
APPENDIX A

INTRODUCTION AND PROJECT BACKGROUND

**APPENDIX A.1. – WISCONSIN PUBLIC MENTAL HEALTH AND SUBSTANCE ABUSE
INFRASTRUCTURE STUDY STEERING COMMITTEE (2009)**

Name	Affiliation
1. Mark Seidl	Wisconsin County Human Service Association (WCHSA)
2. Kathy Roetter	WCHSA
3. Mary Neubauer	Wisconsin Council on Mental Health
4. Scott Stokes	State Council on Alcohol and Other Drug Abuse
5. Kathi Cauley	Human Services Director, Jefferson County
6. Jim Johnston	Division of Health Care Access and Accountability (DHCAA)
7. Anne Olson (alternate)	DHCAA
8. John Easterday	Division of Mental Health and Substance Abuse Services (DMHSAS)
9. Joyce Allen	DMHSAS
10. Gary Nelson	DMHSAS
11. Sue Gadacz	DMHSAS
12. Morgan Groves	DMHSAS
Study Consultants	
Ginny Graves	The Management Group, Inc. (TMG) Project Team
Heidi Pankoke	TMG Project Team
Rob Lefeber	TMG Project Team
DeeAnne Peterson-Meyer	TMG Project Team
Gerry Born	TMG Project Team

APPENDIX A.2. – STEERING COMMITTEE MEETING AGENDAS

Wisconsin Public Mental Health/Substance Abuse Infrastructure Study Steering Committee Meeting

**Thursday, February 19, 2009
9 a.m. to noon**

**Department of Health Services, 1 W. Wilson, Madison
Room B 250 G (Basement Conference Room)**

For call-in instructions please email Heidi Pankoke at heidi.pankoke@tmg-wis.com

AGENDA

- | | |
|------------|---|
| 9:00 a.m. | Welcome and Introductions |
| 9:10 a.m. | Scope of Study (Attachment 1) |
| 9:15 a.m. | Review and Discussion of Study Work Plan (Attachment 2) |
| 9:45 a.m. | Review and Discussion of Study Benchmarks, Indicators and Data Sources
(Attachments 3 and 4) |
| 10:30 a.m. | MH/SA System Issues Identified in Past Studies (Attachments 5 and 6) |
| 11:00 a.m. | Other States for Comparison, Best Practices and Lessons Learned
(Attachment 7) |
| 11:45 a.m. | Closing Comments and Proposed Future Meeting Dates |

APPENDIX A.2. – STEERING COMMITTEE MEETING AGENDAS

Wisconsin Public Mental Health/Substance Abuse Infrastructure Study Steering Committee Meeting

**Friday, May 1, 2009
9 a.m. to noon**

**Department of Health Services, 1 W. Wilson, Madison
Room B 250 G (Basement Conference Room)**

For call-in instructions please email Heidi Pankoke at heidi.pankoke@tmg-wis.com

AGENDA

- 9:00 a.m. Review Status of Study Work Plan (Attachment 1)
- 9:15 a.m. Review Questions for Other States (Attachment 2)
- 9:30 a.m. Discuss List of Proposed Counties for In-depth Review (Attachment 3)
- 9:45 a.m. Review and Discuss Updated List of MH/SA System Issues Identified from Documented Sources (Attachment 4) and SA System Issues List (Attachment 5)
- 10:30 a.m. Discuss Guiding Principles for the Development of Models/Pathways – Brainstorming Session
- 11:30 a.m. Discuss Preliminary Draft Outline for MH/SA Infrastructure Summit (Attachment 6)
- 11:45 a.m. Closing Comments and Proposed Future Meeting Dates

APPENDIX A.2. – STEERING COMMITTEE MEETING AGENDAS

Wisconsin Public Mental Health/Substance Abuse Infrastructure Study Steering Committee Meeting

**Wednesday, September 23, 2009
10 a.m. to 3 p.m.**

**Department of Health Services, 1 W. Wilson, Madison
Room 850 (8th Floor Conference Room)**

AGENDA

- | | |
|------------|---|
| 10:00 a.m. | Review Status of Study Work Plan |
| 10:15 a.m. | Discuss Other States' Reform Efforts/Lessons Learned (Attachments 1 and 1a) |
| 11:00 a.m. | Discuss Targeted County Review (summary to be distributed at meeting) |
| Noon | Break for Lunch (Lunch can be purchased in the DHS cafeteria) |
| 12:45 p.m. | Review/Discuss Changes to Guiding Principles Document from June 2, 2009 (previously emailed) |
| 1:00 p.m. | Review/Discuss Common Elements, Framework and Models/Pathways from September 10, 2009 (previously emailed) |
| 2 p.m. | Discuss/Review State Data for MH/SA Services (Attachment 2) |
| 2:30 p.m. | Discuss Outline for MH/SA Stakeholder Summit (Attachment 3) |
| 2:45 p.m. | Closing Comments and Proposed Last Meeting Date to Review the Draft Report |
| | *Please check your availability on the following proposed meeting dates: |
| | <ul style="list-style-type: none">• Thursday, November 5, 2009 from 9 a.m. to noon• Friday, November 6, 2009 from 9 a.m. to noon |
| 3:00 p.m. | Adjourn |

APPENDIX A.2. – STEERING COMMITTEE MEETING AGENDAS

Wisconsin Public Mental Health/Substance Abuse Infrastructure Study Steering Committee Meeting

**Friday, November 6, 2009
9 a.m. to noon**

**Department of Health Services, 1 W. Wilson, Madison
Room 850 (8th Floor Conference Room)**

AGENDA

- | | |
|------------|--|
| 9 a.m. | Review/Discuss October 28, 2009 Draft Report (previously emailed to Committee) |
| 11 a.m. | Discuss December 3 rd MH/SA Infrastructure Summit <ul style="list-style-type: none">• Discuss Outline for Summit and Finalize (see attachment)• Review Potential Questions for State Speaker Panel (see attachment)• Review List of Participants for Local Reactor Panel (see attachment)• Review Potential Questions for Local Reactor Panel (see attachment) |
| 11:45 a.m. | Closing Comments and Next Steps |
| Noon | Adjourn |

APPENDIX B
WISCONSIN'S PUBLIC MENTAL HEALTH
AND SUBSTANCE ABUSE SYSTEM

APPENDIX B.1. – SUMMARY OF ISSUES REGARDING WISCONSIN’S SYSTEM OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

The issues and concerns regarding the MH/SA funding system in Wisconsin have been well documented and defined in previously issued studies and reports. This document lists the major issues identified in the following recent key reports:

- Proposal to Redesign Wisconsin’s Human/Social Service Delivery System developed by the Wisconsin County Human Services “Visions” Committee¹ – April 2004
- Briefing Paper on Mental Health Funding and Access to Services developed by the Wisconsin Council on Mental Health (WCMH) in collaboration with the Wisconsin County Human Services Association (WCHSA)² – August 2008

In addition, the summary includes feedback from:

- Directors and staff of Aging and Disability Resource Centers (ADRCs) attending the ADRCConnection Workgroup Meeting³ – February 2009
- Members of the Steering Committee for the Public Mental Health and Substance Abuse Infrastructure Study⁴ – February 2009
- Members of the Wisconsin County Human Services Association (WCHSA) Behavioral Health Policy Advisory Committee⁵ – March 2009
- Members of the Wisconsin Counties Association Health and Human Services Committee⁶ – April 2009

Finally, the summary includes issues identified in the following state documents:

- State Plan for the Community Mental Health Services Block Grant for Fiscal Year 2009⁷

The source of each issue identified is footnoted. In addition, the summary of major issues is organized according to the four goal or benchmark areas identified for this study, which are:

1. Equitable access to service across the state
2. Accountability for outcomes
3. Equitable and affordable funding for services
4. Efficiency of service delivery

This summary is not an exhaustive list of every specific issue concerning the current system of MH/SA services. It is intended as a starting point for discussion and to identify some of the major issues identified in previous reports and source documents.

Some of the issues identified in this summary are more programmatic and operational in nature. Since programmatic and operational issues are not the focus of this study, these issues are separated from the

Sources:

¹Visions Committee Proposal (2004)

²Mental Health Access and Funding Briefing Paper (2008)

³ADRC Meeting (2009)

⁴Study Steering Committee (2009)

⁵WCHSA Behavioral Health PAC (2009)

⁶WCA-Health and Human Services Committee (2009)

⁷Wisconsin State Block Grant Plan (2009)

APPENDIX B.1. – SUMMARY OF ISSUES REGARDING WISCONSIN'S SYSTEM OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

major system infrastructure (structure and funding) issues, but still referenced in the appropriate benchmark area.

1. Equitable access to service across the state

System Infrastructure Issues (related to structure and funding)

- a. Access to appropriate, effective mental health care is limited and/or declining.^{2,6,7}
- b. There is no consistent, coherent statewide policy regarding who should receive publicly funded human/social services in Wisconsin.¹
- c. There is an identified population with mental health and/or substance abuse issues that is not yet ill enough to access available services (i.e., appropriate services are not available to that population).³
- d. When individuals needing services do not receive the appropriate services and medications in a timely manner, the result is increased hospitalizations.³
- e. Some county mental health systems try to limit eligibility for and access to services, while ADRCs are trying to open doors to consumers. There are perhaps different service goals and philosophies which impact consumer access to services.³
- f. Some HMOs may not be providing the mental health services they are required to provide under their benefit plans, which may burden the county system.⁵
- g. Wisconsin's statutory and legal framework makes it more difficult to provide involuntary medications to individuals with mental health issues.⁵
- h. It is difficult for children with MH/SA needs to access appropriate services without going through the child welfare system under Chapter 48.⁵
- i. The mental health needs of parents and children in the child welfare and other service systems are not being met.⁷
- j. There is a lack of mental health and substance abuse parity in health care in Wisconsin.⁷

Programmatic and/or Operational Issues

- k. There is a need for transitional services for youth aging out of the children's mental health system.⁷
- l. Even when there are available services for individuals with mental health and/or substance abuse issues, ADRCs often encounter consumer resistance and a greater level of staff effort to get consumers enrolled in the appropriate programs.³
- m. Services available from the county MH/SA system are more focused on the chronically mentally ill population, but services that are needed are often for those with behavioral issues.³
- n. There is a need to provide specialized services to elderly individuals with dementia and challenging behaviors. Many county mental health programs are focused primarily on young,

Sources:

¹Visions Committee Proposal (2004)

²Mental Health Access and Funding Briefing Paper (2008)

³ADRC Meeting (2009)

⁴Study Steering Committee (2009)

⁵WCHSA Behavioral Health PAC (2009)

⁶WCA-Health and Human Services Committee (2009)

⁷Wisconsin State Block Grant Plan (2009)

APPENDIX B.1. – SUMMARY OF ISSUES REGARDING WISCONSIN'S SYSTEM OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

physically able individuals. Programs will need to get ready to serve more elderly with mental health issues.³

- o. ADRCs report that they encounter many consumers who need mental health case management services and supportive services (such as transportation, medication management, job service and housing), as opposed to specific treatment services.³
- p. Some ADRCs are not referring individuals with MH/SA needs to the county service system because they know the individuals do not meet the county eligibility criteria, the service/program is not accepting new consumers, and/or the county has a wait list for the service/program.³
- q. SSI Managed Care HMO MH/SA providers in some areas are not in close proximity to the consumers they serve and/or do not have adequate service capacity, which negatively impacts access.^{3,5}
- r. Professional licensing regulations may negatively impact on provider capacity and access to services.⁵

2. Accountability for outcomes

System Infrastructure Issues (related to structure and funding)

- a. The state receives incomplete information regarding what outcomes it is paying for with current funding sources (e.g., Community Aids, Youth Aids, Community Options Program and Community Integration Program).¹
- b. Taxpayers as well as consumers of human/social services are frustrated by the lack of any clear answer as to who is ultimately responsible for service decisions between the state and the counties.²
- c. Data systems and the capacity of the counties and state to aggregate, analyze and interpret meaningful data is limited, which makes it difficult for the state to make data-informed decisions.⁷

3. Equitable and affordable funding for services

System Infrastructure Issues (related to structure and funding)

- a. Funding for MH/SA services has not kept pace with increasing demand and costs for services.^{1,2,5,6}
- b. The current system of funding sources (e.g., Community Aids, Youth Aids, Community Options Program and Community Integration Program) the state provides to counties has no real correlation to the utilization or cost of providing services.¹

Sources:

¹Visions Committee Proposal (2004)

²Mental Health Access and Funding Briefing Paper (2008)

³ADRC Meeting (2009)

⁴Study Steering Committee (2009)

⁵WCHSA Behavioral Health PAC (2009)

⁶WCA-Health and Human Services Committee (2009)

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APPENDIX B.1. – SUMMARY OF ISSUES REGARDING WISCONSIN'S SYSTEM OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES

- c. While Wisconsin funds a wide array of mental health services in its Medicaid program, key services targeted to persons with the most serious mental illnesses, including community support programs (CSP), comprehensive community services (CCS), targeted case management, some of the children's long-term support waiver slots and in-home treatment for adults, require counties to provide the non-federal match for Medicaid instead of the state. This puts a burden on local funding and impacts the ability and/or willingness of counties to provide these services.²
- d. Given Medicaid reimbursement levels that fall below other payment sources, some mental health providers, such as those providing outpatient therapy and psychiatry services, do not serve Medicaid-eligible consumers.^{2,3,7}
- e. Portions of Community Aids, the major source of state funding to counties for human services, have been carved out for various initiatives, including child welfare and Family Care programs, thereby leaving potentially less funding available for mental health services.²
- f. The requirement for county match for Medicaid mental health services, the decreases in Community Aids, and the lack of availability of waivers for this population has led to a significant county use of property tax funds for mental health services.^{2,6}
- g. County property tax dollars provide proportionately more funding for mental health services than for any other target group at a time when the amount of funding counties can raise through the property tax is limited by state law.^{2,6}
- h. There is a lack of funding for community mental health and substance abuse services. The MH/SA system is very crisis-driven and county funding is prioritized for crisis/emergency services.^{3,6}
- i. There is great variation and fragmentation in funding for substance abuse services provided through the counties. Counties rely on financing from multiple systems (child welfare, TANF, corrections, juvenile justice, etc.), with different requirements, to fund substance abuse services.⁴
- j. Some effective treatment approaches and medication interventions are costly and not supported by available funding sources, which influences consumer outcomes.⁴
- k. In some counties, HMOs access available psychiatric services for their members through the county system and pay only the MA rate, which does not fully cover actual county costs.⁵

4. Efficiency of service delivery

System Infrastructure Issues (related to structure and funding)

- a. There is a need for greater collaboration to serve consumers with multiple needs.⁷

Sources:

¹Visions Committee Proposal (2004)

²Mental Health Access and Funding Briefing Paper (2008)

³ADRC Meeting (2009)

⁴Study Steering Committee (2009)

⁵WCHSA Behavioral Health PAC (2009)

⁶WCA-Health and Human Services Committee (2009)

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- b. Through the SSI Managed Care initiative, many persons with mental illness are now receiving their health care services through HMOs. However, the county matched mental health services have remained fee for service, which causes coordination of care issues.^{2,6}
- c. Counties have not had sufficient time to adjust to major system changes resulting from implementation of Family Care and/or SSI Managed Care.³
- d. There is a lack of coordination between various IT systems for ADRCs, Income Maintenance, Social Services and MH/SA, which causes delays for the consumer (e.g., delay in the approval of medications).³
- e. There is a lack of coordination between the Department of Corrections, DHS and counties regarding provision of MH/SA services to individuals placed into the community by DOC; this is a population that counties struggle to serve.^{5,6}

Programmatic and/or Operational Issues

- f. Many referrals to ADRCs from county staff and others are not appropriate. Some ADRC and county mental health staff is seeing disproportionately greater referrals from SSI Managed Care HMOs to ADRCs and counties for services that should be the responsibility of the HMOs.^{3,5}
- g. In Wisconsin, law enforcement is authorized to make emergency detention decisions, with or without the involvement of trained mental health professionals.⁵
- h. Wisconsin has high rates of readmission to state psychiatric hospitals compared to other states.⁷

Sources:

¹Visions Committee Proposal (2004)

²Mental Health Access and Funding Briefing Paper (2008)

³ADRC Meeting (2009)

⁴Study Steering Committee (2009)

⁵WCHSA Behavioral Health PAC (2009)

⁶WCA-Health and Human Services Committee (2009)

⁷Wisconsin State Block Grant Plan (2009)

APPENDIX B.2. – FINANCING SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES IN WISCONSIN

CURRENT FUNDING

- In Wisconsin, the funding for substance abuse treatment and prevention is a blend of federal state and county funding.
- The total Substance Abuse State and Federal Funding FFY09 - \$44,984,706
 - State (Includes GPR and PR) - \$9,406,100
 - SAPTBG - \$25,679,888
 - Federal Discretionary Grants - \$9,898,718
 - SPF-SIG: \$2,093,000
 - ATR: \$4,830,000
 - SBIRT: \$2,675,718
 - STAR-SI: \$300,000
- Counties reported that they spent \$15,358,203 in county revenue on substance abuse related services in 2007.
- Wisconsin relies heavily upon the federal block grant, Substance Abuse Prevention and Treatment Block Grant (SAPTBG) and Federal Discretionary Grants for 79% of its total funding with the balance of 21% state funding that goes into the funding the state provides to counties, tribes and providers.
- The Office of National Drug Control Policy (ONDCP) released a report in 2006 that ranked Wisconsin as one of the lowest states (40th) in the country for state contributions in the funding for substance abuse prevention and treatment.
- Federal funding is not keeping pace. In fact, in FFY 2003 Wisconsin received \$26,198,447 in FFY 2005 the SAPTBG award was \$25,938,905, this has since been reduced and in FFY 2008 award was \$25,679,888.
- The substance abuse block grant is fully obligated and the state funded specialized grant programs contracted thru the DHS have been level funded and some have recently experienced a reduction in the SFY 2009 and cuts are proposed in the Governor's budget for 2010.
- Historically, there are over 25 counties that apply for intoxicated driver program (IDP) supplemental funding from the Division of Mental Health and Substance Abuse Services (DMHSAS) on an annual basis to meet the treatment demand for operating while intoxicated (OWI) clients. On average, the Division awards 30% of the requested amount. In 2008, 27 counties requested \$2,911,979 in IDP supplemental funding but the Division had only \$1,000,000 available.
- Counties report that these among other factors, have led to increased costs to the counties. Many counties have responded by limiting services to the most severe and acute patients, limiting the length of time in treatment, and/or limiting the number of individuals served annually due to rising costs and reduced budgets.

BLENDING FUNDING

- Recently many federal discretionary grant initiatives have required successful applicants to blend or braid multiple funding streams for project sustainability. Blending or braiding federal funds allows decisions on services to be made with the family and by those working most closely with the family. Collaborative partnerships are an essential component of a successful funding plan.
- The federal Access to Recovery (ATR) discretionary grant issued in 2003 is a prime example of blended or braided funding. Milwaukee County Behavioral Health Division was awarded this grant called Wiser Choice. Wiser Choice is a combination of community aids, county tax levy, ATR, state GPR, Department of Corrections purchase of services funds, and SAPTBG program awards. The federal funding used to support this approach is a time limited discretionary grant program.

APPENDIX B.2. – FINANCING SUBSTANCE ABUSE PREVENTION AND TREATMENT SERVICES IN WISCONSIN

- Blended funding began with the introduction of the use of systems of care in an adult population. This first occurred with the Milwaukee Family Services Coordination Initiative (MFSCI) in 1999.
- The premise of the Initiative was that outcomes for families could be improved through cross-system coordination, blending funding, provision of wraparound philosophy of care and services, development of networks of formal and informal supports, utilizing a family- centered, strength-based, gender/culturally-responsive approach.
- MFSCI led to the development of the Core Values used in Nexus, the precursor to Wiser Choice, the Statewide Urban/Rural Women’s Treatment Project, Coordinates Services Team, and Wiser Choice.
- The Management Group (TMG) was heavily involved in the development of MFSCI, the creation of the Single Coordinated Care Plan (SCCP), and authoring the funding paper. The funding paper was designed to identify other formal support systems that could fund substance abuse treatment and other ancillary services.

TREATMENT CAPACITY

- HSRS (County-authorized clients; 2007) data show that OWI convictions are the most prevalent (31%) source of referral to AODA treatment ahead of other criminal justice referrals (28%), and self, family, or friend (19%).
- According to the National Survey of Substance Abuse Treatment Services (N-SSATS) annual surveys, the number of treatment facilities in Wisconsin has decreased from 324 in 2002, to 290 in 2006.
- Residential treatment services (75.11 and 75.14) are available at 67 facilities thru out the state.
- Even when a client scores at a Level III (indicating high level of need) on the ASAM or WI-Uniform Placement Criteria (UPC), residential care may not be available in their county of residence and in some instances, the county will not fund the service if the person does not have the ability to pay privately.
- 14 facilities offered an opioid treatment program.
- 93 physicians and 59 treatment programs are certified to provide buprenorphine care for opiate addiction.
- Across all survey years and for all age groups, Wisconsin has generally ranked among the 10 states with the highest rates of unmet need for alcohol treatment. This is especially true for the population of young adults age 18 to 25.
- There are only eighteen of the seventy-two counties in Wisconsin that offer women-specific AODA treatment.
- There are five residential (DHS 75. 11 or 75. 14) treatment facilities in the state that accept women with dependent children under the age of 12, and only one facility that will accept a pregnant woman on methadone.
- Medicaid/BadgerCare does not pay for residential AODA treatment in FFS Medicaid services for adults.

APPENDIX B.3. – SUMMARY OF ISSUES REGARDING WISCONSIN’S SYSTEM OF MENTAL HEALTH SERVICES FROM THE FINAL REPORT OF THE BLUE RIBBON COMMISSION ON MENTAL HEALTH

As part of its work over 10 year ago, the Blue Ribbon Commission on Mental Health identified issues and concerns regarding the mental health system in Wisconsin at that time. This document lists the major issues identified in the Commission’s Final Report released in April 1997.

