Wisconsin Public Mental Health and Substance Abuse Infrastructure Study

Final Report

Prepared for the Wisconsin Department of Health Services by The Management Group, Inc.

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WISCONSIN PUBLIC MENTAL HEALTH AND SUBSTANCE ABUSE INFRASTRUCTURE STUDY

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SECTION I. EXECUTIVE SUMMARY

Introduction and Project Background

The Wisconsin Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services (DMHSAS), selected The Management Group, Inc. (TMG) to conduct an in-depth review of Wisconsin's public mental health and substance abuse (MH/SA) services system.

The **Wisconsin Public MH/SA Infrastructure Study** examines the publicly funded system. The system's responsibilities are primarily lodged with county government, as described in Chapter 51.42, Wis. Stats., as well as with the Medicaid managed care programs, which include Family Care, BadgerCare and SSI Managed Care. The MH/SA Infrastructure Study is especially timely, given recent state and national initiatives that will impact the financing and provision of MH/SA services.

Study Purpose

The purpose of the Wisconsin Public MH/SA Infrastructure Study is to: (1) review the current funding and delivery of public MH/SA services in Wisconsin; (2) review alternative funding and delivery systems in other states; and (3) identify strategies for consideration during the 2011-2013 biennial budget process and during other policy-making processes.

The goals or benchmarks used to measure the strengths and weaknesses of the Wisconsin system (as well as alternative state models) include: (A) equitable access to service across the state; (B) accountability for outcomes, including the availability of evidence-based programs and the information technology to evaluate outcomes; (C) equitable and affordable funding for services; and (D) efficiency of service delivery.

The purpose of the study is to examine the broader system issues impacting MH/SA services delivery and funding, as opposed to operational and practice model issues. As such, the MH/SA Infrastructure Study builds on previous study efforts, but is not intended to duplicate them.

Study Scope

The study scope includes:

- A comprehensive summary of the current financing of publicly funded MH/SA services in the state. The study generally includes all services and funding sources. However, it does not include the correctional system, state administration for MH/SA and the operations of state-run facilities (e.g. state mental health institutes).

- A review of other state financing and system structures for public MH/SA services, including their key financing and structural strategies.

- An overview of projected changes and potential impact on county systems of MH/SA services. Since this study began, several changes were enacted in the 2009-11 state budget that will impact the MH/SA system.

- Potential options and strategies to consider for the future delivery and financing of the public MH/SA system, including statutory changes to implement funding and service delivery alternatives.

- A summit of key stakeholders, including state agencies, county, tribal, consumer and advocacy organizations to present and discuss the findings of the study and proposals for next steps.

Study Approach and Methodology

The Wisconsin Public MH/SA Infrastructure Study was a collaborative effort between DHS, the TMG project consultants and a 12-member study Steering Committee. The Steering Committee provided guidance throughout the study process, identifying issues impacting the public MH/SA system, developing guiding principles for development of potential models, reviewing data tables and document drafts, assisting in the planning for the MH/SA Infrastructure Summit, and reviewing the draft study report.

The project consultants used a multi-faceted approach to gather information about Wisconsin's MH/SA system and other states' systems and reform efforts. This included a review of available documents and data for Wisconsin and other states, as well as interviews with individuals involved in Wisconsin's public MH/SA system and representatives of the states selected for this study.

It should be noted that the feedback solicited during the course of this study is limited. It was not the intent to include broader stakeholder input and feedback during the initial study process. The study is intended to provide a foundation and framework for developing a common understanding of the potential options for the future provision and financing of MH/SA services in Wisconsin, so that an informed discussion can take place. The important and necessary dialogue among system stakeholders about the potential options, as well as proposed next steps, is expected to begin at the MH/SA Infrastructure Summit and continue from that point forward.

Wisconsin's Public Mental Health and Substance Abuse System

Structure, Roles and Responsibilities

Wisconsin has a state-supervised, county-administered MH/SA system. The Division of Mental Health and Substance Abuse Services in the Department of Health Services is the state mental health agency. It is responsible for allocating state and federal funding for the provision of MH/SA services and for implementing various responsibilities under the State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act, more commonly referred to as Chapter 51. While the state has broad responsibility for MH/SA system planning, management and oversight, it is the state's 72 counties that are statutorily responsible for administering MH/SA services. As such, Wisconsin is one of about a dozen states that relies primarily on counties to administer MH/SA services. Chapter 51, Wis. Stats., delineates the statutory responsibility for counties to provide for the "well-being, treatment and care" of individuals with mental illness and/or substance abuse problems.

Wisconsin statutes further provide for counties to meet their MH/SA service responsibility through single county systems, such as single county boards and departments of community programs or human services, or through multi-county systems. Wisconsin has a total of 67 county-based systems for MH/SA services, including 64 single county systems and three multi-county systems.

Overview of Mental Health and Substance Abuse Funding

Wisconsin's public MH/SA services are funded through five primary sources:

- Medical Assistance (i.e., Medicaid)
- Federal Block Grants (includes community mental health services block grant and the substance abuse prevention and treatment block grant)
- Community Aids (funds social service, developmental disabilities, and MH/SA service programs)
- County Revenues (primarily county property tax revenues)
- Private Insurance or Individual Payments

Service Utilization and Expenditure Data

The intent of the service and funding data presented in the report is to provide some perspective on the overall utilization and costs related to the provision of MH/SA services to populations in Wisconsin's publicly funded systems. The data in the study is aggregated at a statewide level and a regional level using information from the following sources:

- Medicaid Claims Data
- Managed Care Encounter Data
- Family Care Encounter Data
- Human Services Reporting System (HSRS) Data
- Human Services Revenue Report (HSRR) Data

Selected highlights from Wisconsin's Mental Health and Substance Abuse System data for the period 2005 to 2007 include:

- The county MH/SA system is the predominant system for publicly funded MH/SA services, funding more than 70 percent of all service expenditures.

- The county MH/SA system serves more than 40 percent of MH/SA consumers combined, including more than 70 percent of consumers with substance abuse issues.

- Approximately 73 percent of MH/SA consumers served are between the ages of 18 and 64.

- The per capita rate of MH/SA consumers served by DHS region ranged from an average high of approximately 48 to a low of approximately 31 per 1,000 of the total population.

- Per capita expenditures for all publicly funded MH/SA services by DHS region varied greatly throughout the state, ranging from an average high of approximately $129 to a low of $93.

Limitations of the Data and Other Data Concerns

The information on funding can be used to see how different areas of the state have made allocation decisions. However, higher or lower expenditures among the different regions may not indicate more or less effective service delivery. Therefore, the data should not be used to make positive or negative correlations between the regions. The data may demonstrate that some DHS regions or counties within those regions serve fewer consumers, but may provide more intensive services, while other areas may

provide less intensive services to a broader range of individuals. The data should not be used to draw conclusions about the appropriateness or efficacy of different service or funding levels, especially since the data is aggregated on a broader regional basis.

Beyond these limitations of the data, it is also important to note there are concerns and issues regarding the integrity of the data that DHS was able to provide for analysis, especially the HSRS data reported by counties. **Any steps to implement system reform should also address the critical need to upgrade systems at the state and local levels to ensure that accurate and consistent data is collected and used for decision-making.** Basic utilization and cost data, especially performance outcome data, should be available. Only with robust data systems will state and local MH/SA system policymakers, managers and consumers have the data necessary to effectively inform future system improvements and reform initiatives and gauge the effectiveness of those efforts.

State Managed Care Initiatives

One of the key objectives of the MH/SA Infrastructure Study was to review other state initiatives that impact the public MH/SA system. These include the state's Medicaid managed care programs: BadgerCare, SSI Managed Care and Family Care. Individuals with MH/SA issues who are enrolled in these managed care programs do not typically become eligible for them due to their MH/SA diagnosis. However, all of these programs serve individuals with MH/SA issues and all provide some MH/SA services within their benefit packages.

There are differences in eligibility and MH/SA benefits coverage among these various managed care programs and plans. While these distinctions exist among the managed care programs and plans, the variations that exist between the managed care programs and the county-administered MH/SA services are much greater and more significant. **One of the study's key findings is that Wisconsin appears to have two primary and very distinct publicly funded systems that serve individuals with MH/SA issues: one is the county-administered service delivery system and the other is the system of Medicaid managed care programs.** While service eligibility requirements and benefit requirements for the Medicaid managed care programs are clearly defined, specific and consistent, county-based system service eligibility and coverage are not well defined, and are broad and subject to significant variation among counties. This results in system complexity, inconsistency and fragmentation, and may lead to conflict between the two systems.

Targeted County Review

While the MH/SA Infrastructure Study could not include an examination of all 67 county MH/SA systems, it did provide a more in-depth review of nine selected county MH/SA systems, including one multi-county system: Dane, Jefferson, Kewaunee, La Crosse, Milwaukee, North Central Health Care (serving Marathon, Lincoln and Langlade counties), Price, Sauk and Wood.

The counties were selected to help provide insights into the diversity and commonality of county experiences. The selection took into account county size, as well as different organizational structures, regions, and service arrays. In addition, the selected counties have experience with other initiatives that are in varying stages of implementation. Examples of these initiatives include managed regional long-term care (Family Care) and managed care for individuals receiving Medicaid Supplemental Security Income (SSI Managed Care).

Various factors and issues emerged from the targeted county review that impact county MH/SA systems. These are summarized in the study report, including:

- Service Delivery Model, Structure and Roles
- Service Array, Access and Capacity
- MH/SA System Responsibilities
- Accountability for Outcomes
- Managed Care Initiatives
- Other State Initiatives and Changes
- Use of Funding Sources

In addition, representatives of the county MH/SA systems participating in the targeted county review were asked about potential future system reform efforts and identified:

- Issues that should be addressed in a potential effort to reform the financing and delivery of MH/SA services, and

- Lessons learned from past human service reform efforts in Wisconsin and how these might be applied to future reform efforts.

Trends and Initiatives Impacting Public Mental Health and Substance Abuse Systems

While a review of the literature examined for this study reveals numerous trends that currently influence or have the potential to influence public MH/SA systems, three trends, in particular, are likely to have an increasing impact in shaping the future financing of these systems.

- Preference for Integrated Care Models
- Role of Medicaid as a Major Funding Source for MH/SA Services
- Financial Incentives and Value-Based Purchasing for MH/SA Services

Public MH/SA systems are also impacted by changes in federal law and regulations. The passage of federal parity legislation for MH/SA and eventual federal health care reform efforts may result in changes that impact the availability and funding for publicly financed MH/SA services. With potentially greater health insurance coverage of MH/SA services through public and private health plans, both parity legislation and health care reform legislation have the potential to decrease demands on safety net provider systems, such as county MH/SA systems.

Review of Selected States

The study included a review of five states other than Wisconsin to gain an understanding of each respective state's MH/SA models and efforts to reform the financing and structure of publicly funded MH/SA services. The states included in the study are: Minnesota, New Mexico, North Carolina, Ohio, and Oregon.

While various factors were considered by the MH/SA Infrastructure Study Steering Committee when selecting these five states, some key considerations included:

- Minnesota and Ohio have county-based human service systems that are similar to Wisconsin's system. However, both have more experience with multi-county approaches to MH/SA funding and service delivery than Wisconsin does.

- New Mexico and North Carolina have both implemented significant reforms in funding MH/SA services, and these reforms have been the topic of numerous studies. New Mexico, while a state-administered system, represents a bold initiative to consolidate various funding streams for MH/SA across many state agencies into one entity. North Carolina implemented significant changes to almost every aspect of its MH/SA system and offers many lessons from its experience with reform.

- Oregon is moving toward greater integration of MH/SA and physical health care, and is considered a leader in the implementation of evidence-based practices.

To gain an understanding of these other state systems and reform efforts, the project team reviewed extensive background information from state sources, independent evaluations and national data. Interviews were also conducted with various individuals to gain a more balanced and comprehensive perspective on the respective reform efforts. The project team interviewed representatives of the appropriate state MH/SA agencies and representatives of consumer and county system advocacy.

Key Lessons Learned from Other State Reform Efforts

Despite the differences in approach and scope of system reform in the five states included in this study, there were several overall and recurring themes that can serve as lessons learned for Wisconsin and other states that are contemplating reform efforts.

- Recognize that **leadership is critical** – both executive and legislative.

- Continue to **hold the vision and goals** of reform, in spite of changes in staff and leadership.

- Establish an extensive, **comprehensive and inclusive planning** process involving all the system stakeholders to minimize the risk of creating a reform design that harms a fragile consumer population.

- Make sure reform is **consumer-focused**. Ensure that better consumer outcomes drive the system and that consumers benefit from the reform effort.

- **Demonstrate clear results** of changes – show changes that have meaning in people's lives.

- **Manage expectations** – understand the breadth and depth of what reform will entail; the more significant the change, the longer it will take to implement.

- Give reform time to be successful – **stage reform** and show results instead of trying to do everything at once. Do not take on **too much change at once** because of the impact it will have on service capacity and workforce, as well as the difficulty in assessing the impact of individual changes and taking corrective action.

- **Pilot reform** – do not try to reform the entire state at once.

- Find **compromise solutions** that move system toward reform goals.
- Implement a **core benefit set** and any changes to benefits first.
- Address **service capacity and workforce issues** – these are critical, especially when moving to a uniform benefit package that may require greater service capacity and different types of services.
- Ensure **data informs and shapes the reform effort** and helps evaluate the impact of reform.
- Address the **full costs of the reform effort** and address these with sufficient resources.
- Recognize that the **influx of new dollars** increases the likelihood of a successful reform effort. Publicly funded MH/SA service systems are typically underfunded, with not enough dollars to move to a capitated rate structure, even if all funding streams are combined.

Potential Models for Mental Health and Substance Abuse System Reform

Various factors were considered in the development of possible models for financing the public MH/SA service system. These included:

- The guiding principles established by the Wisconsin MH/SA Infrastructure Study Steering Committee.
- The experience of Wisconsin and other states implementing different models.
- The national trends impacting the financing and delivery of publicly funded MH/SA services.

The purpose of the model development was to identify potential major models available for consideration, but not to recommend any particular model. Pathways were developed for each model, representing different approaches or strategies that could be used to implement a particular model.

The project team was directed to consider all major models (except for a state-administered system model) during discussions about the scope of the study with DHS officials and members of the study Steering Committee. A state-administered model was excluded from consideration because of Wisconsin's strong county-based MH/SA system tradition and the apparent incompatibility in moving to a fully state-administered system in light of that tradition. In addition, transferring all MH/SA responsibilities from counties to the state would be impractical and not financially feasible because of the extensive infrastructure costs and planning such a transfer would require. However, in two of the potential models, there are pathways that would allow counties to opt out of the responsibilities associated with administering MH/SA services.

The Steering Committee identified a set of principles to guide and inform the development of the models/pathways for funding the public MH/SA system.

- Strong Consumer Role
- Future County Role or Choice
- Uniform Benefit Package
- Alignment and Compatibility with Medicaid
- State Incentives to Support Change
- Alignment and Compatibility with Health Care Reform and Related Initiatives

Key among the principles identified by the Steering Committee is a desire for individual county choice regarding the role of counties in a particular model. County representatives on the Steering Committee acknowledged that the future of state/county cost sharing may impact the role counties want to have in a future MH/SA services system, with some counties preferring limited to no county participation in the system.

Common Elements for All Potential Models

It was important to begin the development of the models/pathways with an understanding of the underlying assumptions for all of the models. Based on the guiding principles identified by the Steering Committee, the lessons learned from other state reform efforts and the feedback from counties participating in the targeted county review, a set of elements emerged that would apply to all the major models considered.

The following elements are assumed to be common for all of the major models identified in the study and therefore are not repeated in the study report for each of the model descriptions:

- All models address the four benchmark goal areas, but in different ways and to different degrees, through **incentives to ensure appropriate alignment of system goals**, including appropriate use of and responsibility for community-based and inpatient services. All models assume **greater state financial participation** to achieve implementation of the benchmark goals.

  The **four benchmark goal areas** for the models to finance the public MH/SA services system are:

  - Equitable access to services
  - Accountability for consumer outcomes
  - Equitable and affordable funding
  - Service efficiency

- All models include **publicly funded MH/SA services** to a defined eligible population, which can include Medicaid and non-Medicaid eligible individuals, those with serious and persistent mental illness and others that the publicly funded MH/SA system may be serving.

- All models include the development of a **comprehensive core benefit package** for publicly funded MH/SA services that is driven by functional and financial **eligibility criteria that are consistent throughout the state**. In addition, services to individuals that do not meet the statewide eligibility criteria could be provided based on local choice and available resources.

- All models maintain and seek to improve **quality MH/SA services** that are recovery-oriented, consumer-driven and focused.

- All models include approaches for **better coordination and integration between MH/SA and physical health care services**, ranging from co-location of services, to facilitation of referrals for services across systems, to joint planning and financing of services.

- All models maintain a **local service planning role** that includes effective **consumer/family involvement** in service planning.

- All models have a continued county role or **county choice** in a continued role for providing and funding MH/SA services.

- All models recognize the **breadth of responsibilities** (in addition to the provision of treatment services) that counties perform to support individuals who have MH/SA needs, including information and assistance, law enforcement crisis response, intake and assessment, protective services and court-related services. All models also acknowledge that these **need to be addressed in any reform effort**.

- All models incorporate **principles of managed care and performance-based contracting**, such as utilization management; effective data collection, reporting and analysis; a focus on consumer outcomes; and payment for meeting performance expectations.

Overview of Models/Pathways

Four potential major models for financing the public MH/SA services system are identified in the study report, along with potential pathways for implementing the models. It is helpful to consider the models on a continuum, with Model A reflecting the least amount of change to system financing and governance, and Model D representing the greatest amount of change to system financing and governance. While Model C, the multi-county system, would represent significant change from the current single county systems, the establishment and existence of multi-county systems is not new to Wisconsin.

It is also important to recognize that the models are not mutually exclusive. For example, Model A (the continuation of the current single and multi-county system) is the foundation for Model B, the county collaborative system. Further, the success of county collaboratives formed under Model B could give rise to the creation of additional multi-county systems under Model C. Finally, Model A and Model C can be considered in conjunction with demonstration projects implementing Model D, the public/private integrated care system. However, establishing partnerships with private health care organizations for an integrated care model will likely be easier if the service area reflects the multi-county areas (Model C) within which most HMOs (health plans) operate.

Model A – County-Based System: Fund continuation of current single county and optional multi-county systems.

