive programmatic and clinical outcomes achieved for the youth and families served, such as improved school attendance, reduction in recidivism rates for juvenile offenders, high rates of child permanency, high rates of family satisfaction, and more.

This BBI (Building Bridges Initiative) Leadership Series Document focuses on the innovative fiscal and program practices employed by Wraparound Milwaukee that have directly impacted the reduction in the utilization of residential treatment services (hereafter most often referred to as "residential interventions"), as well as psychiatric inpatient hospitalization, in Milwaukee. Many of these practices are now being used in other communities across the United States to purchase, deliver, and manage child and youth behavioral health services, including residential services.

Twenty years ago, a significant focus of residential treatment programs was the milieu — the treatment environment. Models of group/milieu treatment were often long term and costly, although there was limited research support demonstrating positive outcomes for long-term residential placement.[1] Most states and localities want to serve more youth and families in the community, want to reduce the inappropriate use of residential, want to have shorter lengths of residential stay (i.e., less than six months), and want to fully integrate residential with community systems of care. This was the case in Milwaukee when Wraparound Milwaukee was created in 1995 under one of the first 10 Center for Mental Health Services (CMHS) system of care grants. The county sought to develop new fiscal strategies and practices to reduce

[1] Hair, H.J. (2005). Outcomes for Children and Adolescents After Residential Treatment: A Review of Research from 1993 to 2003. J Child Fam Stud 14(4): 551-575. https://doi.org/10.1007/s10826-005-7188-9

residential treatment costs and encourage new approaches to care that keep youth with their families in their homes and communities. These new strategies also had the goal of achieving better long-term outcomes for youth and their families.[2]

This is the first of BBI's Leadership Series Documents; it is one of many documents on the BBI website (*www.buildingbridges4youth.org*) that support residential and community stakeholders serving youth and families who receive residential interventions to improve practice toward improved positive outcomes for youth and families. BBI would like to thank the diverse group of family and youth partners and other BBI consultants who provided input into this document.

This BBI Leadership Series Document features 10 tips that articulate innovative fiscal practices employed by Wraparound Milwaukee. Wraparound Milwaukee was a pioneer in the use of population-focused Medicaid capitation, population-based case rates, performance contracts with providers, values-based utilization management tied to quality goals, and intensive care coordination using fidelity Wraparound, which incorporates a focus on social determinants of health and use of data to drive quality. The experience of WM holds lessons for today's Medicaid managed care and value-based purchasing environments. This document is intended to be of value to state and county administrators, officials, and purchasers of residential and community interventions. This document should also benefit residential providers by supporting them to focus on developing and implementing innovative programs and strategies that align with these innovative practices.

The 10 tips and innovative fiscal practices included in this document can help states as they transform their systems to respond to the requirements of the Family First Prevention Services Act of 2018 ("Family First"). The legislation focuses on preventing the removal of children and youth from their families and supporting less restrictive and more family-like settings such as foster or kin family when removal is deemed necessary. Family First also limits the use of other types of living situations and sets increased expectations for residential interventions with a newly defined level of care – Qualified Residential Treatment Programs (QRTPs). Therefore, states will need to adopt or expand innovative fiscal practices that promote community-based services and short-term residential interventions, resulting in better long-term outcomes for youth and families. Because Title IV-E funds are essentially the payer of last resort under Family First, the fiscal practices included in this document will also help states consider diverse funding strategies for prevention services (e.g., mental health and substance abuse prevention and treatment) that are to be provided under the legislation.

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[2] Epstein, M.H., Kutash, K., & Duchnowski, A.J. (Eds.). (1998). *Outcomes for Children and Youth With Emotional and Behavioral Disorders and Their Families: Programs and Evaluation Best Practices*. Austin, TX: PRO-ED.

10 Tips: Innovative Fiscal Practices Employed by Wraparound Milwaukee

1. Realigning Funding Streams by Pooling New or Existing Monies

As this BBI document will share, one way to encourage the use of short-term residential treatment or alternatives to residential treatment is creating flexibility to fund a comprehensive array of in-home and out-of-home services. This is best accomplished when systems of care "blend" or "braid" monies from multiple funding streams, such as Medicaid and child welfare, juvenile justice, and education entities. When the dollars that pay for services are pooled, greater flexibility is achieved, and, typically, more dollars become available to pay for services and supports because the purchaser and families choose home- and community-based services over more expensive and restrictive institutional care. Dollars also become more flexible to meet the individual needs of youth and families. The idea is to "de-categorize" funds from their original, often-restricted purpose. Breaking down the funding silos allows money to truly follow the needs of youth and their families. Wraparound Milwaukee's experience demonstrates that when given a choice, and a variety of service options to meet their youth's needs in the home, families choose approaches that incorporate community services more often than institutional services. The image on the next page, "How We Pool Funds," demonstrates how Wraparound Milwaukee blends more than $53 million in Medicaid, child welfare, and juvenile justice funds to create a flexible pool of money to fund all care and treatment needs identified by the youth and family.