This summary of major issues identified in the Commission’s Final Report document is organized according to the four goal or benchmark areas identified for this study, which are:

1. Equitable access to service across the state
2. Accountability for outcomes
3. Equitable and affordable funding for services
4. Efficiency of service delivery

This list is intended as a reference document for the Steering Committee to be aware of the issues that were identified at the time of the Commission’s work and report. These issues do not necessarily reflect the issues that are currently impacting the mental health system in Wisconsin or the progress that has been made to address them in the intervening time.

Some of the issues identified in the Commission’s Final Report are more programmatic and operational in nature. Since programmatic and operational issues are not the focus of this study, these issues are separated from the major system infrastructure (structure and funding) issues, but still referenced in the appropriate benchmark area.

1. Equitable access to service across the state

System Infrastructure Issues (related to structure and funding)

- a. Services are not readily available statewide, and the quality of services varies greatly.
- b. Inadequate access to mental health services results in too many persons being homeless, in jails, prisons, or the juvenile justice system, or involved in substance abuse.
- c. The lack of crisis intervention services results in overuse of inpatient services as well as inappropriate use of the criminal justice system.
- d. There is a lack of certain mental health professionals, especially psychiatrists, in rural areas. There is also a pressing need for professional staff trained in child psychiatry as well as in geriatrics and psychogeriatrics.
- e. The role of the state mental health institutes in the future mental health system has not been clearly defined.
- f. The future role and capacity of managed care organizations (MCOs) to deliver behavioral health services has been questioned as more target populations and publicly-funded care comes under management.

Programmatic and/or Operational Issues

- g. Stigma and discrimination discourage people from acknowledging mental health problems and speaking out.
- h. Persons with different cultural and ethnic backgrounds are poorly served.
- i. Restrictions and limitations in mental health program standards and funding have resulted in insufficient mental health outreach services in community settings.
- j. The current mental health system places insufficient emphasis on prevention and early intervention.
- k. Many service areas need strengthening and improvement, including:

APPENDIX B.3. – SUMMARY OF ISSUES REGARDING WISCONSIN’S SYSTEM OF MENTAL HEALTH SERVICES FROM THE FINAL REPORT OF THE BLUE RIBBON COMMISSION ON MENTAL HEALTH

- Assessment and in-home services for Wisconsin’ older populations by staff trained in geriatric issues
 - Access to community support programs for certain consumer groups
 - Dual diagnosis services for persons with co-occurring MH/SA disorders
 - Integrated services for children with severe emotional disturbance statewide
 - Supported housing services
 - Consumer-operated self-help and peer support services
 - Specialized services for persons with a history of alcohol or other drug abuse
 - Effective services for persons with histories of physical, sexual or emotional abuse
 - Statewide advocacy
 - Jail diversion programs
 - School-based services
- l. The current mental health system is unable to provide sufficient home-based services, especially for children and older persons.
- m. There is a critical lack of employment/vocational services for persons with mental disorders, including adolescents who need school-to-work transition assistance and older people who choose to work.

2. Accountability for outcomes

System Infrastructure Issues (related to structure and funding)

- a. Consumer outcomes are not well defined and do not consistently guide service planning and delivery.
- b. Consumers and family members are not routinely involved as equal partners in mental health system design, decision making, service delivery and evaluation.
- c. The policies, programs and attitudes of the current mental health system foster dependence, not recovery.
- d. Mental health service funding is not based on performance contracts and positive consumer outcomes.
- e. The state does not have an active role in all aspects of monitoring contracts for services to assure quality consumer outcomes.
- f. The Department of Health and Family Services does not have a strong role and sufficient resources to provide technical assistance, consultation and training.
- g. The current data system is unable to provide system-wide data on consumer services, consumer use of services, service costs and consumer outcomes.

Programmatic and/or Operational Issues

None identified.

APPENDIX B.3. – SUMMARY OF ISSUES REGARDING WISCONSIN’S SYSTEM OF MENTAL HEALTH SERVICES FROM THE FINAL REPORT OF THE BLUE RIBBON COMMISSION ON MENTAL HEALTH

3. Equitable and affordable funding for services

System Infrastructure Issues (related to structure and funding)

- a. Funding for MH/SA services has not kept pace with increasing demand and costs for services.
- b. Medicaid reimbursement restrictions make it difficult to provide flexible consumer-centered services.
- c. Funding does not follow the needs of the consumer.
- d. In the past, additional mandates with earmarked funding have been added to the 51/human service system. Although this practice has been reduced in recent years, earmarking has resulted in decreased flexibility in the county-based mental health system.
- e. Medicaid coverage for community-based mental health services has not been aggressively pursued to capture federal funds and to develop fiscally feasible alternatives to psychiatric inpatient and nursing home care.

Programmatic and/or Operational Issues

None identified.

4. Efficiency of service delivery

System Infrastructure Issues (related to structure and funding)

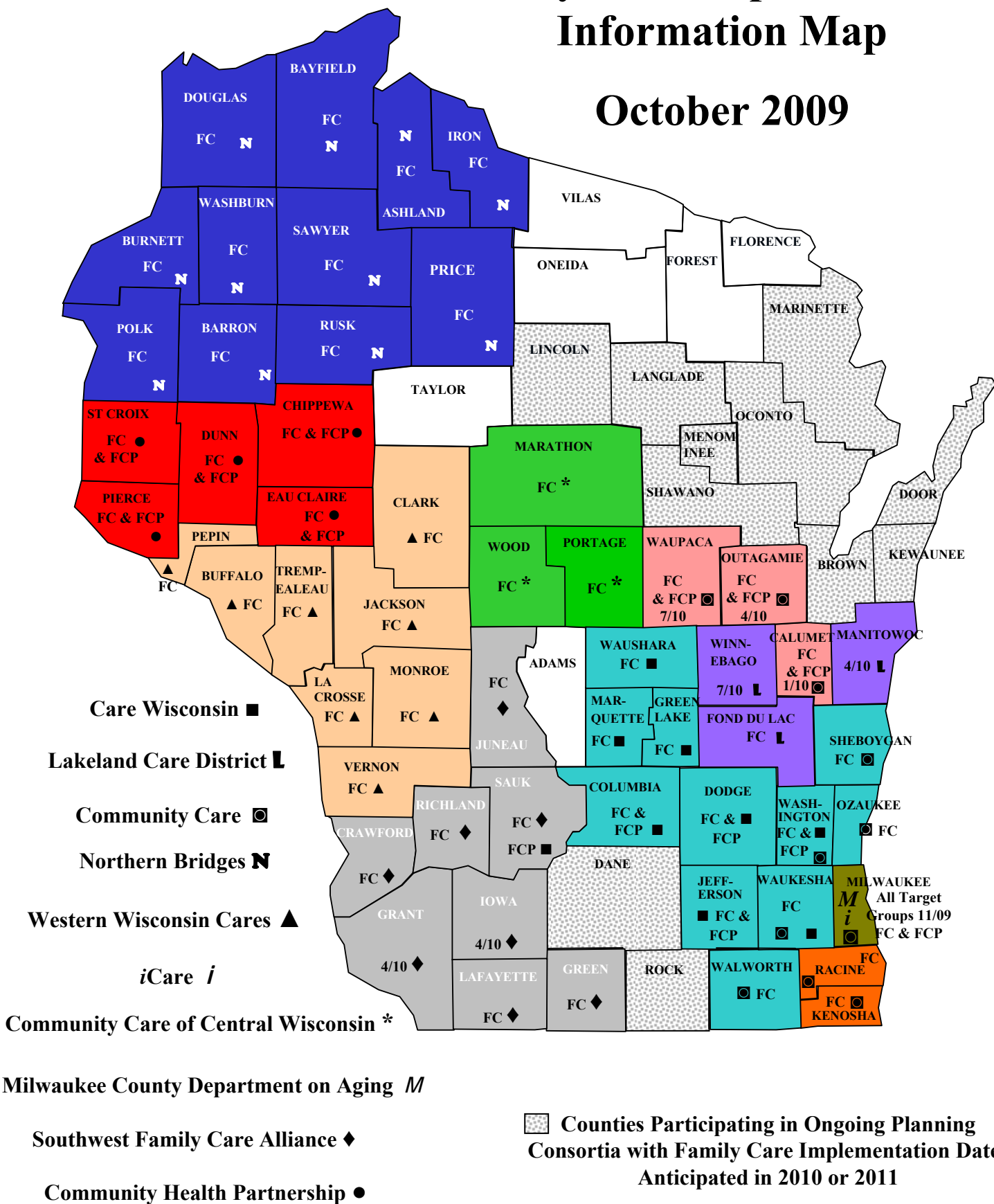
- a. Program standards established by administrative rules are rigid, outdated and time consuming to change.
- b. Numerous conflicts between different state laws (especially Chapters 48, 51 and 55) and administrative rules make service provision rigid and costly to administer.
- c. Some county-based service systems are slow and rigid in their ability to expand or redesign services.

Programmatic and/or Operational Issues

- d. There are significant disincentives to work in Social Security Disability (SSDI) and Supplemental Security (SSI) Income and Medicaid and Medicare programs.

Family Care Implementation Information Map

October 2009



APPENDIX B.5. – MEDICAID MANAGED CARE HEALTH PLANS
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES – CONTRACTED BENEFITS COMPARISON

	BadgerCare Plus			Medicaid SSI
	Standard	Benchmark	Core Plan	
Description	<p>BadgerCare Plus is the program that merges Family Medicaid, BadgerCare, and Healthy Start to form a comprehensive health insurance program for low income children, families, and childless adults. The BadgerCare Plus Core Plan (for adults without dependent children) expansion of the BadgerCare Plus program is the second step in a comprehensive strategy to ensure access to affordable health insurance for virtually all Wisconsin residents.</p>			<p>The Medicaid SSI Managed Care Program is a group of health plans that provide comprehensive health care services. Medicaid SSI provides the same services as regular Medicaid plus <i>Health Care Coordination</i>, a benefit that brings the services of primary and specialty providers and community agencies together. Health Care Coordination helps people with special health care needs, including people with disabilities and other chronic medical conditions get the best possible care.</p>
	<p>Standard Plan: The BadgerCare Plus benefit plan available to children, parents and caretaker relatives, young adults aging out of foster care, and pregnant women with incomes that meet specific thresholds.</p> <p>This plan is a full benefit insurance plan</p>	<p>Benchmark Plan: The BadgerCare Plus benefit plan available to children and pregnant women with incomes above 200 percent of the FPL, certain self-employed parents, and other caretaker relatives.</p> <p>This plan provides more limited services than the Standard Plan.</p>	<p>Core Plan: A BadgerCare Plus benefit plan that covers basic health care services to adults who do not otherwise qualify for Medicaid or the Standard or Benchmark Plans, including primary and preventive care, generic and a limited number of brand name prescription drugs.</p>	
Eligibility	<ul style="list-style-type: none"> • Children • Pregnant women • Parents and caretaker relatives • Young adults who are leaving foster care when they turn 18 (regardless of income) • Parents with incomes up to 200% FPL who have kids in foster care <p>The family's gross monthly income must be at or under the monthly income limit.</p> <p>Standard plan members may be asked to pay a share of the cost of services. The co-pay amount ranges from \$.50-\$3.00 per service.</p>	<ul style="list-style-type: none"> • Children and pregnant women with incomes above 200 percent of the FPL • Certain self-employed parents, and other caretaker relatives. 	<p>Childless adults (ages 19 to 64) with income levels below 200 percent of the FPL. Other eligibility criteria include:</p> <ul style="list-style-type: none"> • Do not have children or do not have dependent children under age 19 living at home; • Are not pregnant; • Do not have private health insurance coverage when requesting coverage or in the 12 months before that date; • Do not currently have access to insurance from an employer; • Did not have access to insurance from an employer in the 12 months before requesting coverage; and • Are not getting BadgerCare Plus, Medicaid or Medicare. 	<p>Adults age 19 years or older meeting these criteria:</p> <ul style="list-style-type: none"> • Living in the HMO service area • Receiving Medicaid SSI or SSI-related Medicaid because of a disability • Not living in an institution or nursing home or participating in the Home and Community Waivers Program.
Mental Health/Substance Abuse Services				
General	<ul style="list-style-type: none"> • The HMO must provide BadgerCare Plus and/or Medicaid SSI covered services, but the HMO is not restricted to providing only those services. Additional or alternative treatments may be provided if other treatment modalities are more appropriate and result in better outcomes than contracted covered services. • HMOs must be in compliance with Wis. Stats., s.632.89 (Required coverage of alcoholism and other services) for Benchmark Plan. • HMOs must be certified according to HFS 105.21 (<i>Hospital IMDs</i>), 105.22 (<i>Psychotherapy providers</i>), 105.23 (<i>AODA treatment providers</i>), 105.25 (<i>AODA day treatment providers</i>) and/or 105.255 (<i>Community support programs</i>), to provide mental health and substance abuse services or have contracted with facilities and/or providers certified. Treatment facilities and/or providers must provide arrangements for covered transitional treatment in addition to other outpatient mental health and/or substance abuse services. 			

APPENDIX B.5. – MEDICAID MANAGED CARE HEALTH PLANS
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES – CONTRACTED BENEFITS COMPARISON

	BadgerCare Plus			Medicaid SSI
	Standard	Benchmark	Core Plan	
General (continued)	Full coverage (not including room and board)	Coverage of mental health and substance abuse services (MH/SA) is based on the Wisconsin State Employee Health Plan. Substance abuse services may be limited to \$7,000 per enrollment year.	Coverage is limited to mental health therapy services provided by a psychiatrist	<i>Same as BadgerCare Plus Standard Plan</i>
Cost Sharing Information	\$.50 to \$3 co-payment per service, limited to the first 15 hours or \$500 of services, whichever comes first, provided per calendar year.	Participants pay a share of the cost of services and may be required to pay co-pays and deductibles <i>prior</i> to receiving services; certain participants are not required to pay co-pays.	\$.50 to \$3 co-payment per service, limited to \$30 per provider, per calendar year. There are different copayments for different income levels.	<i>Same as BadgerCare Plus Standard Plan</i>
Inpatient Hospital Services	Full coverage	Includes inpatient hospital services; allowable limitations per enrollment year are outlined below	Full coverage for inpatient hospital services for <i>medical stays</i> but does <u>not</u> include inpatient psychiatric stays in either an IMD or the psychiatric ward of an acute care hospital. Coverage is provided for services provided by a psychiatrist or physician only.	<i>Same as BadgerCare Plus Standard Plan</i>
<i>Limitations</i>	The HMO may not establish any monetary limit or limit on the number of days of inpatient hospital treatment where it has been determined that this treatment is medically necessary.	Mental Health/Substance Abuse Inpatient stays for MH/SA services have a 30-day limit, may be limited to \$7,000 each enrollment year Substance Abuse Treatment <ul style="list-style-type: none"> Stays in an IMD (Institutes for Mental Disease) may be limited to \$7,000/year Stays in a <i>general acute hospital</i> may be limited to \$6,300/year 	<u>Not</u> including inpatient psychiatric stays in either an IMD or the psychiatric ward of an acute care hospital	
<i>Cost Sharing</i>	Co-payment is not required when services provided in hospital setting	Co-payments are \$100 for medical stays; \$50 per stay for MH/SA treatment.	Co-payments vary depending on level of income.	
Outpatient Services	Full coverage (group and individual)	Outpatient mental health and outpatient substance abuse treatment (group and individual), including narcotic treatment, subject to limitations	Coverage is provided for services provided by a psychiatrist or physician only.	<i>Same as BadgerCare Plus Standard Plan</i>
<i>Limitations</i>	No limit may be placed on the number of hours of outpatient treatment that the HMO must provide or reimburse where it has been determined that treatment for mental illness and/or substance abuse	Substance abuse services may be limited to a total of \$7,000 per enrollment year, including \$4,500 for outpatient substance abuse services (which includes \$2,700 for substance abuse day treatment)	Outpatient MH/SA coverage is limited to services provided by a psychiatrist/physician only.	

APPENDIX B.5. – MEDICAID MANAGED CARE HEALTH PLANS
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES – CONTRACTED BENEFITS COMPARISON

	BadgerCare Plus			Medicaid SSI
	Standard	Benchmark	Core Plan	
	is medically necessary.			
<i>Cost Sharing</i>	\$.50 to \$3 co-payment per service, limited to the first 15 hours or \$500 of services, whichever comes first, provided per calendar year.	<ul style="list-style-type: none"> \$15 per visit for outpatient mental health diagnostic interview exam, psychotherapy (individual or group) - no co-payment for electroconvulsive therapy and pharmacological management \$15 per visit for outpatient substance abuse services \$15 per visit for narcotic treatment services (no co-payment for lab tests) 	\$.50 to \$3 co-payment per service, limited to \$30 per provider, per calendar year. There are different copayments for different income levels.	<i>Same as BadgerCare Plus Standard Plan</i>
Day Treatment Services Also referred to as <i>Transitional Treatment or Partial Hospitalization</i>	Full coverage (not including room and board)	<ul style="list-style-type: none"> Mental health day treatment for adults, children and adolescents Substance abuse day treatment for adults and children 	Not covered - coverage is provided for services provided by a psychiatrist or physician only.	<i>Same as BadgerCare Plus Standard Plan</i>
<i>Limitations</i>	No limit may be placed on the number of hours of treatment that the HMO must provide or reimburse where it has been determined that the covered transitional treatment is medically necessary.	Substance abuse day treatment may be limited to \$2,700 each enrollment year for outpatient services (including narcotic treatment)		
<i>Cost Sharing</i>	\$.50 to \$3 co-payment per service, limited to the first 15 hours or \$500 of services, whichever comes first, provided per calendar year.	\$10 per day for all day treatment services		
Prescription Drugs Members are automatically enrolled in <i>Badger RX Gold*</i> , which provides a discount on the cost	Comprehensive drug benefit with coverage of generic and brand name prescription drugs, and some over-the-counter (OTC) drugs	<ul style="list-style-type: none"> Generic-only formulary drug benefit with a few generic OTC drugs Brand name drugs are available through the <i>Badger Rx Gold*</i> 	<ul style="list-style-type: none"> Generic-only formulary drug benefit with a few generic OTC drugs Brand name mental health drugs are covered only for persons previously covered under the General Assistance Medical Program (GAMP)** 	<i>Same as BadgerCare Plus Standard Plan</i>
<p><i>*BadgerRx Gold</i> is a separate program administered by the pharmacy benefit manager, Navitus Health Solutions, to provide a discount on the cost of drugs. Modeled after a landmark drug benefit program developed for employees of the State of Wisconsin, BadgerRx Gold is a public-private sector partnership between the State of Wisconsin and Navitus Health Solutions to bring affordable prescription drugs to the uninsured and underinsured.</p> <p><i>**As noted above, for certain BadgerCare Plus Plan members previously covered under GAMP:</i></p> <ul style="list-style-type: none"> Drugs for certain conditions (Alzheimer's disease, bipolar disease or schizophrenia) continue to be covered as long as the members remain enrolled Specific drugs to treat certain conditions (depression, Parkinson's disease, epilepsy and other seizure disorders, and attention deficit disorder) are covered, as long as members remain enrolled. If members need to change to a different drug for these conditions, it may not be covered. 				