Potential Pathways for Model A:

A.1. Greater state financial participation.
A.2. State elevation of Medicaid.
A.3. In the absence of greater state financial participation, changes to funding approach or service delivery expectations would not be implemented.

Model B – County Collaborative System: Fund consortium of counties for specific services and/or functional areas.

Potential Pathway for Model B:

B.1. Use intergovernmental agreements to establish scope and parameters of county collaboration.

Model C – Multi-County System: Fund mandatory multi-county system structure.

Potential Pathways for Model C:

C.1. Create multi-county MH/SA systems through Chapter 51 statutory framework.
C.2. Create multi-county MH/SA systems through Family Care statutory framework.
C.3. Integrate MH/SA programs and all remaining county human services functions into broader multi-county human services systems.

Model D – Public/Private Integrated Care System: Fund demonstration projects of public/private partnerships that integrate MH/SA and physical health care.

Potential Pathways for Model D:

D.1. Single or multi-county MH/SA systems work in contractual partnerships with HMOs.
D.2. HMOs contract with single or multi-county MH/SA systems.
D.3. Public or private MH/SA managed care organizations provide MH/SA services and coordinate physical health care with HMOs.
D.4. HMOs provide fully-integrated MH/SA and physical health care services.

Summary of Summit Feedback and Next Steps

The study project was presented and discussed at the Mental Health and Substance Abuse Infrastructure Summit held on December 3, 2009 in Stevens Point, Wisconsin. The Summit marked the beginning of a dialogue about the future of the publicly financed and delivered MH/SA system in Wisconsin. Participants at the Summit had an opportunity to receive an overview of the study, hear from representatives of other states included in the study, and discuss potential models and pathways for financing the MH/SA system that Wisconsin could consider. A summary of the Summit dialogue on key issues and proposed next steps is included in the Addendum to the Study Report .

SECTION II. INTRODUCTION AND PROJECT BACKGROUND

A. Study Purpose and Scope

The Wisconsin Department of Health Services (DHS), Division of Mental Health and Substance Abuse Services (DMHSAS), selected The Management Group, Inc. (TMG) to conduct an in-depth review of Wisconsin's public mental health and substance abuse (MH/SA) services system.

The **Wisconsin Public MH/SA Infrastructure Study** examines the publicly funded system. The system's responsibilities are primarily lodged with county government, as described in Chapter 51.42, Wis. Stats., as well as with the Medicaid managed care programs, which include Family Care, BadgerCare and SSI Managed Care. The MH/SA Infrastructure Study is especially timely given recent state and national initiatives that will impact the financing and provision of MH/SA services.

Purpose of the Study

The purpose of the Wisconsin Public MH/SA Infrastructure Study is to: (1) review the current funding and delivery of public MH/SA services in Wisconsin; (2) review alternative funding and delivery systems in other states; and (3) identify strategies for consideration during the 2011-2013 biennial budget process and during other policy-making processes.

The goals or benchmarks used to measure the strengths and weaknesses of the Wisconsin system (as well as alternative state models) include: (A) equitable access to service across the state; (B) accountability for outcomes, including the availability of evidence-based programs and the information technology to evaluate outcomes; (C) equitable and affordable funding for services; and (D) efficiency of service delivery.

The purpose of the study is to examine the broader system issues impacting MH/SA services delivery and funding, as opposed to operational and practice model issues. As such, the MH/SA Infrastructure Study builds on previous study efforts, but is not intended to duplicate them.

Study Scope

The study scope includes:

- A comprehensive summary of the current financing of publicly funded mental health and substance abuse services in the state. The study generally includes all services and funding sources. However, it does not include the correctional system, state administration for MH/SA and the operations of state-run facilities (e.g. state mental health institutes). In addition, private insurance as a funding source is only included in the scope of this study to the extent that it interfaces with the public MH/SA system by enhancing or impeding consumer access to services.

- A review of other state financing and system structures for public MH/SA services, including their key financing and structural strategies.

- An overview of projected changes and potential impact on county systems of MH/SA services, including but not limited to the impact of the following:

  - Medicaid managed care programs, such as Family Care, BadgerCare Plus expansion to childless adults, and Medicaid SSI Managed Care.
  - Wisconsin Medicaid Cost Reporting (WIMCR).
  - Further development of Comprehensive Community Services (CCS) and other similar Medicaid benefits.
  - Cost of living increases for staff and infrastructure in county MH/SA systems, which are often addressed through a reallocation of funding for MH/SA treatment services.

- Potential options and strategies to consider for the future delivery and financing of the public MH/SA system, including statutory changes to implement funding and service delivery alternatives. The only model excluded from consideration was a primarily state-administered system of funding and service provision.

- A summit of key stakeholders, including state agencies, county, tribal, consumer and advocacy organizations to present and discuss the findings of the study and proposals for next steps

- A document outlining the proceedings of the summit and recommended next steps.

B. Study Approach and Methodology

The Wisconsin Public MH/SA Infrastructure Study was a collaborative effort between DHS, the TMG project consultants and a 12-member study Steering Committee. A list of Steering Committee members can be found in **Appendix A**. The Steering Committee held four meetings during the course of the study. The agendas of the February, May, September and November 2009 meetings of the Steering Committee can also be found in **Appendix A**.

The Steering Committee provided guidance throughout the study process, identifying issues impacting the public MH/SA system, developing guiding principles for development of potential models, reviewing data tables and document drafts, assisting in the planning for the Summit, and reviewing the draft study report. TMG would like to thank the Steering Committee members for their participation, insights and dedication of time to the study process.

Study Approach

The project consultants used a multi-faceted approach to gather information about Wisconsin's MH/SA system and other states' systems and reform efforts. This included a review of available documents and data for Wisconsin and other states, as well as interviews with individuals involved in Wisconsin's public MH/SA system and representatives of the states selected for this study.

Since the issues and concerns regarding the public MH/SA system in Wisconsin have been well documented in previous studies and reports, the project consultants summarized this information using the four goal or benchmark areas established for this study.

The summary document in **Appendix B** lists the major issues identified in the following more recent key reports:

- Proposal to Redesign Wisconsin's Human/Social Service Delivery System developed by the Wisconsin County Human Services "Visions" Committee – 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) – August 2008

In addition, the summary of major issues in **Appendix B** includes feedback from:

- Directors and staff of Aging and Disability Resource Centers (ADRCs) attending the ADRConnection Workgroup Meeting – February 2009
- Members of the Steering Committee for the Public Mental Health and Substance Abuse Infrastructure Study – February 2009
- Members of the Wisconsin County Human Services Association (WCHSA) Behavioral Health Policy Advisory Committee – March 2009
- Members of the Wisconsin Counties Association Health and Human Services Committee[6] – April 2009

Finally, the summary in **Appendix B** includes issues identified in the following state document:

- State Plan for the Community Mental Health Services Block Grant for Fiscal Year 2009

Since many of the issues identified from the previously-listed sources focus more on mental health services, DHS developed a supplemental document regarding financing substance abuse prevention and treatment services in Wisconsin. This document along with a summary of issues identified in the 1997 Report of The Blue Ribbon Commission on Mental Health can also be found in **Appendix B**.

It should be noted that the feedback solicited during the course of this study is generally limited to the sources identified above. It was not the intent to include broader stakeholder input and feedback during the initial study process. The study is intended to provide a foundation and framework for developing a common understanding of the potential options for the future provision and financing of MH/SA services in Wisconsin, so that an informed discussion can take place. The important and necessary dialogue among system stakeholders about the potential options for the future provision and financing of MH/SA services in Wisconsin, as well as proposed next steps, is expected to begin at the Infrastructure Summit and continue from that point forward.

Study Methodology

The study approach and methodology consisted of several key components, which are outlined in **Table 1:**

- Project initiation and planning
- Funding and service utilization analysis for Wisconsin's MH/SA system
- Data gathering and analysis for other states' MH/SA systems
- Development of options for funding and provision of MH/SA services
- Presentation of study findings and potential models and pathways

Table 1 – Project Work Plan

1. Project Initiation and Planning

- Submit the study design, data sources and analysis methodology (i.e., work plan).
- Appointment of the study Steering Committee by DHS.
- Establish regular project check-in meetings with DHS.
- Selection of five states for comparison: Minnesota, New Mexico, North Carolina, Ohio and Oregon.
- Identify indicators for the four benchmark areas used to assess Wisconsin's and other states' MH/SA service delivery and funding structure:
  - Equitable access to service across the state
  - Accountability for outcomes, including the availability of EBPs and the information technology to evaluate outcomes
  - Equitable and affordable funding for services
  - Efficiency of service delivery

2. Funding and Service Utilization Analysis for Wisconsin's MH/SA System

- Inventory public MH/SA programs and funding sources for children and adults. Review existing program and financial data and reports. In conjunction with DHS, assess the accuracy and consistency of the data (i.e., identify the limitations of each data source):
  - Human Services Reporting System (HSRS)
  - Human Services Revenue Report (HSRR)
  - Medicaid Claims Data (Encounter Data)
- Collect available historical information regarding the funding for and utilization of MH/SA services.
- Conduct trend analysis of major sources of MH/SA funding showing levels and changes in the proportion of funding.
- Identify federal and state policy initiatives impacting the public MH/SA system.
- Document identified concerns and issues with the current service delivery and funding structure based on a review of previous study reports and research, including:
  - Mental Health Funding and Access to Services Briefing Paper developed by the Wisconsin Council on Mental Health (WCMH) in collaboration with the Wisconsin County Human Services Association (WCHSA) in 2008
  - Human Services Visions Report developed by the Wisconsin Counties Association (WCA) and WCHSA in 2005

- Blue Ribbon Commission Report on Mental Health issued in 1997

- Solicit feedback from the study Steering Committee, WCHSA Behavioral Health Policy Advisory Committee, WCA Health and Human Services Committee, and Aging and Disability Resource Center (ADRC) directors regarding MH/SA system issues and concerns.

- Conduct data analysis and interviews with selected county MH/SA systems to gain a deeper understanding of MH/SA service delivery and financing, including a review of unmet service need, use of evidence based practices, use of staff and financial resources, and examples of best practice approaches and cost-effective service delivery.

3. Data Gathering and Analysis for Other States' MH/SA Systems

- Review data of other states' MH/SA service delivery and funding structure, including annual reports and special studies produced by:

  - National Association of State Mental Health Program Directors (NASMHPD) National Research Institute (NRI).
  - Substance Abuse and Mental Health Services Administration (SAMHSA) National Survey of Substance Abuse Treatment Services (N-SSATS) and Treatment Episode Data Set (TEDS).
  - Other national organizations comparing state systems.

- Gather data from the selected states (Minnesota, New Mexico, North Carolina, Ohio and Oregon) in order to:

  - Define their service delivery model, especially the respective roles of counties and the state.
  - Determine the services and/or populations included or excluded in each model.
  - Identify the funding structure and relative proportion of funding by source.
  - Identify recent or pending changes in funding and/or funding structure.

- Conduct phone interviews with state agency officials from the selected states to address specific critical factors and information about their service delivery and funding structure and system reform efforts, including lessons learned from their experience.

- Conduct phone interviews with representatives responsible for system advocacy (e.g., representatives of designated protection and advocacy agency, peer specialist agency and/or state mental health and substance abuse councils) in the selected states. These were conducted to assess the consumer perspective on the relative strengths and challenges of these states' service delivery models, funding structures and reform efforts.

- Based on a suggestion from WCHSA, conduct interviews with representatives of county MH/SA service associations in the selected states that have county involvement in MH/SA system (all except New Mexico).

4. Develop Options for Funding and Provision of MH/SA Services

- Based on the review of the other state systems, identify the models and primary pathways for further development. Consider all models for development, except for a primarily state-administered MH/SA system.
- Define potential models, and identify key considerations, strengths and challenges of each model for Wisconsin.
- Develop a decision-making framework for considering the models.
- Present the potential models and pathways to DHS and the study Steering Committee and incorporate feedback.

5. Present Study Findings and Potential Models and Financing Options

- Present the draft report to DHS and the study Steering Committee and incorporate changes, as appropriate.
- In conjunction with the study Steering Committee, plan for the MH/SA Infrastructure Summit to discuss the future of MH/SA service delivery and funding.
- Distribute the report of study findings and potential models prior to the Summit.
- Present study findings and potential models for delivering and financing MH/SA services, and gather initial stakeholder feedback from Summit participants.
- Finalize the study report with a summary of stakeholder feedback from the Summit, and issue the final report to DHS and the study Steering Committee.

A. Structure, Roles and Responsibilities

Wisconsin has a state-supervised, county-administered MH/SA system. The Division of Mental Health and Substance Abuse Services (DMHSAS) in the Department of Health Services (DHS) is the state mental health authority (SMHA) responsible for allocating state and federal funding for the provision of MH/SA services. It is also responsible for implementing various responsibilities under the State Alcohol, Drug Abuse, Developmental Disabilities and Mental Health Act, more commonly referred to as Chapter 51. The duties that DHS may perform under Chapter 51 and within the limits of available state and federal funds include:

- Promoting coalitions among the state, counties, providers, consumers, families and advocates in order to provide a range of resources to advance prevention, early intervention, treatment, recovery and other positive outcomes.
- Implementing a comprehensive strategy to reduce stigma of persons with MH/SA issues.
- Involving stakeholders as equal partners in service planning and delivery.
- Promoting responsible use of resources in service provision.
- Developing and implementing methods to identify and measure consumer outcomes.
- Promoting access to appropriate MH/SA services regardless of a person's geographic location, age, degree of illness or financial resources.
- Promoting consumer decision-making to enable greater self-sufficiency.
- Promoting use of individualized and collaborative service planning to promote treatment and recovery.

While the state has broad responsibility for MH/SA system planning, management and oversight, it is the state's 72 counties that are statutorily responsible for administering MH/SA services. As such, Wisconsin is one of about a dozen states that relies primarily on counties to administer MH/SA services. Section 51.42(1)(b), Wis. Stats., delineates the statutory responsibility for counties:

> *(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, alcohol 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 match state funds.*

Counties are required to provide services in the least restrictive environment that is appropriate to a person's needs. The statutorily required MH/SA services include:

- Collaborative and cooperative services for prevention.

- Diagnostic and evaluation services.

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

- Related research and staff in-service training, including periodic training on emergency detention and protective placement procedures.

- Continuous planning, development and evaluation of programs and services.

Wisconsin statutes allow counties to meet their MH/SA service requirements through single county systems such as single county boards and departments of community programs or human services. They can also meet the requirements through multi-county systems such as multi-county boards of community programs or human services. Wisconsin has a total of 67 county-based systems for MH/SA services including:

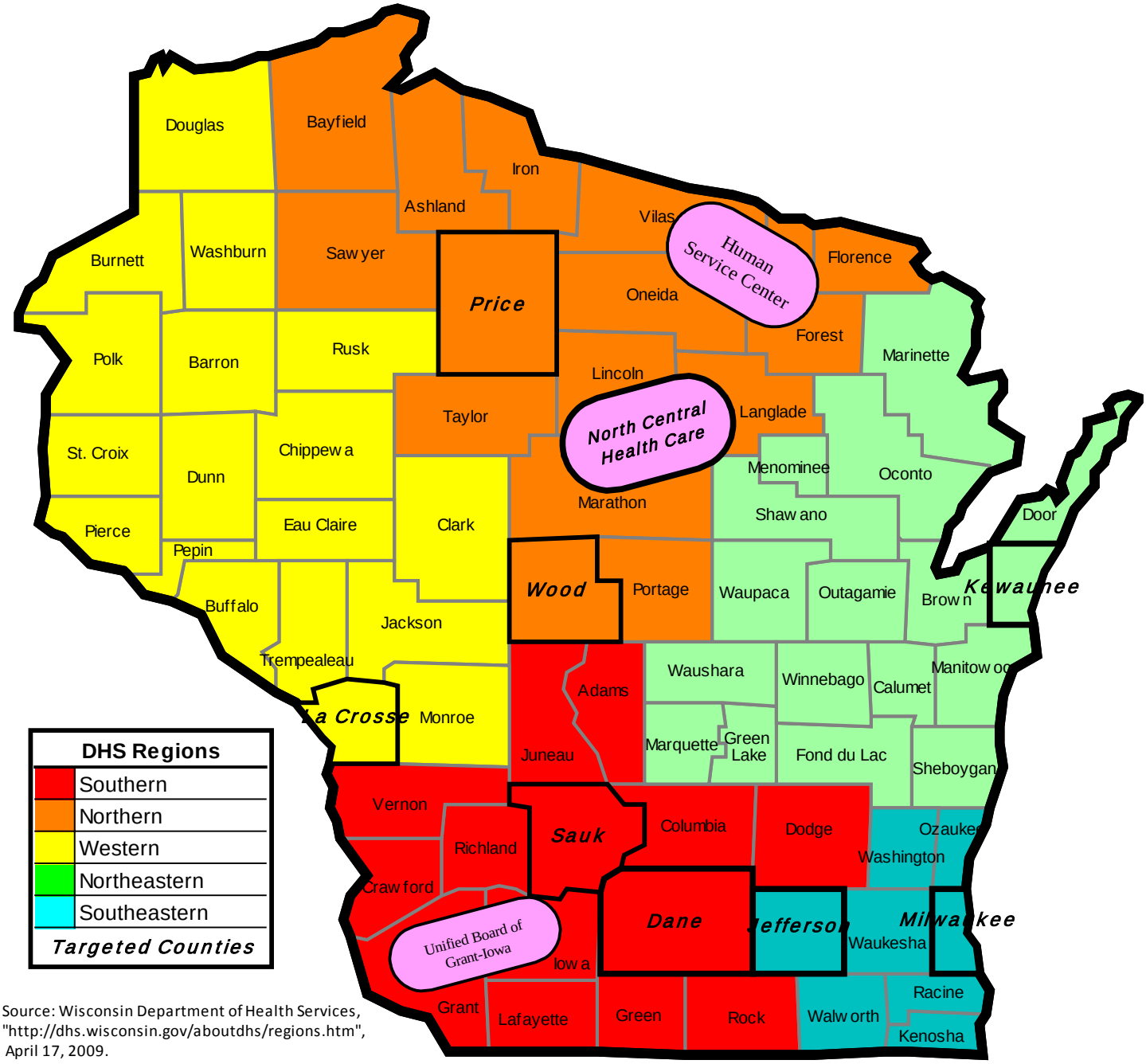
- 64 single county systems

- Three multi-county systems

    - Grant-Iowa Unified Board
    - Human Service Center serving Forest, Vilas and Oneida Counties
    - North Central Health Care serving Langlade, Lincoln and Marathon Counties

The **map** of on the next page shows the counties by DHS region. The names of the counties that participated in the targeted county review are bolded and italicized. Section IV of this report summarizes the information obtained from the targeted county review.