The image on the next page depicts that the funds are received by Wraparound Milwaukee through the following mechanisms: a capitation agreement with the Wisconsin Medicaid Program to cover mental health services; a case rate negotiated with Wisconsin's Child Welfare Department; and case rates from the county's delinquency and court services program. The funds are managed by the Milwaukee County child behavioral health division, which has organized itself as a Care Management Entity (CME) for this purpose (discussed more fully below).

Once the funds reach Wraparound Milwaukee's "blended" funding pool, the dollars are available to support individualized plans of care developed by Child and Family Teams (CFT), which identify what the youth's and family's strengths and needs are and decide what services and supports best meet those needs. A comprehensive network of community providers, organized by Wraparound Milwaukee, is available to provide those services under agreed-upon rates and standards established by Wraparound Milwaukee. The providers then invoice Wraparound Milwaukee for payment. The approach is seamless for families, who once enrolled in Wraparound Milwaukee, do not have to worry about applying for funds or submitting documents to access services for their child. Other states and communities, such as the New Jersey and Louisiana Children's Systems of Care, have adopted similar ways to blend or braid funds[3].

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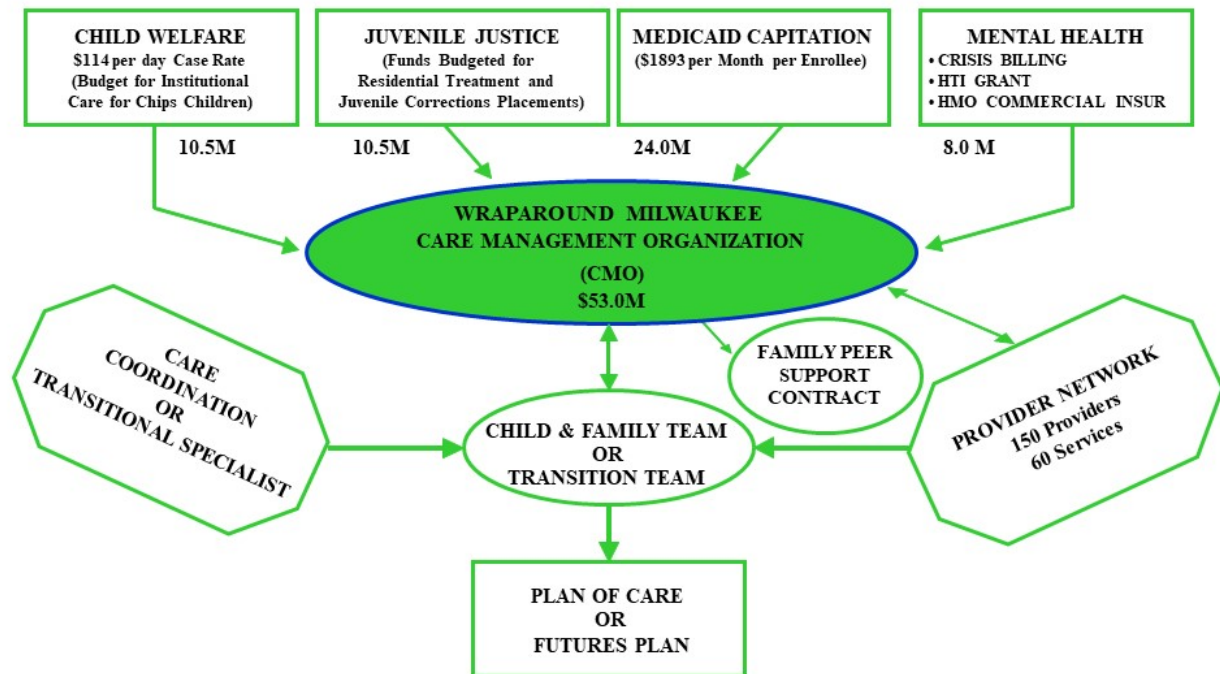
[3] For more information on other states that have pooled funds, see: http://rtckids.fmhi.usf.edu/rtcpubs/hctrking/pubs/Study3secondedition.pdf