APPENDIX B.5. – MEDICAID MANAGED CARE HEALTH PLANS
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES – CONTRACTED BENEFITS COMPARISON

	BadgerCare Plus			Medicaid SSI
	Standard	Benchmark	Core Plan	
	SOURCE - Navitus Health Solutions website: https://www.navitus.com/			
Overall Limitations Mental Health/Substance Abuse Services	Full coverage	Substance Abuse services may be limited to \$7,000 each year, Costs of mental health services, including inpatient stays, apply to this overall limit.	Coverage is provided for services provided by a psychiatrist or physician only.	
Non-Covered Services	Not covered by BadgerCare Plus HMOs or Medicaid SSI HMOs but are provided on a fee-for-service basis: • Community Support Program (CSP) benefits • Crisis intervention services (coordination is required as outlined below)	• Crisis intervention services • Community Support Program (CSP) • Comprehensive Community Services (CCS) • Outpatient services in the home and community for adults • Substance abuse residential treatment	Coverage is provided for services provided by a psychiatrist or physician only.	Same as BadgerCare Plus Standard Plan
Mental Health/Substance Abuse Assessment Requirements	The HMO must assure that authorization for mental health/substance abuse treatment for its enrollees is governed by the findings of an assessment performed promptly by the HMO upon request of a client or referral from a primary care provider or physician in the HMO’s network.		N/A	Same as BadgerCare Plus Standard and Benchmark Plans
	All denials of service and the selection of particular modalities of service shall be governed by the findings of this assessment, the effectiveness of the therapy for the condition (including best practice, evidence based practice), and the medical necessity of treatment.			
	The HMO must involve and engage the enrollee in the process used to select a provider and treatment option. The purpose of the participation is to ensure participants have culturally competent providers and culturally appropriate treatment and that their medical needs are met.			
Court-Related Children’s Services	The HMO is liable for the cost of providing assessments under the Children’s Code (s. 48.295, Wis. Stats.) and is responsible for reimbursing for the provision of medically necessary treatment if the HMO is unable to provide for such treatment ordered by a juvenile court .		Not responsible for any costs relating to court-ordered services (unless those services are outpatient MH/SA services provided by psychiatrists/physicians).	Same as BadgerCare Plus Standard and Benchmark Plans
Court-Related Substance Abuse Services	The HMO is liable for the cost of providing medically necessary substance abuse treatment, as long as the treatment occurs in the HMO-approved facility or by the HMO-approved provider ordered in the subject’s Driver Safety Plan, pursuant to Wis. Stats., Ch. 343, and Wis. Adm. Code HFS 62. There are mental health and substance abuse coverage limitations as outlined above		Not responsible for any costs relating to court-ordered services (unless those services are outpatient MH/SA services provided by psychiatrists/physicians).	Same as BadgerCare Plus Standard and Benchmark Plans
Crisis Intervention Benefit	Covered on a fee-for-service basis: The HMO must assign a medical representative to coordinate with the designees of crisis intervention agencies certified under Wis. Adm. Code HFS 34 to provide services	Listed as a non-covered service	Not responsible for any costs relating to crisis intervention services (unless those services are outpatient MH/SA services provided by psychiatrists/physicians).	Same as BadgerCare Plus Standard Plan

APPENDIX B.5. – MEDICAID MANAGED CARE HEALTH PLANS
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES – CONTRACTED BENEFITS COMPARISON

	BadgerCare Plus			Medicaid SSI
	Standard	Benchmark	Core Plan	
	within the HMO's service area. The HMO must work with the certified Crisis Intervention Agency to coordinate the transition from crisis intervention care to ongoing BadgerCare Plus and/or Medicaid SSI covered MH/SA care within the HMO's network.			
Emergency Detention and Court-Related Mental Health Services	The HMO is liable for the cost of all emergency detention and court-related mental health/substance abuse treatment, including stipulated and involuntary commitment provided by non-HMO providers to HMO enrollees where the time required to obtain such treatment at the HMO's facilities, or the facilities of a provider with which the HMO has arrangements, would have risked permanent damage to the enrollee's health or safety, or the health or safety of others.	Listed as a non-covered service	Not responsible for any costs relating to emergency detentions or court-ordered services (unless those services are outpatient MH/SA services provided by psychiatrists/physicians).	<i>Same as BadgerCare Plus Standard Plan</i>
Coverage for Institutionalized Individuals <i>Institutionalized Children</i>	If inpatient or institutional services are provided in the HMO facility, or approved by the HMO for provision in a non-contracted facility, the HMO shall be financially liable for all children enrolled under this Contract for the entire period for which capitation is paid. The HMO remains financially liable for the entire period a capitation is paid even if the child's medical status code changes, or the child's relationship to the original BadgerCare Plus case changes.		No coverage	<i>Same as BadgerCare Plus Standard and Benchmark Plans</i>
Coverage for Institutionalized Individuals <i>Institutionalized Adults</i>	The HMO is not liable for expenditures for any service to a person 21 to 64 years of age who is a resident of an institution for mental disease (IMD), except to the extent that expenditures for a service to an individual on convalescent leave from an IMD are reimbursed by Medicaid FFS. If a person 21 to 64 years of age is in need of hospitalization for mental health or substance abuse issues, the HMO must make arrangements with a general acute care hospital to provide coverage.		No coverage	
Transportation Following Emergency Detention	The HMO shall be liable for the provision of medical transportation to the HMO-affiliated provider when the enrollee is under emergency detention or commitment and the HMO requires the enrollee to be moved to a participating provider, provided the transfer can be made safely. If a transfer requires a secured environment by local law enforcement officials, (i.e., Sheriff Department, Police Department, etc.), the HMO shall not be liable for the cost of the transfer. The HMO is not prohibited from entering into an MOU or agreement with local law enforcement agencies or with county agencies for		No coverage	<i>Same as BadgerCare Plus Standard and Benchmark Plans</i>

APPENDIX B.5. – MEDICAID MANAGED CARE HEALTH PLANS
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES – CONTRACTED BENEFITS COMPARISON

	BadgerCare Plus			Medicaid SSI
	Standard	Benchmark	Core Plan	
	such transfer. The county agency or law enforcement agency makes the decision whether the transfer requires a secured environment.			
	BadgerCare Plus			Medicaid SSI
	Standard	Benchmark	Core Plan	
Exemptions	<p>The contract includes the option of disenrolling an enrollee meeting one or more of the mental health and/or substance abuse criteria of the contract, or applying to have the affected person remain in the FFS system.</p> <p>Criteria include:</p> <ul style="list-style-type: none"> • A child meeting criteria for severe emotional disturbance (SED) who is enrolled or has been accepted in a SED program • A person participating in a methadone treatment program, or who has been determined to need methadone treatment unless the person declines to receive such treatment. • A person with a complex physical or psychiatric condition who has extensive non-medical programming needs best provided or coordinated by the 51.42, 51.437, and/or social or human services systems (such as Community Support Programs, Comprehensive Community Services, etc.). 	N/A	N/A	
Contract Provisions Related to Providers and Provider Contracting				
Other Organizations - Contracts/MOUs - Coordination - Consultation	The Department encourages the HMO to contract with community-based health organizations and local health departments for provision of care to include outreach, screening, and immunizations.			
	The HMO must use its best efforts to sign a MOU with all School-Based Services providers in the HMO service area to ensure continuity of care and avoid duplication of services.			
	HMOs must make a good faith attempt to negotiate either a MOU or a contract with the county(ies) in its service area. The MOU must be signed every two years as a part of the HMO certification with the Department.			
	The HMO must assure expertise for child abuse, child neglect and domestic violence and consult with human services agencies on appropriate providers in their community.			
	A Milwaukee County HMO must designate at least one individual to serve as a contact person for the Bureau of Milwaukee Child Welfare.			
	HMOs must interface with the case manager from the Targeted Care Management agency to identify what BadgerCare Plus and/or Medicaid SSI covered services or social services are to be provided to an enrollee.			
	The HMO must assign a medical representative to coordinate with the designees of crisis intervention agencies. The HMO must work with the certified Crisis Intervention Agency to coordinate the transition from crisis intervention care to ongoing BadgerCare Plus covered mental health and substance abuse care within the HMO network.			
	The HMO shall develop a working relationship with community agencies involved in the provision of mental health and/or substance abuse services and work cooperatively with other community agencies to treat mental health and/or substance abuse conditions as legitimate health care problems.			
	The HMO must designate at least one individual to serve as a contact person for case management providers and may make referrals to case management agencies when they identify an enrollee who could benefit from these services. If an enrollee or case manager request, the HMO to conduct an assessment, the HMO will determine whether there are signs and symptoms indicating the need for an assessment – Guidelines for Coordination of Service.s			
	The HMO must employ a BadgerCare Plus HMO Advocate to work with both enrollees and providers to facilitate the provision of benefits to enrollees.			
Access	HMO providers must provide arrangements for covered transitional treatment in addition to other outpatient mental health and/or substance abuse services to include child/adolescent day treatment and substance abuse day treatment.			
	HMOs must guarantee all enrolled BadgerCare Plus members access to all medically necessary outpatient mental health/substance abuse and covered			

APPENDIX B.5. – MEDICAID MANAGED CARE HEALTH PLANS
MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES – CONTRACTED BENEFITS COMPARISON

	<i>BadgerCare Plus</i>			Medicaid SSI
	Standard	Benchmark	Core Plan	
	transitional treatment.			
	HMOs must have a mental health or substance abuse provider within a 35 mile distance from any enrollee residing in the HMO service area.			

SOURCES

- Contract for BadgerCare Plus and/or Medicaid SSI between the HMO and the Department of Health Services, February 1, 2008 – December 31, 2009
- Contract Amendment for BadgerCare Plus and SSI Medicaid Services (Childless Adults – BadgerCare Plus Core Plan), including Addendum V – Summary of BadgerCare Plus Covered Services
- Department of Health Services website - <http://dhs.wisconsin.gov/>

APPENDIX B.5. – MEDICAID MANAGED CARE HEALTH PLANS

MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES – CONTRACTED BENEFITS COMPARISON

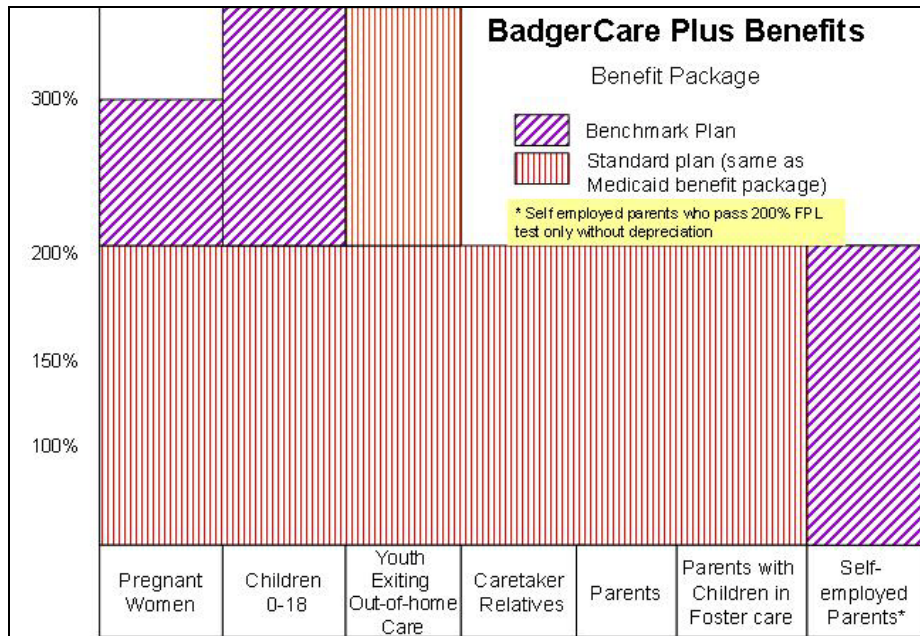
BadgerCare Plus

The BadgerCare Plus initiative has four strategic goals:

1. Cover all children
2. Provide coverage and enhanced benefits for pregnant women
3. Make the program simple
4. Promote prevention and healthy behaviors

In addition, BadgerCare Plus has several limited health plans. These include:

- Family Planning Waiver program
- Prenatal Care Services
- Emergency Services
- Well Women (cervical and breast cancer related) Care



The following income levels are used to determine enrollment for BadgerCare Plus.

Family size	100% Monthly Income	150% Monthly income	200% Monthly income	300% Monthly income
1	\$ 902.50	\$1,353.75	\$1,805.00	\$2,707.50
2	\$1,214.17	\$1,821.25	\$2,428.33	\$3,642.50
3	\$1,525.83	\$2,288.75	\$3,051.67	\$4,577.50
4	\$1,837.50	\$2,756.25	\$3,675.00	\$5,512.50
5	\$2,149.17	\$3,223.75	\$4,298.33	\$6,447.50
6	\$2,460.83	\$3,691.25	\$4,921.67	\$7,385.50
7	\$2,772.50	\$4,158.75	\$5,545.00	\$8,317.50
8	\$3,084.17	\$4,626.25	\$6,168.33	\$9,252.50

*These amounts are based on the 2009 federal guidelines, which increase by a small percentage each year.

SOURCE

Department of Health Services website - <http://dhs.wisconsin.gov/>






***BadgerCare Plus HMO Participation for
Contract Period February 2008 - December 2009***

BadgerCare Plus HMO Participation for Contract Period February 2008 - December 2009

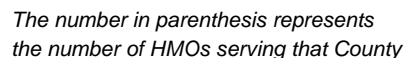
Effective 09/01/09

The parenthesized number is the number of HMOs serving that county.

County	Number of HMOs
DOUGLAS	3
BAYFIELD	3
IRON	1
ASHLAND	4
VILAS	3
BURNETT	3
WASHBURN	4
SAWYER	4
PRICE	2
ONEIDA	3
FLORENCE	0
POLK	3
BARRON	3
RUSK	3
FOREST	3
MARINETTE	0
ST CROIX	3
DUNN	2
CHIPPEWA	3
TAYLOR	5
LINCOLN	4
LANGLADE	4
PIERCE	2
PEPIN	2
EAU CLAIRE	3
CLARK	4
MARATHON	5
SHAWANO	3
MENOMINEE	3
OCONTO	3
DOOR	0
BUFFALO	4
TREMP-EALEAU	4
JACKSON	4
WOOD	3
PORTAGE	4
WAUPACA	5
OUTAGAMIE	4
BROWN	4
KEWAUNEE	2
ADAMS	1
WAUSHARA	3
WINNEBAGO	4
MANITOWOC	3
LA CROSSE	3
MONROE	4
MARQUETTE	3
GREEN LAKE	3
FOND DU LAC	3
SHEBOYGAN	4
WASHINGTON	6
VERNON	4
CRAWFORD	4
RICHLAND	2
SAUK	4
COLUMBIA	4
DODGE	6
OZAUKEE	7
JUNEAU	4
WAUKESHA	7
MILWAUKEE	7
GRANT	5
IOWA	3
DANE	6
JEFFERSON	7
WALWORTH	5
RACINE	5
KENOSHA	7
LAFAYETTE	2
GREEN	5
ROCK	5

	Mandatory HMO counties
	Mandatory HMO for selected zip codes in county, voluntary or Fee-for-Service in other zip codes.
	Voluntary HMO counties
	Voluntary HMO for selected zip codes in county, Fee-for-Service in other zip codes.
	Fee-for-Service counties (HMOs do not participate).

Page 20 of 21



Page 21 of 21

APPENDIX C

REVIEW OF SELECTED STATES

APPENDIX C.1. WISCONSIN PUBLIC MENTAL HEALTH AND SUBSTANCE ABUSE INFRASTRUCTURE STUDY

Consideration of States for Comparison, Best Practices & Lessons Learned

February 12, 2009

The overall objective of the comparisons to other states' systems is to gain an understanding of the critical factors and information about service delivery and funding structures and to obtain insights into lessons learned from their experiences with initiatives they may have undertaken to restructure their service delivery systems. The intent is to select no more than five states for review that represent the major models to be considered in the development of the future model/pathway options.

1. States that directly fund, but do not operate local community-based providers.
Based on an annual survey of state mental health agencies, there were 27 states in this category in 2007.

State	Undertaking Initiatives to Restructure Community-based Mental Health System	Extent to Which Counties Administer Mental Health Services	Do Counties Pay A Share of the State Medicaid Match	Is the State Using Managed Care to Provide Behavioral Health Services	Organizational Location of Substance Abuse Services
Maine	Adults: Continue to be under the AMHI consent Decree and Court approved Settlement agreement for restructuring the Adult community MH system to improve continuity of care. Children: Major initiatives with Child Welfare to improve access and enhance overall quality of MH services.	Not at All	No	No	Not part of State Mental Health Agency, but located in same umbrella department
Michigan	Mental Health Commission issued a report in 2004 with recommendations on improving the mental health system. The Department of Community Health developed an implementation plan to guide system transformation.	Not at All	Yes	Yes	Not part of State Mental Health Agency, but located in same umbrella department
New Mexico	Through the Interagency Behavioral Health Purchasing Collaborative, the Transformation State Incentive Grant and the contract with ValueOptions New Mexico the service delivery system is changing to reflect a system that is responsive to consumer and family needs, and has recovery and resilience practices. ValueOptions New Mexico has been working to insure that services continue to be made available, that providers continue to receive payment for their services, that data is collected, and that the quality of services is equal to, if not better than, services provided in the past.	Not at All	Yes	Yes	Part of State Mental Health Agency

Sources: National Association of State Mental Health Program Directors Research Institute, Inc. (NRI); State Mental Health Profiling System: 2007

State Mental Health Agency Websites

APPENDIX C.1. WISCONSIN PUBLIC MENTAL HEALTH AND SUBSTANCE ABUSE INFRASTRUCTURE STUDY

Consideration of States for Comparison, Best Practices & Lessons Learned

February 12, 2009

State	Undertaking Initiatives to Restructure Community-based Mental Health System	Extent to Which Counties Administer Mental Health Services	Do Counties Pay A Share of the State Medicaid Match	Is the State Using Managed Care to Provide Behavioral Health Services	Organizational Location of Substance Abuse Services
Oregon	Oregon Legislative Assembly directed the Oregon Department of Human Services (DHS) to conduct an assessment and evaluation of the adult community mental health care component of the state's mental health care delivery system. Final report issued in November 2008.	Statewide	No	Yes	Part of State Mental Health Agency

2. States that fund local governments, which in turn, operate and contract for community-based services. Based on an annual survey of state mental health agencies, there were 14 states in this category in 2007.

State	Undertaking Initiatives to Restructure Community-based Mental Health System	Extent to Which Counties Administer Mental Health Services	Do Counties Pay A Share of the State Medicaid Match	Is the State Using Managed Care to Provide Behavioral Health Services	Organizational Location of Substance Abuse Services
Arizona	None indicated.	Not at All	No	Yes	Part of State Mental Health Agency
Iowa	Recently issued an RFP seeking a contractor to administer the provision of mental health and substance abuse treatment services for the Medicaid program and substance abuse treatment services funded by federal block grant and state appropriations.	Statewide	Not reported	Yes	Located in a different state department
Minnesota	With the recent passage of the State's Mental Health Systems Improvement bill there are major sections in the legislation that require that the Department of Human Services (DHS) Division of Mental Health and Disability Services (MHDS) form planning workgroups. These workgroups are to make recommendations to the MHMRDDBI commission, to the DHS director, and the legislature.	Statewide	No	Yes	Not part of State Mental Health Agency, but located in same umbrella department

Sources: National Association of State Mental Health Program Directors Research Institute, Inc. (NRI); State Mental Health Profiling System: 2007

State Mental Health Agency Websites

APPENDIX C.1. WISCONSIN PUBLIC MENTAL HEALTH AND SUBSTANCE ABUSE INFRASTRUCTURE STUDY

Consideration of States for Comparison, Best Practices & Lessons Learned

February 12, 2009

State	Undertaking Initiatives to Restructure Community-based Mental Health System	Extent to Which Counties Administer Mental Health Services	Do Counties Pay A Share of the State Medicaid Match	Is the State Using Managed Care to Provide Behavioral Health Services	Organizational Location of Substance Abuse Services
North Carolina	Area authorities are being restructured to be Local Management Entities (LMEs) that contract for and monitor service delivery rather than being service providers. There is also ongoing consolidation of area authorities/LMEs to reduce the number.	Statewide	Yes	Yes	Part of State Mental Health Agency
Ohio	None indicated.	Statewide	Not reported	No	Located in a different state department
Pennsylvania	Statewide expansion of Medicaid managed care.	Statewide	No	Yes	Alcohol Abuse services located in a different state department but Substance Abuse services part of State Mental Health Agency
Washington	Mental Health benefit redesign, increase use/availability of EBPs, development of housing plan, review of payment methods, review of involuntary treatment laws.	Statewide	No	Only Mental Health	Not part of State Mental Health Agency, but located in same umbrella department
Wisconsin	Conducting a public mental health and substance abuse infrastructure study.	Statewide	Yes	Yes	Part of State Mental Health Agency

3. States that directly operate community-based programs.

Based on an annual survey of state mental health agencies, there were 7 states in this category in 2007. These states included: Delaware, Hawaii, Idaho, Louisiana, Massachusetts, Nevada, and South Carolina.

Sources: National Association of State Mental Health Program Directors Research Institute, Inc. (NRI); State Mental Health Profiling System: 2007

State Mental Health Agency Websites

APPENDIX C.2 – LIST OF INDIVIDUALS AND/OR ORGANIZATION INTERVIEWED FOR THE WISCONSIN PUBLIC MH/SA INFRASTRUCTURE STUDY

Interviews with Selected States – The project team interviewed representatives of the appropriate state mental health and substance abuse services agency(s), and representatives of consumer and system advocacy in the selected states.

Minnesota – Contacts Interviewed

- Sharon Autio, Director, Adult Mental Health Division, Minnesota Department of Human Services
- John Zakelj, Grants Specialist (legislative and budget contact), Adult Mental Health Division, Minnesota Department of Human Services
- Carol Falkowski, Director, Alcohol and Drug Abuse Division, Minnesota Department of Human Services
- Representatives of consumer advocacy and county systems from the following organizations:
 - Mental Health Association of Minnesota
 - Minnesota Citizens' Advisory Council for Alcohol and Drug Abuse
 - Minnesota Association of County Social Service Administrators and Association of Minnesota Counties

New Mexico – Contacts Interviewed

- Karen Meador, Senior Policy Director, HSD/New Mexico Behavioral Health Collaborative
- Representatives of consumer advocacy from the following organizations:
 - NAMI New Mexico
 - Recovery-Based Solutions for substance abuse services

North Carolina – Contacts Interviewed

- Leza Wainwright, Director, Division of Mental Health, Developmental Disabilities and Substance Abuse Services, North Carolina Department of Human Services
- Flo Stein, Chief, Community Policy Management Section of DMHDDSAS – This section is primarily responsible for leadership, guidance and management of relationships with the local management entities (LMEs). Flo Stein is also the president of the National Association of State Alcohol and Drug Abuse Directors (NASADAD)
- Representatives of consumer advocacy and county systems from the following organizations:
 - NAMI North Carolina
 - Governor's Institute on Alcohol and Substance Abuse
 - North Carolina Council of Community Programs (MH, DD, SA)

APPENDIX C.2 – LIST OF INDIVIDUALS AND/OR ORGANIZATION INTERVIEWED FOR THE WISCONSIN PUBLIC MH/SA INFRASTRUCTURE STUDY

Ohio – Contacts Interviewed

- Rick Tully, Program Administrator Office, of Systems Transformation, Ohio Department of Mental Health
- Angie Bergefurd, Assistant Deputy Director for Fiscal Policy, Ohio Department of Mental Health – Office of Medicaid
- Representatives of consumer advocacy and county systems from the following organizations:
 - Mental Health America of Franklin County
 - Ohio Citizen Advocates for Chemical Dependency Prevention & Treatment
 - Ohio Association of County Behavioral Health Authorities

Oregon – Contacts Interviewed

- Richard Harris, Director, Addictions and Mental Health Division, Oregon Department of Human Services
- Representatives of consumer advocacy and county systems from the following organizations:
 - Mental Health America of Oregon
 - Association of Oregon Community Mental Health Programs
 - Mental Health Organization (MHO) provider for a multi-county area under the Oregon Health Plan

Other Contacts with National Organizations:

- **National Association of State Alcohol and Drug Abuse Directors (NASADAD)** – discussed NASADAD project to update 2002-03 State Profiles of Mental Health and Substance Abuse Services in Medicaid, and in particular how states use Medicaid to pay for SA services; also discussed the common themes for state financing reform of SA services with Rick Harwood, Research and Program Applications Director and AOD Research Analyst from NASADAD.
- **OPEN MINDS, Behavioral Health and Social Service Industry Analyst** – discussed industry trends and other state systems with Monica Oss, the CEO of OPEN MINDS.