Wisconsin Department of Health Services
Regions by County



Source: Wisconsin Department of Health Services, "http://dhs.wisconsin.gov/aboutdhs/regions.htm", April 17, 2009.

B. Overview of Mental Health and Substance Abuse Funding

Wisconsin's public MH/SA services are funded through five primary sources, including 1) Medical Assistance (MA), 2) federal block grants (community mental health services block grant and substance abuse prevention and treatment block grant), 3) community aids, 4) county funds, and 5) private insurance/individual payments.

Medical Assistance (Medicaid)

Medical Assistance is a joint federal and state program that is administered by states following federal guidelines. States must provide coverage to individuals that meet certain functional and financial eligibility criteria following a standardized set of services defined by federal law. States can also choose to cover additional services including clinic, rehabilitation, and case management services under waivers or amendments to the state Medicaid Plan. Nationally, Medicaid comprises over half of all spending for public mental health system community services[1].

In Wisconsin, virtually all eligible individuals qualifying for Medicaid receive services through the BadgerCare, SSI Managed Care, or Family Care programs. Services funded though these programs are based on a defined set of benefits that are provided for MH/SA services (as discussed later in this report section).

There are also services covered under Medicaid that are focused on individuals with severe, serious, and persistent mental illness, but the funds for these services are matched by counties rather than the state. The federal Medicaid program funds approximately 60 percent of these services, with counties responsible for providing the remaining 40 percent of the cost. Services for which counties provide the nonfederal share include community support program (CSP), crisis intervention, case management, comprehensive community services (CCS) and outpatient services in a home- or community-based setting. CSP services are included in the Family Care benefits package and are funded by counties in those areas that have not yet converted to Family Care. Counties will also be responsible for providing the nonfederal share of community recovery services when the 1915(i) application is approved by the Centers for Medicare and Medicaid Services (CMS).

Federal Block Grants

The federal Department of Health and Human Services, Substance Abuse and Mental Health Services Administration (SAMHSA), allocates the community mental health services block grant (MHBG) to states to fund the provision of comprehensive community mental health services to adults and children with serious mental illness. Wisconsin's MHBG plan lists several priority areas in which Wisconsin should focus its use of funds. A portion of these block grant funds is distributed to counties for direct service provision and to fund some of the community aids allocation. Wisconsin also relies heavily upon the substance abuse prevention and treatment block grant (SAPTBG) to fund substance abuse services. This block grant provides a significant portion of the funding that covers substance abuse services, with the share of county dollars reportedly expanding.

[1] Judge David L. Bazelon Center for Mental Health Law, "The Role of Federal Programs: Medicaid, SCHIP & Medicare".

Community Aids

Section 46.40, Wis. Stats., requires DHS to distribute community aids to support county human services spending for the following:

- Community social services
- Mental health services
- Developmental disabilities services
- Alcohol and other drug abuse services
- Alzheimer's family and caregiver support program
- Family support program
- Community support program

The distribution of community aids is based on the limits of available federal funds and amounts budgeted to support services provided by county departments. Statutes describe funding allocations that include the basic county allocation (BCA) and several categorical allocations. The allocations that most directly impact the MH/SA system include:

- Basic County Allocation: The BCA is allocated to counties to be used at their discretion to fund the services indicated above.

- Prevention and Treatment of Substance Abuse: A portion of the SAPTBG received by Wisconsin is required to be allocated through community aids to counties, which must utilize these funds based on federal guidelines.

- Community Mental Health Services: A portion of the MHBG for Wisconsin is required to be allocated through community aids to counties, which must utilize these funds based on federal guidelines.

There have been a few adjustments to the community aids allocation in recent years. This has included the reallocation of a portion of the funds that counties previously used for long-term care services. These funds now partially fund the capitation payments DHS makes to managed care organizations for individuals enrolled in Family Care. 2007 Wisconsin Act 20 established the county contribution level for Family Care at an amount not exceeding 22 percent of the 2006 BCA. If a county's contribution exceeded 22 percent, the law established a buy-down provision. Under this provision, the expected county contribution is phased-down to 22% over a five year period following the implementation of Family Care.

The other significant adjustment to the community aids allocation was established in 2003 Wisconsin Act 318, which created the Wisconsin Medicaid Cost Reporting (WIMCR) program. This is a complex program that aims to increase the amount of federal funds the state can claim under the Medicaid program by leveraging Medicaid payments to counties for certain eligible services they provide. The state makes Medicaid payments to counties under WIMCR and reduces community aids funding. WIMCR was originally established to sunset at the end of calendar year 2005, but this sunset provision was removed.

County Funds

Overall, counties provide a significant share of funding to support MH/SA programs, while the specific level of local contribution varies from county to county. Nearly all of this funding comes from county property tax levies that are appropriated to fund services provided by county human service, community program and social service departments. While counties are required to meet a "maintenance-of-effort" requirement or match equal to approximately 10 percent of community aids, most counties also provide county funding over and above the required match. This is commonly referred to as "county overmatch." In addition, as indicated previously, counties are responsible for funding the nonfederal share of Medicaid for certain services, which is financed by county funds and/or community aids.

Since 1993, the state has imposed a tax rate limit on the general operations portion of county property tax levies. The county tax rate is limited to an amount that is no more than the prior year's allowable levy, plus an adjustment for the percentage change in equalized value. In essence, the rate limit means that county property tax rates cannot exceed those that were in effect for taxes payable in 1993. If a county exceeds the allowable operating levy rate, shared revenue or other aid payments are reduced by a level that equals the excess levy amount.

Since 2005, counties have also had to operate under a property tax levy limit. The current limit applies to taxes levied through December 2010. The levy limit prohibits counties from increasing the amount raised from property taxes by more than the greater of the percentage change in equalized value due to new construction, less improvements removed, from the prior year's value, or a statutorily set minimum percentage, which is three percent for taxes levied in 2009 and 2010.

Both of the property tax limits described above impact the ability of counties to raise additional funds to support services at the local level, especially in the existing economic environment. Since approximately 22 percent of all human services provided by Wisconsin counties are funded through the property tax levy, these limits have constrained the ability of counties to fund additional human services or even maintain existing services.

Private Insurance/Individual Payments

A smaller portion of funding for services provided within the publicly run MH/SA system is generated from private insurance or individual payments. Several Wisconsin counties have negotiated contracts with private insurance companies to provide MH/SA services through their networks. Counties also provide services to individuals based on an ability to pay.

Key Changes Enacted in the 2009-11 State Budget

There were several key changes enacted as part of the state biennial budget that impact the funding of MH/SA services in the future. These included changes relating to the responsibility for the costs of certain state institute placements, approval for emergency detentions in state institutes, funding for community-based services, the creation of a new Medicaid benefit for community recovery services, and the provision allowing licensed mental health professionals to bill Medicaid and private insurance directly for outpatient services.

- State Mental Health Institute Costs and Related Provisions: Changes enacted as part of the 2009-2011 state budget will require counties to be responsible for the nonfederal share of expenditures associated with inpatient stays for individuals under 21 and over 64 years of age in the state mental health institutes. The payment provision goes into effect on January 1, 2010. Previously, counties were only responsible for covering the costs of individuals between 22 and 64 years of age who are not covered by Medicaid. While the state appropriated $4 million in additional funds over the biennium for community-based services to help counties with this transition, some counties are concerned that the payment provision for mental health institute costs will put additional pressure on county property tax revenues.

  Additionally, the state budget modified statutory provisions to require prior county approval of law enforcement emergency detentions in order to help counties better control the number of individuals who are subject to emergency detentions and admitted to the state mental health institutes or other emergency detention facilities.

- Community Recovery Services: The state budget establishes a new Medicaid benefit for community recovery services, pending federal approval of the 1915(i) state plan amendment. This new Medicaid benefit would fund community-based services to individuals with MH/SA issues. While county participation in the program would be optional, counties that choose to participate would be responsible for paying the nonfederal share of Medicaid.

- Vendorship Provision: The state budget enacted the so-called "vendorship provision" which allows master's level licensed mental health professionals to obtain direct reimbursement from private insurance and Medicaid for outpatient mental health services. Currently, outpatient mental health services provided by master's level licensed mental health professionals must be billed through a DHS certified clinic. This provision gives master's level mental health professionals the choice to provide outpatient services through a certified or non-certified clinic, or to practice independently and bill insurance and Medicaid directly. Some professional organizations and licensed professionals anticipate that this provision may help maintain or increase the pool of Medicaid outpatient providers and, therefore, may improve access to outpatient services in the publicly funded system.

Summary of County Human Services Funding by Target Population

Since 2005, county human service, community program and social service departments, as well as offices on aging, have reported financial information to the state via the Human Services Revenue Report (HSRR). This report includes a breakdown of county spending by target population and major revenue categories. **Table 1** provides a summary of the 2006 and 2007 information submitted by county agencies. The 2005 report was not used for this study because of questions about the accuracy of the information submitted in the initial year of the report.

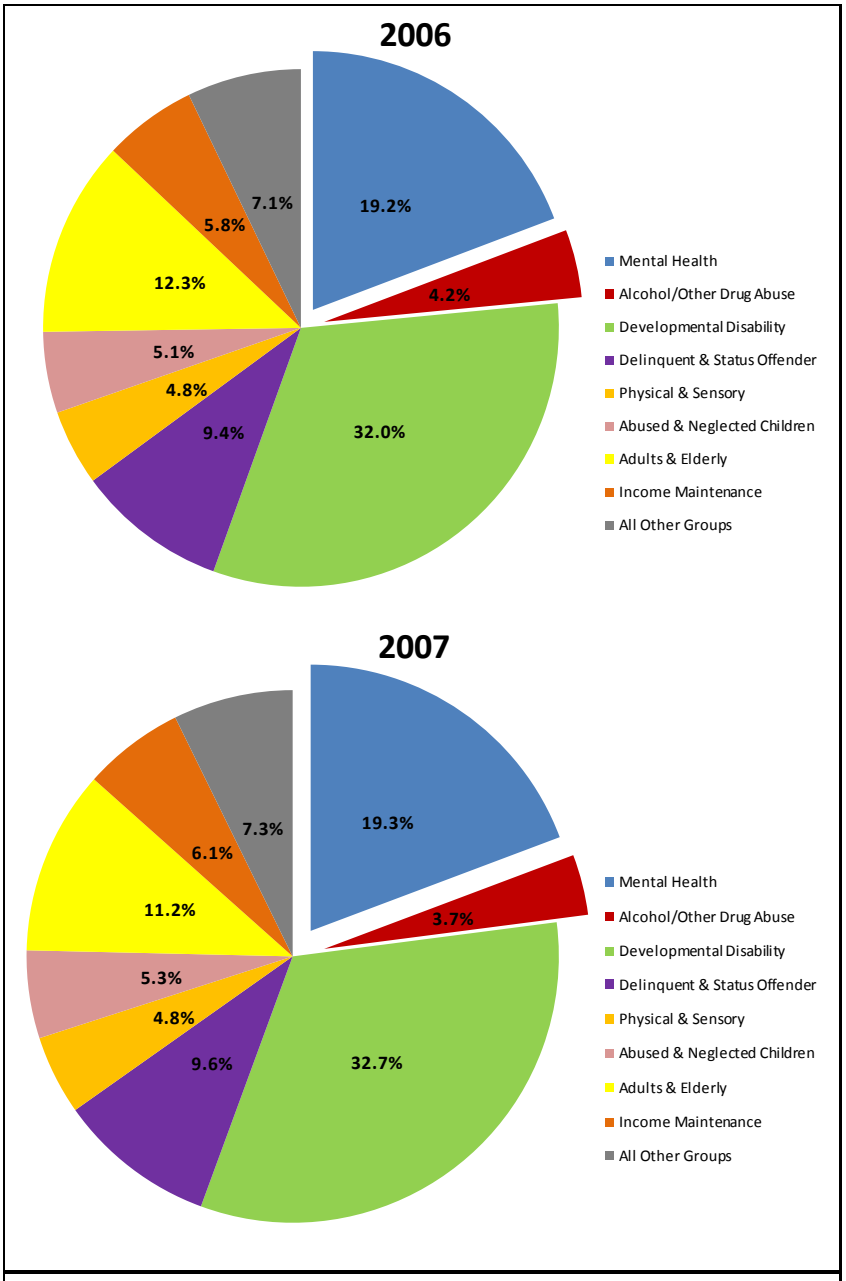
Table 1 on the next page shows that total spending reported by counties was approximately $2 billion in both 2006 and 2007, with a 3.1 percent increase in total between the two years. Spending funded by county revenue (e.g., property tax levy) made up approximately 22 percent of the total in each of the two years, increasing from $435.2 million in 2006 to $449.1 million in 2007, a 3.2 percent increase.

Table 1 – Summary of Total County Human Services Expenditures by Revenue Source (2006 and 2007)

2006	County Revenue		BCA		Other State/Federal		MA FFS		WIMCR		Other		TOTAL	
	$	%	$	%	$	%	$	%	$	%	$	%	$	%
Developmental Disability	$70,336,446	16.2%	$53,536,198	23.3%	$422,833,792	45.1%	$41,795,235	30.4%	$8,119,005	33.4%	$38,557,393	17.7%	$635,178,069	32.0%
Mental Health	124,886,810	28.7%	$77,761,195	33.8%	$45,202,162	4.8%	55,170,082	40.2%	11,713,443	48.1%	66,648,984	30.6%	381,382,676	19.2%
Alcohol/Other Drug Abuse	18,587,151	4.3%	$14,222,533	6.2%	$34,462,412	3.7%	643,511	0.5%	635,202	2.6%	15,502,921	7.1%	84,053,730	4.2%
Physical & Sensory Disability	7,027,073	1.6%	$4,482,596	1.9%	$65,527,862	7.0%	12,846,095	9.4%	662,271	2.7%	3,769,111	1.7%	94,315,009	4.8%
Delinquent & Status Offender	74,831,115	17.2%	$23,529,167	10.2%	$72,643,134	7.7%	947,410	0.7%	287,656	1.2%	14,598,146	6.7%	186,836,628	9.4%
Abused & Neglected Children	51,457,651	11.8%	$30,045,413	13.1%	$13,045,063	1.4%	489,166	0.4%	392,545	1.6%	5,350,637	2.5%	100,780,475	5.1%
Children & Families	26,596,479	6.1%	$13,562,356	5.9%	$18,621,831	2.0%	527,246	0.4%	491,807	2.0%	4,517,630	2.1%	64,317,349	3.2%
Adults & Elderly	29,209,257	6.7%	$11,304,174	4.9%	$162,731,974	17.3%	9,938,933	7.2%	2,028,230	8.3%	28,203,604	12.9%	243,416,171	12.3%
Income Maintenance	18,214,912	4.2%	$1,433,691	0.6%	$76,130,795	8.1%	14,980,529	10.9%	1	0.0%	4,649,100	2.1%	115,409,028	5.8%
Child Care Administration	(52,669)	0.0%	$0	0.0%	$15,009,920	1.6%	0	0.0%	0	0.0%	251,670	0.1%	15,208,921	0.8%
Energy Assistance	256,466	0.1%	$18,523	0.0%	$10,384,333	1.1%	0	0.0%	0	0.0%	96,678	0.0%	10,756,000	0.5%
General Relief/Interim Assistance	13,800,381	3.2%	$19,339	0.0%	$1,851,980	0.2%	0	0.0%	0	0.0%	35,697,795	16.4%	51,369,496	2.6%
TOTAL	**$435,151,073**	100.0%	**$229,915,186**	100.0%	**$938,445,257**	100.0%	**$137,338,207**	100.0%	**$24,330,158**	100.0%	**$217,843,670**	100.0%	**$1,983,023,552**	100.0%
% of Total	**21.9%**		**11.6%**		**47.3%**		**6.9%**		**1.2%**		**11.0%**		**100.0%**	
2007	**County Revenue**		**BCA**		**Other State/Federal**		**MA FFS**		**WIMCR**		**Other**		**TOTAL**	
	$	%	$	%	$	%	$	%	$	%	$	%	$	%
Developmental Disability	$74,471,875	16.6%	$58,608,498	25.0%	$437,759,684	45.4%	$44,022,600	30.1%	$11,198,472	41.2%	$41,323,244	18.5%	$667,384,372	32.7%
Mental Health	$126,567,599	28.2%	$78,454,246	33.5%	$60,611,409	6.3%	$60,273,524	41.2%	$10,861,404	40.0%	$57,050,222	25.6%	393,818,404	19.3%
Alcohol/Other Drug Abuse	$15,358,203	3.4%	$12,694,678	5.4%	$28,459,502	3.0%	$547,489	0.4%	$1,596,893	5.9%	$16,525,979	7.4%	75,182,743	3.7%
Physical & Sensory Disability	$7,868,862	1.8%	$4,695,576	2.0%	$69,210,817	7.2%	$12,501,747	8.5%	$1,178,108	4.3%	$3,016,748	1.4%	98,471,857	4.8%
Delinquent & Status Offender	$82,634,050	18.4%	$24,733,231	10.6%	$73,138,502	7.6%	$877,917	0.6%	$62,713	0.2%	$15,001,502	6.7%	196,447,915	9.6%
Abused & Neglected Children	$57,303,527	12.8%	$30,756,405	13.1%	$13,195,646	1.4%	$616,703	0.4%	$118,759	0.4%	$6,967,454	3.1%	108,958,495	5.3%
Children & Families	$25,871,318	5.8%	$12,901,451	5.5%	$19,669,179	2.0%	$457,333	0.3%	$491,197	1.8%	$3,815,532	1.7%	63,206,010	3.1%
Adults & Elderly	$27,018,073	6.0%	$8,921,476	3.8%	$154,940,912	16.1%	$11,709,528	8.0%	$1,665,826	6.1%	$25,037,938	11.2%	229,293,753	11.2%
Income Maintenance	$17,815,913	4.0%	$2,295,949	1.0%	$79,519,586	8.2%	$15,250,642	10.4%	$0	0.0%	$10,668,085	4.8%	125,550,175	6.1%
Child Care Administration	$186,590	0.0%	$0	0.0%	$14,169,801	1.5%	$0	0.0%	$0	0.0%	$171,272	0.1%	14,527,663	0.7%
Energy Assistance	$245,921	0.1%	$2,744	0.0%	$10,026,597	1.0%	$0	0.0%	$0	0.0%	$57,120	0.0%	10,332,382	0.5%
General Relief/Interim Assistance	$13,720,392	3.1%	$9,788	0.0%	$3,323,972	0.3%	$0	0.0%	$0	0.0%	$43,508,549	19.5%	60,562,701	3.0%
TOTAL	**$449,062,322**	100.0%	**$234,074,041**	100.0%	**$964,025,609**	100.0%	**$146,257,483**	100.0%	**$27,173,373**	100.0%	**$223,143,644**	100.0%	**$2,043,736,471**	100.0%
% of Total	**22.0%**		**11.5%**		**47.2%**		**7.2%**		**1.3%**		**10.9%**		**100.0%**	

Source: Department of Health Services, "Human Service Revenue Report", 2006 and 2007.