How We Pool Funds



Braided funding, while not principally used in Milwaukee, is another method to pay for services and supports. While similar to blended funding, the dollars used to purchase services in a "braided" approach remain within the system that originally received them, which allows for tracking at the administrative level by each contributing agency. Agreements to fund services with braided funds may be operationalized on an individual child basis, where the dollars follow each child referred, or they may be braided systemically through agreements among agencies that certain identified funds can be tapped to support children served through the braided funding approach. Blended or braided funding approaches are more flexible and more efficient than strict categorical funding of services because they support individualized service provision and help to ensure that youth and families receive what they actually need, want, and will use.

2. Funding a Care Management Entity (CME) Model Can Incentivize Short-Term, Outcome-Focused Residential Interventions

Blending or braiding funding necessitates the development or designation of a “locus of accountability,” such as a CME, for the purchase and management of services and funding for the population or populations of youth who are the intended beneficiaries of the funding arrangement. Often, communities focus on youth at risk of or in a residential intervention, as Milwaukee did, because of opportunities to improve the quality of care and create cost efficiencies for these youth by redirecting dollars from “high-cost, poor outcome” spending to home and community-based services and intensive care coordination, typically through a high-fidelity Wraparound approach, as Milwaukee did. Medicaid, child welfare, juvenile justice, mental health, and schools may contract with and contribute funds to the CME, charging the CME with purchasing all or many of the services required by these youth with complex needs.

To have one entity oversee and manage the care of youth with severe emotional and mental health needs who are at risk of out-of-home “institutional” placement was the decision made in Milwaukee County in 1995 to create the Wraparound Milwaukee CME. CMEs focus on developing comprehensive, community-based systems of care that can appropriately reduce the number of youth receiving residential interventions and psychiatric hospitalization. Models such as Wraparound Milwaukee, New Jersey’s and Louisiana’s systems of care, and others have seen reductions in the numbers of youth receiving residential interventions, and reductions in the length of stay and use of psychiatric inpatient hospitalization because they focus on building community-based systems of care for youth with complex needs and their families.[4]

It is critical in communities adopting the CME model that the residential programs and the CME work collaboratively. CMEs are usually focused on “purchasing outcomes” rather than placements, so they want to incentivize providers to achieve the best possible outcomes for these youth. To do this, they look for residential interventions that are willing to be innovative in their service delivery, highly individualized to the needs of each youth and their family, willing to keep length of stay short, ensure families are full partners in all aspects of their child’s treatment and actively involved in treatment decisions, and focus on ways to support transitional plans and services.

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[4] Stroul, B.A., Pires, S.A., Boyce, S., Krivelyova, A., and Walrath, C. (2014). Return on Investment in Systems of Care for Children With Behavioral Health Challenges. National Technical Assistance Center for Children’s Mental Health. Available at https://gucchdtacenter.georgetown.edu/publications/Return_onInvestment_inSOCsReport6-15-14.pdf See also McGill, K., and Rea, K. (2015). New Jersey’s Historical Development of a Statewide Children’s System of Care, Including the Lessons Learned From Embedding CANS Tools: Developments, Innovations, and Data Analysis. SAGE Open: 1-11. https://doi.org/10.1177/2158244015602806

Payment options to a residential provider can include the use of case rates or "bundled payments" to provide an array of residential and community options within a specified time period. There can be graduated payment schemes developed with payment higher at the start of an intervention, and then reduced as the child progresses in treatment and achieves the stability needed to transition back to the community.

Wraparound Milwaukee uses a type of per-diem case rate to pay three residential providers to provide care coordination services for youth and families in the system of care. Care coordination has been a critical component in the success of Wraparound Milwaukee's model. Coordinators facilitate the Wraparound process for families, coordinate the delivery of services determined by the CFT, work closely with child welfare and juvenile justice workers to ensure there is agreement with the plan and continually monitor the effectiveness of the plan making revisions as determined needed by the Child and Family Team. Many other states have adopted strong care coordination models, including New Jersey, Massachusetts, Maryland, Connecticut, Louisiana, and Oklahoma.