APPENDIX C.3.A. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

Minnesota ¹	
Consumer Advocacy Involvement and Role in Reform Effort (Planning, Implementation and Evaluation)	<ul style="list-style-type: none"> • Broad-based consumer involvement in reform planning efforts through the Minnesota Mental Health Action Group (MMHAG) with direct involvement by NAMI and Consumer/Survivor Network. • Consumers were involved in development of Preferred Integrated Networks (PINS) contract and instrumental in adoption of provision to allow consumers to self-select enrollment in PIN or remain in fee-for-service (FFS). • Consumer involvement was meaningful; reform plan would have looked different if consumers/advocates had not been involved.
Impact of Reform on Consumers (Access to Services and Service Capacity; Accountability for and Focus on Consumer Outcomes; Service Coordination, Integration and Effectiveness)	<p>Most Positive Aspects of Reform:</p> <ul style="list-style-type: none"> • Expanded MH/SA service coverage (ACT, ERP and crisis services) to low income populations enrolled in MinnesotaCare and General Assistance Medical Care (GAMC). An estimated 70 percent of individuals receiving GAMC have mental health and/or substance abuse issues. • PINs provide choice for consumers to self select or remain in FFS. • Funding for regional treatment centers. • Voluntary regional approach and funding for substance abuse services, especially in rural areas, has encouraged consortia of counties to respond to competitive bids to coordinate services and develop programs, such as residential programs. Regional approach has resulted in better use of limited resources to serve the most people. • Movement of funding focus from state hospitals to community programs has been positive. In the past, state primarily funded inpatient services. • Evidence-based practices (EBPs) have been widely implemented and help to ensure some uniformity and accountability statewide. • Reform has made system more consumer-focused; state is working to get Medicaid benefit for peer specialists and certified peer specialist program. • Very positive that all levels of state government (from the Governor on down) and various stakeholder groups recognized that something had to be done to reform the MH/SA system and MH/SA reform was made a priority with an influx of new dollars; also MH/SA system in the past has been spared when other program areas have been cut. • Cost efficiency not cost cutting was the goal of reform. Cost was a driver of reform, but in a positive sense. • Adult mental health survey was developed.

¹ Summary based on interviews with representatives of MH/SA consumer advocacy conducted in May and June of 2009.

APPENDIX C.3.A. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

Minnesota ¹	
	<p>Challenges:</p> <ul style="list-style-type: none"> • Budget deficit is impacting reductions in GAMC; these cuts will in turn reduce provider capacity for other populations. • Inequitable funding for and access to services, as well as provider shortages, are very problematic for consumers, and are more pronounced in rural areas; transportation problems continue. In urban areas, the populations at greatest risk may not be the ones served. • Challenge is how to address inequities in funding; barriers to services are artificial county boundaries; in some areas there is very little population to support an adequate service capacity. • Prefer to see more regional funding so there is a better flow of funding from one county to another; single county grants have stopped and there is more of a regional funding allocation approach for regional initiatives to try to make services more accessible statewide across regions. • No actual outcome measurement is being used other than attempt at SAMHSA EBPs; no statewide tracking of consumer satisfaction with services and no funding for evaluations. • Not serving dually diagnosed consumers well due to fragmented organizational structures at state and county level; integration occurs at provider level. • Service integration is a huge issue in adult system, to a lesser extent in the children's system; no coordination between jails and community services, some coordination between Department of Corrections and counties related to pre-discharge planning; lack of funding and funding cuts jeopardize service integration across services systems (e.g., mental health courts may face elimination due to budget cuts). People are aware that service integration between different service systems is a problem, but they haven't gotten to the next step of comprehensively addressing the issues. Data collected for the planning of the Preferred Integrated Networks (PINS) shows that there are individuals with MH/SA issues whose lives are spread out over 5 different systems. • County maintenance of effort requirement in substance abuse funding (i.e., Consolidated Chemical Dependency Treatment Fund) varies from county to county and results in inequitable funding. However, efforts to move to a more equitable funding approach have not been successful due state unwillingness to assume larger financial participation. • Challenge is to get substance abuse service diversification and family involvement in treatment plan. Family involvement is best achieved when the services are provided locally. • Greater commitment of resources is required to adequately fund certified programs (which are more costly) and to attract qualified staff in the substance abuse area. • Constituency that supports mental health is more active than substance abuse advocacy; easier to fund mental health services due to stigma that substance abuse issues are self-inflicted.

APPENDIX C.3.A. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

Minnesota ¹	
Lessons Learned	<ul style="list-style-type: none">• Make sure that better consumer outcomes drive the system and that consumers benefit from the reform effort.• Minnesota is looking at health care reform in general and is open to and mindful of including MH/SA as an integrated part of health care reform, not simply as an add-on.• Need to look at MH/SA system within broader health care reform efforts, otherwise MH/SA will be a separate silo that does not get integrated.• Consider MH/SA services in a model that is more integrated and prevention-focused.• Reform requires a shared vision of what is to be accomplished and why.• Data collection and focus on outcomes is very important to any reform effort. While there is little question about the need for additional dollars, data can demonstrate that the expenditure of additional resources has been worthwhile.• Need to make sure that the flow of funding to service providers is timely, since some agencies have very tight cash flow requirements.

APPENDIX C.3.B. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

New Mexico ¹	
Consumer Advocacy Involvement and Role in Reform Effort (Planning, Implementation and Evaluation)	<ul style="list-style-type: none"> • Reform was driven by Governor; not consumer-driven. • Consumers liked the idea of the local collaborative and thought the voice of the local collaborative would have an impact on New Mexico Behavioral Health Purchasing Collaborative's decision-making. • If local collaboratives operated as they should, they would be very positive for consumers and focus on organizing peers for consumers and encourage a dialogue between consumers/peers and providers. • Local collaboratives as a feedback tool are not working well in practice and the state Behavioral Health Purchasing Collaborative does not really listen to the local collaborative when making decisions about how the money is spent on services (e.g., when state collaborative asked each local collaborative to identify two priority areas for the legislation session, the state collaborative did not attempt to push them). • Family members and consumers on the State Behavioral Health Purchasing Collaborative were involved in the selection and evaluation of the Statewide Entity (SE). • State Behavioral Health Purchasing Collaborative heard from advocates about the need for more consumer-run services (e.g., peer specialists, support groups); while these services have blossomed under reform they haven't yet come to total fruition. • Goal of reform was to be consumer-centered; reform "talks the talk", but much of reform was based on finding less costly approaches. For example, there is a huge focus on peer-based services, but these should not replace the need for psychiatric care. If you believe that mental health issues are medically-based, then there will always be a need for psychiatric intervention. • There is a consumer "presence" in the reformed system, but consumers are not as strong a voice as they could or should be. • State wants consumers to be part of the process, however, only a handful of consumers get actively involved and those individuals are involved in multiple groups and meetings. • More mental health as opposed to substance abuse consumers are involved in system advocacy, partly due to differences in the nature of the recovery process for each and the time commitment required for system advocacy.
Impact of Reform on Consumers (Access to Services and	<p>Most Positive Aspects of Reform:</p> <ul style="list-style-type: none"> • Pooling of MH/SA resources among various state agencies was very positive to help get resources to where they are needed most for greater service efficiency and to provide greater funding options for services to consumers. Previously, service funding (especially substance abuse funding) was scattered throughout the state with little

¹ Summary based on interviews with representatives of MH/SA consumer advocacy conducted in May and June of 2009.

APPENDIX C.3.B. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

New Mexico ¹	
Service Capacity; Accountability for and Focus on Consumer Outcomes; Service Coordination, Integration and Effectiveness)	<p>continuity. Service integration for substance abuse consumers is working better than before.</p> <ul style="list-style-type: none"> • State got large amount of funding for dually diagnosed and allocated funds for provider training to make more of these services available to consumers. • Better outreach to Native American community, including the creation of a “local” collaborative to serve Native Americans and provide them a voice statewide; services to this population were minimal prior to reform. • Trying to address some of the rural access issues with telepsychiatry (e.g., new SE will be using teleconferencing to provide rural access to more psychiatrists than under the previous SE). • System is becoming more accountable for consumer outcomes and there is a greater emphasis on recovery-oriented, as opposed to clinical, outcomes. However, this focus is not yet widespread across the state and is lacking in the rural areas. • SE is required by contract to train peer specialists and implement peer specialist services. <p>Challenges:</p> <ul style="list-style-type: none"> • There is great variation in how the local collaboratives are run and organized. Consumers, providers and families feel under-represented on some local collaboratives (e.g., some are top heavy with providers and not enough consumers). Also, consumers often find it difficult to get involved with statewide advocacy because they are too busy with their own lives and work. • Providers and consumers are involved, to varying degrees, in the local collaboratives, but community stakeholders (e.g., landlords, business people, emergency personnel) are not, which causes difficulty in gaining community buy-in for initiatives that require broader community buy-in (e.g., housing, supported employment, emergency service issues). • There have been problems and a high degree of consumer dissatisfaction with the previous Statewide Entity (ValueOptions) that managed behavioral health services in New Mexico and many complaints to legislators from consumers and families. As a result, different expectations have been incorporated into the new SE construct. • There is less provider choice for consumers; prior to reform there were three mental health entities and the competition was good for consumer choice (i.e., if a consumer was not satisfied with one entity he/she could select another). New Mexico switched to a new SE (OptumHealth) in July 2009 and the state will impose new expectations on the new vendor. • There is not enough inpatient capacity (including capacity for medical detox) and there are very limited appropriate community supports, especially for those who are uninsured without ability to pay. There has been a detrimental shift to less hospitalization; it is very difficult to get anyone in a hospital now and the focus is on quick discharges. • Previous Statewide Entity (ValueOptions) focused more on mental health than substance abuse because that is

APPENDIX C.3.B. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

New Mexico ¹	
	<p>what the entity knew best. SE provides more mental health services, while substance abuse services tend to be limited to those who are dually-diagnosed.</p> <ul style="list-style-type: none"> • There are not enough intensive services for children, including limited residential treatment. • While there is a huge move by the state to get people out of prison due to budget pressures, there is concern that the state does not have the resources to deal with MH/SA issues in the community. • Underfunding of services is a key problem. State offers mostly Medicaid funded services. Substance abuse is not included in the state Medicaid plan and does not receive MA funding. • Access to services in rural areas of the state is very difficult due to lack of service providers and transportation problems (e.g., some consumers have to drive 3-4 hours to the closest city and/or provider). • Not all MH/SA services are pooled at the state level and managed by the SE, as some state agencies are reluctant to give up control over all of these resources.
Lessons Learned	<ul style="list-style-type: none"> • There were no guidelines as to how local collaboratives were to operate which resulted in great variation among the collaboratives and especially in regards to consumer involvement. Variation also occurs because of the differences between communities in how MH/SA consumers are viewed (empowered individuals able to make choices vs. learned helplessness). • Local collaboratives, if operated effectively, can be a good avenue for consumers to have a voice in the system. • Make reform effort inclusive. Do not establish the local collaboratives and then invite consumers to the table. Involve consumers from the beginning. • Make sure consumers understand their role in the reform effort or actually design their role and provide training and other supports so consumers can effectively carry out their role. • Consumers have a lot to say and contribute, but they do not always know how to contribute. • Be careful about “burning out” consumers with too much of a time commitment for participation. A few people end up always be asked to be involved. Consumer “self care” is important to maintain meaningful participation. Consider barriers to consumer participation such as travel and time in order to ensure consumer involvement. • Make sure that all the key stakeholders (state, providers and consumers) are on the same page for the reform effort from the beginning. • Base service allocation decisions on actual data regarding local needs, and do not assume what those needs are for the entire state. • Reform should include peer support and mentoring to help guide an individual’s recovery in addition to clinical treatment services. Continuum of care is important.

APPENDIX C.3.C. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

North Carolina ¹	
Consumer Advocacy Involvement and Role in Reform Effort (Planning, Implementation and Evaluation)	<ul style="list-style-type: none"> • In addition to politics and budgets, one of the key drivers of reform was the need for consumers and families to have a stronger voice. Reform was partially due to the stories heard by legislators that consumers were not being served. • Consumers and NAMI supported reform effort and participated in it. There were consumer representatives on the Blueprint for Change taskforce. Everyone bought into the reform effort and there was a rally and excitement about reform. Everyone approved of the four main drivers of reform (e.g., uniformity, services that work, move focus from hospital to community-based services, and greater consumer voice). • While goals of reform were stated in a consumer-centered way, how they were implemented through privatization was not consumer-centered. • As a result of the reform effort, consumers came together and are now a force. • Consumers have been given a voice in the Consumer Family Action Councils (CFACs), but the impact of consumer involvement is yet to be seen. • Substance abuse consumers have not been as involved in reform efforts due to the nature of their condition (i.e., good outcomes for substance abuse consumer involves returning to work with little time to attend meetings and participate in a consumer advocacy role).
Impact of Reform on Consumers (Access to Services and Service Capacity; Accountability for and Focus on Consumer Outcomes; Service Coordination, Integration and Effectiveness)	<p>Most Positive Aspects of Reform:</p> <ul style="list-style-type: none"> • System has stabilized in the past year. • Reform has potential to make the system more consumer-focused – the building blocks are in place. However, implementation takes longer than expected. • The number of evidence-based practices like ACTs increased, but there were problems billing Medicaid for these. • The number of consumer drop-in centers and peer support and peer specialist training have increased. • While there was choice of providers with the public system pre-reform, consumers have more choice in the private system. • There is better monitoring of provider performance since reform. • Children's services have fared somewhat better than adult services. • Before reform, substance abuse services were a small part of overall service mix; reform improved access to substance abuse services. • Privatization has been positive for workforce development in the substance abuse area, because these services broke their reliance on the county salary structure and increased compensation for licensed workers was the

¹ Summary based on interviews with representatives of MH/SA consumer advocacy conducted in May and June of 2009.

APPENDIX C.3.C. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

North Carolina ¹	
	<p>result.</p> <ul style="list-style-type: none"> • Now there is a major momentum toward integrated MH/SA services and physical health care, which would not have been possible under the county system. • Reform also increased the level of state funding for substance abuse; prior to reform substance abuse services relied more on federal funding. • Cross Area Service Programs implemented in the 1990s allocated substance abuse funding for consumers who accessed services in another county. <p>Challenges:</p> <ul style="list-style-type: none"> • There is a lack of understanding at the state and local bureaucracy levels about managed care which resulted in “turbulent times” for the system. LMEs had a learning curve in figuring out how to manage programs; for some that transitioned from county programs, the learning curve was steeper. • Authority of the state over counties is weak; state lacks the type of control needed to implement reform statewide (General Assembly ended up as mediators in the reform process). Not all new LMEs embraced organizational changes and there was lots of variation built into the system due to county program variations prior to reform that continued during reform. • Privatization (divestiture of the public programs run by counties) was a huge change that kept changing due to changes in provider groups, failure of providers, etc. (“providers failed by the 100s”). This issue goes to the importance of the continuing relationship between consumers and service providers. In the past, consumers could always default to the public system if they had problems getting their medications; now that was no longer the case – complete loss of the public safety net and no statutory provision to protect people under privatization. Public system lost case management capacity due to privatization. • There was a greater development of lower end services due to the profit motive of MCOs. • There are no incentives to reward good providers that have better outcomes. • The new service definition for community support (a bundled service including medical home wrap-around and case management) was poorly defined which, in part, led to allegations of financial mismanagement. • North Carolina has lots of geographic diversity (“haves and have nots”) in terms of access to services – this was a major driver of reform and reform has not been able to fully address this; there are still poor counties. In some cases, reform has improved equitable funding; but in other cases, reform has exacerbated the disparity between rich and poor areas. • There are mixed reviews regarding the performance of Consumer Family Action Councils (CFACs) at each LME; some are very effective and others are not. • State MH trust fund that was set up to build service capacity was used for other purposes.

APPENDIX C.3.C. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

North Carolina ¹	
	<ul style="list-style-type: none"> • State hospital placements are not the responsibility of LMEs, but there are pilots for LMEs to manage both state hospital and community placements. • There are greater workforce challenges in areas of the state without a university; universities have helped develop substance abuse workforce capacity. • There is a tremendous amount of variation in how MH/SA services are integrated with other systems, depending on current and past working relationships between entities.
Lessons Learned	<ul style="list-style-type: none"> • Implementation takes longer than expected. Reform needs to be sequenced. Cannot expect to do everything at once. There was so much change brought about by the reform effort and not enough energy left to pay attention to the service delivery side and ensure that service capacity is adequate. State could have had some pilot programs to implement a privatized model in order to better evaluate the impact of reform. • Need rapid response approach to address unintended consequences of policy changes. • There was too much attention focused on governance (i.e., “who’s in charge”), as opposed to the services. Consumer outcomes have gotten lost in the rush to administer and manage the system. • Infrastructure and systems are needed to support reform effort. Need a lot of time to implement a billing system in a privatized model. This is difficult to do when a system is undergoing a lot of change and is under stress (e.g., providers got lots of denials for dual eligibles). Need one managed care computer system otherwise you waste too much time with multiple systems that are not integrated. • Need to implement principles of managed care to drive services to be more person-centered. • Do not set up financial system as FFS system because there are many services that providers will not be able to bill for (e.g., travel, state hospitals). Lost lots of psychosocial rehab services due to low rates. • Consumers want continuity in service provision and they want choice (choice can be achieved with public and private provider involvement). • Key to successful reform is in the design. The same entity that assesses for services or provides case management should not also provide the services. A public entity could do the assessment and a private entity could provide the services. • Do not plan reform during an economic downturn. The state planned reform during dot.com bust and never had enough money to implement the reform plan. Not only do you need sufficient resources to implement reform, but those resources are needed at key critical moments if the implementation is to be successful. Money and timing need to be aligned (i.e., when funds were needed to increase community capacity, it wasn’t available). • Planning process should use milestones and not end products to measure progress with the reform effort. Instead of trying to link the whole state plan to statewide outcomes, plan should deal with smaller milestones.

APPENDIX C.3.D. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

Ohio ¹	
Consumer Advocacy Involvement and Role in Reform Effort (Planning, Implementation and Evaluation)	<ul style="list-style-type: none"> • Consumers and advocates for developmental disability (DD) services are more vocal and more local and state funds go to DD services as opposed to MH/SA services. • Organization of mental health consumers and families has longer history than substance abuse consumer advocacy. Substance abuse consumers/advocates are not as well-organized and many are afraid to be identified (mental illness is widely accepted as a no-fault disease, but substance abuse is not). Also, many consumers who are doing well in managing their substance abuse issues are working and unable to commit the time to advocacy efforts, to attend meetings, etc. • Consumers are at the table to plan for system changes as part of the Coalition for Healthy Communities, which represents about 30 different statewide groups involved in consumer advocacy. • Consumers have more of an education as opposed to policy design and implementation role on local consumer, family and provider advocacy boards (i.e., consumers help educate others about MH/SA issues, but many consumers are not policy-oriented). • Reform is not generally driven by consumers, but rather by local boards and providers. • Transportation continues to be a problem in getting consumers to participate in reform efforts and discussions.
Impact of Reform on Consumers (Access to Services and Service Capacity; Accountability for and Focus on Consumer Outcomes; Service Coordination, Integration and Effectiveness)	<p>Most Positive Aspects of Reform:</p> <ul style="list-style-type: none"> • Advocates favor moving Medicaid match to the state from the local boards to help with local funding inequities and shortfalls, and to put MH/SA on par with physical health care. • Accountability for consumer outcomes has improved. • State agency leadership recognizes the importance of non-traditional supports and services and has funded a variety of services in addition to direct treatment (e.g., acupuncture, housing, employment, consumer-operated services). • Goals of reform are consumer-centered; there is a greater focus on the recovery model. Local boards embrace recovery and social integration, but lack the resources to support model, with most of the funding directed to services for the seriously mentally ill. • Centers of Excellence have been successful in promoting integration of physical and behavioral health care through integration pilot programs. Centers are primarily focused on mental health services; substance abuse is not generally included except for one Center that is focused on co-occurring disorders. • No major reform efforts in substance abuse system; some pockets of reform initiatives and attempts to reform

¹ Summary based on interviews with representatives of MH/SA consumer advocacy conducted in May and June 2009.

APPENDIX C.3.D. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

Ohio ¹	
	<p>(e.g., some demonstration projects to enhance treatment capacity and outcomes).</p> <ul style="list-style-type: none"> • A few years ago a substance abuse continuum of care work group was successful in adding a dimension of recovery to the prevention, intervention and treatment philosophy and approach in recognition that treatment is not the end point in the process. However, funding has not been allocated to specifically support this inclusion. • Changing the method of provider reimbursement for substance abuse services from a fiscal reconciliation method to a fixed fee basis is expected to increase service capacity due to greater provider ability for better financial planning and greater certainty as to how and when they will be paid. <p>Challenges:</p> <ul style="list-style-type: none"> • Lack of funding for MH/SA system is a major challenge, as local boards are cutting back and local resources are stretched too thin. State budget deficit is a major problem. • Per capita funding is better in urban areas and there is greater availability of providers. • Too much of the funding for MH/SA still goes to the local boards for administration. • Medicaid rates are too low to support sufficient provider capacity. • There are long waits for child and adult psychiatrists (estimated at 6 and 9 months respectively). • Access to care is not possible unless an individual has a payer source like Medicaid. The Ohio parity legislation that passed a few years ago resulted in better access to mental health services for the insured population. • The cost of evidence-based practices (EBPs) is greater than that for regular treatment and this becomes a barrier to implementation. • Service integration between MH/SA and other systems does not work well. Integration of children's services varies depending on the county (e.g., some parents need to relinquish their custody in order to get MH treatment for their children). • There are Family and Children's Councils that involve the schools, courts, MH/SA services, and DD services to do planning and service integration. These councils provide the mechanism for integration of children's services. A similar mechanism to promote service integration does not exist in the adult system. • Mental health courts are good at diverting individuals, but face an uncertain fiscal future. • People are staying longer in state hospitals due to a lack of community resources. • There are challenges between HMOs and behavioral health agencies regarding service coordination that are primarily related to access to medication, and not with respect to service access. • The state mental health system and state agency receives more funding than the substance abuse system and agency.