Table 2 – Percentage of Total County Human Services Revenues by Target Group (2006 and 2007)



Source: Department of Health Services, "Human Service Revenue Report", 2006 and 2007.

Table 2 provides a graphical summary of total human services spending by county agencies. As the information shows:

- MH/SA services combined represent 23 percent of total county expenditures for all human services programs, increasing 0.8 percent between these two years.
    - County mental health expenditures represent 19 percent of total human services expenditures, increasing 3.3 percent between 2006 and 2007.

- County substance abuse expenditures represent 4 percent of total human services expenditures, decreasing 10.6 percent between 2006 and 2007.

While county spending on developmental disabilities programs represents nearly one-third of total county expenditures for human services programs in each of these years, the information does not yet reflect the ongoing transition to Family Care on a statewide basis. As this transition continues, the funds devoted to developmental disabilities programs will become a smaller portion of the total, as MH/SA services become a larger portion of the total.

Table 3 provides a summary of the percentage of funding by revenue type and target population. Other state and federal revenue sources represented approximately 47 percent of total funding in 2006 and 2007. The largest amount of revenue in this category is from the waiver programs for long-term care services as well as other categorical state and federal revenue that funds income maintenance programs and child care administration. Other key highlights include:

- Revenue from county property taxes funded approximately 22 percent of all human services programs administered by county agencies in 2006 and 2007.
- The total county property tax allocated to fund MH/SA services represented more than 30 percent of all revenue for those programs.
- Basic County Allocation represented another nearly 20 percent of total revenue allocated by counties to fund MH/SA services.

Table 3 – Percentage of County Human Services Expenditures by Revenue Type and Target Group (2006 and 2007)

2006	County Revenue	BCA	Other State/Federal	MA FFS	WIMCR	Other	TOTAL
Developmental Disability	11.1%	8.4%	66.6%	6.6%	1.3%	6.1%	100.0%
Mental Health	32.7%	20.4%	11.9%	14.5%	3.1%	17.5%	100.0%
Substance Abuse	22.1%	16.9%	41.0%	0.8%	0.8%	18.4%	100.0%
Mental Health/Substance Abuse	30.8%	19.8%	17.1%	12.0%	2.7%	17.7%	100.0%
Physical & Sensory Disability	7.5%	4.8%	69.5%	13.6%	0.7%	4.0%	100.0%
Delinquent & Status Offender	40.1%	12.6%	38.9%	0.5%	0.2%	7.8%	100.0%
Abused & Neglected Children	51.1%	29.8%	12.9%	0.5%	0.4%	5.3%	100.0%
Children & Families	41.4%	21.1%	29.0%	0.8%	0.8%	7.0%	100.0%
Adults & Elderly	12.0%	4.6%	66.9%	4.1%	0.8%	11.6%	100.0%
Income Maintenace	15.8%	1.2%	66.0%	13.0%	0.0%	4.0%	100.0%
Child Care Administration	-0.3%	0.0%	98.7%	0.0%	0.0%	1.7%	100.0%
Energy Assistance	2.4%	0.2%	96.5%	0.0%	0.0%	0.9%	100.0%
General Relief/Interim Assistance	26.9%	0.0%	3.6%	0.0%	0.0%	69.5%	100.0%
TOTAL	**21.9%**	**11.6%**	**47.3%**	**6.9%**	**1.2%**	**11.0%**	**100.0%**

2007	County Revenue	BCA	Other State/Federal	MA FFS	WIMCR	Other	TOTAL
Developmental Disability	11.2%	8.8%	65.6%	6.6%	1.7%	6.2%	100.0%
Mental Health	32.1%	19.9%	15.4%	15.3%	2.8%	14.5%	100.0%
Substance Abuse	20.4%	16.9%	37.9%	0.7%	2.1%	22.0%	100.0%
Mental Health/Substance Abuse	30.3%	19.4%	19.0%	13.0%	2.7%	15.7%	100.0%
Physical & Sensory Disability	8.0%	4.8%	70.3%	12.7%	1.2%	3.1%	100.0%
Delinquent & Status Offender	42.1%	12.6%	37.2%	0.4%	0.0%	7.6%	100.0%
Abused & Neglected Children	52.6%	28.2%	12.1%	0.6%	0.1%	6.4%	100.0%
Children & Families	40.9%	20.4%	31.1%	0.7%	0.8%	6.0%	100.0%
Adults & Elderly	11.8%	3.9%	67.6%	5.1%	0.7%	10.9%	100.0%
Income Maintenace	14.2%	1.8%	63.3%	12.1%	0.0%	8.5%	100.0%
Child Care Administration	1.3%	0.0%	97.5%	0.0%	0.0%	1.2%	100.0%
Energy Assistance	2.4%	0.0%	97.0%	0.0%	0.0%	0.6%	100.0%
General Relief/Interim Assistance	22.7%	0.0%	5.5%	0.0%	0.0%	71.8%	100.0%
TOTAL	**22.0%**	**11.5%**	**47.2%**	**7.2%**	**1.3%**	**10.9%**	**100.0%**

Source: Department of Health Services, "Human Service Revenue Report", 2006 and 2007.

As previously discussed, counties have wide latitude in allocating property tax and BCA revenues to support the human services programs provided at the local level. While some target populations other than MH/SA had a higher percentage of funding provided by property tax levy and BCA in 2006 and 2007, the total dollar amount devoted to programs for these other target populations is significantly lower by comparison to MH/SA. In 2006 and 2007, counties allocated over $200 million in combined property tax levy and BCA to fund MH/SA programs. This represented 30 percent of the total from these two funding sources for all human services programs. The next largest percentage was funding for developmental disabilities services at 19 percent.

Summary of Mental Health and Substance Abuse Funding by Program

While the next section of this report, **Section IV. Targeted County Review**, discusses funding of MH/SA services in more detail, **Table 4** below provides a summary of the total expenditures by program source for the publicly funded system between 2005 and 2007. During this three year period, total expenditures for the publicly funded MH/SA services system grew from $577.6 million to $642.3 million, an increase of 11.2 percent. Other key highlights for the publicly funded MH/SA service system include:

- Mental health services provided by all publicly funded programs represented approximately 84 percent of total MH/SA expenditures and increased 12.3 percent between 2005 and 2007.
    - County system expenditures for mental health services decreased from 75.8 percent of total mental health expenditures in 2005 to 72.1 percent in 2007, but increased 6.8 percent in total.
    - Fee-for-service system expenditures for mental health services increased from 13.5 percent of total mental health expenditures in 2005 to 15.5 percent, growing 28.7 percent.
    - Managed care system expenditures for mental health services (e.g., BadgerCare, SSI Managed Care and Family Care) increased from 10.7 percent of total mental health expenditures to 12.4 percent in 2007, growing 29.8 percent.
- Substance abuse services provided by all publicly funded programs represented approximately 16 percent of total MH/SA expenditures and increased 5.6 percent between 2005 and 2007.
    - County system expenditures for substance abuse services decreased from 86 percent of total substance abuse expenditures in 2005 to 78.1 percent in 2007, and dropped 4.2 percent in total.
    - Fee-for-service system expenditures for substance abuse services increased from 9.9 percent of total substance abuse expenditures in 2005 to 17.3 percent, growing 84 percent.
    - Managed care system expenditures for substance abuse services (e.g., BadgerCare, SSI Managed Care and Family Care) increased from 4.1 percent of total substance abuse expenditures to 4.6 percent in 2007, growing 19.9 percent.

Table 4 – Summary of Total MH/SA Services by Program Source (2005- 2007)

	2005		2006		2007	
Mental Health Services	**Expenditures**	**% of Total**	**Expenditures**	**% of Total**	**Expenditures**	**% of Total**
County System	$ 368,619,911	75.8%	$ 381,382,675	71.4%	$ 393,818,405	72.1%
Fee-for-Service System	65,661,989	13.5%	87,120,077	16.3%	84,519,442	15.5%
Managed Care System[1]	52,179,307	10.7%	65,332,983	12.2%	67,735,700	12.4%
Total	$ 486,461,206	100.0%	$ 533,835,735	100.0%	$ 546,073,547	100.0%
Substance Abuse Services						
County System	$ 78,438,195	86.0%	$ 84,053,730	81.4%	$ 75,182,744	78.1%
Fee-for-Service System	9,028,989	9.9%	14,543,985	14.1%	16,613,820	17.3%
Managed Care System[1]	3,693,541	4.1%	4,607,361	4.5%	4,427,473	4.6%
Total	$ 91,160,725	100.0%	$ 103,205,076	100.0%	$ 96,224,037	100.0%
Total MH/SA Services						
County System	$ 447,058,106	77.4%	$ 465,436,405	73.1%	$ 469,001,149	73.0%
Fee-for-Service System	74,690,978	12.9%	101,664,062	16.0%	101,133,262	15.7%
Managed Care System[1]	55,872,847	9.7%	69,940,343	11.0%	72,163,173	11.2%
Total	$ 577,621,931	100.0%	$ 637,040,811	100.0%	$ 642,297,584	100.0%

Notes:

1 Managed Care System includes BadgerCare, SSI-Managed Care, and Family Care.

Sources:

Wisconsin Department of Health Services Medicaid claims, managed care encounter, and family care encounter data sets.

Wisconsin Department of Health Services Human Services Revenue Report (2006 and 2007).

Wisconsin Department of Health Services Human Services Reporting System 942 Report (2005).

C. Benchmark Goals and Data

The previous subsection of this report provides a summary of total expenditures by funding source in 2005, 2006, and 2007. This subsection addresses both funding and consumers served, utilizing data generated by DHS. The information in this subsection was collected from the following sources:

- Medicaid Claims data, which indicates the number of consumers served and total expenditures for MH/SA services funded through the fee-for-service system.
- Managed Care Encounter data, which indicates the number of consumers served and total expenditures for MH/SA services funded through the BadgerCare and SSI Managed Care programs.
- Family Care Encounter data, which indicates the number of consumers served and total expenditures for MH/SA services funded through the Family Care program.
- Human Services Reporting System (HSRS) data, which indicates the number of consumers receiving MH/SA services funded through county human service, community program and social service departments.

- Human Services Revenue Report (HSRR) data, which indicates the total gross expenditures by revenue source for all human service programs reported for each of the target populations served through county human service, community program and social service departments.

Limitations of the Data

The project consultants also reviewed data from the Program for All Inclusive Care for the Elderly (PACE) and Partnership program, but that data is not included in the analysis for the following reasons. First, the PACE/Partnership data is not integrated with other data collection or reporting systems which makes it difficult to include the data in any overall analysis. Second, the MH/SA services provided by the PACE/Partnership programs are a relatively small percentage of the public MH/SA service delivery system.

Intent of the Data

The intent of the service and funding data presented in this report is to provide some perspective on the overall utilization and costs related to the provision of MH/SA services to populations in Wisconsin's publicly funded systems. The data is aggregated at a statewide level and at the regional level based on the five DHS regions (see previous map in this section). The study Steering Committee determined that presenting the data at a regional level is a better method for displaying data, because it helps alleviate concerns that the information may portray individual counties in a positive or negative light. The presentation of the data by region also helps distribute larger year to year county variances over a broader base.

It is important to note the following cautions regarding the information presented in this section:

- The intent of this data is not to make comparisons between DHS regions or make assumptions on how the unique and varied features of individual counties within DHS regions may be impacting the information. There is significant variation among counties regarding who is served, priority populations, the range of service providers and service capacity, and the extent to which other options (e.g., managed care programs) are available.

- Differences in service priorities, population characteristics, and availability of other program options can also impact funding. As noted previously in this section, county boards have responsibility to serve individuals with MH/SA issues within the limits of available state and federal funds, and required county matching funds. Beyond that, county boards have wide latitude to make funding and service delivery decisions that are based on local factors and preferences.

- The information on funding can be used to see how different areas of the state have made allocation decisions. However, higher or lower expenditures among the different regions may not indicate more or less effective service delivery. Therefore, the data should not be used to make positive or negative correlations between the regions. The data may demonstrate that some DHS regions or counties within those regions serve fewer consumers, but may provide more intensive services, while other areas may provide less intensive services to a broader range of individuals. The data should not be used to draw conclusions about the appropriateness or efficacy of different service or funding levels, especially since the data is aggregated on a broader regional basis.

Data Accuracy

Beyond the limitations and intent of the data described above, it is also important to note that the accuracy of the data that DHS was able to provide for analysis, especially the HSRS data for county reported services, was questioned by nearly all of the nine targeted county MH/SA systems selected for review in this study.

Counties reported the following primary issues that impact the integrity of the data:

- Some county data systems are antiquated and the ability to collect and report information becomes challenging.

- Some counties have experienced staff turnover and other staffing issues that impact the accuracy and consistency of the data entered and reported to the state.

- The reporting of MH/SA services through HSRS has not historically been used to document activities for funding and reimbursement purposes (as it has for the long-term care waiver programs). Therefore, the emphasis that some counties place on submitting complete and accurate MH/SA data varies widely and seems to have a significant impact on the quality of the data.

At the state level, the systems established to collect the data have been in existence for some time, but resources have not been assigned to ensure consistent statewide reporting and utilization of the information for decision-making. Lastly, neither the counties nor the state appear to have sufficient quality review built into the data collection process and systems in order to ensure that the integrity of the data is maintained from year-to-year. Both the counties and the state lack standards and training for data entry and quality control.

Any steps to implement system reform should also address the critical need to upgrade systems at the state and local levels to ensure that key measures of data are collected and used for decision-making. Basic utilization and cost data, especially performance outcome data, should be available. Only with robust data systems will state and local MH/SA system policymakers, managers and consumers have the data necessary to effectively inform future system improvements and reform initiatives and gauge the effectiveness of those efforts.

Summary of Consumers Served

The compiled information that integrated the HSRS, Medicaid fee-for-service, and encounter data provides a picture of the individuals served by the publicly funded MH/SA system. Over the three years analyzed for this study (2005, 2006 and 2007), a total of 352,850 unique individuals received publicly funded MH/SA services.

Table 5 provides a summary of the number of unduplicated individuals served within each of the publicly funded program areas over the three year period. Since consumers can receive services from more than one system, the total number of individuals among all of the program areas represents a larger number than the actual number of people served. The most likely combination of systems would include individuals who are Medicaid eligible and receive some of their MH/SA services through their Medicaid card, but were also served by at least one of the other systems (e.g., managed care or county). Likewise, consumers can receive both mental health and substance abuse services; therefore the client

counts in **Table 5** represent unduplicated numbers within each system, but are likely duplicated across the various systems and between MH/SA.

Table 5 – Summary of Total MH/SA Consumers Serviced by Program Source (2005-2007)

	2005		2006		2007	
Mental Health Services	**Clients**	**% of Total**	**Clients**	**% of Total**	**Clients**	**% of Total**
County System	60,244	34.6%	58,675	32.7%	59,912	32.9%
Fee-for-Service System	73,145	42.1%	76,741	42.8%	76,451	42.0%
Managed Care System[1]	40,534	23.3%	43,968	24.5%	45,715	25.1%
Total Unduplicated	139,194		143,640		145,953	
Substance Abuse Services						
County System	48,705	83.9%	48,911	74.9%	47,225	72.8%
Fee-for-Service System	7,373	12.7%	14,332	21.9%	15,665	24.1%
Managed Care System[1]	1,975	3.4%	2,074	3.2%	1,988	3.1%
Total Unduplicated	55,261		62,013		61,409	
Total MH/SA Services						
County System	102,484	46.5%	100,815	43.8%	100,318	43.2%
Fee-for-Service System	76,797	34.8%	84,894	36.9%	85,369	36.8%
Managed Care System[1]	41,200	18.7%	44,591	19.4%	46,348	20.0%
Total Unduplicated	182,208		190,392		191,660	

Notes:

1 Managed Care System includes BadgerCare, SSI-Managed Care, and Family Care.

2 Totals will not sum across or down because while clients are unduplicated within each target group (e.g., Mental Health or Substance Abuse) and age group, an individual may be counted in more than one of each if they received services for both mental health and substance abuse and their age changed during the year.

Source: Wisconsin Department of Health Services Medicaid claims, managed care encounter, family care encounter, and Human Services Reporting System data sets.

The total number of unduplicated consumers served by the combined MH/SA system increased 5.2 percent between 2005 and 2007, from 182,208 to 191,660. During this same period, though, unduplicated consumers in the county system decreased from 102,484 to 100,318, a 2.1 percent drop between 2005 and 2007. At the same time, both the Medicaid fee-for-service and managed care funded service delivery systems served between 11 and 12 percent more consumers between 2005 and 2007.

Other key highlights regarding consumers served between 2005 and 2007 include:

- The county system served the highest percentage of consumers for MH/SA services combined, an average of 44.5 percent over the three year period.

- The managed care system served an increasingly larger percentage of total consumers, increasing to 20 percent of the total served by 2007.

- The total number of mental health consumers served by all systems increased 4.9 percent between 2005 and 2007, with the largest increase coming from managed care (where the percentage of consumers served exceeded 25 percent in 2007).
    - The fee-for-service system funded the largest percentage of consumers for mental health services, averaging approximately 42 percent of the total receiving mental health services between 2005 and 2007.
    - The county system had a decrease of 0.6 percent in the number of mental health consumers served between 2005 and 2006, and represented approximately one-third of all consumers served for mental health services.