Finally, the creation of a pool of flex funds, which are non-designated and can be used to pay for services and supports that are part of treatment plans for youth and families that might otherwise go unreimbursed (e.g., YMCA memberships, schoolbooks, music or art lessons, bus tickets, emergency food, clothing, shelter). Such services and supports can be critical to ensuring that a residential intervention remains short-term by meeting youth's and families' critical needs and addressing issues related to social determinants of health. While CMEs routinely invest in these funds to support families, residential programs can also make flex funds available to support family involvement (e.g., transportation for the youth to spend time at home and in the community frequently, buying bedroom furniture so the youth can sleep at home) while a youth and family are receiving the residential intervention and throughout the time they are transitioning home.

3. Creating a Comprehensive Service Array to Broaden Service Options

To truly be effective in reducing the need for residential interventions and/or reducing lengths of stay to, ideally, 90 to 120 days, communities need to build comprehensive service networks with a robust array of services and quality providers to meet the needs of youth and families. A comprehensive benefit in Medicaid is especially helpful, but a funding arrangement that also draws on non-Medicaid dollars can help ensure that a range of alternatives is available to youth and families. On the residential side, most county and state purchasers consider residential treatment as a means to stabilize a youth's behavior. They want the residential intervention to initiate services that are specifically addressed at meeting the presenting need for an out-of-home treatment program, and, as those needs are met, to work on continuing treatment and support services in the community. Purchasers also are looking, as Wraparound Milwaukee

was, to find residential programs that will diversify service options, including providing intensive in-home family therapy, crisis/respite beds for short-term residential interventions of 24 hours to a few weeks, and therapeutic or professional foster care. Many states and communities, such as Connecticut, New Jersey, Oklahoma, Michigan, and Wisconsin, have moved toward developing or have developed mobile crisis and crisis stabilization services that also are covered by Medicaid to help youth and their families avoid or address a crisis that could lead to an unnecessary use of residential intervention.[5] In Wraparound Milwaukee, other systems, such as child welfare, have contributed general revenue dollars for Medicaid match to expand mobile response and stabilization capacity.

Diversifying service options means diversifying residential programming, and, perhaps most importantly, developing an array of community-based services that can be delivered in the community as an alternative to residential treatment or as a follow-up intervention from the residential program to transition the child back to their home, family, and community. The image on the next page, "Comprehensive Service Array," is a sample list of services and supports developed by Wraparound Milwaukee. Services and supports are available to families based on needs identified by the CFT. Families have a choice of providers who they think can best meet their child's and family's needs. Clinical and behavioral interventions, access to a 24/7 mobile response and stabilization service operated by Wraparound Milwaukee, strong youth and family peer supports (Wraparound Milwaukee contracts with community vendors for this service), and short-term crisis/respite placement options are critical to enable youth and families to live successfully in their homes and communities.

[5] For more information, see Chapter 1.1. "Crisis Management at the Service Delivery and Systems Levels" in Pires, S.A. (2002). *Building Systems of Care: A Primer.* Washington, DC: National Technical Assistance Center for Children's Mental Health, Georgetown University.

Comprehensive Service Array

Behavioral & Clinical Services	Supportive Services	Service Coordination
Crisis intervention	Mentors	Care coordination
Individual therapy	Crisis 1:1 stabilizer	**Respite**
Intensive in-home therapy	Tutor	Crisis/planned respite
Evaluation	Parent/family aide	Residential respite
Substance abuse therapy (individual and group)	Life coach – independent living	**Discretionary**
Special therapy (i.e. behavioral management team)	Employment preparation and placement	Flex Funds
Day treatment	Job – internship	Clothing
Medication management	**Other Supportive**	Food/groceries
Placement Services	Camps	Housing assistance
Acute hospitalization	After school	Child care
Foster home and treatment foster home	Suspension accountability	Furniture, appliances
Group home care	Transportation	YMCA membership
Residential treatment	Interpretive services	Educational expenses
Crisis/residential, group care, treatment foster care	Equine therapy	
Supported independent living	Consultation with other professionals	

Use of blended or braided funds, managed by an accountable entity like a CME, allows for creativity in payment and purchasing strategies with providers. Service descriptions, standards of care, and rates paid are set by Wraparound Milwaukee as the CME. Rates can be hourly, daily, monthly, or, in some cases, “bundled,” depending on the service type. Wraparound Milwaukee develops a qualified provider network. Competition promotes quality and cost efficiency as families have a choice of providers and of the types of services and supports needed. Basically, providers must do a good job to attract customers to use their services and get paid. The Wraparound Milwaukee provider network includes more than 150 community agencies, a sizable number of racially diverse providers, and all the residential treatment providers in the area. The provider network encompasses more than 70 types of services; see Appendix A for a full list of services.