APPENDIX C.3.D. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

Ohio ¹	
	<ul style="list-style-type: none"> • At the local board level, substance abuse is more of an afterthought; historically more focus has been on MH services. Stigma of SA plays a large role in the lesser focus on substance abuse services and funding. • There is a need for more programs to serve individuals with co-occurring disorders (MH and SA). • Access to substance abuse services is a major challenge, with waiting lists especially prevalent for assessment services. There is a lack of appropriate levels of care (e.g., after an assessment an individual is placed in a level of care based on what is available and not on what he/she needs). This perpetuates a revolving door for consumers and sets them up for failure. Metro areas may fare slightly better due to more resources.
Lessons Learned	<ul style="list-style-type: none"> • There needs to be a shared vision for the reform effort, as well as state level leadership and stakeholder involvement for the reform effort to be successful. • In an ideal system, services would be funded directly by the state, and local boards would be eliminated as the middle layer to contract with providers. This would save and re-direct local administrative dollars. There is still a need for a local planning function, but all the staff currently associated with local boards (which do not provide direct services) is not needed to accomplish this. It is unlikely that local boards will ever be eliminated due to the level of local funding they provide to the system. • An ideal system would integrate physical and behavioral health care. • An ideal system would fully embrace the recovery model and adequately fund it. • While Ohio is sometimes held up as a model, there is still a long ways to go for the MH/SA system to become a consumer-driven system of care. This would include consumer involvement in service planning, service plans that are based on consumer needs, and consumer access to a continuum of care, including recovery services.

APPENDIX C.3.E. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

Oregon ¹	
Consumer Advocacy Involvement and Role in Reform Effort (Planning, Implementation and Evaluation)	<ul style="list-style-type: none"> • Consumers had to persevere to get a seat at the table. • Reform efforts have become more consumer-focused, but only through the involvement of consumer advocates. For example, the state codified formal consumer/survivor participation to require a minimum mental health consumer representation on any public body that discusses mental health issues. This does not apply to substance abuse.
Impact of Reform on Consumers (Access to Services and Service Capacity; Accountability for and Focus on Consumer Outcomes; Service Coordination, Integration and Effectiveness)	<p>Most Positive Aspects of Reform:</p> <ul style="list-style-type: none"> • Advocates favor an integrated care model, but it remains to be seen how outcomes will be tracked for the proposed demonstration projects. • In Oregon, MH/SA services are automatically part of health care reform discussions at the state level due to their cost implications. • Some legislators tried to minimize the cuts to MH/SA services, and largely restored proposed budget cuts. • The state's Children's Change Initiative has resulted in significant improvements for children with MH/SA issues; children's system is moving toward better integration due to a wraparound approach. <p>Challenges:</p> <ul style="list-style-type: none"> • There are large variations in funding throughout the state; some counties do not spend any local dollars and do not provide services beyond the Medicaid-funded Oregon Health Plan (OHP) services and crisis services funded by the general fund. • Funding has been set aside for indigent care; however, most of the money is spent on hospitalization. • State does not have a common definition of integration. • State is now a Medicaid-driven state, and no longer has a community health and prevention focus. • There is large variation in service capacity; rural areas tend to use inpatient services less because there are fewer providers and resources. • Individuals that lack insurance and are not ill enough to be eligible for publicly funded MH/SA services get left out. • For Medicaid recipients with MH/SA issues, providers may limit the number of individuals they serve due to low reimbursement rates. • There have been cuts in individual therapy services that consumers relied on. • State has struggled to finance and increase peer-delivered services; not all HMOs have implemented peer specialist billing code and are supporting peer specialist services; peer specialist program is not a certified, quality

¹ Summary based on interviews with representatives of MH/SA consumer advocacy conducted in May and June 2009.

APPENDIX C.3.E. – SUMMARY OF CONSUMER ADVOCACY PERSPECTIVE FOR OTHER STATE REFORM EFFORTS

Oregon ¹	
	<p>program across the state.</p> <ul style="list-style-type: none"> • Much of the recovery orientation in the state has been about the language used as opposed to implementation changes. • It is difficult to find managed care organizations that will serve small, frontier counties due to the lack of providers and resources in these areas – no economies of scale for service providers. • Psychiatrists in rural areas appear to be doing a much better job of getting clients in to see primary care doctors. • Reform has not had a positive impact on accountability for consumer outcomes; treatment approach doesn't always address intense service needs of individuals. • State provides funding to address the public safety needs for the forensically committed population, but not the treatment needs. • There is a lack of integration between the MH/SA system and jail system (e.g., challenges include a lack of medication for jail inmates and the suspension of OHP and SSI benefits when an individual is in jail). • Reform has impacted the number of individuals with mental health issues under civil commitment. • Holds placed by law enforcement have increased. One county was putting people on a hold in order to get payment. There is no "one stop shop" or crisis triage center where law enforcement can take individuals in need of services.
Lessons Learned	<ul style="list-style-type: none"> • Primary care physicians need to be involved in discussions on integrated care, and there needs to be a shared language and common understanding between primary care doctors and MH/SA providers as to what integrated care means. • Oregon is pursuing service integration between physical and behavioral health care and needs the contracting experience to ensure the necessary collaboration takes place for an integrated care model. • Reform efforts that result from budget cuts are generally not well thought out, and do not involve system stakeholders in finding solutions. • There is interest in developing a peer-run crisis center and respite programs; these have demonstrated cost effectiveness. • There needs to be a better mix of sub-acute services to reduce hospital admissions and provide greater access to necessary treatment.

APPENDIX D

POTENTIAL MODELS FOR MH/SA SYSTEM REFORM

D.1. STATUTORY LANGUAGE FOR MULTI-COUNTY MH/SA SYSTEMS

nity to be heard are provided to all affected counties and parties. Notice under this subdivision shall be sent to the corporation counsel of each affected county by certified mail.

(g) *Determination of county of responsibility.* 1. An individual, an interested person on behalf of the individual, or any county may request that the department make a determination of the county of responsibility of the individual. Any motion for change of venue pending before the court of jurisdiction may be stayed until the determination under this paragraph is final. Within 10 days after receiving the request, the department shall provide written notice to the individual; to the individual's guardian, guardian ad litem, and counsel, if any; to the individual's immediate family, if they can be located; and to all potentially responsible counties that a determination of county of responsibility shall be made and that written information and comments may be submitted within 30 days after the date on which the notice is sent.

2. The department shall review information submitted under subd. 1. and make such investigation as it deems proper. Within 30 days after the end of the period for submitting information, the department shall make a decision as to residence, and send a copy of the decision to the individual and to all involved counties. The decision may be appealed under s. 227.44 by the individual or the county determined to be responsible.

3. Pending a determination under subd. 2., a county department which has been providing services to the individual shall continue to provide services if necessary to meet the individual's needs. If no county department is currently providing services, the county in which the client is physically present shall provide necessary services pending the determination.

4. A determination under subd. 2. may provide for a period of transitional services to assure continuity of services by specifying a date until which the county department which has been providing services shall continue to do so.

5. The decision of the department under subd. 2. is binding on the individual and on any county which received notice of the proceeding. Except as provided in the determination, the county determined to be the county of responsibility shall act as the county of responsibility immediately after receiving notice of the determination, and during the pendency of any appeal of the determination that is brought under ch. 227.

6. The county that is determined to be the county of responsibility shall reimburse any other county for all care, treatment, and services provided by the other county to the individual under ch. 46, 51, or 55. Full reimbursement by the county that is determined to be the county of responsibility shall be made within 120 days after the date of the department's determination of the county of responsibility or within 120 days after the date of the outcome of any appeal of the department's determination that is brought under ch. 227, or by a date or under a schedule of 2 or more payments that is agreed to by both counties.

History: 1987 a. 27; 1989 a. 31, 359; 1995 a. 27 s. 9126 (19); 2005 a. 264, 387; 2007 a. 20 s. 9121 (6) (a); 2007 a. 45.

The residence of an adult who was protectively placed as a minor is discussed. *Waukesha County v. B.D.* 163 Wis. 2d 779, 472 N.W.2d 563 (Ct. App. 1991).

A community-based residential facility is neither a nursing home nor a state facility. Sub. (2) is limited to individuals living in nursing homes or state facilities. *Juneau County v. Sauk County*, 217 Wis. 2d 705, 580 N.W.2d 694 (Ct. App. 1998), 97–1365.

51.42 Community mental health, developmental disabilities, alcoholism and drug abuse services. (1) **PROGRAM.** (a) *Purpose and intent.* All of the following are the purposes and intent of this section:

1. To enable and encourage counties to develop a comprehensive range of services offering continuity of care.

2. To utilize and expand existing governmental, voluntary and private community resources for provision of services to prevent or ameliorate mental disabilities, including but not limited to mental illness, developmental disabilities, alcoholism and drug abuse.

3. To provide for the integration of administration of those services and facilities organized under this section through the establishment of a county department of community programs.

4. To authorize state consultative services, reviews and establishment of standards and grants-in-aid for such program of services and facilities.

(b) *County liability.* The county board of supervisors has the primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services. This primary responsibility is limited to the programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds. County liability for care and services purchased through or provided by a county department of community programs established under this section shall be based upon the client's county of residence except for emergency services for which liability shall be placed with the county in which the individual is found. For the purpose of establishing county liability, "emergency services" includes those services provided under the authority of s. 55.05 (4), 2003 stats., or s. 55.06 (11) (a), 2003 stats., or s. 51.15, 51.45 (11) (a) or (b) or (12), 55.13, or 55.135 for not more than 72 hours. Nothing in this paragraph prevents recovery of liability under s. 46.10 or any other statute creating liability upon the individual receiving a service or any other designated responsible party, or prevents reimbursement by the department of health services for the actual cost of all care and services from the appropriation under s. 20.435 (7) (da), as provided in s. 51.22 (3).

(2) **DEFINITION.** In this section, "program" means community services and facilities for the prevention or amelioration of mental disabilities, including but not limited to mental illness, developmental disabilities, alcoholism and drug abuse.

(3) **COUNTY DEPARTMENT OF COMMUNITY PROGRAMS.** (a) *Creation.* Except as provided under s. 46.23 (3) (b), the county board of supervisors of any county, or the county boards of supervisors of 2 or more contiguous counties, shall establish a county department of community programs on a single-county or multicounty basis to administer a community mental health, developmental disabilities, alcoholism and drug abuse program, make appropriations to operate the program and authorize the county department of community programs to apply for grants-in-aid under s. 51.423. The county department of community programs shall consist of a county community programs board, a county community programs director and necessary personnel.

(ar) *Duties.* A county department of community programs shall do all of the following:

1. Enter into contracts to render services to or secure services from other agencies or resources including out-of-state agencies or resources. Notwithstanding ss. 59.42 (1) and (2) (b) and 978.05, any multicounty department of community programs may contract for professional legal services that are necessary to carry out the duties of the multicounty department of community programs if the corporation counsel of each county of the multicounty department of community programs has notified the multicounty department of community programs that he or she is unable to provide those services in a timely manner.

2. Enter into contracts for the use of any facility as an approved public treatment facility under s. 51.45 for the treatment of alcoholics if the county department of community programs deems it to be an effective and economical course to follow.

3. Plan for and establish a community developmental disabilities program to deliver the services required under s. 51.437 if, under s. 51.437 (4g) (b), the county board of supervisors in a

51.42 MENTAL HEALTH ACT

county with a single-county department of community programs or the county boards of supervisors in counties with a multicounty department of community programs transfer the powers and duties of the county department under s. 51.437 to the county department of community programs. The county board of supervisors in a county with a single-county department of community programs and the county boards of supervisors in counties with a multicounty department of community programs may designate the county department of community programs to which these powers and duties have been transferred as the administrative agency of the long-term support community options program under s. 46.27 (3) (b) 1. and 5. and the community integration programs under ss. 46.275, 46.277 and 46.278.

4. Within the limits of available state and federal funds and of county funds required to be appropriated to match state funds, provide for the program needs of persons suffering from mental disabilities, including mental illness, developmental disabilities, alcoholism or drug abuse, by offering the following services:

a. Collaborative and cooperative services with public health and other groups for programs of prevention.

b. Comprehensive diagnostic and evaluation services, including assessment as specified under ss. 114.09 (2) (bm), 343.30 (1q) and 343.305 (10) and assessments under ss. 48.295 (1) and 938.295 (1).

c. Inpatient and outpatient care and treatment, residential facilities, partial hospitalization, emergency care and supportive transitional services.

d. Related research and staff in-service training, including periodic training on emergency detention procedures under s. 51.15, emergency protective services under s. 55.13, and emergency protective placement procedures under s. 55.135, for persons within the jurisdiction of the county department of community programs who are authorized to take individuals into custody under ss. 51.15 and 55.135. In developing in-service training on emergency detention and emergency protective placement procedures, the county department of community programs shall consult the county department of developmental disabilities services under s. 51.437 in counties where these departments are separate.

e. Continuous planning, development and evaluation of programs and services for all population groups.

4m. If state, federal and county funding for alcohol and other drug abuse treatment services provided under subd. 4. are insufficient to meet the needs of all eligible individuals, ensure that first priority for services is given to pregnant women who suffer from alcoholism or alcohol abuse or are drug dependent.

5. Prepare a local plan which includes an inventory of all existing resources, identifies needed new resources and services and contains a plan for meeting the needs of the mentally ill, developmentally disabled, alcoholic, drug abusers and those with other psychiatric disabilities for citizens residing within the jurisdiction of the county department of community programs and for persons in need of emergency services found within the jurisdiction of the county department of community programs. The plan shall also include the establishment of long-range goals and intermediate-range plans, detailing priorities and estimated costs and providing for coordination of local services and continuity of care. The plan shall state how the needs of homeless persons and adults with serious and persistent mental illness, children with serious emotional disturbances and minorities will be met by the county department of community programs. The county department of community programs shall submit the plan to the department for review under sub. (7) (a) 9. and s. 51.02 (1) (f) in accordance with the schedule and deadlines established under sub. (7) (a) 9.

6. Under the supervision of the county community programs director, using qualified personnel with training or experience, or both, in mental health, developmental disabilities, or in alcoholism and drug abuse, be responsible for the planning and implementation of programs relating to mental health, developmental disabilities, alcoholism or drug abuse. A single coordinator may

be responsible for alcoholism, drug abuse, mental health and developmental disabilities programs.

7. Acknowledge receipt of the notification received under s. 115.812 (2).

8. By September 30, submit for inclusion as part of the proposed county budget to the county executive or county administrator or, in those counties without a county executive or county administrator, directly to the county board of supervisors in a county with a single-county department of community programs or the county boards of supervisors in counties with a multicounty department of community programs a proposed budget for the succeeding calendar year covering services, including active treatment community mental health center services, based on the plan required under subd. 5. The final budget shall be submitted to the department of health services.

9. Develop the cost of all services which it purchases based on the standards and requirements of s. 46.036.

11. Annually report to the department of health services regarding the use of any contract entered into under s. 51.87.

13. Except in an emergency, review and approve or disapprove all admissions to nursing homes of mentally ill persons under age 65 who are residents of the county.

14. If the county board of supervisors establishes an integrated service program for children with severe disabilities under s. 59.53 (7), participate in and may administer an integrated service program for children with severe disabilities under s. 59.53 (7), including entering into any written interagency agreements or contracts.

15. Submit to the department in a timely fashion, as specified by the department, any reports necessary to comply with the requirements under 42 USC 300x-52.

17. If authorized under s. 46.283 (1) (a) 1., apply to the department of health services to operate a resource center under s. 46.283 and, if the department contracts with the county under s. 46.283 (2), operate the resource center.

18. If authorized under s. 46.284 (1) (a) 1., apply to the department of health services to operate a care management organization under s. 46.284 and, if the department contracts with the county under s. 46.284 (2), operate the care management organization and, if appropriate, place funds in a risk reserve.

(as) *Care in other facilities.* 1g. In this paragraph, “county department” means county department of community programs.

1m. A county department shall reimburse a mental health institute at the institute’s daily rate for custody of any person who is ordered by a court located in that county to be examined at the mental health institute under s. 971.14 (2) for all days that the person remains in custody at the mental health institute, beginning 48 hours, not including Saturdays, Sundays, and legal holidays, after the sheriff and county department receive notice under s. 971.14 (2) (d) that the examination has been completed.

1r. A county department shall authorize all care of any patient in a state, local, or private facility under a contractual agreement between the county department and the facility, unless the county department governs the facility. The need for inpatient care shall be determined by the program director or designee in consultation with and upon the recommendation of a licensed physician trained in psychiatry and employed by the county department or its contract agency. In cases of emergency, a facility under contract with any county department shall charge the county department having jurisdiction in the county where the patient is found. The county department shall reimburse the facility for the actual cost of all authorized care and services less applicable collections under s. 46.036, unless the department of health services determines that a charge is administratively infeasible, or unless the department of health services, after individual review, determines that the charge is not attributable to the cost of basic care and services. Except as provided in subd. 1m., a county department may not reimburse any state institution or receive credit for collections for care received in a state institution by nonresidents of this state,

interstate compact clients, transfers under s. 51.35 (3), transfers from Wisconsin state prisons under s. 51.37 (5) (a), commitments under s. 975.01, 1977 stats., or s. 975.02, 1977 stats., or s. 971.14, 971.17 or 975.06 or admissions under s. 975.17, 1977 stats., or children placed in the guardianship of the department of children and families under s. 48.427 or 48.43 or under the supervision of the department of corrections under s. 938.183 or 938.355. The exclusionary provisions of s. 46.03 (18) do not apply to direct and indirect costs that are attributable to care and treatment of the client.

2. If a mental health institute has provided a county department with service, the department of health services shall regularly collect for the cost of care from the county department. If collections for care from the county department and from other sources exceed current billings, the difference shall be remitted to the county department through the appropriation under s. 20.435 (2) (gk). For care provided on and after February 1, 1979, the department of health services shall adjust collections from medical assistance to compensate for differences between specific rate scales for care charged to the county department and the average daily medical assistance reimbursement rate. The department of health services shall deduct the amount due from a county department under this subdivision from any payment due from the department of health services to the county department.

3. Care, services and supplies provided after December 31, 1973, to any person who, on December 31, 1973, was in or under the supervision of a mental health institute, or was receiving mental health services in a facility authorized by s. 51.08 or 51.09, but was not admitted to a mental health institute by the department of health services, shall be charged to the county department which was responsible for such care and services at the place where the patient resided when admitted to the institution. The department of health services may bill county departments for care provided at the mental health institutes at rates which the department of health services sets on a flexible basis, except that this flexible rate structure shall cover the cost of operations of the mental health institutes.

(aw) *Powers.* 1. Within the limits of state and county appropriations and maximum available funding from other sources, a county department of community programs may provide for the program needs of persons suffering from mental disabilities, including but not limited to mental illness, developmental disability, alcoholism or drug abuse, by offering the following services:

- a. Precare, aftercare and rehabilitation and habilitation services.
- b. Professional consultation.
- c. Public informational and educational services.
- d. Provide treatment and services that are specified in a conditional release plan approved by a court for a person who is a county resident and is conditionally released under s. 971.17 (3) or (4) or that are specified in a supervised release plan approved by a court under s. 980.06 (2) (c), 1997 stats., s. 980.08 (5), 2003 stats., or s. 980.08 (4) (g). If the county department provides treatment and services under this subdivision, the department of health services shall, from the appropriation under s. 20.435 (2) (bj), pay the county department for the costs of the treatment and services.

2. A county department of community programs may allocate services among service recipients to reflect the availability of limited resources.

3. A county department of community programs may own, lease or manage real property for the purposes of operating a treatment facility.

(b) *Other powers and duties.* The county board of supervisors of any county with a single-county department of community programs and the county boards of supervisors of counties with a multicounty department of community programs may designate the county department of community programs as the administrator of any other county health care program or institution, but the

operation of such program or institution is not reimbursable under s. 51.423.

(bm) *Educational services.* A county department of community programs may not furnish services and programs provided by the department of public instruction and local educational agencies.

(c) *Multicounty contract.* No grant-in-aid may be made under s. 51.423 to any multicounty department of community programs until the counties which established the multicounty department of community programs have drawn up a detailed contractual agreement, approved by the secretary, setting forth the plans for joint sponsorship.

(e) *Exchange of information.* Notwithstanding ss. 46.2895 (9), 48.78 (2) (a), 49.45 (4), 49.83, 51.30, 51.45 (14) (a), 55.22 (3), 146.82, 252.11 (7), 253.07 (3) (c) and 938.78 (2) (a), any subunit of a county department of community programs or tribal agency acting under this section may exchange confidential information about a client, without the informed consent of the client, with any other subunit of the same county department of community programs or tribal agency, with a resource center, a care management organization, or a family [long-term] care district, or with any person providing services to the client under a purchase of services contract with the county department of community programs or tribal agency or with a resource center, care management organization, or family [long-term] care district, if necessary to enable an employee or service provider to perform his or her duties, or to enable the county department of community programs or tribal agency to coordinate the delivery of services to the client. Any agency releasing information under this paragraph shall document that a request was received and what information was provided.

NOTE: The correct term is shown in brackets. Corrective legislation pending.

(4) COUNTY COMMUNITY PROGRAMS BOARD. (a) *Appointment.* 1. Except as provided under subd. 2., the county board of supervisors of every county with a single-county department of community programs or the county boards of supervisors in counties with a multicounty department of community programs shall, before qualification under this section, appoint a governing and policy-making board to be known as the county community programs board. A county community programs board appointed under this subdivision shall govern the single-county or multicounty department of community programs and shall assume all of the powers and duties of the county department of community programs under sub. (3) (ar) to (bm). A member of a county community programs board appointed under this subdivision may be removed from office under the following circumstances:

a. For cause, by a two-thirds vote of each county board of supervisors participating in the appointment, on due notice in writing and hearing of the charges against the member.

b. If the member when appointed was a member of the county board of supervisors and the member is not reelected to that office, on due notice in writing.

2. In any county with a county executive or county administrator and which has established a single-county department of community programs, the county executive or county administrator shall appoint, subject to confirmation by the county board of supervisors, the county community programs board, which shall be only a policy-making body determining the broad outlines and principles governing the administration of programs under this section. A member of a county community programs board appointed under this subdivision may be removed by the county executive or county administrator under the following circumstances:

a. For cause.

b. If the member when appointed was a member of the county board of supervisors and the member is not reelected to that office.