- A significant majority of substance abuse services were provided through the county MH/SA system.
    - There was a significant increase in the percentage of consumers served through the fee-for-service system between 2005 and 2007. The percentage increased from approximately 12 percent to nearly one-quarter of all consumers receiving substance abuse services.
    - The managed care system consistently served approximately 3 percent of the total consumers receiving substance abuse services.

Table 6 provides a summary of MH/SA consumers by age group served between 2005 and 2007. The table also provides an indication of the number of individuals who received both substance abuse and mental health services during each year. While the percentage of "dual clients" appears to be below the number commonly estimated by most professionals in the field, this could be a factor of how counties reported the data as noted above.

Table 6 – Summary of MH/SA Consumers Served by Age Group (2005-2007)

	2005				2006				2007			
	Under 18	18-64	65 and Over	Total	Under 18	18-64	65 and Over	Total	Under 18	18-64	65 and Over	Total
Mental Health	39,131	94,274	8,661	139,194	40,341	97,821	8,445	143,640	40,883	100,169	7,949	145,953
Substance Abuse	2,618	52,076	787	55,261	3,191	58,281	811	62,013	3,088	57,840	789	61,409
Total	40,779	135,258	9,322	182,208	42,215	142,346	9,119	190,392	42,711	143,780	8,591	191,660
Dual Clients	970	11,092	126	12,247	1,317	13,756	137	15,261	1,260	14,229	147	15,702

Notes:

1. Totals will not sum across or down because while clients are unduplicated within each target group (e.g., Mental Health or Substance Abuse) and age group, an individual may be counted in more than one of each if they received services for both mental health and substance abuse and their age changed during the year.

Source: Wisconsin Department of Health Services Medicaid claims, managed care encounter, family care encounter, and Human Services Reporting System data sets.

- Approximately 73 percent of all consumers served were between the ages of 18 and 64. This group represents approximately 60 percent of Wisconsin's total population.

- Approximately 70 percent of all consumers received mental health services.
    - Approximately two-thirds of consumers in the 18 to 64 age group received mental health services.

- Over 90 percent of consumers in both the under 18 and 65 and older age groups received mental health services.

- Between 7 percent and 8 percent of all consumers received both mental health and substance abuse services.

At a regional level, **Table 7** provides a summary of the number of unduplicated consumers per 1,000 of the total population. This data differs from the penetration rate data for Wisconsin in **Section V. Review of Selected States** of this report, because the latter only includes data for mental health funding controlled by the state mental health agency (SMHA). The data in **Table 7** includes consumers served by all of the publicly funded systems included in this study, not just those receiving services through the county MH/SA system or controlled by the SMHA. Because of the variation in the total population among the five DHS regions, standardizing the data based on the number of consumers per 1,000 of the total population provides a better base from which to gauge the volume of services provided. However, based strictly on the number of consumers served, the following picture develops:

- Three of the five DHS regions served a similar number of consumers as a percentage of the statewide total as the region's percentage of Wisconsin's total population:

  - The southeastern region served an average of 33 percent of all MH/SA consumers over the three years, and this region represents 37 percent of Wisconsin's population.
  - The northern region served an average of 12 percent of all MH/SA consumers over the three years, and represents 9 percent of Wisconsin's population.
  - An average of 4 percent of consumers received MH/SA services in more than one region.

Table 7 – Unduplicated Consumers[1] Served by DHS Region per 1,000 Population (2005-2007)

	2005			2006			2007		
DHS Region	Mental Health	Substance Abuse	Total	Mental Health	Substance Abuse	Total	Mental Health	Substance Abuse	Total
Northeastern	22.25	11.05	31.40	27.30	12.77	37.40	27.79	12.31	37.16
Northern	31.97	13.96	42.93	38.71	16.61	51.13	38.12	17.13	50.88
Southeastern	26.34	7.29	31.45	26.02	8.18	31.74	25.07	7.83	30.51
Southern	22.09	12.76	32.81	23.48	13.94	34.81	23.91	13.67	34.88
Western	25.01	9.69	32.49	25.81	10.47	33.39	25.02	10.42	32.76
Wisconsin	25.12	9.97	32.89	25.78	11.13	34.17	26.06	10.96	34.21

Notes:

1 Clients counts are unduplicated only within the individual target group (Mental Health or Substance Abuse) for each region. Clients may be served in both target groups and in more than one region.

Sources:

Unduplicated Clients: Wisconsin Department of Health Services Medicaid claims, managed care encounter, family care encounter, and Human Services Reporting System data sets.

Population: Table 1: Annual Estimates of the Population for Counties of Wisconsin: April 1, 2000 to July 1, 2007 (CO-EST2007-01-55), Population Division, U.S. Census Bureau Release Date: March 20, 2008

- The per capita rate of consumers served for both mental health and substance abuse services ranged from an average high of approximately 48 (northern region) to a low of 31 (southeastern) per 1,000 of the total population over the three year period.

  - The per capita rate of consumers served for mental health services ranged from an average high of 36 (northern) to a low of 23 (southern).
  - The per capita rate of consumers served for substance abuse services ranged from an average high of 16 (northern) to a low of 10 (western).

- The northern region consistently served consumers at a significantly higher rate per capita than the statewide rate or other regions for both mental health and substance abuse services in each of the three years.

- The southeastern region consistently served consumers at a significantly lower rate per capita than the statewide rate or other regions for substance abuse services in each of the three years, averaging 27 percent below the statewide rate.

- The southern region consistently served consumers at a lower rate per capita than the statewide rate or other regions for mental health services in each of the three years, averaging 10 percent below the statewide rate.

Table 8 provides a breakdown of the consumers receiving mental health by service type. The data is divided into "HSRS Clients," which represents the total number of individuals served as reported by counties through the HSRS reporting system, and "Total Clients," which includes all of the consumers served through all publicly funded systems included in this study. The data is presented by DHS region, with a summary of the statewide totals shown at the bottom of the table.

Key highlights of the information on the following table include:

- Total duplicated consumers (i.e., those receiving more than one service type) receiving mental health services from all publicly funded programs increased 5.3 percent from 2005 to 2007.

  - The northeastern region has the largest percentage increase in duplicated consumers receiving publicly funded mental health services at 24.5 percent, followed by the northern region at 16.9 percent and the southern region at 13.2 percent.
  - The southeastern region had a decrease of 5.4 percent in the number of duplicated consumers receiving publicly funded mental health services.

- Outpatient services represented the largest percentage of mental health services to duplicated consumers from all publicly funded programs at 64 percent statewide.

  - The percentage of outpatient services for all publicly funded mental health programs ranged from a high of 68.2 percent (western region) to a low of 61.2 percent (southern region).

- Inpatient services represented 10 percent of mental health services to duplicated consumers from all publicly funded programs.

  - The percentage of inpatient services for all publicly funded mental health programs ranged from a high of 14.5 percent (southeastern region) to a low of 5.6 percent (southern region).

Table 8 – Summary of Consumers Served by Mental Health Service Type by DHS Region (2005-2007)

		2005				2006				2007			
DHS Region	Service Type	HSRS Clients[2]	%	Total Clients[3]	%	HSRS Clients[2]	%	Total Clients[3]	%	HSRS Clients[2]	%	Total Clients[3]	%
Northeastern	Case Management	2,158	12.1%	2,768	7.8%	2,102	12.1%	3,080	7.1%	2,127	11.8%	2,953	6.7%
	Child/Adolescent Day Treatment	0	0.0%	281	0.8%	0	0.0%	554	1.3%	0	0.0%	539	1.2%
	Clozapine Management	0	0.0%	276	0.8%	0	0.0%	319	0.7%	0	0.0%	272	0.6%
	Community Support Program	959	5.4%	1,108	3.1%	958	5.5%	1,637	3.8%	936	5.2%	1,549	3.5%
	Comprehensive Community Services	103	0.6%	118	0.3%	162	0.9%	342	0.8%	287	1.6%	457	1.0%
	Crisis Intervention	1,784	10.0%	3,474	9.7%	1,660	9.6%	3,685	8.5%	1,846	10.2%	4,044	9.1%
	In-home Intensive Psychotherapy	0	0.0%	372	1.0%	0	0.0%	431	1.0%	0	0.0%	430	1.0%
	Inpatient	2,108	11.8%	2,664	7.5%	1,870	10.8%	3,250	7.5%	2,224	12.3%	3,543	8.0%
	Medical Day Treatment	42	0.2%	159	0.4%	36	0.2%	137	0.3%	36	0.2%	122	0.3%
	Outpatient	9,400	52.5%	23,063	64.7%	9,300	53.7%	28,835	66.3%	9,417	52.1%	29,273	66.0%
	Outpatient Services in the Home & Community	138	0.8%	145	0.4%	100	0.6%	105	0.2%	94	0.5%	96	0.2%
	Other	1,211	6.8%	1,211	3.4%	1,135	6.6%	1,135	2.6%	1,094	6.1%	1,094	2.5%
	Northeastern Region Total	17,903	100.0%	35,639	100.0%	17,323	100.0%	43,510	100.0%	18,061	100.0%	44,372	100.0%
Northern	Case Management	2,478	19.2%	2,658	12.3%	2,448	20.5%	3,036	11.8%	2,291	19.6%	2,798	11.1%
	Child/Adolescent Day Treatment	0	0.0%	263	1.2%	0	0.0%	359	1.4%	0	0.0%	321	1.3%
	Clozapine Management	0	0.0%	115	0.5%	0	0.0%	173	0.7%	0	0.0%	135	0.5%
	Community Support Program	1,229	9.5%	1,306	6.1%	607	5.1%	865	3.4%	606	5.2%	875	3.5%
	Comprehensive Community Services	0	0.0%	157	0.7%	238	2.0%	304	1.2%	246	2.1%	342	1.4%
	Crisis Intervention	1,190	9.2%	1,238	5.7%	1,187	10.0%	1,728	6.7%	1,336	11.4%	2,037	8.1%
	In-home Intensive Psychotherapy	0	0.0%	29	0.1%	0	0.0%	144	0.6%	0	0.0%	171	0.7%
	Inpatient	1,398	10.8%	1,600	7.4%	1,365	11.4%	2,007	7.8%	1,465	12.5%	2,062	8.2%
	Medical Day Treatment	65	0.5%	92	0.4%	53	0.4%	80	0.3%	49	0.4%	77	0.3%
	Outpatient	6,071	47.0%	13,611	63.1%	5,530	46.4%	16,427	64.1%	5,226	44.6%	15,911	63.1%
	Outpatient Services in the Home & Community	33	0.3%	38	0.2%	35	0.3%	36	0.1%	40	0.3%	40	0.2%
	Other	465	3.6%	465	2.2%	465	3.9%	465	1.8%	448	3.8%	448	1.8%
	Northern Region Total	12,929	100.0%	21,572	100.0%	11,928	100.0%	25,624	100.0%	11,707	100.0%	25,217	100.0%
Southeastern	Case Management	4,215	14.3%	5,553	7.7%	3,568	12.5%	5,025	7.1%	3,558	12.5%	4,670	6.8%
	Child/Adolescent Day Treatment	0	0.0%	1,189	1.6%	0	0.0%	1,001	1.4%	0	0.0%	731	1.1%
	Clozapine Management	0	0.0%	411	0.6%	0	0.0%	309	0.4%	0	0.0%	246	0.4%
	Community Support Program	2,273	7.7%	2,602	3.6%	2,465	8.7%	2,837	4.0%	2,455	8.6%	2,753	4.0%
	Comprehensive Community Services	18	0.1%	60	0.1%	81	0.3%	155	0.2%	134	0.5%	203	0.3%
	Crisis Intervention	2,012	6.8%	4,730	6.5%	1,898	6.7%	4,570	6.4%	2,449	8.6%	5,306	7.7%
	In-home Intensive Psychotherapy	0	0.0%	257	0.4%	0	0.0%	293	0.4%	0	0.0%	288	0.4%
	Inpatient	9,092	30.8%	10,057	13.9%	9,010	31.7%	10,401	14.6%	9,021	31.8%	10,361	15.1%
	Medical Day Treatment	291	1.0%	548	0.8%	237	0.8%	452	0.6%	151	0.5%	362	0.5%
	Outpatient	9,881	33.4%	45,193	62.4%	9,422	33.1%	44,389	62.3%	9,118	32.1%	42,090	61.4%
	Outpatient Services in the Home & Community	21	0.1%	55	0.1%	16	0.1%	33	0.0%	24	0.1%	24	0.0%
	Other	1,745	5.9%	1,745	2.4%	1,740	6.1%	1,740	2.4%	1,475	5.2%	1,475	2.2%
	Southeastern Region Total	29,548	100.0%	72,400	100.0%	28,437	100.0%	71,205	100.0%	28,385	100.0%	68,509	100.0%
Southern	Case Management	4,280	25.4%	4,404	13.8%	4,321	26.0%	4,538	13.2%	5,022	27.4%	5,209	14.5%
	Child/Adolescent Day Treatment	0	0.0%	186	0.6%	0	0.0%	217	0.6%	0	0.0%	232	0.6%
	Clozapine Management	0	0.0%	232	0.7%	0	0.0%	75	0.2%	0	0.0%	142	0.4%
	Community Support Program	1,354	8.0%	1,422	4.5%	1,383	8.3%	1,563	4.6%	1,412	7.7%	1,604	4.5%
	Comprehensive Community Services	17	0.1%	20	0.1%	56	0.3%	77	0.2%	76	0.4%	97	0.3%
	Crisis Intervention	1,944	11.5%	2,552	8.0%	1,670	10.0%	2,616	7.6%	2,098	11.4%	3,108	8.6%
	In-home Intensive Psychotherapy	0	0.0%	234	0.7%	0	0.0%	306	0.9%	0	0.0%	347	1.0%
	Inpatient	1,140	6.8%	1,630	5.1%	1,124	6.8%	2,006	5.9%	1,203	6.6%	2,083	5.8%
	Medical Day Treatment	185	1.1%	217	0.7%	178	1.1%	218	0.6%	176	1.0%	208	0.6%
	Outpatient	6,662	39.5%	19,526	61.4%	6,634	39.9%	21,314	62.2%	7,021	38.3%	21,570	59.9%
	Outpatient Services in the Home & Community	112	0.7%	197	0.6%	107	0.6%	168	0.5%	95	0.5%	162	0.5%
	Other	1,181	7.0%	1,181	3.7%	1,164	7.0%	1,164	3.4%	1,238	6.7%	1,238	3.4%
	Southern Region Total	16,875	100.0%	31,801	100.0%	16,637	100.0%	34,262	100.0%	18,341	100.0%	36,000	100.0%
Western	Case Management	1,632	19.3%	1,861	7.9%	1,526	19.2%	1,873	7.6%	1,657	19.3%	1,951	8.0%
	Child/Adolescent Day Treatment	0	0.0%	500	2.1%	0	0.0%	534	2.2%	0	0.0%	471	1.9%
	Clozapine Management	0	0.0%	129	0.5%	0	0.0%	102	0.4%	0	0.0%	91	0.4%
	Community Support Program	982	11.6%	1,203	5.1%	953	12.0%	1,297	5.3%	725	8.4%	1,062	4.4%
	Comprehensive Community Services	0	0.0%	7	0.0%	4	0.1%	155	0.6%	2	0.0%	181	0.7%
	Crisis Intervention	334	4.0%	901	3.8%	398	5.0%	1,020	4.1%	1,298	15.1%	1,655	6.8%
	In-home Intensive Psychotherapy	0	0.0%	238	1.0%	0	0.0%	240	1.0%	0	0.0%	227	0.9%
	Inpatient	966	11.4%	1,380	5.9%	910	11.4%	1,673	6.8%	933	10.9%	1,673	6.9%
	Medical Day Treatment	44	0.5%	100	0.4%	35	0.4%	108	0.4%	36	0.4%	98	0.4%
	Outpatient	3,663	43.4%	16,349	69.6%	3,351	42.1%	16,896	68.4%	3,275	38.1%	16,184	66.7%
	Outpatient Services in the Home & Community	11	0.1%	11	0.0%	23	0.3%	25	0.1%	16	0.2%	17	0.1%
	Other	813	9.6%	813	3.5%	765	9.6%	765	3.1%	657	7.6%	657	2.7%
	Western Region Total	8,445	100.0%	23,492	100.0%	7,965	100.0%	24,688	100.0%	8,599	100.0%	24,267	100.0%

Table 8 continued:
Summary of Consumers Served by Mental Health Service Type by DHS Region (2005-2007)

		2005				2006				2007			
DHS Region	Service Type	HSRS Clients[2]	%	Total Clients[3]	%	HSRS Clients[2]	%	Total Clients[3]	%	HSRS Clients[2]	%	Total Clients[3]	%
Other[1]	Case Management	36	8.0%	179	3.7%	28	7.4%	191	3.7%	29	8.0%	204	4.2%
	Child/Adolescent Day Treatment	0	0.0%	239	5.0%	0	0.0%	295	5.7%	0	0.0%	266	5.5%
	Clozapine Management	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Community Support Program	24	5.3%	32	0.7%	13	3.4%	20	0.4%	9	2.5%	16	0.3%
	Comprehensive Community Services	0	0.0%	14	0.3%	0	0.0%	28	0.5%	0	0.0%	31	0.6%
	Crisis Intervention	52	11.6%	352	7.4%	53	14.1%	362	7.0%	53	14.6%	333	6.8%
	In-home Intensive Psychotherapy	0	0.0%	197	4.1%	0	0.0%	210	4.1%	0	0.0%	218	4.5%
	Inpatient	256	56.9%	322	6.7%	229	60.7%	467	9.1%	219	60.5%	475	9.7%
	Medical Day Treatment	1	0.2%	1	0.0%	1	0.3%	1	0.0%	2	0.6%	3	0.1%
	Outpatient	60	13.3%	3,417	71.6%	38	10.1%	3,568	69.2%	31	8.6%	3,313	67.9%
	Outpatient Services in the Home & Community	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Other	21	4.7%	21	0.4%	15	4.0%	15	0.3%	19	5.2%	19	0.4%
	Other Total	450	100.0%	4,774	100.0%	377	100.0%	5,157	100.0%	362	100.0%	4,878	100.0%
State-wide	Case Management	14,799	17.2%	17,235	9.2%	13,993	16.9%	16,804	8.7%	14,684	17.2%	17,179	8.7%
	Child/Adolescent Day Treatment	0	0.0%	2,609	1.4%	0	0.0%	2,695	1.4%	0	0.0%	2,559	1.3%
	Clozapine Management	0	0.0%	1,143	0.6%	0	0.0%	842	0.4%	0	0.0%	886	0.5%
	Community Support Program	6,821	7.9%	7,530	4.0%	6,379	7.7%	7,051	3.7%	6,143	7.2%	6,857	3.5%
	Comprehensive Community Services	138	0.2%	373	0.2%	541	0.7%	875	0.5%	745	0.9%	1,110	0.6%
	Crisis Intervention	7,316	8.5%	13,011	7.0%	6,866	8.3%	13,255	6.9%	9,080	10.6%	15,823	8.0%
	In-home Intensive Psychotherapy	0	0.0%	1,293	0.7%	0	0.0%	1,474	0.8%	0	0.0%	1,681	0.9%
	Inpatient	14,960	17.4%	17,431	9.3%	14,508	17.5%	19,082	9.9%	15,065	17.6%	19,451	9.9%
	Medical Day Treatment	628	0.7%	1,072	0.6%	540	0.7%	962	0.5%	450	0.5%	846	0.4%
	Outpatient	35,737	41.5%	119,174	63.8%	34,275	41.5%	124,253	64.4%	34,088	39.9%	124,978	63.6%
	Outpatient Services in the Home & Community	315	0.4%	445	0.2%	281	0.3%	366	0.2%	269	0.3%	339	0.2%
	Other	5,436	6.3%	5,430	2.9%	5,284	6.4%	5,277	2.7%	4,931	5.8%	4,922	2.5%
	State-wide Total	86,150	100.0%	186,746	100.0%	82,667	100.0%	192,936	100.0%	85,455	100.0%	196,631	100.0%

Notes:

1 Other includes Native American tribes, out-of-state, and unidentified clients.

2 County clients represent those reported to the Department of Health Services on the Human Services Reporting System (HSRS).