The use of residential interventions, or “bed” days, has gone down significantly over the past 20 years, from about 350 beds to around 100 beds. In Milwaukee, residential providers that have diversified their service array to include community-based services have greater financial

viability. As the volume of services provided and the number of families served have gone up, the monies saved from institutional costs have stayed in the system, and been redirected to home- and community-based services. Many of these home- and community-based services are now provided by residential providers that formerly offered only beds.

4. Maximizing Medicaid as a Payer Source

A core strategy to finance alternatives to residential interventions and support short-term residential interventions is for child- and family-serving systems to access Medicaid dollars to finance a broad array of services and supports that may have traditionally been fully covered by local or general state funds. Use of Medicaid dollars expands available dollars by bringing in the federal Medicaid match. Rather than taking advantage of various Medicaid options and strategies — and maximizing Medicaid eligibility and/or using enrollment in the Children's Health Insurance Program (CHIP) — some communities have restricted the funds used to pay for services for youth with complex needs to child welfare, juvenile justice, and other local or general state funds. This approach restricts development of service arrays and diversification of providers that have limited funding options and forgoes the state's ability to draw down federal Medicaid match for populations of youth who are Medicaid-eligible.

The Joint CMCS/SAMHSA Informational Bulletin issued in May 2013 is a helpful resource for states that wish to maximize Medicaid coverage of behavioral health services for children and youth with serious emotional and mental health needs. This bulletin is intended to assist states in designing their Medicaid benefit to meet the needs of these children and youth by outlining effective community support services that can be covered by Medicaid. Intensive care coordination, peer support services, intensive in-home services, mobile crisis response, residential crisis stabilization, and flex funds are among the services described.

Some states have looked to increase Medicaid eligibility to as high as 300 percent of federal poverty level ($75,300 for a family of four in 2018)[6] to enhance eligibility for services. Others, such as Massachusetts, have expanded their state Medicaid plan by adding new services such as peer support, in-home therapy, intensive care coordination using Wraparound, mobile crisis, and other supports. States also may use various Medicaid waivers — including 1915(a), which Wisconsin used for Wraparound Milwaukee, 1915(b), 1915(c) (Louisiana uses both of these), and 1115, used by New Jersey — and some states have used the Health Home State Plan option, including Oklahoma and New Jersey, all of which can be used as vehicles for expanding Medicaid coverage for services and care coordination for children with complex health and behavioral health needs.

[6] See https://aspe.hhs.gov/poverty-guidelines

Wisconsin received approval for a 1915(a) waiver that allows selected counties to create unique managed care entities, such as Wraparound Milwaukee or Children Come First in Dane County, WI. Coverage for all services in the state plan, all Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)-covered services, and several new services, such as peer support specialist, health care coordination, and psycho-education, are included in the waiver. Wraparound Milwaukee's contract with the state Medicaid agency also covers the treatment portion of residential services, or about 50 percent of residential costs. The inclusion of Medicaid funds in the system significantly reduced child welfare and juvenile justice expenditures for out-of-home care as well as for community services, producing a win-win situation for these agencies in return for their contribution to the funding pool that supports Wraparound Milwaukee.

5. Reinvestment and Redirection of Savings

A key strategy in any system of care is to redirect resources from more restrictive settings, including residential treatment, psychiatric hospitalization, and juvenile correctional placements, to fund alternative home- and community-based services. Redirection is critical because in most child-serving systems, new funds are not available to expand community-based services. The idea is to redirect funds going into institutional care to instead build community capacity and/or to reinvest monies saved from reduced out-of-home care to expand the community service array.

In systems like Wraparound Milwaukee, where funds get blended from child welfare, juvenile justice, and Medicaid, this has worked extremely well. Previously, child welfare and juvenile justice paid for residential treatment. With Wraparound Milwaukee as the CME, assuming placement and payment responsibility and focusing on short-term residential stays and alternatives to residential care, the number of youths in placements decreased from an average of 375 to 100, and the average length of stay dropped from more than 400 days to about 120. The monies saved were reinvested into creating an expanded community-based delivery system with more than 70 services. (See Appendix A.) Reinvestment occurs because saved institutional dollars stay in the community system and are not returned to fund other governmental services not related to the needs of youth with complex mental health needs and their families. Creating a mechanism to ensure that funds are reinvested in the community system is essential.