51.42 MENTAL HEALTH ACT

(b) *Composition.* 1. In a single-county department of community programs the county community programs board shall be composed of not less than 9 nor more than 15 persons of recognized ability and demonstrated interest in the problems of the mentally ill, developmentally disabled, alcoholic or drug dependent persons and shall have representation from the interest group of the mentally ill, the interest group of the developmentally disabled, the interest group of the alcoholic and the interest group of the drug dependent. At least one member appointed to a county community programs board shall be an individual who receives or has received services for mental illness, developmental disability, alcoholism or drug dependency or shall be a family member of such an individual. No more than 5 members may be appointed from the county board of supervisors.

2. In a multicounty department of community programs, the county community programs board shall be composed of 11 members with 3 additional members for each county in a multicounty department of community programs in excess of 2. Appointments shall be made by the county boards of supervisors of the counties in a multicounty department of community programs in a manner acceptable to the counties in the multicounty department of community programs and shall have representation from the interest group of the mentally ill, the interest group of the developmentally disabled, the interest group of the alcoholic and the interest group of the drug dependent. At least one member appointed to a county community programs board shall be an individual who receives or has received services for mental illness, developmental disability, alcoholism or drug dependency or shall be a family member of such an individual. Each of the counties in the multicounty department of community programs may appoint to the county community programs board not more than 3 members from its county board of supervisors.

(d) *Term.* The term of office of any member of a county community programs board shall be 3 years, but of the members first appointed, at least one-third shall be appointed for one year; at least one-third for 2 years; and the remainder for 3 years. Vacancies shall be filled for the residue of the unexpired term in the manner that original appointments are made.

(5) POWERS AND DUTIES OF COUNTY COMMUNITY PROGRAMS BOARD IN CERTAIN COUNTIES. (a) A county community programs board appointed under sub. (4) (a) 1. shall do all of the following:

1. Establish long-range goals and intermediate-range plans, detail priorities and estimate costs.
2. Develop coordination of local services and continuity of care where indicated.
3. Utilize available community resources and develop new resources necessary to carry out the purposes of this section.
4. Appoint a county community programs director, subject to the approval of each county board of supervisors which participated in the appointment of the county community programs board, on the basis of recognized and demonstrated interest in and knowledge of the problems of mental health, developmental disability, alcoholism and drug addiction, with due regard to training, experience, executive and administrative ability, and general qualification and fitness for the performance of the duties of the county community programs director under sub. (6). The county board of supervisors in a county with a single-county department of community programs or the county boards of supervisors in counties with a multicounty department of community programs may delegate this appointing authority to the county community programs board.

5. Fix the salaries of the employees of the county department of community programs, subject to the approval of each county board of supervisors which participated in the appointment of the county community programs board unless such county board of supervisors elects not to review the salaries.

6. Prepare a proposed budget for submission to the county board and a final budget for submission to the department of health services in accordance with s. 46.031 (1).

7. Appoint committees consisting of residents of the county to advise the county community programs board as it deems necessary.

8. Develop county community programs board operating procedures.

9. Comply with state requirements.

10. Assist in arranging cooperative working agreements with persons providing health, education, vocational or welfare services related to services provided under this section.

11. Evaluate service delivery.

12. Determine, subject to the approval of the county board of supervisors in a county with a single-county department of community programs or the county boards of supervisors in counties with a multicounty department of community programs and with the advice of the county community programs director appointed under subd. 4., whether services are to be provided directly by the county department of community programs or contracted for with other providers and make such contracts. The county board of supervisors in a county with a single-county department of community programs or the county boards of supervisors in counties with a multicounty department of community programs may elect to require the approval of any such contract by the county board of supervisors in a county with a single-county department of community programs or the county boards of supervisors in counties with a multicounty department of community programs.

13. Administer funds provided under s. 46.266 in accordance with s. 46.266 (5).

(b) Subject to the approval of the county board of supervisors in a county with a single-county department of community programs or the county boards of supervisors in counties with a multicounty department of community programs and with the advice of the county community programs director appointed under par. (a) 4., a county community programs board appointed under sub. (4) (a) 1. may, together with a private or public organization or affiliation, do all of the following:

1. Organize, establish and participate in the governance and operation of an entity to operate, wholly or in part, any mental health-related service.

2. Participate in the financing of the entity under subd. 1.

3. Provide administrative and financial services or resources for operation of the entity under subd. 1. on terms prescribed by the county board of supervisors.

(5a) POWERS AND DUTIES OF COUNTY COMMUNITY PROGRAMS BOARD IN CERTAIN COUNTIES WITH A COUNTY EXECUTIVE OR COUNTY ADMINISTRATOR. (a) A county community programs board appointed under sub. (4) (a) 2. shall do all of the following:

1. Appoint committees consisting of residents of the county to advise the county community programs board as it deems necessary.

2. Recommend program priorities, identify unmet service needs and prepare short-term and long-term plans and budgets for meeting such priorities and needs.

3. Prepare, with the assistance of the county community programs director appointed under sub. (6m), a proposed budget for submission to the county executive or county administrator and a final budget for submission to the department of health services in accordance with s. 46.031 (1) for authorized services.

4. Advise the county community programs director appointed under sub. (6m) regarding purchasing and providing services and the selection of purchase of service vendors, and make recommendations to the county executive or county administrator

regarding modifications in such purchasing, providing and selection.

5. Develop county community programs board operating procedures.

6. Comply with state requirements.

7. Assist in arranging cooperative working agreements with persons providing health, education, vocational or welfare services related to services provided under this section.

8. Advise the county community programs director regarding coordination of local services and continuity of care.

(b) The county community programs director, subject only to the supervision of the county executive or county administrator, may do all of the following:

1. Organize, establish and participate in the governance and operation of an entity to operate, wholly or in part, any mental health–related service.

2. Participate in the financing of the entity under subd. 1.

3. Provide administrative and financial services or resources for operation of the entity under subd. 1. on terms prescribed by the county executive or county administrator.

(6) POWERS AND DUTIES OF COUNTY COMMUNITY PROGRAMS DIRECTOR IN CERTAIN COUNTIES. A county community programs director appointed under sub. (5) (a) 4. shall have all of the administrative and executive powers and duties of managing, operating, maintaining, and improving the programs of the county department of community programs, subject to such delegation of authority as is not inconsistent with this section and the rules of the department of health services promulgated under this section. In consultation and agreement with the county community programs board, the county community programs director appointed under sub. (5) (a) 4. shall do all of the following:

(a) Prepare an annual comprehensive plan and budget of all funds necessary for the program and services authorized by this section in which priorities and objectives for the year are established as well as any modifications of long–range objectives.

(b) Prepare intermediate–range plans.

(c) Prepare an annual report of the operation of the program.

(d) Prepare other reports as are required by the secretary and the county board of supervisors in a county with a single–county department of community programs or the county boards of supervisors in counties with a multicounty department of community programs.

(e) Make recommendations to the county community programs board under sub. (5) for all of the following:

1. Personnel and the salaries of employees.

2. Changes in program services.

(f) After consultation with the county community programs board, administer the duties of the county department of community programs under sub. (3) (aw) 2.

(g) Comply with state requirements.

(6m) COUNTY COMMUNITY PROGRAMS DIRECTOR IN CERTAIN COUNTIES WITH A COUNTY EXECUTIVE OR COUNTY ADMINISTRATOR. In any county with a county executive or county administrator in which the county board of supervisors has established a single–county department of community programs, the county executive or county administrator shall appoint and supervise the county community programs director. In any county with a population of 500,000 or more, the county executive or county administrator shall appoint the director of the county department of human services under s. 46.21 as the county community programs director. The appointment of a county community programs director under this subsection shall be on the basis of recognized and demonstrated interest in and knowledge of the problems of mental health, mental retardation, alcoholism and drug addiction, with due regard to training, experience, executive and administrative ability, and general qualification and fitness for the performance of the duties of the director. The appointment of a county community programs director under this subsection is subject to confirmation

by the county board of supervisors unless the county board of supervisors, by ordinance, elects to waive confirmation or unless the appointment is made under a civil service system competitive examination procedure established under s. 59.52 (8) or ch. 63. The county community programs director, subject only to the supervision of the county executive or county administrator, shall:

(a) Supervise and administer any program established under this section, subject to such delegation of authority as is not inconsistent with this section and the rules of the department of health services promulgated under this section.

(b) Determine administrative and program procedures.

(c) Determine, subject to the approval of the county board of supervisors and with the advice of the county community programs board, whether services are to be provided directly by the county department of community programs or contracted for with other providers and make such contracts. The county board of supervisors may elect to require the approval of any such contract by the county board of supervisors.

(e) Assist the county community programs board under sub. (5a) in the preparation of the budgets required under sub. (5a) (a) 3.

(f) Make recommendations to the county executive or county administrator regarding modifications to the proposed budget prepared by the county community programs board under sub. (5a) (a) 3.

(g) Evaluate service delivery.

(h) After consultation with the county community programs board under sub. (5a), administer the duties of the county department of community programs under sub. (3) (aw) 2.

(i) Establish salaries and personnel policies of the programs of the county department of community programs subject to approval of the county executive or county administrator and county board of supervisors unless the county board of supervisors elects not to review the salaries and personnel policies.

(j) Perform other functions necessary to manage, operate, maintain and improve programs.

(k) Comply with state requirements.

(L) Utilize available community resources and develop new resources necessary to carry out the purposes of this section.

(m) In consultation with the county community programs board under sub. (5a), prepare:

1. Intermediate–range plans and budget.

2. An annual report of the operation of the county department of community programs.

3. Such other reports as are required by the secretary and the county board of supervisors.

(n) Provide for coordination of local services and continuity of care.

(o) Administer funds provided under s. 46.266 in accordance with s. 46.266 (5).

(7) DUTIES OF THE DEPARTMENT OF HEALTH SERVICES. (a) The department of health services shall:

1. Review requests and certify county departments of community programs and community mental health programs to assure that those county departments and those programs are in compliance with this section.

2. Periodically review and evaluate county departments of community programs to assure compliance with this section. The review shall include a periodic assessment of need which shall separately identify elements of service required under this section. The periodic review of community mental health programs shall be made at least once every 36 months, except that all of the following apply:

a. The secretary may require annual review of a community mental health program that, in the immediately preceding 36 months, substantially failed to comply with the requirements for certification or was the subject of grievances or an investigation.

51.42 MENTAL HEALTH ACT

b. The department may review and evaluate a community mental health program at any time.

2m. Review and evaluate at random at least 5 community mental health programs each year. Review and evaluation under this subdivision may be coincident with or in addition to that made under subd. 2. and may be conducted with or without notice to a community mental health program.

3. Provide consultative staff services to communities to assist in ascertaining local needs and in planning, establishing and operating programs.

3m. Develop a training curriculum for use in training members of county community programs boards and county human services boards. The training curriculum shall delineate the board members' roles and responsibilities and shall provide information on client groups served and programs provided by the county department of community programs or human services. In developing the training curriculum, the department shall consult with representatives of county interests, consumer and advocacy groups and community mental health program providers. The department shall submit the training curriculum to the council on mental health under s. 51.02 (1) (h) for the council's review and comment.

3r. Establish a training schedule that ensures that county community programs boards and county human services boards in all geographical areas of the state are provided access to training under the training curriculum under subd. 3m. once every 2 years.

4. Develop and implement a uniform cost reporting system according to s. 46.18 (8) to (10).

5. Ensure that county departments of community programs that elect to provide special education programs to children aged 3 years and under comply with requirements established by the department of public instruction.

6. Provide, as available after provision of services under s. 51.05 (6), the following:

a. Mental health outpatient and follow-up services appropriate for hearing-impaired mentally ill individuals, including advocacy training relating to the rights of mentally ill individuals.

b. Technical assistance to a county department of community programs concerning provision of services to hearing-impaired mentally ill individuals.

7. Develop a program in consultation with the department of regulation and licensing to use voluntary, uncompensated services of licensed or certified professionals to assist the department of health services in evaluating community mental health programs in exchange for continuing education credits for the professionals under ss. 448.40 (2) (e) and 455.065 (5).

8. Enter into an agreement with an institution of higher education or a private, nonprofit organization to develop a community mental health client survey prototype. The department shall attempt to secure a grant to fund the development of the survey prototype.

9. Develop a model community mental health plan available for use by counties and to assist them in developing their community plans as required under s. 51.42 (3) (ar) 5. In the process of developing the model community mental health plan, the department shall select 6 counties, both urban and rural, to submit plans to the department for review. The department shall revise the model plan, if necessary, considering the comments of the 6 counties selected. The department shall also consult with the council on mental health and with groups that represent counties, consumers of mental health services and family members of the consumers in developing the model community mental health plan. The department shall establish a schedule that requires each county in this state to submit a plan under s. 51.42 (3) (ar) 5. once every 3 years, in accordance with deadlines established by the subunit of the department with jurisdiction over community mental health. The department, in conjunction with the council on mental health, shall review the plans submitted by counties.

(b) The department shall promulgate rules which do all of the following:

1. Govern the administrative structure deemed necessary to administer community mental health, developmental disabilities, alcoholism and drug abuse services.

2. Establish uniform cost record-keeping requirements.

3. Prescribe standards for qualifications and salaries of personnel.

4. Prescribe standards for quality of professional services.

5. Prescribe requirements for in-service and educational leave programs for personnel.

6. Prescribe standards for establishing patient fee schedules.

7. Govern eligibility of patients to the end that no person is denied service on the basis of age, race, color, creed, location or inability to pay.

7m. Define "first priority for services" under and otherwise implement sub. (3) (ar) 4m.

8. Prescribe such other standards and requirements as may be necessary to carry out the purposes of this section.

9. Promulgate rules establishing medication procedures to be used in the delivery of mental health services.

10. Establish criteria for the level of scrutiny for evaluation of community mental health programs.

11. Prescribe requirements for certification of community mental health programs, except as provided in s. 51.032, including all of the following:

a. A requirement that, as part of the certification process, community mental health programs must demonstrate that their staff have knowledge of laws, regulations and standards of practice which apply to the program and its clients.

b. A requirement that, when conducting certifications, certification staff must use a random selection process in reviewing client records.

c. A requirement that certification staff conduct client interviews as part of the certification process.

d. A requirement that certification staff provide certification results to the community mental health program reviewed, to subunits within the department responsible for community mental health program monitoring and to the county department under this section in which the community mental health program is located upon completion of certification.

(c) The secretary shall designate the subunit of the department that is responsible for supervising the grievance process for clients of mental health services.

(8) CONSTRUCTION. (a) Any reference in any law to a county department of community programs applies to a county department under s. 46.23 in its administration of the powers and duties of the county department of community programs under s. 46.23 (3) (b) or applies to a county department under s. 46.21 (2m) in its administration of the powers and duties of the county department of community programs under s. 46.21 (2m) (b) 1. a.

(b) 1. Any reference in any law to a county community programs director appointed under sub. (5) (a) 4. applies to the director of a county department appointed under s. 46.23 (5) (f) in his or her administration of the powers and duties of that county community programs director.

2. Any reference in any law to a county community programs director appointed under sub. (6m) (intro.) applies to the director of a county department appointed under s. 46.23 (6m) (intro.) or appointed under s. 46.21 (1m) (a) in his or her administration of the powers and duties of that county community programs director.

(c) 1. Any reference in any law to a county community programs board appointed under sub. (4) (a) 1. applies to the board of a county department appointed under s. 46.23 (4) (b) 1. in its administration of the powers and duties of that county community programs board.

2. a. Except as provided in subd. 2. b., reference in any law to a county community programs board appointed under sub. (4) (a) 2. applies to the board of a county department appointed under s. 46.23 (4) (b) 2. in its administration of the powers and duties of that county community programs board.

b. Any reference in any law to a county community programs board appointed under sub. (4) (a) 2. is limited, with respect to the county department of human services under s. 46.21 (2m), to the powers and duties of the county community programs board as specified in sub. (5a).

History: 1971 c. 125; 1973 c. 90, 198, 333, 336; 1975 c. 39, 198, 199, 224, 422; 1975 c. 428 s. 16; 1975 c. 430 ss. 24 to 31, 80; 1977 c. 26 ss. 37, 38, 75; 1977 c. 29 ss. 612 to 623p, 1656 (18); 1977 c. 193; 1977 c. 203 s. 106; 1977 c. 272; 1977 c. 354 s. 101; 1977 c. 418, 428, 447; 1979 c. 34, 117, 177, 221, 330, 355; 1981 c. 20 ss. 923 to 942, 2202 (20) (d), (n), (q); 1981 c. 93 ss. 105 to 122, 186; 1981 c. 329; 1983 a. 27 ss. 1106 to 1112, 2202 (20); 1983 a. 189 ss. 44, 329 (5); 1983 a. 192, 239, 365, 375, 524; 1985 a. 29, 120, 176; 1987 a. 3, 27, 199, 339, 366; 1989 a. 31, 122; 1991 a. 39, 274, 315; 1993 a. 16, 437, 445; 1995 a. 27 ss. 3260 to 3262, 9126 (19), 9145 (1); 1995 a. 64, 77, 92, 201, 224, 276, 352, 417; 1997 a. 27, 164, 237, 268; 1999 a. 9; 2001 a. 10, 16, 38; 2003 a. 320; 2005 a. 264, 388, 431, 434; 2007 a. 20 ss. 1819m to 1821, 9121 (6) (a); 2007 a. 45, 97; 2009 a. 28.

Cross Reference: See also chs. DHS 34, 40, 61, 63, 65, and 75, Wis. adm. code. Costs could not be assessed under sub. (1) (b) against the subject of an emergency protective placement proceeding that was outside of the statutory guidelines under s. 55.06 (11) [now s. 55.135]. *Ethelyn I.C. v. Waukesha County*, 221 Wis. 2d 109, 584 N.W.2d 211 (Ct. App. 1998), 97–2236.

Members of a county board appointed to a unified board, created under sub. (4) (b), serve for the full term for which appointed, without reference to the termination of their office as county board members by election defeat. 63 Atty. Gen. 203.

The corporation counsel should provide legal advice and representation to ss. 51.42 and 51.437 boards as well as to the county board. 63 Atty. Gen. 468.

Liability, reimbursement, and collection for services provided under ss. 51.42 and 51.437 programs are discussed. 63 Atty. Gen. 560, 65 Atty. Gen. 49.

The county board of supervisors may require its approval of contracts for purchase of services by a community services board if it so specified in its coordinated plan and budget. Otherwise it may not. 69 Atty. Gen. 128.

Menominee Tribe members are eligible to participate in voluntary programs but the state cannot accept tribe members into involuntary programs on the basis of tribal court orders alone. 70 Atty. Gen. 219.

A multicounty 51.42/51.437 board may retain private legal counsel only when the corporation counsel of each county, or the district attorney of each county not having a corporation counsel, notifies the board that he or she is unable to provide specific services in a timely manner. 73 Atty. Gen. 8.

The appointing authority has broad discretion to determine the interests and abilities of persons appointed to a “51.42 board.” 78 Atty. Gen. 56.

51.421 Community support programs. (1) PURPOSE. In order to provide the least restrictive and most appropriate care and treatment for persons with serious and persistent mental illness, community support programs should be available in all parts of the state. In order to integrate community support programs with other long-term care programs, community support programs shall be coordinated, to the greatest extent possible, with the community options program under s. 46.27, with the protective services system in a county, with the medical assistance program under subch. IV of ch. 49 and with other care and treatment programs for persons with serious and persistent mental illness.

(2) SERVICES. If funds are provided, and within the limits of the availability of funds provided under s. 51.423 (2), each county department under s. 51.42 shall establish a community support program. Each community support program shall use a coordinated case management system and shall provide or assure access to services for persons with serious and persistent mental illness who reside within the community. Services provided or coordinated through a community support program shall include assessment, diagnosis, identification of persons in need of services, case management, crisis intervention, psychiatric treatment including medication supervision, counseling and psychotherapy, activities of daily living, psychosocial rehabilitation which may include services provided by day treatment programs, client advocacy including assistance in applying for any financial support for which the client may be eligible, residential services and recreational activities. Services shall be provided to an individual based upon his or her treatment and psychosocial rehabilitation needs.

(3) DEPARTMENTAL DUTIES. The department shall:

(a) Promulgate rules establishing standards for the certified provision of community support programs by county departments

under s. 51.42, except as provided in s. 51.032. The department shall establish standards that ensure that providers of services meet federal standards for certification of providers of community support program services under the medical assistance program, 42 USC 1396 to 1397e. The department shall develop the standards in consultation with representatives of county departments under s. 51.42, elected county officials and consumer advocates.

(b) Ensure the development of a community support program in each county through the provision of technical assistance, consultation and funding.

(c) Monitor the establishment and the continuing operation of community support programs and ensure that community support programs comply with the standards promulgated by rule. The department shall ensure that the persons monitoring community support programs to determine compliance with the standards are persons who are knowledgeable about treatment programs for persons with serious and persistent mental illness.

(d) Develop and conduct training programs for community support program staff.

(e) Distribute, from the appropriation account under s. 20.435 (5) (bL), moneys in each fiscal year for community support program services.

History: 1983 a. 441; 1985 a. 120, 176; 1987 a. 27, 368; 1989 a. 31; 1993 a. 16; 1995 a. 27; 1997 a. 237; 2001 a. 16; 2005 a. 264; 2009 a. 28.

Cross Reference: See also chs. DHS 63 and 65, Wis. adm. code.

51.423 Grants-in-aid. (1) The department shall fund, within the limits of the department’s allocation for mental health services under s. 20.435 (7) (b) and (o) and subject to this section, services for mental illness, developmental disability, alcoholism, and drug abuse to meet standards of service quality and accessibility. The department’s primary responsibility is to guarantee that county departments established under either s. 51.42 or 51.437 receive a reasonably uniform minimum level of funding and its secondary responsibility is to fund programs which meet exceptional community needs or provide specialized or innovative services. Moneys appropriated under s. 20.435 (7) (b) and earmarked by the department for mental health services under s. 20.435 (7) (o) shall be allocated by the department to county departments under s. 51.42 or 51.437 in the manner set forth in this section.