3 Total clients are unduplicated for the service type and include individuals served through other publically funded systems (e.g., MA Fee-for-Service, BadgerCare, SSI, and Family Care).

Source: Wisconsin Department of Health Services Medicaid claims, managed care encounter, family care encounter, and Human Services Reporting System data sets.

- Total duplicated consumers receiving mental health services reported by counties represented an average of 44 percent of all publicly funded mental health services provided from 2005 to 2007.
    - The percentage of duplicated consumers receiving mental health services reported by counties compared to all publicly funded mental health services ranged from a high of 51 percent (northern and southern regions) to a low of 34.5 percent (western region).
- Total duplicated consumers receiving mental health services reported by counties decreased 0.8 percent from 2005 to 2007.
    - The southern region has the largest percentage increase in duplicated consumers receiving mental health services reported by counties at 8.7 percent.
    - The northern region had the largest percentage decrease in the number of duplicated consumers receiving mental health services reported by counties at 9.5 percent, followed by the southeastern region at 3.9 percent.
- Outpatient services represented the largest percentage of services to duplicated consumers receiving mental health services reported by counties at 41.5 percent statewide.

  - The percentage of outpatient services for mental health services reported by counties ranged from a high of 52.5 percent (northeastern region) to a low of 33.4 percent (southeastern region).

- Inpatient services represented 17.4 percent of services to duplicated consumers receiving mental health services reported by counties.

  - The percentage of inpatient services for mental health ranged from a high of 30.8 percent (southeastern region) to a low of 6.8 percent (southern region).

Table 9 provides a breakdown of the consumers receiving substance abuse by service type. As with **Table 8**, the data is divided into "HSRS Clients" and "Total Clients." It shows information by DHS region, with a summary of the statewide totals shown at the bottom of the table.

Key highlights of the information on the following table include:

- Total duplicated consumers (i.e., those receiving more than one service type) receiving substance abuse services from all publicly funded programs increased 7.7 percent from 2005 to 2007.

  - The northern region has the largest percentage increase in duplicated consumers served at 19.9 percent followed by the northeastern region at 13.2 percent.
  - The southeastern region had a decrease of 1.8 percent in the number of duplicated consumers served.

- Outpatient services represented the largest percentage of substance abuse services to duplicated consumers from all publicly funded programs at 38.8 percent statewide.

  - The percentage of outpatient services ranged from a high of 42.2 percent (northern region) to a low of 33.0 percent (southern region).

- Case management services represented the next largest percentage of substance abuse services to duplicated consumers from all publicly funded programs at 38.5 percent statewide.

  - The percentage of case management services for substance abuse ranged from a high of 49.7 percent (northeastern region) to a low of 30.9 percent (southern region).

- Inpatient services represented 3.3 percent of substance abuse services to duplicated consumers from all publicly funded programs.

  - The percentage of inpatient services for substance abuse ranged from a high of 4.4 percent (western region) to a low of 1.6 percent (southern region).

Table 9 – Summary of Consumers Served by Substance Abuse Service Type by DHS Region (2005-2007)

		2005				2006				2007			
		HSRS		Total		HSRS		Total		HSRS		Total	
	Service Type	Clients[2]	%	Clients[3]	%	Clients[2]	%	Clients[3]	%	Clients[2]	%	Clients[3]	%
Northeastern	Case Management	9,055	64.5%	9,068	56.8%	8,864	63.7%	8,877	48.3%	7,933	60.2%	7,944	44.0%
	Community Support Program	1	0.0%	1	0.0%	1	0.0%	1	0.0%	2	0.0%	2	0.0%
	Comprehensive Community Services	0	0.0%	0	0.0%	1	0.0%	1	0.0%	4	0.0%	4	0.0%
	Inpatient	259	1.8%	432	2.7%	272	2.0%	627	3.4%	276	2.1%	675	3.7%
	Medical Day Treatment	74	0.5%	74	0.5%	114	0.8%	114	0.6%	126	1.0%	126	0.7%
	Narcotic Treatment	0	0.0%	236	1.5%	0	0.0%	383	2.1%	0	0.0%	388	2.1%
	Outpatient	3,460	24.7%	4,882	30.6%	3,377	24.3%	7,042	38.3%	3,602	27.3%	7,608	42.1%
	Outpatient Services in the Home & Community	16	0.1%	16	0.1%	68	0.5%	68	0.4%	96	0.7%	96	0.5%
	SA Day Treatment	0	0.0%	77	0.5%	0	0.0%	51	0.3%	0	0.0%	73	0.4%
	Other	1,169	8.3%	1,169	7.3%	1,215	8.7%	1,215	6.6%	1,145	8.7%	1,145	6.3%
	Northeastern Region Total	14,034	100.0%	15,955	100.0%	13,912	100.0%	18,379	100.0%	13,184	100.0%	18,061	100.0%
Northern	Case Management	4,348	54.2%	4,349	48.3%	4,413	54.8%	4,444	42.0%	4,451	54.1%	4,486	41.6%
	Community Support Program	38	0.5%	38	0.4%	41	0.5%	41	0.4%	17	0.2%	17	0.2%
	Comprehensive Community Services	0	0.0%	0	0.0%	4	0.0%	4	0.0%	5	0.1%	5	0.0%
	Inpatient	260	3.2%	345	3.8%	267	3.3%	506	4.8%	209	2.5%	422	3.9%
	Medical Day Treatment	160	2.0%	160	1.8%	142	1.8%	142	1.3%	207	2.5%	207	1.9%
	Narcotic Treatment	0	0.0%	89	1.0%	0	0.0%	157	1.5%	0	0.0%	176	1.6%
	Outpatient	2,631	32.8%	3,376	37.5%	2,607	32.4%	4,635	43.8%	2,828	34.4%	4,899	45.4%
	Outpatient Services in the Home & Community	28	0.3%	28	0.3%	43	0.5%	43	0.4%	27	0.3%	27	0.3%
	SA Day Treatment	0	0.0%	63	0.7%	0	0.0%	66	0.6%	0	0.0%	71	0.7%
	Other	550	6.9%	550	6.1%	537	6.7%	537	5.1%	481	5.8%	481	4.5%
	Northern Region Total	8,015	100.0%	8,998	100.0%	8,054	100.0%	10,575	100.0%	8,225	100.0%	10,791	100.0%
Southeastern	Case Management	8,054	47.0%	8,100	39.3%	5,993	36.0%	6,032	28.8%	5,922	37.9%	5,957	29.5%
	Community Support Program	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Comprehensive Community Services	0	0.0%	0	0.0%	1	0.0%	1	0.0%	1	0.0%	1	0.0%
	Inpatient	249	1.5%	623	3.0%	229	1.4%	779	3.7%	187	1.2%	718	3.6%
	Medical Day Treatment	485	2.8%	485	2.4%	1,144	6.9%	1,144	5.5%	898	5.7%	898	4.4%
	Narcotic Treatment	0	0.0%	641	3.1%	0	0.0%	620	3.0%	0	0.0%	583	2.9%
	Outpatient	4,730	27.6%	6,703	32.6%	5,697	34.2%	8,524	40.7%	5,139	32.8%	8,327	41.2%
	Outpatient Services in the Home & Community	394	2.3%	398	1.9%	237	1.4%	241	1.2%	347	2.2%	348	1.7%
	SA Day Treatment	0	0.0%	404	2.0%	0	0.0%	263	1.3%	0	0.0%	242	1.2%
	Other	3,238	18.9%	3,238	15.7%	3,352	20.1%	3,352	16.0%	3,150	20.1%	3,150	15.6%
	Southeastern Region Total	17,150	100.0%	20,592	100.0%	16,653	100.0%	20,956	100.0%	15,644	100.0%	20,224	100.0%
Southern	Case Management	5,513	35.1%	5,522	32.4%	5,476	36.4%	5,489	29.8%	5,593	37.7%	5,632	30.4%
	Community Support Program	10	0.1%	10	0.1%	9	0.1%	9	0.0%	8	0.1%	8	0.0%
	Comprehensive Community Services	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Inpatient	79	0.5%	175	1.0%	113	0.8%	355	1.9%	111	0.7%	351	1.9%
	Medical Day Treatment	187	1.2%	187	1.1%	178	1.2%	178	1.0%	193	1.3%	193	1.0%
	Narcotic Treatment	0	0.0%	260	1.5%	0	0.0%	294	1.6%	0	0.0%	327	1.8%
	Outpatient	3,923	25.0%	4,793	28.1%	3,574	23.8%	6,336	34.4%	3,803	25.6%	6,788	36.6%
	Outpatient Services in the Home & Community	162	1.0%	164	1.0%	70	0.5%	73	0.4%	34	0.2%	38	0.2%
	SA Day Treatment	0	0.0%	89	0.5%	0	0.0%	90	0.5%	0	0.0%	91	0.5%
	Other	5,833	37.1%	5,833	34.2%	5,604	37.3%	5,604	30.4%	5,108	34.4%	5,108	27.6%
	Southern Region Total	15,707	100.0%	17,033	100.0%	15,024	100.0%	18,428	100.0%	14,850	100.0%	18,536	100.0%
Western	Case Management	3,990	51.1%	4,010	43.0%	3,656	50.2%	3,680	36.9%	3,654	49.1%	3,681	37.0%
	Community Support Program	59	0.8%	59	0.6%	59	0.8%	59	0.6%	60	0.8%	60	0.6%
	Comprehensive Community Services	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Inpatient	231	3.0%	359	3.8%	232	3.2%	498	5.0%	184	2.5%	424	4.3%
	Medical Day Treatment	99	1.3%	99	1.1%	33	0.5%	33	0.3%	31	0.4%	31	0.3%
	Narcotic Treatment	0	0.0%	51	0.5%	0	0.0%	71	0.7%	0	0.0%	73	0.7%
	Outpatient	2,472	31.7%	3,722	39.9%	2,379	32.7%	4,629	46.4%	2,679	36.0%	4,776	48.0%
	Outpatient Services in the Home & Community	1	0.0%	1	0.0%	0	0.0%	0	0.0%	1	0.0%	1	0.0%
	SA Day Treatment	0	0.0%	78	0.8%	0	0.0%	90	0.9%	0	0.0%	71	0.7%
	Other	955	12.2%	955	10.2%	917	12.6%	917	9.2%	831	11.2%	831	8.4%
	Western Region Total	7,807	100.0%	9,334	100.0%	7,276	100.0%	9,977	100.0%	7,440	100.0%	9,948	100.0%

Table 9 continued – Summary of Consumers Served by Substance Abuse Service Type by DHS Region (2005-2007)

		2005				2006				2007			
	Service Type	HSRS Clients[2]	%	Total Clients[3]	%	HSRS Clients[2]	%	Total Clients[3]	%	HSRS Clients[2]	%	Total Clients[3]	%
Other[1]	Outpatient	3,990	51.1%	4,010	43.0%	3,656	50.2%	3,680	36.9%	3,654	49.1%	3,681	37.0%
	Outpatient Services in the Home & Community	59	0.8%	59	0.6%	59	0.8%	59	0.6%	60	0.8%	60	0.6%
	Medical Day Treatment	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%	0	0.0%
	Community Support Program	231	3.0%	359	3.8%	232	3.2%	498	5.0%	184	2.5%	424	4.3%
	Case Management	99	1.3%	99	1.1%	33	0.5%	33	0.3%	31	0.4%	31	0.3%
	Child/Adolescent Day Treatment	0	0.0%	51	0.5%	0	0.0%	71	0.7%	0	0.0%	73	0.7%
	Comprehensive Community Services	2,472	31.7%	3,722	39.9%	2,379	32.7%	4,629	46.4%	2,679	36.0%	4,776	48.0%
	Inpatient	1	0.0%	1	0.0%	0	0.0%	0	0.0%	1	0.0%	1	0.0%
	Narcotic Treatment Services	0	0.0%	78	0.8%	0	0.0%	90	0.9%	0	0.0%	71	0.7%
	Other	955	12.2%	955	10.2%	917	12.6%	917	9.2%	831	11.2%	831	8.4%
	Other Total	7,807	100.0%	9,334	100.0%	7,276	100.0%	9,977	100.0%	7,440	100.0%	9,948	100.0%
State-wide	Case Management	34,950	49.6%	35,059	43.2%	32,058	47.0%	32,202	36.5%	31,207	0.0%	31,381	35.9%
	Community Support Program	167	0.2%	167	0.2%	169	0.2%	169	0.2%	147	0.0%	147	0.2%
	Comprehensive Community Services	0	0.0%	0	0.0%	6	0.0%	6	0.0%	10	0.0%	10	0.0%
	Inpatient	1,309	1.9%	2,293	2.8%	1,345	2.0%	3,263	3.7%	1,151	0.0%	3,014	3.4%
	Medical Day Treatment	1,104	1.6%	1,104	1.4%	1,644	2.4%	1,644	1.9%	1,486	0.0%	1,486	1.7%
	Narcotic Treatment	0	0.0%	1,328	1.6%	0	0.0%	1,596	1.8%	0	0.0%	1,620	1.9%
	Outpatient	19,688	27.9%	27,198	33.5%	20,013	29.3%	35,795	40.5%	20,730	0.0%	37,174	42.5%
	Outpatient Services in the Home & Community	602	0.9%	608	0.7%	418	0.6%	425	0.5%	506	0.0%	511	0.6%
	SA Day Treatment	0	0.0%	789	1.0%	0	0.0%	650	0.7%	0	0.0%	619	0.7%
	Other	12,700	18.0%	12,700	15.6%	12,542	18.4%	12,542	14.2%	11,546	0.0%	11,546	13.2%
	State-wide Total	70,520	100.0%	81,246	100.0%	68,195	100.0%	88,292	100.0%	66,783	0.0%	87,508	100.0%

Notes:

1 Other includes Native American tribes, out-of-state, and unidentified clients.

2 County clients represent those reported to the Department of Health Services on the Human Services Reporting System (HSRS).

3 Total clients are unduplicated for the service type and include individuals served through other publically funded systems (e.g., MA Fee-for-Service, BadgerCare, SSI, and Family Care).

Source: Wisconsin Department of Health Services Medicaid claims, managed care encounter, family care encounter, and Human Services Reporting System data sets.

- Total duplicated consumers receiving substance abuse services reported by counties represented an average of 80 percent of all publicly funded substance abuse services provided from 2005 to 2007.
    - The percentage of duplicated consumers served compared to all publicly funded substance abuse services ranged from a high of 84.6 percent (southern region) to a low of 77.1 percent (western region).
- Total duplicated consumers receiving substance abuse services reported by counties decreased 5.3 percent from 2005 to 2007.
    - The northern region had the only percentage increase in duplicated consumers at 2.6 percent.
    - The southeastern region had the largest percentage decrease in the number of duplicated consumers at 8.8 percent followed by the northeastern region at 6.1 percent.
- Case management services represented the largest percentage of services provided to duplicated consumers receiving substance abuse services reported by counties at 49.6 percent statewide.
    - The percentage of case management services ranged from a high of 64.5 percent (northeastern region) to a low of 35.1 percent (southern region).

- Outpatient services represented the next largest percentage of services provided to duplicated consumers receiving substance abuse services reported by counties at 27.9 percent statewide.
    - The percentage of outpatient services ranged from a high of 32.8 percent (northern region) to a low of 24.7 percent (northeastern region).
- Inpatient services represented the 1.9 percent of services to duplicated consumers receiving substance abuse services reported by counties.
    - The percentage of inpatient services for substance abuse ranged from a high of 3.2 percent (northern region) to a low of 0.5 percent (southern region).

Summary of Expenditures

Total expenditures for the publicly funded MH/SA systems included in this study have grown from $577.6 million in 2005 to $642.3 million in 2007. Nearly three-fourths of these expenditures are funded through the county human service, community program and social service departments, with the remainder nearly equally distributed between the Medicaid fee-for-service and managed care systems. **Table 10** provides a summary of total expenditures by age group and target population between 2005 and 2007.

Unlike the information regarding consumers served presented in **Table 9**, which was entirely generated from data compiled from the Medicaid, encounter, and Human Services Reporting System (HSRS) data sets, the expenditure information for **Table 10** was developed from two sources, including the Medicaid/encounter data sets and the Human Services Revenue Report (HSRR). Counties do not report expenditures by service type in HSRR, and only report total costs by target population in broader age categories (e.g. under 18 and over 18). Therefore, the age groupings differ from those in the consumers served data. Correspondingly, since counties do not report on the costs at the service level on the HSRR, the report was unable to include a breakdown of expenditures at that level.