Wraparound Milwaukee spends about $10 million annually on residential interventions. Because there would have been higher placement levels and higher costs for placement without Wraparound Milwaukee, it has been projected that Milwaukee County would have been spending more than $85 million a year for such placements had this redirection/reinvestment strategy not been implemented 20 years ago.

6. Managed Care Strategies, Child and Family Teams (CFT), and Family Advocacy Services Can Encourage Alternatives to Residential Interventions

Increasingly, states are using managed care approaches for the delivery of Medicaid behavioral health services for children and adolescents and, within managed care systems, are experimenting with care coordination approaches, especially for youth with intensive needs and multi-system involvement. Intensive care coordination using high-fidelity Wraparound is an evidence-informed care coordination model for these youth. In a number of states, such as Louisiana, New Jersey, Massachusetts, Wisconsin, and others, Wraparound care coordination is provided through a care management entity as a key feature of the managed care design. Either the CME or the Medicaid managed care contractor, or both in partnership, have responsibility for the management of residential treatment and alternative, community-based services for youth involved in Wraparound. Techniques used by Wraparound Milwaukee that are emerging in other state Medicaid managed care approaches include: prior authorization to use a residential intervention (which Wraparound Milwaukee authorizes for only 30 days at a time to create a sense of urgency to plan for a youth's return home); purchasing outcomes rather than placement; incentive-based contracting; and risk-sharing arrangements. Wraparound Milwaukee shares both risk and savings through the Medicaid capitation and child welfare and juvenile justice case rates it receives.

In a fidelity Wraparound model, which has been the cornerstone of the Wraparound Milwaukee population management approach, CFTs are teams chosen by the family and youth and include formal and informal supports. Informal supports, such as extended family members, friends, and relatives, and community supports, such as a church pastor or coach, join the formal supports, who are the paid clinical and system professionals (therapists, mentors, crisis workers, etc.). Finally, there are family and peer support mentors with "lived experience" who support and advocate for the family and the youth. The CFT focuses on identifying and using child/family strengths to meet the needs of the youth and family. The goal of the CFT is to ensure that the family receives services and supports to meet the child's needs to keep them in their home with their family whenever possible. The family drives its own care planning team, so it has investment and ownership of decision-making.

As part of Wraparound Milwaukee's overall utilization management approach, the CFT is asked to discuss the need for a residential intervention if that is proposed, expected outcomes, and anticipated length of stay to achieve those outcomes, and to ascertain if residential intervention is necessary, given other community-based care options. If it is determined to be necessary, the CFT creates a plan for collaboration with the residential program. Initial plans for placement are authorized for 30 days, with regular weekly or monthly progress reports expected. Rather than a handoff of the youth to the residential program, the CFT stays involved and collaborates with the residential program to oversee the implementation of the treatment

and transition plans. This benefits the purchaser, such as Wraparound Milwaukee, and the residential program by keeping the family involved in planning for their child's return home. Transition planning begins on the first day of placement. As a managed care strategy, the utilization of prior authorization for residential, involvement of the CFT, and weekly reviews of placement progress have contributed to shorter and more effective residential interventions.

The purchase of outcomes — or performance-based contracting — is another managed care strategy used by Wraparound Milwaukee. This is difficult to do in some states because per-diem rates paid for residential treatment centers are fixed, and all purchasers must pay the same rate. In some states, though, residential treatment centers can be paid using a more flexible approach, for example, with a bundled rate that includes time spent by the residential program to support the family and youth to be at home, or a higher rate is paid at the beginning of the placement when the child's needs are higher, and then that rate is reduced as the child progresses in treatment and intensity of need lessens. At Wraparound Milwaukee, the three residential treatment programs providing care coordination services to about 300 families have incentives built into their contracts, with bonus payments for achieving successful outcomes for the youth and families. Examples of successful outcomes include specific youth needs being met, education outcomes achieved, inclusion of informal supports as part of the formal treatment plan, and percent of days youths spend in the community versus in out-of-home care.

Finally, there can be risk-sharing arrangements with the residential program in which the purchaser pays the residential program a "case rate" or fixed monthly amount per child, and if the center can provide services and meet outcomes under the amount received, it can retain the "profit" or certain amount of the excess revenue. On the flip side, if the center exceeds the cost threshold and costs exceed the case rate, there can be some risk sharing in which a certain amount of the loss, usually around 5 percent, must be covered by the residential program. Such an arrangement can contribute to short-term residential intervention with a focus on achieving positive outcomes because it is tied to fiscal incentives.