(2) From the appropriations under s. 20.435 (7) (b) and (o), the department shall distribute the funding for services provided or purchased by county departments under s. 46.23, 51.42, or 51.437 to such county departments as provided under s. 46.40. County matching funds are required for the distributions under s. 46.40 (2) and (9) (b). Each county’s required match for the distributions under s. 46.40 (2) for a year equals 9.89% of the total of the county’s distributions under s. 46.40 (2) for that year for which matching funds are required plus the amount the county was required by s. 46.26 (2) (c), 1985 stats., to spend for juvenile delinquency-related services from its distribution for 1987. Each county’s required match for the distribution under s. 46.40 (9) (b) for a year equals 9.89% of that county’s amounts described in s. 46.40 (9) (ar) (intro.) for that year. Matching funds may be from county tax levies, federal and state revenue sharing funds, or private donations to the counties that meet the requirements specified in sub. (5). Private donations may not exceed 25% of the total county match. If the county match is less than the amount required to generate the full amount of state and federal funds distributed for this period, the decrease in the amount of state and federal funds equals the difference between the required and the actual amount of county matching funds.

(3) From the appropriation account under s. 20.435 (5) (bL), the department shall award one-time grants to applying counties that currently do not operate certified community support programs, to enable uncertified community support programs to meet requirements for certification as providers of medical assistance services.

APPENDIX D
POTENTIAL MODELS FOR MH/SA SYSTEM REFORM
D.2. STATUTORY LANGUAGE FOR FAMILY CARE DISTRICTS

46.286 SOCIAL SERVICES

within one or more care management organizations to provide the family care benefit to all entitled persons in that client group in the county.

(3m) INFORMATION ABOUT ENROLLEES. The department shall obtain and share information about family care enrollees as provided in s. 49.475.

(4) DIVESTMENT; RULES. The department shall promulgate rules relating to prohibitions on divestment of assets of persons who receive the family care benefit, that are substantially similar to applicable provisions under s. 49.453.

(5) TREATMENT OF TRUST AMOUNTS; RULES. The department shall promulgate rules relating to treatment of trust amounts of persons who receive the family care benefit, that are substantially similar to applicable provisions under s. 49.454.

(6) PROTECTION OF INCOME AND RESOURCES OF COUPLE FOR MAINTENANCE OF COMMUNITY SPOUSE; RULES. The department shall promulgate rules relating to protection of income and resources of couples for the maintenance of the spouse in the community with regard to persons who receive the family care benefit, that are substantially similar to applicable provisions under s. 49.455.

(7) RECOVERY OF FAMILY CARE BENEFIT PAYMENTS; RULES. The department shall promulgate rules relating to the recovery from persons who receive the family care benefit, including by liens and from estates, of correctly and incorrectly paid family care benefits, that are substantially similar to applicable provisions under ss. 49.496 and 49.497.

History: 1999 a. 9, 185; 2001 a. 16, 109; 2003 a. 33; 2005 a. 25, 264, 388; 2007 a. 20; 2009 a. 28.

Cross Reference: See also ch. DHS 10, Wis. adm. code.

46.287 Hearings. (1) DEFINITION. In this section, “client” means a person applying for eligibility for the family care benefit, an eligible person or an enrollee.

(2) HEARING. (a) 1. Except as provided in subd. 2., a client may contest any of the following applicable matters by filing, within 45 days of the failure of a resource center or care management organization to act on the contested matter within the time frames specified by rule by the department or within 45 days after receipt of notice of a decision in a contested matter, a written request for a hearing under s. 227.44 to the division of hearings and appeals created under s. 15.103 (1):

- a. Denial of eligibility under s. 46.286 (1).
- b. Determination of cost sharing under s. 46.286 (2).
- c. Denial of entitlement under s. 46.286 (3).
- d. Failure to provide timely services and support items that are included in the plan of care.
- e. Reduction of services or support items under the family care benefit.
- f. Development of a plan of care that is unacceptable because the plan of care requires the enrollee to live in a place that is unacceptable to the enrollee or the plan of care provides care, treatment or support items that are insufficient to meet the enrollee’s needs, are unnecessarily restrictive or are unwanted by the enrollee.
- g. Termination of the family care benefit.
- h. Imposition of ineligibility for the family care benefit under s. 46.286 (4).
- i. Denial of eligibility or reduction of the amounts of the family care benefit under s. 46.286 (5).
- j. Determinations similar to those specified under s. 49.455 (8) (a), made under s. 46.286 (6).
- k. Recovery of family care benefit payments under s. 46.286 (7).

2. An applicant for or recipient of medical assistance is not entitled to a hearing concerning the identical dispute or matter under both this section and 42 CFR 431.200 to 431.246.

(b) An enrollee may contest a decision, omission or action of a care management organization other than those specified in par.

(a), or may contest the choice of service provider. In these instances, the enrollee shall first send a written request for review by the unit of the department that monitors care management organization contracts. This unit shall review and attempt to resolve the dispute. If the dispute is not resolved to the satisfaction of the enrollee, he or she may request a hearing under the procedures specified in par. (a) 1. (intro.).

(c) Information regarding the availability of advocacy services and notice of adverse actions taken and appeal rights shall be provided to a client by the resource center or care management organization in a form and manner that is prescribed by the department by rule.

History: 1999 a. 9; 2003 a. 33.

46.288 Rule-making. The department shall promulgate as rules all of the following:

(1) Standards for performance by resource centers and for certification of care management organizations, including requirements for maintaining quality assurance and quality improvement.

(2) Criteria and procedures for determining functional eligibility under s. 46.286 (1) (a), financial eligibility under s. 46.286 (1) (b), and cost sharing under s. 46.286 (2) (a). The rules for determining functional eligibility under s. 46.286 (1) (a) 1m. shall be substantially similar to eligibility criteria for receipt of the long-term support community options program under s. 46.27. Rules under this subsection shall include definitions of the following terms applicable to s. 46.286:

- (d) “Long-term or irreversible”.
- (e) “Requires ongoing care, assistance or supervision”.
- (f) “Condition that is expected to last at least 90 days or result in death within one year”.
- (g) “At risk of losing independence or functional capacity”.
- (h) “Gross monthly income”.
- (i) “Deductions and allowances”.
- (j) “Countable assets”.

(3) Procedures and standards for procedures for s. 46.287 (2), including time frames for action by a resource center or a care management organization on a contested matter.

History: 1999 a. 9; 2007 a. 20; 2009 a. 28.

46.2895 Long-term care district. (1) CREATION. (a) A county, a tribe or band, or any combination of counties or tribes or bands, may create a special purpose district that is termed a “long-term care district”, that is a local unit of government, that is separate and distinct from, and independent of, the state and the county or tribe or band that created it, and that has the powers and duties specified in this section, if each county or tribe or band that participates in creating the district does all of the following:

1. Adopts an enabling resolution that does all of the following:
 - a. Declares the need for establishing the long-term care district.
 - b. Specifies the long-term care district’s primary purpose, which shall be to operate, under contract with the department, a resource center under s. 46.283, a care management organization under s. 46.284, or a program described under s. 46.2805 (1) (a) or (b).
 - c. Specifies the number of individuals who shall be appointed as members of the long-term care district board, the length of their terms, and, if the long-term care district is created by more than one county or tribe or band, how many members shall be appointed by each county or tribe or band.
2. Files copies of the enabling resolution with the secretary of administration, the secretary of health services and the secretary of revenue.

(c) A long-term care district may not operate a care management organization under s. 46.284 or a program described under

s. 46.2805 (1) (a) or (b) if the district operates a resource center under s. 46.283.

(d) A county or tribe or band may create more than one long-term care district.

(e) A long-term care district may change its primary purpose specified under par. (a) 1. b. if all the counties or tribes or bands that created the district and that have not withdrawn or been removed from the district under sub. (14), adopt a resolution approving the change in primary purpose and if the change in purpose does not violate par. (c) or any provision of a contract between the department and the district.

(2) JURISDICTION. A long-term care district's jurisdiction is the geographical area of the county or counties that created the long-term care district and the geographic area of the reservation of, or lands held in trust for, any tribe or band that created the long-term care district.

(3) LONG-TERM CARE DISTRICT BOARD. (a) The county board of supervisors of a county or, in a county with a county administrator or county executive, the county administrator or county executive shall appoint the long-term care district board members whom the county is allotted, by resolutions adopted under sub. (1) (a) 1. c., to appoint.

(b) 1. At least one-fourth of the members of a long-term care district board shall be representative of the client group or groups whom it is the long-term care district's primary purpose to serve or those clients' family members, guardians, or other advocates.

3. Membership of a long-term care district board shall reflect the ethnic and economic diversity in the jurisdiction of the long-term care district.

4. No member of a long-term care district board may have a private financial interest in or profit directly or indirectly from any contract or other business of the long-term care district.

5. Only individuals who reside within the jurisdiction of a long-term care district may serve as members of the long-term care district board.

(d) As soon as possible after the appointment of the initial members of the long-term care district board, the board shall organize for the transaction of business and elect a chairperson and other necessary officers. Each chairperson shall be elected by the board from time to time for the term of that chairperson's office as a member of the board or for the term of 3 years, whichever is shorter, and shall be eligible for reelection. A majority of the board shall constitute a quorum. Unless specified otherwise in a bylaw adopted by the board, the board may act based on the affirmative vote of a majority of a quorum.

(4) POWERS. Subject to sub. (1) (c), a long-term care district has all the powers necessary or convenient to carry out the purposes and provisions of ss. 46.2805 to 46.2895. In addition to all these powers, a long-term care district may do all of the following:

(a) Adopt and alter, at pleasure, an official seal.

(b) Adopt bylaws and policies and procedures for the regulation of its affairs and the conduct of its business. The bylaws, policies and procedures shall be consistent with ss. 46.2805 to 46.2895 and, if the long-term care district contracts with the department under par. (d) or (dm), with the terms of that contract.

(c) Sue and be sued.

(d) Negotiate and enter into leases or contracts, including a contract with the department to operate either a resource center or a portion of its functions under s. 46.283 or a care management organization under s. 46.284, but not both a resource center or its functions and a care management organization.

(dm) Subject to sub. (1) (c), enter into a contract with the department to operate a program described under s. 46.2805 (1) (a) or (b) and provide services related to the contracted services.

(e) Provide services related to services available under the family care benefit, to older persons and persons with disabilities,

in addition to the services funded under the contract with the department that is specified under par. (d).

(f) Acquire, construct, equip, maintain, improve or manage a resource center under s. 46.283 or a care management organization under s. 46.284, but not both.

(g) Subject to sub. (8), employ any agent, employee, or special adviser that the long-term care district finds necessary, fix and regulate his or her compensation and provide, either directly or subject to an agreement under s. 66.0301 as a participant in a benefit plan of another governmental entity, any employee benefits, including an employee pension plan.

(h) Mortgage, pledge or otherwise encumber the long-term care district's property or funds.

(i) Buy, sell or lease property, including real estate, and maintain or dispose of the property.

(j) Invest any funds not required for immediate disbursement in any of the following:

1. An interest-bearing escrow account with a financial institution, as defined in s. 69.30 (1) (b).

2. Time deposits in any financial institution, as defined in s. 69.30 (1) (b), if the time deposits mature in not more than 2 years.

3. Bonds or securities issued or guaranteed as to principal and interest by the federal government or by a commission, board or other instrumentality of the federal government.

(k) Create a risk reserve or other special reserve as the long-term care district board desires or as the department requires under the contract with the department that is specified under par. (d).

(L) Accept aid, including loans, to accomplish the purpose of the long-term care district from any local, state or federal governmental agency or accept gifts, loans, grants or bequests from individuals or entities, if the conditions under which the aid, loan, gift, grant or bequest is furnished are not in conflict with this section.

(m) Make and execute other instruments necessary or convenient to exercise the powers of the long-term care district.

(5) LIMITATION ON POWERS. A long-term care district may not issue bonds or levy a tax or assessment.

(6) DUTIES. The long-term care district board shall do all of the following:

(a) Appoint a director, who shall hold office at the pleasure of the board.

(b) Subject to sub. (8), develop and implement a personnel structure and other employment policies for employees of the long-term care district.

(c) Assure compliance with the terms of any contract with the department under sub. (4) (d) or (dm).

(d) Establish a fiscal operating year and annually adopt a budget for the long-term care district.

(e) Contract for any legal services required for the long-term care district.

(f) Subject to sub. (8), procure liability insurance covering its officers, employees, and agents, insurance against any loss in connection with its property and other assets and other necessary insurance; establish and administer a plan of self-insurance; or, subject to an agreement under s. 66.0301, participate in a governmental plan of insurance or self-insurance.

(7) DIRECTOR; DUTIES. The director appointed under sub. (6) (a) shall do all of the following:

(a) Manage the property and business of the long-term care district and manage the employees of the district, subject to the general control of the long-term care district board.

(b) Comply with the bylaws and direct enforcement of all policies and procedures adopted by the long-term care district board.

(c) Perform duties in addition to those specified in pars. (a) and (b) as are prescribed by the long-term care district board.

46.2895 SOCIAL SERVICES

(8) EMPLOYMENT AND EMPLOYEE BENEFITS OF CERTAIN EMPLOYEES. (a) A long-term care district board that is created at least in part by a county shall do all of the following:

1. If the long-term care district offers employment to any individual who was previously employed by a county, which participated in creating the district and at the time of the offer had not withdrawn or been removed from the district under sub. (14), and who while employed by the county performed duties relating to the same or a substantially similar function for which the individual is offered employment by the district and whose wages, hours and conditions of employment were established in a collective bargaining agreement with the county under subch. IV of ch. 111 that is in effect on the date that the individual commences employment with the district, with respect to that individual, abide by the terms of the collective bargaining agreement concerning the individual's wages and, if applicable, vacation allowance, sick leave accumulation, sick leave bank, holiday allowance, funeral leave allowance, personal day allowance, or paid time off allowance until the time of the expiration of that collective bargaining agreement or adoption of a collective bargaining agreement with the district under subch. IV of ch. 111 covering the individual as an employee of the district, whichever occurs first.

3. If the long-term care district offers employment to any individual who was previously employed by a county, which participated in creating the district and at the time of the offer had not withdrawn or been removed from the district under sub. (14), and who while employed by the county performed duties relating to the same or a substantially similar function for which the individual is offered employment by the district, with respect to that individual, recognize all years of service with the county for any benefit provided or program operated by the district for which an employee's years of service may affect the provision of the benefit or the operation of the program.

4. If the county has not established its own retirement system for county employees, adopt a resolution that the long-term care district be included within the provisions of the Wisconsin retirement system under s. 40.21 (1). In this resolution, the long-term care district shall agree to recognize 100% of the prior creditable service of its employees earned by the employees while employed by the district.

(b) The county board of supervisors of each county that creates a long-term care district shall do all of the following:

1. If the county has established its own retirement system for county employees, provide that long-term care district employees are eligible to participate in the county retirement system.

2m. If the long-term care district employs any individual who was previously employed by the county, provide the individual health care coverage that is similar to the health care coverage that the county provided the individual when he or she was employed by the county.

(c) A long-term care district and any county that created the district and has not withdrawn from or been removed from the district under sub. (14) may enter into an agreement allocating the costs of providing benefits described under this section between the district and the county.

(9) CONFIDENTIALITY OF RECORDS. No record, as defined in s. 19.32 (2), of a long-term care district that contains personally identifiable information, as defined in s. 19.62 (5), concerning an individual who receives services from the long-term care district may be disclosed by the long-term care district without the individual's informed consent, except as required to comply with s. 16.009 (2) (p) or 49.45 (4).

(10) EXCHANGE OF INFORMATION. Notwithstanding sub. (9) and ss. 48.78 (2) (a), 49.45 (4), 49.83, 51.30, 51.45 (14) (a), 55.22 (3), 146.82, 252.11 (7), 253.07 (3) (c) and 938.78 (2) (a), a long-term care district acting under this section may exchange confidential information about a client, as defined in s. 46.287 (1), without the informed consent of the client, under s. 46.21 (2m) (c), 46.215 (1m), 46.22 (1) (dm), 46.23 (3) (e), 46.283 (7), 46.284 (7),

51.42 (3) (e) or 51.437 (4r) (b) in the jurisdiction of the long-term care district, if necessary to enable the long-term care district to perform its duties or to coordinate the delivery of services to the client.

(11) OBLIGATIONS, DEBTS, AND RESPONSIBILITIES NOT THOSE OF COUNTY. The obligations and debts of a long-term care district are not the obligations or debts of any county that created the district. If a long-term care district is obligated by statute or contract to provide or pay for services or benefits, no county is responsible for providing or paying for those services or benefits.

(12) ASSISTANCE TO LONG-TERM CARE DISTRICT. From moneys in a county treasury that are not appropriated to some other purpose, the county board of supervisors may appropriate moneys to a long-term care district that the county participated in creating as a gift or may lend moneys to the long-term care district.

(13) DISSOLUTION. Subject to the performance of the contractual obligations of a long-term care district and if first approved by the secretary of the department, the long-term care district may be dissolved by the joint action of the long-term care district board and each county or tribe or band that created the long-term care district and has not withdrawn or been removed from the district under sub. (14). If [the] a long-term care district that is created by one county or tribe or band is dissolved, the property of the district shall be transferred to the county or tribe or band that created it. If a long-term care district is created by more than one county or tribe or band, all of the counties or tribes or bands that created the district and that have not withdrawn or been removed from the district under sub. (14) shall agree on the apportioning of the long-term care district's property before the district may be dissolved. If the long-term care district operates a care management organization under s. 46.284, disposition of any remaining funds in the risk reserve under s. 46.284 (5) (e) shall be made under the terms of the district's contract with the department.

NOTE: The bracketed word is unnecessary. Corrective legislation is pending.

(14) WITHDRAWAL OR REMOVAL OF A COUNTY OR TRIBE OR BAND. Subject to approval from the department, a long-term care district may establish conditions for a county or tribe or band that participated with one or more counties or tribes or bands in creating the district to withdraw from the district or for the district to remove the county or tribe or band from the district.

History: 1999 a. 9, 185; 2001 a. 30; 2005 a. 25, 264; 2007 a. 20 ss. 1021 to 1073, 9121 (6) (a).

46.2897 Self-directed services option; advocacy services. The department shall allow a participant in the self-directed services option that is operated under a waiver from the secretary of the federal department of health and human services under 42 USC 1396n (c) to access the advocacy services contracted for by the department under s. 46.281 (1n) (e).

History: 2009 a. 28.

46.2898 Quality home care. (1) DEFINITIONS. In this section:

(a) "Authority" means the Wisconsin Quality Home Care Authority.

(b) "Care management organization" has the meaning given in s. 46.2805 (1).

(cm) "Consumer" means an adult who receives home care services and who meets all of the following criteria:

1. Is a resident of any of the following:

a. A county that has acted under sub. (2) (a).

b. A county in which the Family Care Program under s. 46.286 is available.

c. A county in which the Program of All-Inclusive Care for the Elderly under 42 USC 1396u-4 is available.

d. A county in which the self-directed services option program under 42 USC 1396n (c) is available or in which a program operated under an amendment to the state medical assistance plan under 42 USC 1396n (j) is available.

APPENDIX D

POTENTIAL MODELS FOR MH/SA SYSTEM REFORM

D.3. STATUTORY LANGUAGE FOR MULTI-COUNTY HUMAN SERVICES SYSTEMS

46.22 SOCIAL SERVICES

17. In consultation with the county social services board under sub. (2g), prepare:

a. Intermediate–range plans and budget.

b. Such other reports as are required by the secretary of health services, the secretary of children and families, the secretary of corrections, and the county board of supervisors.

(4) CONSTRUCTION. (a) Any reference in any law to a county department of social services under this section applies to a county department under s. 46.23 in its administration of the powers and duties of the county department of social services under s. 46.23 (3) (b).

(b) 1. Any reference in any law to a county social services director appointed under sub. (2) (b) applies to the director of a county department appointed under s. 46.23 (5) (f) in his or her administration of the powers and duties of that county social services director.

2. Any reference in any law to a county social services director appointed under sub. (3m) (a) applies to the director of a county department appointed under s. 46.23 (6m) (intro.) in his or her administration of the powers and duties of that county social services director.

(c) 1. Any reference in any law to a county social services board appointed under sub. (1m) (b) 1. and 3. applies to the board of a county department appointed under s. 46.23 (4) (b) 1. in its administration of the powers and duties of that county social services board.

2. Any reference in any law to a county social services board appointed under sub. (1m) (b) 2. applies to the board of a county department appointed under s. 46.23 (4) (b) 2. in its administration of the powers and duties of that county social services board.

History: 1971 c. 164, 218; 1973 c. 90 ss. 226, 560 (3); 1973 c. 147, 333; 1975 c. 39; 1975 c. 189 s. 99 (1), (2); 1975 c. 224 ss. 52p, 146m; 1975 c. 307, 422; 1975 c. 430 s. 78; 1977 c. 29 ss. 560, 1656 (18); 1977 c. 83 s. 26; 1977 c. 418, 449; 1979 c. 34, 221; 1981 c. 20 ss. 759 to 763m, 2202 (20) (j); 1981 c. 329; 1981 c. 390 s. 252; 1983 a. 27 s. 2202 (20); 1983 a. 190 s. 7; 1983 a. 192, 193, 447; 1985 a. 29, 120; 1985 a. 176 ss. 28, 30, 59 to 105; 1985 a. 332; 1987 a. 5, 27; 1989 a. 31, 107, 336, 359; 1991 a. 39, 274; 1993 a. 16; 1995 a. 27 ss. 2077 to 2111, 9126 (19), 9130 (4); 1995 a. 64, 77, 201, 289, 352, 404, 417; 1997 a. 3, 27, 35, 252; 1999 a. 9, 83; 2001 a. 16, 103; 2003 a. 33; 2005 a. 25, 264, 344, 388, 406; 2007 a. 20 ss. 857 to 877, 9121 (6) (a); 2007 a. 45, 96; 2009 a. 28; s. 13.92 (2) (i).

Members of a social services board in a county with a county executive or a county administrator may be granted access to child abuse and neglect files under s. 48.981 if access is necessary for the performance of their statutory duties. 79 Atty. Gen. 212.

46.225 Indigency determinations. If applicable under s. 977.07 (1), a county department under s. 46.21, 46.22 or 46.23 shall make indigency determinations.

History: 1979 c. 356; 1985 a. 176.