Table 10 – Summary of Expenditures by Age Group (2005-2007)

	2005			2006			2007		
	Under 18	Over 18	Total	Under 18	Over 18	Total	Under 18	Over 18	Total
Mental Health	$ 139,145,908	$ 347,315,298	$ 486,461,206	$ 162,378,303	$ 371,457,431	$ 533,835,735	$ 163,223,575	$ 382,849,972	$ 546,073,546
Substance Abuse	9,741,596	81,419,129	91,160,725	10,890,547	92,314,528	103,205,075	10,854,372	85,369,665	96,224,037
Total	$ 148,887,504	$ 428,734,427	$ 577,621,931	$ 173,268,851	$ 463,771,959	$ 637,040,810	$ 174,077,946	$ 468,219,637	$ 642,297,583

Sources:
Wisconsin Department of Health Services Medicaid claims, managed care encounter, and family care encounter data sets.
Wisconsin Department of Health Services Human Services Revenue Report (2006 and 2007).
Wisconsin Department of Health Services Human Services Reporting System 942 Report (2005).

Overall highlights of MH/SA spending between 2005 and 2007 include:

- Total expenditures for MH/SA services increased 11.2 percent between 2005 and 2007.
    - Total mental health expenditures increased 12.3 percent between 2005 and 2007.
    - Total substance abuse expenditures increased 5.6 percent between 2005 and 2007.

- Approximately 73 percent of all MH/SA services are for consumers over the age of 18. This population group represents 72 percent of Wisconsin's total population.

    - An average of approximately 70 percent of all mental health expenditures were consumers over the age of 18.
    - An average of approximately 90 percent of all substance abuse expenditures were consumers over the age of 18.

- Mental health services represent an average of 84 percent of all expenditures for MH/SA services.

    - Mental health services represent 81 percent of all expenditures for consumers over the age of 18 compared to 94 percent for those under 18.

Table 11 provides a summary of the per capita MH/SA expenditures across the total population at the regional level. This data includes consumers served by all of the publicly funded systems included in this study, not just those receiving services through the county MH/SA system. Because of the variation in the size and budgets for programs in each of the five DHS regions, standardizing the data based on a per capita basis provides a better measure from which to gauge the overall investment in services provided. However, based strictly on actual expenditure levels, the following picture develops:

- Four of the five DHS regions' expenditures as a percentage of the statewide totals varied when compared to the percentage of Wisconsin's total population:

    - The southeastern region had the largest variance, with 43.4 percent of all statewide expenditures in MH/SA over the three years, but only 37.2 percent of Wisconsin's population.
    - The northeastern region represented 18.3 percent of all expenditures in MH/SA over the three years and represented 21.5 percent of Wisconsin's population.
    - The southern region represented 15.9 percent of all expenditures in MH/SA over the three years and represented 19.1 percent of Wisconsin's population.
    - The western region represented 11.9 percent of all expenditures in MH/SA over the three years and represented 13.5 percent of Wisconsin's population.

Table 11 – Summary of Per Capita Expenditures by DHS Region (2005-2007)

	2005			2006			2007		
	Mental Health	Substance Abuse	Total	Mental Health	Substance Abuse	Total	Mental Health	Substance Abuse	Total
Northeastern	$ 72.06	$ 13.42	$ 85.48	$ 81.38	$ 15.56	$ 96.95	$ 85.45	$ 16.40	$ 101.85
Northern	83.47	19.82	103.29	100.14	23.46	123.60	98.90	23.94	122.84
Southeastern	106.53	19.10	125.63	111.53	21.69	133.21	111.48	17.68	129.16
Southern	71.54	15.89	87.43	77.08	17.02	94.10	80.88	15.54	96.42
Western	77.34	12.44	89.78	87.42	13.22	100.64	89.15	14.76	103.92
Wisconsin	$ 86.52	$ 16.43	$ 102.96	$ 94.24	$ 18.49	$ 112.72	$ 95.92	$ 17.14	$ 113.06

Notes:

1 Other includes Native American tribes, out-of-state, and unidentified clients.

Sources:

Expenditures: Wisconsin Department of Health Services Medicaid claims, managed care encounter, and family care encounter data sets Wisconsin Department of Health Services Human Services Revenue Report (2006 and 2007). Wisconsin Department of Health Services Human Services Reporting System 942 Report.

Population: Table 1: Annual Estimates of the Population for Counties of Wisconsin: April 1, 2000 to July 1, 2007 (CO-EST2007-01-55), Population Division, U.S. Census Bureau Release Date: March 20, 2008

- Per capita expenditures for both mental health and substance abuse services ranged from an average high of approximately $129 (southeastern region) to a low of $93 (southern region).
    - Per capita expenditures for mental health services ranged from an average high of $110 (southeastern) to a low of $77 (southern).
    - Per capita expenditures for substance abuse services ranged from an average high of $22 (northern) to a low of $13 (western).
- The southeastern region consistently had significantly higher rates of per capita expenditures than the statewide rate or other regions for both mental health and substance abuse services in each of the three years.
    - The northeastern, southern and western regions consistently had lower per capita expenditures for both mental health and substance abuse services than the statewide rate.
- The northern region consistently had significantly higher rates of per capita expenditures than the statewide rate or other regions for substance abuse services in each of the three years, averaging 12 percent above the statewide rate.

Table 12 and Table 13 provide a summary of per capita expenditures by revenue source for county reported MH/SA services in 2006 and 2007 based on DHS regions.

Table 12 – Summary of 2006 County MH/SA Per Capita Expenditures by Revenue Source

DHS Region	County Revenue/ Tax Levy	Basic County Allocation	MA Fee for Service	WIMCR	3rd Party Collections	Client Fees/ Donations	All Other Revenue	Total Revenue
Southern	$ 25.93	$ 14.67	$ 13.08	$ 2.95	$ 1.40	$ 2.63	$ 11.11	$ 71.78
Northern	28.53	14.69	9.03	1.66	9.58	2.85	12.78	$ 79.12
Western	23.49	15.15	6.23	2.12	1.46	3.45	19.20	$ 71.09
Northeastern	29.46	15.15	3.81	3.05	5.36	3.44	13.52	$ 73.79
Southeastern	24.00	19.33	13.53	1.57	7.60	3.85	31.68	$ 101.57
Wisconsin	$ 25.82	$ 16.55	$ 10.04	$ 2.22	$ 5.26	$ 3.38	$ 20.48	$ 83.76

Source:
Department of Health Services, "Human Services Revenue Report," 2006.

Table 13 – Summary of 2007 County MH/SA Per Capita Expenditures by Revenue Source

DHS Region	County Revenue/ Tax Levy	Basic County Allocation	MA Fee for Service	WIMCR	3rd Party Collections	Client Fees/ Donations	All Other Revenue	Total Revenue
Southern	$ 27.38	$ 14.78	$ 13.76	$ 2.07	$ 0.88	$ 2.41	$ 12.13	$ 73.41
Northern	27.68	13.72	10.72	3.44	10.62	1.59	11.40	$ 79.18
Western	22.31	16.50	6.61	1.98	1.30	3.32	21.52	$ 73.54
Northeastern	31.41	15.76	5.04	1.96	3.82	4.41	16.18	$ 78.58
Southeastern	21.60	17.88	14.07	2.23	8.32	3.71	29.08	$ 96.91
Wisconsin	$ 25.34	$ 16.27	$ 10.86	$ 2.22	$ 5.20	$ 3.34	$ 20.50	$ 83.73

Source:
Department of Health Services, "Human Services Revenue Report," 2007.

- The southeastern region had the highest county-based per capita expenditures for combined MH/SA services in both 2006 and 2007 at $102 and $97 respectively; however, as noted above, it had the lowest rate of consumers served per 1,000 of the total population.

- The northern region, which had a significantly higher rate of consumers served per 1,000 of the total population compared to the other DHS regions and the state overall, had total per capita expenditures below the state rate in both 2006 and 2007.

- Combined per capita funding ranged from a two-year average high of $99 (southeastern) to a low of $72 (western).
  - The western region had the lowest rate of per capita spending on MH/SA services and also had the second lowest rate of consumers served per 1,000 of the total population.

- The northeastern region had the highest county based per capita expenditures for combined MH/SA services funded from county levy and BCA in both 2006 and 2007 at $45 and $47 respectively.

  - Combined per capita funding from county levy and BCA ranged from an average high of $46 (northeastern) to a low of $38 (western).

- The northeastern region had the highest county based per capita expenditures for combined MH/SA services funded from county levy in both 2006 and 2007 at $29 and $31 respectively.

    - Combined per capita funding from county levy ranged from an average high of $30 (northeastern) to a low of $23 (southeastern).

State Mental Health Institute Utilization

In addition to the information gathered from Medicaid, encounter, HSRS, and HSRR that has formed the basis for the service and expenditures summaries presented in this section, DHS also provided data regarding discharges from the state mental health institutes. This information provides some perspective on how the institutes are used, with key measures indicating the number of discharges per 1,000 of the total population, average lengths of stay, and the number of discharges with a length of stay of three days or less. In addition to the rates for each of the regions, the information presented in the tables also includes the range within each of the regions.

Table 14 provides a summary by DHS region of the number of discharges per 1,000 of the total population from the state mental health institutes over a three year period.

Table 14 – Discharges per 1,000 Population from State Mental Health Institutes by Region (2005-2007)

	2005			2006			2007		
DHS Region	Discharges per 1,000 Population	Regional High	Regional Low	Discharges per 1,000 Population	Regional High	Regional Low	Discharges per 1,000 Population	Regional High	Regional Low
Southern	0.79	2.38	0.24	0.85	2.49	0.29	0.97	2.48	0.28
Northern	0.39	0.68	0.00	0.42	0.63	0.12	0.38	0.53	0.07
Western	0.32	1.09	0.00	0.33	1.11	0.02	0.28	0.65	0.05
Northeastern	0.39	4.13	0.05	0.45	3.03	0.05	0.54	3.47	0.08
Southeastern	0.24	1.65	0.01	0.30	1.57	0.02	0.28	1.35	0.01
Wisconsin	0.47	4.13	0.00	0.49	3.03	0.02	0.49	3.47	0.01
Notes: Includes only individuals discharged during the calendar year regardless of admission date.									
Source: Department of Health Services, Division of Mental Health & Substance Abuse									

- The rate of discharge from Wisconsin's state mental health institutes per 1,000 of the total population remained consistent between 2005 and 2007.

    - All regions other than the northern and western experienced an increase in discharge rates ranging from a high of 36.9 percent (northeastern) to a low of 16.3 percent (southeastern).

- The southern region consistently had significantly higher discharge rates than the statewide rate or other regions.

- The western and southeastern regions consistently had lower discharge rates than the statewide rate or other regions.

Table 15 provides a summary of the average lengths of stay in state mental health institutes between 2005 and 2007.

- Average lengths of stay in state mental health institutes have decreased 10 percent each between 2005 and 2006 and between 2006 and 2007. The overall rate of decrease in average lengths of stay was 19.6 percent statewide between 2005 and 2007.
    - All regions other than the northern region experienced a decrease in average lengths of stay ranging from a high of 30.5 percent (northeastern) to a low of 14.5 percent (southeastern).
- The northern and western regions consistently had higher rates in average lengths of stay than the statewide rate or other regions.
- The southern and southeastern regions consistently had lower rates in average lengths of stay than the statewide rate or other regions.

Table 15 – Average Lengths of Stay in State Mental Health Institutes by Region (2005-2007)

	2005			2006			2007		
DHS Region	Average Length of Stay	Regional High	Regional Low	Average Length of Stay	Regional High	Regional Low	Average Length of Stay	Regional High	Regional Low
Southern	24.36	55.47	7.69	20.80	38.36	6.22	19.42	32.35	7.40
Northern	47.18	118.00	10.43	34.99	59.85	0.00	50.98	143.83	11.86
Western	46.20	318.75	0.00	36.30	91.47	0.00	38.29	190.33	9.59
Northeastern	38.19	135.35	3.25	36.84	178.67	11.43	26.55	68.00	7.21
Southeastern	28.77	131.00	15.24	29.38	70.46	13.35	24.60	53.30	15.59
Other	50.76	n/a	n/a	50.51	n/a	n/a	54.05	n/a	n/a
Wisconsin	33.10	318.75	0.00	29.60	178.67	0.00	26.60	190.33	7.21
Notes: Includes only individuals discharged during the calendar year regardless of admission date.									
Source: Department of Health Services, Division of Mental Health & Substance Abuse									

Table 16 provides a summary of the number of discharges of three days or less per 1,000 of the total population by DHS region. Over the three year period between 2005 and 2007, an average of 54 counties had at least one discharge with a length of stay of three days or less. The average number of discharges of three days or less increased from 13 stays in 2005 to 14.4 stays in 2006 and 16.5 stays in 2007. The highest number of discharges of three days or less from any one county was 80 in 2005, 79 in 2006, and 97 in 2007. During these three years, 11 counties had 20 or more discharges with lengths of stay of three days or less in 2005, with 13 counties in both 2006 and 2007.

Table 16 – Average Lengths of Stay in State Mental Health Institutes by Region (2005-2007)

	2005			2006			2007		
DHS Region	Discharges 3 days or less per 1,000 Population	Regional High	Regional Low	Discharges 3 days or less per 1,000 Population	Regional High	Regional Low	Discharges 3 days or less per 1,000 Population	Regional High	Regional Low
Southern	0.23	0.95	0.06	0.27	1.07	0.08	0.32	1.12	0.03
Northern	0.07	0.16	0.00	0.09	0.35	0.00	0.05	0.15	0.00
Western	0.09	0.54	0.00	0.10	0.68	0.00	0.06	0.30	0.00
Northeastern	0.15	1.10	0.00	0.17	1.74	0.00	0.20	1.52	0.00
Southeastern	0.08	0.56	0.00	0.09	0.39	0.00	0.10	0.55	0.00
Wisconsin	0.12	1.10	0.00	0.14	1.74	0.00	0.17	1.52	0.00
Notes: Includes only individuals discharged during the calendar year regardless of admission date.									
Source: Department of Health Services, Division of Mental Health & Substance Abuse									

- The rate of discharge from state mental health institutes of three days or less per 1,000 of the total population have consistently increased between 2005 and 2007.
    - The northern and western regions were the only regions that experienced a decrease in discharge rates of three days or less at 35.4 percent and 32.9 percent respectively.
- The northern, western, and southeastern regions consistently had significantly lower discharge rates of three days or less when compared to the statewide rate or other regions.
- The southern and northeastern regions consistently had higher discharge rates of three days or less when compared to the statewide rate or other regions.

D. State Managed Care Initiatives

One of the key objectives of the MH/SA Infrastructure Study was to review other state initiatives that impact the public MH/SA system. These include the state's Medicaid managed care programs: BadgerCare, SSI Managed Care and Family Care. Individuals with MH/SA issues who are enrolled in these managed care programs do not typically become eligible for them due to their MH/SA diagnosis. However, all of these programs serve individuals with MH/SA issues and all provide some MH/SA services within their benefit packages.

- **The Family Care Program** is a comprehensive and flexible managed long-term care benefit for the elderly and individuals with disabilities. When a person decides to enroll in Family Care, they become a member of a managed care organization (MCO), which manages and delivers the Family Care benefit. The Family Care benefit combines funding and services from a variety of existing programs into one flexible long-term care benefit, tailored to each individual's needs, circumstances and preferences. As of October 2009, Family Care is operating in 48 counties in the state, with planned expansion to an additional 16 counties anticipated in 2010 or 2011 (see DHS Family Care implementation map in **Appendix B**). **Table 17** describes program eligibility and MH/SA benefits for the Family Care program.

Table 17 – Family Care Program MH/SA Benefits

Family Care	
Program Eligibility	Individuals who meet the following criteria (defined by the Family Care Managed Care Organization (MCO)) are eligible to enroll: • Frail older adults (65 years or older; age 60 or older in Milwaukee County) • People with physical disabilities (17 years, 9 months or older) • People with developmental disabilities (17 years, 9 months or older) Persons must be financially eligible for Medicaid. They must also be functionally eligible as determined via the long-term care functional screen or grandfathered for Family Care functional eligibility prior to enrollment and annually thereafter.
Assessment and Service Plan	A comprehensive assessment is the initial and ongoing process employed by the interdisciplinary team (IDT) to identify the member's needs and strengths, preferences, informal supports, and outcomes. The assessment is also used to identify any ongoing conditions of the member that require a course of treatment or regular care monitoring. The assessment includes identification of mental health, cognition and substance abuse issues. The individual service plan (ISP) addresses comprehensive service needs regardless of whether the service is covered in the long-term care benefit package or there is another source of payment (e.g., Medicare, Medicaid fee-for-service, private insurance).
MH/SA Services	Service definitions in the Family Care benefit package include: **Counseling and therapeutic resources** are services that are needed to treat a personal, social, behavioral, cognitive or MH/SA disorder. Services are usually provided in a natural setting or service office. Services include: counseling to assist in understanding capabilities and limitations or assist in the alleviation of problems of adjustment and interpersonal relationships, recreational therapy, music therapy, nutritional counseling, medical and legal counseling, and grief counseling.
	State Plan services in the Family Care benefit package include: • **Mental health and AODA services** defined in HFS 107.13 (not inpatient or physician provided) • **AODA day treatment services** defined in HFS 107.13 (in all settings) • **Community support program** defined in HFS 107.13 (6) • **Mental health day treatment services** defined in HFS 107.13 (in all settings)
	Services coordinated through Medicaid fee-for-service – for members who are Medicaid beneficiaries, the following Medicaid services remain fee-for-service: • Mental health services provided by a physician or in an inpatient setting • Substance abuse services provided by a physician or in an inpatient setting

SOURCES
- Family Care Programs Contract between DHS Division of Long Term Care and [MCO] - January 1, 2009–December 31, 2009
- DHS Web site - http://dhs.wisconsin.gov/

- **The BadgerCare Plus Program** 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. BadgerCare Plus is available in all counties. In most counties BadgerCare Plus is provided through HMOs (health plans) and in a few it is provided

through fee-for-service (see DHS BadgerCare Plus HMO participation map in **Appendix B**). Different benefit plans in this managed care program include:

- **Standard Plan:** The BadgerCare Plus Standard benefit plan is available to children, parents and caretaker relatives, young adults aging out of foster care, and pregnant women with incomes that meet specific thresholds. This plan is a full benefit insurance plan.

- **Benchmark Plan:** The BadgerCare Plus Benchmark benefit plan is available to children and pregnant women with incomes above 200 percent of the federal poverty level (FPL), certain self-employed parents, and other caretaker relatives. This plan provides more limited services than the Standard Plan.