7. Fiscal Strategies Can Involve the Courts

One factor in youth staying in a residential program longer than government purchasers and the residential programs consider necessary has been the role the courts play in such decisions. Often, a placement in a residential program is accompanied by an order from a juvenile or family court that mandates placement in a specific treatment program for a prescribed period and requires any change of that placement to be done only with court review and revision of the original order. The result is a longer-than-necessary placement driven by court practice rather than the needs of the youth and family. Such placements are usually made under an order related to child welfare or juvenile justice jurisdiction.

Wraparound Milwaukee negotiated with the courts to develop a "flex order." The court writes in the dispositional order that decisions related to the care and treatment needs of the youth, including the need for residential treatment placement, are overseen by Wraparound Milwaukee as the CME. This frees the CME, which is using the CFT process and working in collaboration with the residential program, to determine when the youth has made sufficient progress to be transitioned to a less-restrictive placement, including directly back to their family and community. Courts must be notified of the change in placement, and if there are no objections requiring a court hearing, the youth can move out of the placement. This has unburdened courts from unnecessary and time-consuming reviews and hearings and contributed to shorter-term residential placements.

8. Finance Mechanisms to Track and Manage Utilization, Quality, Cost, and Outcomes

A growing number of communities are realizing the importance of developing and using good information technology systems to track utilization, cost, quality, and outcomes for youth with complex mental health needs. This includes youth using residential treatment programs as part of the service delivery system. No financial strategy is a sound one unless it can demonstrate through data capabilities that the approaches achieve better outcomes at less cost. Wraparound Milwaukee developed its own data system, called Synthesis, now also used by Ohio's Cuyahoga County (Cleveland). Synthesis serves as the clinical electronic record and the financial management system. The Synthesis system captures all care planning, crisis plans, and progress notes. The system also tracks all services and supports provided to youths and families, including the cost, and tracks all the patterns of service utilization and outliers. The Synthesis system is used for billing and claims adjudication and as an electronic payment system to vendors, including the residential treatment centers, and it captures demographic data and outcome data on a real-time as well as retrospective basis. Data from this system also can be shared with other system stakeholders, including child welfare, juvenile justice, and Medicaid.

When these systems see that the average monthly cost of a youth enrolled in Wraparound Milwaukee is one-third of the cost of a residential treatment center, there is a strong desire to enroll more youth with the CME. The average all-inclusive cost of a youth involved with Wraparound Milwaukee (inclusive of services/supports, placements, care coordination, and administration) for 2016 was $3,200 per youth per month, compared to average residential treatment facility costs of $9,500 per youth per month. The average cost per month per child of youth in Wraparound Milwaukee has continued to fall from 2011 through 2016 while residential treatment costs have significantly increased over the same period. Other outcomes, including child permanency, community safety, school performance and attendance, and results of the use of clinical measurement tools, can be tracked and are important for system partners to receive. Access to good data and the ability to measure and disseminate outcomes

to system partners are critical to support the financial strategies being employed in the community.

9. Financing Evidence-Based, Evidence-Informed, and Promising Practices

Another financing strategy involves incorporating evidence-based, evidence-informed, and promising practices. Counties and states have established billing codes for specific, evidence-based practices to encourage the development of these types of practices as alternatives to out-of-home placement and to reduce longer-term residential placement. Such practices include Multisystemic Therapy, Functional Family Therapy, Dialectical Behavior Therapy, and cognitive behavioral therapy, among others. Medicaid, child welfare, and juvenile justice funds have been used in many states to support the development of these community-based interventions. Nebraska, Indiana, Hawaii, Ohio, and Colorado have funded these types of services for high-risk youth populations and their families.

10. Other Fiscal and Program Strategies to Promote Alternatives to Residential Interventions and Short-Term Residential Interventions

Other strategies that have been employed in the Wraparound Milwaukee program that, while not directly fiscal, have contributed to considerable cost savings include:

1. The development and use of **educational advocates** to work with families to remove educational barriers that hinder the return of youth to their homes and community schools. These advocates can greatly shorten the residential stay by coordinating with the family and school system to develop or update an individualized education plan (IEP) and find a more appropriate school or classroom setting. Families often need support when trying to work with school systems that may not be eager to have a youth return from the residential program to a community school.
2. **Specialized clinical staff** with expertise in the needs of youth with complex needs can review and help the care coordinator, CFT, and court with high-risk youth such as adjudicated sex offenders, fire setters, and others who often are not seen as candidates for community treatment but can actually be successful in these settings. Wraparound Milwaukee uses a psychologist with experience in developing community plans with strong crisis/community safety planning skills to review all youth who meet a high-risk designation. All care plans are reviewed to ensure that attention is paid to community safety and services to ensure the clinical needs of those youth are met and that the information is communicated to the court. This can be especially important to partners from child welfare and juvenile justice.
3. The use of **specialized care coordination consultants**, who can be assigned to the CFT when new strategies are needed to meet the needs of youth in placement, has been

effective in Milwaukee. For example, a care coordinator with specialized skills in working with youth who have cognitive delays may be assigned to the CFT when that expertise is needed.