46.23 County department of human services.

(1) INTENT. The intent of this section is to enable and encourage counties to develop and make available to all citizens of this state a comprehensive range of human services in an integrated and efficient manner; to utilize and expand existing governmental, voluntary and private community resources for the provision of services to prevent or ameliorate social, mental and physical disabilities; to provide for the integration of administration of those services and facilities organized under this section through the establishment of a unified administrative structure and of a unified policy-making body; and to authorize state consultative services, reviews and establishments of standards and grants-in-aid for such programs of services and facilities.

(2) DEFINITIONS. Except as otherwise provided, in this section:

(a) “Human services” means the total range of services to people including, but not limited to, health care, mental illness treatment, developmental disabilities services, relief funded by a block grant under ch. 49, income maintenance, probation, extended supervision and parole services, alcohol and drug abuse services, services to children, youth and aging, family counseling, special education services and manpower services.

NOTE: Par. (a) is amended eff. 7–1–11 by 2009 Wis. Act 28 to read:

(a) “Human services” means the total range of services to people including, but not limited to, health care, mental illness treatment, developmental disabilities services, income maintenance, probation, extended supervision and parole services, alcohol and drug abuse services, services to children, youth and aging, family counseling, special education services, and manpower services.

(b) “Program” means community services and facilities for the prevention and amelioration of social, mental and physical disabilities.

(3) COUNTY DEPARTMENT OF HUMAN SERVICES. (a) *Creation.* Upon approval by the secretary of health services, by the secretary of corrections, and by the secretary of children and families of a feasibility study and a program implementation plan, the county board of supervisors of any county with a population of less than 500,000, or the county boards of supervisors of 2 or more contiguous counties, each of which has a population of less than 500,000, may establish by resolution a county department of human services on a single-county or multicounty basis to provide the services required under this section. The county department of human services shall consist of the county human services board, the county human services director and necessary personnel.

(am) *Delivery of services plan.* 1. The county department of human services shall prepare a local plan for the delivery of human services which includes an inventory of all existing resources, identifies needed new resources and services and contains a plan for meeting the health, mental health and social needs of individuals and families. The plan shall be based on an annual need survey of the prevalence and incidence of the various disabilities within the geographic boundaries of the county department of human services. The plan shall also include the establishment of long-range goals and intermediate-range plans, detailing priorities and estimated costs and providing for coordination of local services and continuity of care.

2. Prior to adoption of the plan by the county department of human services under subd. 1., it shall hold a public hearing on the plan. As far as practicable, the county department of human services shall annually publish or otherwise circulate notice of its proposed plan and afford interested persons opportunity to submit data or views orally or in writing.

3. The county board of supervisors in a county with a single-county department of human services and the county boards of supervisors in counties with a multicounty department of human services shall review and approve the overall plan, program and budgets proposed by the county department of human services.

4. No funds may be allocated to any multicounty department of human services until the counties have drawn up a detailed contractual agreement, approved by the secretary of health services, by the secretary of corrections, and by the secretary of children and families, setting forth the plan for joint sponsorship.

(b) *Transfer of other county powers and duties.* 1. If a county department of human services is established under par. (a), the county board of supervisors in a county with a single-county department of human services or the county boards of supervisors in counties with a multicounty department of human services shall transfer the powers and duties of the county departments under ss. 46.22 and 51.42 to the county department of human services. The county board of supervisors in a county with a single-county department of human services and the county boards of supervisors in counties with a multicounty department of human services may transfer the powers and duties of the following to the county department of human services established under par. (a):

a. A county unit created by the county board of supervisors exercising its authority under s. 59.03 (1).

am. A county department under s. 51.437.

b. A local board of health for a local health department, as defined in s. 250.01 (4) (a) 1. or 2. or (c).

bm. A local health officer for a local health department, as defined in s. 250.01 (4) (a) 1. or 2. or (c)

c. A local health department, as defined in s. 250.01 (4) (a) 1. or 2. or (c).

d. Any other human services program under county control.

2. a. Except as provided in s. 46.21 (2m) (b) 2. a., any reference in any law to a county department under s. 46.22, 51.42 or 51.437 applies to the county department of human services under this section in its administration of the powers and duties of the county department to which the reference is made.

b. Any reference in any law to a county director appointed under s. 46.22 (2) (b), 51.42 (5) (a) 4. or 51.437 (9) (a) applies to the county human services director appointed under sub. (5) (f) in his or her administration of the powers and duties of the county director to which the reference is made. Except as provided in s. 46.21 (2m) (b) 2. b., any reference in any law to a county director appointed under s. 46.22 (3m) (a), 51.42 (6m) (intro.) or 51.437 (10m) (intro.) applies to the county human services director appointed under sub. (6m) (intro.) in his or her administration of the powers and duties of the county director to which the reference is made.

c. Any reference to a county board appointed under s. 46.22 (1m) (b) 1., 51.42 (4) (a) 1. or 51.437 (7) (a) 1. applies to the county human services board appointed under sub. (4) (b) 1. in its administration of the powers and duties of the county board to which the reference is made. Except as provided in s. 46.21 (2m) (b) 2. c., any reference in any law to the county board appointed under s. 46.22 (1m) (b) 2., 51.42 (4) (a) 2. or 51.437 (7) (a) 2. applies to the county human services board appointed under sub. (4) (b) 2. in its administration of the powers and duties of the county board to which the reference is made.

d. The powers and duties of the county department of human services under s. 46.21 (2m) do not apply to this section.

(bm) *Long-term support community options program.* If the county board of supervisors in a county with a single-county department of human services or the county boards of supervisors in counties with a multicounty department of human services designate the county department of human services as the administrative agency under s. 46.27 (3) (b) 3., the county department of human services shall administer the long-term support community options program under s. 46.27.

(d) *Employee protections.* All persons employed by a county or by the state, whose functions are assumed by a county department of human services shall continue as employees of the county department of human services without loss in seniority, status or benefits, subject to the merit or civil service system.

(e) *Exchange of information; long-term care.* Notwithstanding ss. 46.2895 (9), 48.78 (2) (a), 49.45 (4), 49.83, 51.30, 51.45 (14) (a), 55.22 (3), 146.82, 252.11 (7), 253.07 (3) (c) and 938.78 (2) (a), a subunit of a county department of human services or tribal agency acting under this section may exchange confidential information about a client, without the informed consent of the client, with any other subunit of the same county department of human services or tribal agency, with a resource center, a care management organization, or a family [long-term] care district, with an elder-adult-at-risk agency, an adult-at-risk agency, or any agency to which referral for investigation is made under s. 46.90 (5) (a) 1. or 55.043 (1r) (a) 1g., or with a person providing services to the client under a purchase of services contract with the county department of human services or tribal agency or with a resource center, a care management organization, or a family [long-term] care district, if necessary to enable an employee or service provider to perform his or her duties, or to enable the county department of human services or tribal agency to coordinate the delivery of services to the client. An agency that releases information under this paragraph shall document that a request for information was received and what information was provided.

NOTE: The correct term is shown in brackets. Corrective legislation pending.

(ed) *Exchange of information; statewide automated child welfare information system.* Notwithstanding ss. 46.2895 (9), 48.396 (1) and (2) (a), 48.78 (2) (a), 48.981 (7), 49.45 (4), 49.83, 51.30, 51.45 (14) (a), 55.22 (3), 146.82, 252.11 (7), 252.15, 253.07 (3)

(c), 938.396 (1) (a) and (2), and 938.78 (2) (a), a county department under this section may enter the content of any record kept or information received by that county department into the statewide automated child welfare information system established under s. 48.47 (7g).

NOTE: Par. (ed) is shown as affected by 2 acts of the 2007 Wisconsin legislature and as merged by the legislative reference bureau under s. 13.92 (2) (i).

(4) **COUNTY HUMAN SERVICES BOARD.** (a) *Composition.* 1. In any single-county or multicounty department of human services, the county human services board shall be composed of not less than 7 nor more than 15 persons of recognized ability and demonstrated interest in human services. Not less than one-third nor more than two-thirds of the county human services board members may be members of the county board of supervisors. At least one member appointed to a county human services board shall be an individual who receives or has received human services or shall be a family member of such an individual. The remainder of the county human services board members shall be consumers of services or citizens-at-large. No public or private provider of services may be appointed to the county human services board.

2. In a multicounty department of human services, the county human services board shall be constituted so that the representation shall be as equal as possible among the participating counties.

(b) *Appointment.* 1. Except as provided under subd. 2., the county board of supervisors in a county which has established a single-county department of human services or the county boards of supervisors in counties which have established a multicounty department of human services shall, before qualification under this section, appoint a governing and policy-making board to be known as the county human services board.

2. In any county with a county executive or county administrator and which has established a single-county department of human services, the county executive or county administrator shall appoint, subject to confirmation by the county board of supervisors, the county human services board, which shall be only a policy-making body determining the broad outlines and principles governing the administration of programs under this section. A member of a county human services board appointed under this subdivision may be removed by the county executive or county administrator for cause or, on due notice in writing, if the member when appointed was a member of the county board of supervisors and was not reelected to that office.

(c) *Terms.* Members of a county human services board shall serve for terms of 3 years, so arranged that as nearly as practicable, the terms of one-third of the members shall expire each year. Vacancies shall be filled in the same manner as the original appointments. A county human services board member appointed under par. (b) 1. may be removed from office for the following reasons:

1. For cause, by a two-thirds vote of each county board of supervisors participating in the appointment, on due notice in writing and hearing of the charges against the member.

2. If the member when appointed was a member of the county board of supervisors and was not reelected to that office, on due notice in writing.

(5) **POWERS AND DUTIES OF COUNTY HUMAN SERVICES BOARD IN CERTAIN COUNTIES.** A county human services board appointed under sub. (4) (b) 1.:

(a) 1. Shall determine administrative and program policies, except as provided under ch. 48 and subch. III of ch. 49 and except for juvenile delinquency-related policies, within limits established by the department of health services. Policy decisions, except as provided under ch. 48 and subch. III of ch. 49 and except for juvenile delinquency-related policies, not reserved by statute for the department of health services may be delegated by the secretary to the county human services board.

2. Shall determine administrative and program policies under ch. 48 and subch. III of ch. 49 within limits established by the department of children and families. Policy decisions under ch.

46.23 SOCIAL SERVICES

48 and subch. III of ch. 49 not reserved by statute for the department of children and families may be delegated by the secretary of children and families to the county human services board.

3. Shall determine juvenile delinquency–related administrative programs and policies within limits established by the department of corrections. Juvenile delinquency–related policy decisions not reserved by statute for the department of corrections may be delegated by the secretary of corrections to the county human services board.

(b) Shall establish priorities in addition to those mandated by the department of health services, the department of corrections, or the department of children and families.

(c) 1. Shall determine whether state mandated services, except for services under ch. 48 and subch. III of ch. 49 and juvenile delinquency–related services, are provided or purchased or contracted for with local providers, and monitor the performance of such contracts. Purchase of services contracts shall be subject to the conditions specified in s. 46.036.

2. Shall determine whether state mandated services under ch. 48 and subch. III of ch. 49 are provided or purchased or contracted for with local providers, and monitor the performance of such contracts. Purchase of services contracts shall be subject to the conditions specified in s. 49.34.

3. Shall determine whether state mandated juvenile delinquency–related services are provided or purchased or contracted for with local providers, and monitor the performance of such contracts. Purchase of service contracts shall be subject to the conditions specified in s. 301.031.

(d) Shall determine, subject to the approval of the county board of supervisors in a county with a single–county department of human services or the county boards of supervisors in counties with a multicounty department of human services and with the advice of the county human services director appointed under par. (f), whether services are to be provided directly by the county department of human services or contracted for with other providers and make such contracts. The county board of supervisors in a county with a single–county department of human services or the county boards of supervisors in counties with a multicounty department of human services may elect to require the approval of any such contract by the county board of supervisors in a county with a single–county department of human services or the county boards of supervisors in counties with a multicounty department of human services.

(e) Shall represent human service agencies, professionals and consumers of services in negotiations with the state and federal governments.

(f) Shall appoint a county human services director on the basis of recognized and demonstrated interest in and knowledge of human services problems, with due regard to training, experience, executive and administrative ability and general qualification and fitness for the performance of the duties of the county human services director. The appointment is subject to the personnel policies and procedures established by each county board of supervisors which participated in the appointment of the county human services board.

(g) Shall appoint advisory committees for the purpose of receiving community, professional or technical information concerning particular policy considerations.

(h) Shall determine the number and location of outstations when appropriate to meet service demands.

(i) May recommend the removal of the county human services director for cause to each county board of supervisors which participated in the appointment of the county human services board, and each such county board of supervisors may remove the county human services director for cause by a two–thirds vote of each such county, on due notice in writing and hearing of the charges against the county human services director.

(j) Shall develop county human services board operating procedures.

(k) Shall oversee the operation of one or more service delivery programs.

(L) Shall evaluate services delivery.

(m) May perform such other general functions necessary to administer the program.

(n) 1. Shall submit a final budget in accordance with s. 46.031 (1) for authorized services, except for services under ch. 48 and subch. III of ch. 49 and juvenile delinquency–related services. Notwithstanding the categorization of or limits specified for funds allocated under s. 46.495 or 51.423 (2), with the approval of the department of health services the county human services board may expend these funds consistent with any service provided under s. 46.495 or 51.42.

2. Shall submit a final budget in accordance with s. 49.325 (1) for authorized services under ch. 48 and subch. III of ch. 49. Notwithstanding the categorization of or limits specified for funds allocated under s. 48.569, with the approval of the department of children and families the county human services board may expend these funds consistent with any service provided under s. 48.569.

3. Shall submit a final budget in accordance with s. 301.031 (1) for authorized juvenile delinquency–related services.

(o) Shall cooperate to the extent feasible with the school board, health planning agencies, law enforcement agencies, and other human service agencies, committees and planning bodies in the geographic area served by the county human services board.

(p) Shall comply with state requirements.

(5m) POWERS AND DUTIES OF COUNTY HUMAN SERVICES BOARD IN CERTAIN COUNTIES WITH A COUNTY EXECUTIVE OR COUNTY ADMINISTRATOR. A county human services board appointed under sub. (4) (b) 2. shall:

(a) Appoint committees consisting of residents of the county to advise the county human services board as it deems necessary.

(b) Recommend program priorities and policies, identify unmet service needs and prepare short–term and long–term plans and budgets for meeting such priorities and needs.

(c) Prepare, with the assistance of the county human services director under sub. (6m) (e), a proposed budget for submission to the county executive or county administrator, a final budget for submission to the department of health services in accordance with s. 46.031 (1) for authorized services, except services under ch. 48 and subch. III of ch. 49 and juvenile delinquency–related services, a final budget for submission to the department of children and families in accordance with s. 49.325 for authorized services under ch. 48 and subch. III of ch. 49, and a final budget for submission to the department of corrections in accordance with s. 301.031 for authorized juvenile delinquency–related services.

(d) Advise the county human services director under sub. (6m) regarding purchasing and providing services and the selection of purchase of service vendors, and make recommendations to the county executive or county administrator regarding modifications in such purchasing, providing and selection.

(e) Develop county human services board operating procedures.

(f) Comply with state requirements.

(g) Assist in arranging cooperative working agreements with persons providing health, education, vocational or welfare services related to services provided under this section.

(6) POWERS AND DUTIES OF COUNTY HUMAN SERVICES DIRECTOR IN CERTAIN COUNTIES. (a) A county human services director appointed under sub. (5) (f) shall have all of the administrative and executive powers and duties of managing, operating, maintaining, and improving the programs of the county department of human services, subject to the rules promulgated by the department of health services for programs, except services or programs under ch. 48 and subch. III of ch. 49 and juvenile delinquency–related services or programs, subject to the rules promulgated by the department of children and families for services or programs

under ch. 48 and subch. III of ch. 49, and subject to the rules promulgated by the department of corrections for juvenile delinquency-related services or programs. In consultation with the county human services board under sub. (5) and subject to its approval, the county human services director shall prepare:

1. An annual comprehensive plan and budget of all funds necessary for the program and services authorized by this section in which priorities and objectives for the year are established as well as any modifications of long-range objectives.

2. Intermediate-range plans and budget.

3. Such other reports as are required by the secretary of health services, by the secretary of corrections, or by the secretary of children and families and the county board of supervisors in a county with a single-county department of human services or the county boards of supervisors in counties with a multicounty department of human services.

(c) A county human services director under this subsection shall make recommendations to the county human services board under sub. (5) for:

1. Personnel and salaries of employees.
2. Changes in the organization and management of the program.
3. Changes in program services.

(e) A county human services director under this subsection shall comply with state requirements.

(6m) COUNTY HUMAN SERVICES DIRECTOR IN CERTAIN COUNTIES WITH A COUNTY EXECUTIVE OR COUNTY ADMINISTRATOR. In any county with a county executive or county administrator in which the county board of supervisors has established a single-county department of human services, the county executive or county administrator shall appoint a county human services director on the basis of recognized and demonstrated interest in and knowledge of human services problems, with due regard to training, experience, executive and administrative ability and general qualification and fitness for the performance of the duties of the director. The appointment is subject to confirmation by the county board of supervisors unless the county board of supervisors, by ordinance, elects to waive confirmation or unless the appointment is made under a civil service system competitive examination procedure established under s. 59.52 (8) or ch. 63. The county human services director, subject only to the supervision of the county executive or county administrator, shall:

- (a) Supervise and administer any program for which supervision and administration is authorized under this section.

- (b) Determine administrative and program procedures and administrative policies.

- (c) Determine, subject to the approval of the county board of supervisors and with the advice of the county human services board under sub. (5m), whether services are to be provided directly by the county department of human services or contracted for with other providers and make such contracts. The county board of supervisors may elect to require the approval of any such contract by the county board of supervisors.

- (e) Assist the county human services board under sub. (5m) (c) in the preparation of the budgets required under sub. (5m) (c).

- (f) Make recommendations to the county executive or county administrator regarding modifications to the proposed budget prepared by the county human services board under sub. (5m) (c).

- (g) Evaluate service delivery.

- (j) Perform other functions necessary to manage, operate, maintain and improve programs.

- (k) Comply with state requirements.

- (L) Represent human service agencies, professionals and consumers of services in negotiations with the state and federal governments.

(m) Determine the number and location of outstations when appropriate to meet service demands.

History: 1975 c. 39, 224; 1977 c. 29; 1981 c. 20, 93, 291; 1981 c. 329 s. 31; 1983 a. 27 ss. 962, 2202 (20); 1985 a. 29 ss. 844m to 860, 3200 (56) (a); 1985 a. 120, 176, 332; 1987 a. 186; 1987 a. 403 s. 256; 1989 a. 56, 359; 1991 a. 274; 1993 a. 16, 27, 83, 445, 491; 1995 a. 27 ss. 2112 to 2127, 9126 (19), 9130 (4); 1995 a. 64, 201, 352, 417; 1997 a. 3, 164, 268, 283; 1999 a. 9; 2005 a. 264, 388, 406; 2007 a. 20 ss. 878 to 891, 9121 (6) (a); 2007 a. 45, 96; 2009 a. 28; s. 13.92 (2) (i).

There is no unconditional guarantee of continued employment under sub. (3) (d); employment is continued during a reorganization unless civil service rules provide otherwise. *Dane County v. McCartney*, 166 Wis. 2d 956, 480 N.W.2d 830 (Ct. App. 1992).

Boards and directors may view client information without written and informed consent for any purpose related to their powers and duties. 69 Atty. Gen. 273.

Officers, employees, and directors of public or private entities that furnish "human services" to a county may not be appointed to the board under sub. (4) (a); this provision does not extend to family members of "human services" providers. 80 Atty. Gen. 30.

Because there is no explicit statutory authority for county human services departments to accept gifts, the statutory scheme contemplates that gifts, grants, and donations to a county human services department created under this section may be accepted only by the county board of supervisors. OAG 1–08.

46.238 Infants and unborn children whose mothers abuse controlled substances or controlled substance analogs. If a county department under s. 46.22 or 46.23 or, in a county having a population of 500,000 or more, a county department under s. 51.42 or 51.437 receives a report under s. 146.0255 (2), the county department shall offer to provide appropriate services and treatment to the child and the child's mother or to the unborn child, as defined in s. 48.02 (19), and the expectant mother of the unborn child or the county department shall make arrangements for the provision of appropriate services or treatment.

History: 1989 a. 122; 1993 a. 16; 1995 a. 386, 448; 1997 a. 27, 292.

46.245 Information for certain pregnant women. Upon request, a county department under s. 46.215, 46.22 or 46.23 shall distribute the materials described under s. 253.10 (3) (d), as prepared and distributed by the department. A physician who intends to perform or induce an abortion or another qualified physician, as defined in s. 253.10 (2) (g), who reasonably believes that he or she might have a patient for whom the information under s. 253.10 (3) (d) is required to be given, shall request a reasonably adequate number of the materials from the county department under this section or from the department under s. 253.10 (3) (d). An individual may request a reasonably adequate number of the materials.

History: 1985 a. 56, 176; 1993 a. 27; 1995 a. 309; 1997 a. 27.

46.266 Treatment funds for mentally ill persons.

(1) Notwithstanding s. 49.45 (6m) (ag) and except as provided in sub. (3), if before July 1, 1989, the federal health care financing administration or the department found a skilled nursing facility or intermediate care facility in this state that provides care to medical assistance recipients for which the facility receives reimbursement under s. 49.45 (6m) to be an institution for mental diseases, the department shall allocate funds from the appropriation account under s. 20.435 (5) (be) for distribution under this section to a county department under s. 51.42 for the care, in the community or in a facility found to be an institution for mental diseases, of the following persons:

- (a) A person who resided in the facility on the date of the finding whose care in the facility is disallowed for federal financial participation.

- (b) A person who is aged 21 to 64, who has a primary diagnosis of mental illness, who would meet the level of care requirements for medical assistance reimbursement in a skilled nursing facility or intermediate care facility but for a finding that the facility is an institution for mental diseases, and for whom services would be provided in place of a person specified in par. (a) who discontinues services.

- (c) A person who is provided services in the community under this subsection, who was relocated from a nursing home found to be an institution for mental diseases and who reenters, within 6