Summary of Tips for Financial Strategies to Promote Short-Term Residential Interventions, Community-Based Services, and Positive Long-Term Outcomes

All the tips presented in this paper can be achieved in county or state systems. Wraparound Milwaukee has used almost every strategy presented in this document. There should never be just one financing strategy to build a system of care. To achieve appropriate reductions in the use of residential interventions and build a robust system of community-based care, states and communities should look at multiple strategies. To help provide further guidance, the fiscal strategies included in this document have been summarized and rated, from the perspective of Wraparound Milwaukee, from "easier" to "moderate" to "more difficult" to achieve. However, what may be difficult to achieve in one system may prove easier in another. The efforts taken to implement these strategies are well worth the time in any system.

**Using Fiscal Approaches to Transform Service Delivery:
Easier, Moderate, and More Difficult Strategies**

Easier	Moderate	More Difficult
Expand service array	Blend or braid monies across child-serving systems	Redirect spending from deep-end to home- and community-based services
Maximize Title IV-E	Create care management entities (CMEs)	Reinvest savings from reduced institutional care
Maximize Medicaid in lieu of 100 percent general funds	Reimburse evidence-based and promising practices and consider higher rates	Invest in good data systems to track utilization, quality, costs, and outcomes
Finance through EPSDT behavioral health screens	Adopt managed care practices (i.e., prior authorization)	Modify court orders through flex orders
Finance an individualized, Wraparound approach to service delivery	Utilize and coordinate multiple funding streams	Utilize federal waivers such as 1915(a), 1915(b), 1915(c), or 1115
Procurement through performance-based contracting	Use of educational advocates and specialized consultants	Provide contract incentives, risk-sharing arrangement

Appendix A: List of services provided through Wraparound Milwaukee

- After school programs
- Anger management counseling groups
- AODA (alcohol and other drug abuse) assessment
- AODA day services
- AODA detoxification
- AODA group and family counseling
- AODA lab and medical services
- AODA residential treatment services
- Care coordination
- Commodity and emergency food purchase
- Crisis bed – foster homes
- Crisis bed – group home
- Crisis bed – residential treatment centers
- Crisis 1:1 stabilization in home/community
- Crisis runaway shelters
- Daily living skills/skills training/development
- Day treatment – medical/psychiatric (Medicaid certified)
- Day treatment (non-Medicaid certified)
- Day treatment (summer programs)
- Discretionary funds (i.e., flex funds for youth/families)
- Employment preparation and placement
- Foster care
- Group counseling and therapeutic behavioral services
- Group psychotherapy
- High-risk counseling and therapy (e.g., sex offender treatment)
- Home based management team – Aide
- Home based management team – Lead therapist
- Household management assistance and support
- Independent living skills training
- Individual/Family Therapy (psychologist provided)
- Intensive in-home Case aide
- Intensive in-home Lead therapist
- Interpreter services
- Job internship services/supported employment
- Kinship care services
- Life skills training
- Mentoring

- Multisystemic therapy services
- Nursing assessments
- Occupational therapy services (e.g., sensory integration therapy)
- On-the-job training
- Parent assistance (i.e., home care training)
- Placement stabilization center
- Professional foster care services
- Psychiatric assessment
- Psychiatric hospital – daily placement
- Psychiatric hospital – ER visit
- Psychiatric hospital – medication review
- Psychological evaluation or testing
- Psychological testing
- Recreational programming
- Residential Care Center (treatment)
- Residential Treatment Center (short-term placement)
- Respite care
- School accountability program
- Shelter care
- Special therapies (e.g., equine therapy, art, dance)
- Specialized academic support
- Supervision/observations services
- Supported independent living services
- Supported living housing
- Therapeutic camping programs
- Therapeutic foster care
- Therapeutic group homes
- Transitional specialists (care coordination)
- Transportation
- Transportation to correctional center to visit child
- Treatment foster care
- Tutor
- Youth peer support services