- **Core Plan:** The BadgerCare Plus Core benefit plan covers basic health care services to adults who do not otherwise qualify for Medicaid or the Standard/Benchmark Plans. The plan includes primary and preventive care, as well as generic prescription drugs and a limited number of brand name prescription drugs.

- **The SSI Medicaid 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 health care coordination, 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 get the best possible care, including people with disabilities and other chronic medical conditions. SSI Managed Care is operating in more than 40 counties in the state (see DHS SSI Managed Care map in **Appendix B**).

Table 18 on the next page contains summary information for the BadgerCare and SSI Managed Care programs. The table in **Appendix B** provides additional and more detailed information and contractual language describing the HMO-contracted MH/SA benefits and limitations, cost sharing, and HMO provider and care coordination requirements for these managed care programs. As **Tables 17 and 18** show, there are differences in MH/SA benefits coverage among the various Medicaid managed care programs. While there are distinctions that exist among the Medicaid managed care programs, the variations that exist between the managed care programs and the county-administered MH/SA services are much greater and more significant.

One of the study's key findings is that Wisconsin appears to have **two primary and very distinct publicly funded systems that serve individuals with MH/SA issues**: one is the county-administered service delivery system and the other is the system of Medicaid managed care programs. While service eligibility requirements and benefit requirements in the contract for services for the managed care programs are clearly defined, specific and consistent, county-based system service eligibility and coverage are not well defined, and are broad and subject to significant variation among counties. This results in system complexity, inconsistency and fragmentation, and may lead to conflict between the two systems. Some of the challenges and problems resulting from this system fragmentation and inconsistency were identified by the counties participating in the targeted county review. The results of the targeted county review are summarized in **Section IV**.

Table 19 – Medicaid Managed Care Health Plans - MH/SA Services Contracted Benefits

	BadgerCare Plus			Medicaid SSI
	Standard	**Benchmark**	**Core Plan**	
Eligibility	• 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 percent Federal Poverty Level (FPL) who have kids in foster care The family's gross monthly income must be at or below the monthly income limit.	• Children and pregnant women with incomes above 200 percent of the FPL • Certain self-employed parents, and other caretaker relatives	Childless adults (ages 19 to 64) with income levels below 200 percent of the FPL. Other eligibility criteria includes people who : • Do not have children or do not have dependent children, under age 19 living at home; • Are not pregnant; • Do not have or have access to private/employer health insurance coverage when requesting Core Plan coverage or in the 12 months before that date; and • Are not getting BadgerCare Plus, Medicaid or Medicare.	Adults age 19 years or older meeting these criteria: • 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.
MH/SA Services	• Inpatient hospital services • Outpatient services • Day Treatment • Prescription drugs • Assessments • Court-related children's services • Court-related substance abuse services • Emergency detention and court-related mental health services • Transportation following emergency detention • Services for children who are institutionalized	• Inpatient hospital services* • Outpatient services* • Day Treatment* • Prescription drugs • Assessments • Court-related children's services • Court-related substance abuse services • Transportation following emergency detention • Services for children who are institutionalized *Specific limits noted below	• Coverage is provided for treatment or services by a psychiatrist or physician only • Prescription drugs	• Inpatient hospital services • Outpatient services • Day Treatment • Prescription drugs • Assessments • Court-related substance abuse services • Emergency detention and court-related mental health services • Transportation following emergency detention
Limitations	• No limitations are allowed for treatment that is medically necessary • Covered hospitalization for persons 21-64 years of age includes stays in a general acute care hospital only • Prescription drugs include generic, brand name, and some over-the–counter (OTC) drugs • Members are automatically enrolled in *Badger Rx Gold*	*Limitations/enrollment year:* • MH/SA services may be limited to a total of $7,000 • Hospitalization is limited to 30 days • Hospitalization for substance abuse in a general acute hospital may be limited to $6,300 • Outpatient services for substance abuse may be limited to $4,500 (includes $2,700 for substance abuse day treatment)	• Coverage is limited to services provided by a psychiatrist or physician only • Generic only formulary prescription 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 • Members are automatically enrolled in *Badger Rx Gold*	• Wisconsin Medicaid requires contracted HMOs to provide all medically necessary Medicaid-covered services; no limitations are allowed for treatment that is medically necessary • Covered hospitalization for persons 21-64 years of age includes stays in a general acute care hospital only • Prescription drugs include generic, brand name, and some OTC drugs

Table 19 – Medicaid Managed Care Health Plans - MH/SA Services Contracted Benefits

	BadgerCare Plus			Medicaid SSI
	Standard	**Benchmark**	**Core Plan**	
		Other limitations: • Generic only formulary prescription drug benefit with a few generic OTC drugs; brand name drugs are available through *Badger Rx Gold* • Members are automatically enrolled in *Badger Rx Gold*		
Services Covered through Medicaid Fee-for-Service	• Community Support Program (CSP) • Crisis intervention services (coordination is required) • Expenditures for persons on convalescent leave from an institution for mental disease (IMD)	• Expenditures for persons on convalescent leave from an institution for mental disease (IMD)	N/A	• CSP • Crisis intervention services (coordination is required) • Expenditures for persons on convalescent leave from an institution for mental disease (IMD)
Non-Covered services	• Services for persons 21-64 years of age when a resident of an IMD	• Crisis intervention services • CSP • Comprehensive Community Services (CCS) • Outpatient services in the home and community for adults • Substance abuse residential treatment	• Inpatient psychiatric stays in an IMD or psychiatric ward of a general acute hospital • Outpatient services, except services provided by a psychiatrist or physician • Day treatment • Assessments • Emergency detention and court-related services of any kind • Transportation following emergency detention • Crisis intervention services • CSP • CCS • Outpatient services in the home and community • Substance abuse residential treatment	• Services for persons 21-64 years of age when a resident of an IMD
Exemptions	Requests for exemption from HMO enrollment or disenrollment from the HMO may be considered for members meeting certain criteria.		N/A	N/A

NOTE: This table contains summary information only. Please refer to Appendix B for additional information and contractual language describing the HMO-contracted MH/SA benefits and limitations, cost sharing, and HMO provider and care coordination requirements for these services.

SOURCES

- Contract for BadgerCare Plus and/or Medicaid SSI between the HMO and the Department of Health Services, February 1, 2008 – December 31, 2009
- Department of Health Services Web site - http://dhs.wisconsin.gov/

SECTION IV. TARGETED COUNTY REVIEW

A. Background to Targeted Review

Given scope and budget constraints, the MH/SA Infrastructure Study could not include an examination of all 67 county MH/SA systems. Instead, the study consisted of nine county MH/SA systems, including one multi-county system that serves three counties:

- Dane
- Jefferson
- Kewaunee
- La Crosse
- Milwaukee
- North Central Health Care (NCHC) – serving Marathon, Lincoln and Langlade counties
- Price
- Sauk
- Wood

The factors considered in selecting the nine systems for the study are identified in **Table 1** on the next page. The counties range in size and are representative of different organizational structures, regions, and service arrays. In addition, the counties have experience with other initiatives that are in varying stages of implementation. Examples of these initiatives include managed regional long-term care (Family Care) and managed care for individuals receiving Medicaid Supplemental Security Income (SSI managed care).

The counties were selected to help provide a representative sample of the experiences of various county MH/SA systems. While the selected counties do not represent a scientifically valid sampling of organizational, program and/or funding experiences, they do provide insights into the diversity and commonality of county experiences.

Two telephone conference sessions were held with each of the counties during July and August 2009. The first was an introductory session held with multiple counties to serve as an orientation to the individual county interview. This session also served to review the questions and data that would be discussed. The second was a telephone conference with each county that served as the interview for the study. Follow-up communications occurred as needed with the selected counties to provide clarification and/or additional information.

The information and comments from the targeted county review are summarized in this section. As with other county data and information provided in this report, the summary information is presented in a way that generally does not identify particular counties, except when county identification is important to understand the information presented.

TMG would like to thank the representatives from the targeted county review for their participation, insights and the information they provided regarding their respective county MH/SA systems.

SECTION IV. TARGETED COUNTY REVIEW
Table 1 – Counties Selected for Targeted Review

The overall objectives of the in-depth review of targeted Wisconsin counties was to 1) gain a deeper understanding of the critical factors and information about service delivery and funding (e.g., what is "behind the numbers" of county-specific data reviewed for this study) and 2) to obtain insights into county experiences with other initiatives (e.g., BadgerCare, Family Care, SSI Managed Care) that may impact the MH/SA system. The intent was to select a few counties for review that are representative of various factors and initiatives. These factors for consideration are identified in the table below.

County	Structure	Size	DHS Region	Family Care	SSI Managed Care	Consideration for Inclusion in Study
1. Dane	HSD	L	S	Planning	N/A	• Implemented an integrated model (including community-based MH/SA services) for persons who are SSI eligible • Implemented original PACT model for community support • Managed Care Children's Wraparound
2. Jefferson	HSD	M	SE	2008	2007 2 HMOs	• Human Services Study in 2006 • Evidence-based practices (EBPs) and use of outcome measures • State Quality Improvement Grant Recipient
3. Kewaunee	HSD	S	NE	Planning for 2011	N/A	• County expressed interest in participating
4. La Crosse	HSD	M	W	Pilot/ Expansion	2007 1 HMO	• Organizational restructuring • Original Family Care pilot
5. Milwaukee	HSD	L	SE	Pilot/ Expansion to Persons with Developmental Disabilities	2005 5 HMOs	• Current study by Public Policy Forum • Milwaukee Addition Treatment Initiative (MATI) • Managed Care Children's Wraparound • County inpatient • Original Family Care pilot
6. NCHC – Marathon, Lincoln, Langlade	Multi-County 51 System	M	N	Marathon (2008)	2008 Marathon and Langlade – 2 HMOs	• Multi-county 51 system • Human Services Study in 2006 and organizational restructuring • Marathon – State Quality Improvement Grant Recipient • County Inpatient • Early CCS implementer
7. Price	HSD	S	N	2009	N/A	• Representative northern county
8. Sauk	HSD	M	S	2008	N/A	• County expressed interest in participating
9. Wood	Separate DCP	M	N	2009	2008 2 HMOs	• Single county 51 system

Abbreviations Used: HSD – Human Services Department; DCP – Department of Community Programs; S, M, L (Small, Medium, Large); CSP – Community Support Program; CCS – Comprehensive Community Services; PACT – Program of Assertive Community Treatment

B. Service Delivery Model, Structure and Roles

Counties with organizationally integrated MH and SA service structures:

- *Jefferson, Milwaukee and Wood counties* – MH/SA services are organizationally combined in a behavioral health division.

- *NCHC* – MH/SA services are organizationally combined in an outpatient unit and a behavioral health unit; however, the multi-county system is not yet programmatically combined. To accomplish this, NCHC is developing an enterprise-wide service structure that emphasizes consistency and standardization in service, quality and operational productivity. The service structure will work to eliminate the barriers and differences that exist between MH/SA programs in multiple locations in the tri-county system.

- *Price County* – MH/SA services are organizationally combined in the Disabilities and Long-Term Services Unit.

- *Sauk County* – MH/SA services are combined in an outpatient unit, with CSP as a separate unit and in a different physical location.

Counties with organizationally separate MH and SA service structures:

- *Dane County* – mental health services are in the Adult Community Services Division (along with other disability, aging and AODA jail diversion services). Substance abuse services for the non-jail population were transferred from the Adult Division to the Children, Youth and Families Division.

- *Kewaunee County* – Separate mental health and substance abuse programs report to one of the program managers acting as the MH/SA manager. Integration with other systems is complicated by multiple office structures and locations.

- *La Crosse County* – The Clinical Services Section is separate from substance abuse services. Substance abuse services have been merged with the Human Services Justice Sanctions Unit, which is aligned with the courts. The connection with the court system is intended to eventually result in one assessment process and determination of available treatment options. The clinical section's organizational structure differentiates between shorter-term crisis services and longer-term (over 90 days) psychosocial rehabilitative programs.

Best practices in integrating MH and SA services:

- A division structure for MH/SA services can foster better communication, planning and accountability for programs. Separate MH/SA units can also be effective if an agency is smaller and staff can work together on case reviews.

- Dane and Price counties each contract with two major service providers that provide both mental health and substance abuse services, which is a major component of their service integration.

- Several counties use staff that is dually licensed and certified in mental health and substance abuse treatment.

- Some counties use cross-functional teams and cross-over staff to support MH/SA consumers.

- Several counties reported working on initiatives to improve better service integration to those with co-occurring disorders.

- A few counties reported central access points to intake and assessment, including Milwaukee County's central intake units (CIUs) that function as the "front door" to services for consumers with substance abuse issues. Another central access point includes the service access to independent living (SAIL) unit that centrally manages access to all long-term community-based care.

- Wisconsin Supports Everyone's Recovery Choice (The WIser Choice) program was implemented as part of a complete redesign of the substance abuse services system in Milwaukee County. The program resulted in the use of a braided funding matrix to determine all the funding sources for which a consumer in multiple systems is eligible. The stated goals of The WIser Choice program include:

    - Enhancing and expanding the Milwaukee County Behavioral Health Division (BHD) Central Intake System to improve initial engagement, access and treatment retention.
    - Providing recovery support services and recovery support coordination in addition to treatment, thus addressing needs that are directly related to substance abuse and achieving better outcomes.
    - Identifying and developing a broader provider network, including a focused outreach to the faith-based community.
    - Developing a comprehensive continuum of low/no cost natural supports in the community to help sustain recovery. This would include organizing faith congregations to provide such resources as mentors, employment opportunities, housing, child-care and transportation.
    - Fostering genuine, free and independent consumer choice by making available provider profiles, including provider score cards.
    - Coordinating multiple systems and encouraging improved client choice and a client empowerment and self-determination model using the Single Coordinated Care Plan (SCCP).
    - Establishing a data-driven, results-oriented management system to monitor and improve outcomes.
    - Rewarding results by implementing an innovative system of provider incentives.
    - Enhancing the county's existing management information system so that most performance and financial indicators and measures will be reported on and maintained electronically to enhance provider and system accountability.

Most challenging elements of MH/SA system structure:

- One of key barriers to service integration is categorical program funding and regulatory requirements. There is a need to move to a more integrated funding and regulatory system to achieve better integration of services.

- It is challenging to integrate MH/SA services, and there needs to be more system-based ways to achieve integration other than co-location. It was also noted that it is challenging to recruit staff that is adequately trained in both mental health and substance abuse.

- There is concern regarding the sustainability of The WIser Choice Program in Milwaukee, since it is grant funded through an Access to Recovery Grant from the federal Substance Abuse and Mental Health Services Administration (SAMHSA) and will require continued funding to sustain the effort. Also, while the program is a best practice model, it does not address the underfunding of community MH/SA services.

- Several counties indicated that the greatest challenges are not structural, but rather the lack of funding for the MH/SA system.

Regional service provision:

- North Central Health Care is a regional provider of MH/SA services to the counties within and outside of NCHC's service area (e.g., crisis and inpatient services are provided to counties outside of the tri-county area).

- Counties reported involvement in crisis service planning that is being supported by regional crisis grants. The focus of these efforts includes getting counties certified to receive Medicaid that do not currently have a certified crisis program, and potentially providing a regional crisis hotline and crisis beds.

- Few counties have contractual relationships with other counties for regional services. Some counties noted they would like to pursue more regional initiatives and others indicated they must focus on providing services within their own counties.

Method of service provision – directly or through contract:

- Counties reported contracting for some or most of their MH/SA services. While Dane County contracts for all adult MH/SA services and provides some children's services directly, NCHC provides almost all treatment services directly and has very few contracted services. **Table 3** shows which services are primarily provided directly by counties or contracted out for the nine county MH/SA systems included in the study.

- Services most commonly provided directly by the selected counties, based on reports by six or more of the nine county systems, included:

    - Mobile Crisis Screening and Evaluation
    - Mental Health Outpatient

- AODA Outpatient
- Targeted Case Management
- Community Support Program
- Comprehensive Community Services
- Children's Wraparound or Coordinated Service Teams
- MH/SA Services to County Jail Inmates

- Services most commonly contracted out by the selected counties, based on reports by six or more of the nine county systems, included:

  - Crisis Stabilization
  - Mental Health Inpatient
  - AODA Inpatient Detox
  - Residential Services/Group Homes
  - Work-Related services

C. Service Array, Access and Capacity

Available services reported by all targeted counties included:

- Mobile Crisis Screening and Evaluation
- Mental Health Inpatient
- Mental Health Outpatient
- AODA Outpatient
- Targeted Case Management
- Community Support Program (all but one are certified)
- Children's Wraparound or Coordinated Service Teams
- Residential Services/Group Homes
- AODA Operating while Intoxicated (OWI) Assessment

Services less commonly available, based on reports by four or fewer of the nine county systems, included:

- AODA Non-Hospital Medical Detox
- AODA Social Setting Detoxification/Intoxification Monitoring
- Mental Health Day Treatment
- Mental Health and/or Drug Courts

Table 2 – Service Array for Nine Selected County MH/SA Systems

Service Array	# Reporting Available Services	Additional Information
Emergency and Crisis Services:		
• Mobile Crisis Screening and Evaluation	9	• Several have limited mobile crisis screening, performing most screens over the phone. • Four reported well-developed programs with most screens on-site and/or at the

Service Array	# Reporting Available Services	Additional Information
		emergency room. • One contracts mobile crisis/hotline services to counties in a broader region. • One is certified but is not billing MA for crisis due to issues with the crisis response plan requirement.
• Crisis Stabilization (Bed, Apartment)	8	• One contracts crisis beds to other counties.
• Mental Health Inpatient - Hospital	9	• Three have county-operated inpatient units.
• AODA Inpatient Detoxification	7	• One has county-operated inpatient detox.
• AODA Non-Hospital Medical Detoxification	3	• All contract out this service.
• AODA Social Setting Detoxification and Intoxification Monitoring	4	• All contract out this service.
Outpatient and Day Treatment Services:		
• MH Outpatient	9	• Six have county-operated outpatient clinics. • Several reported that the reasons for county-operated clinics include better coordination with other county MH/SA staff and/or limited outpatient providers to meet needs.
• MH Day Treatment	4	• One county that does not provide this service reported preference for supported employment instead.
• AODA Outpatient	9	• One county also reported providing AODA intensive outpatient.
• AODA Day Treatment	5	
• Other reported services	2	Other reported services: • AODA Jail Diversion program and Driving with Care program
Community-Based Services:		
• Targeted Case Management (TCM)	9	• All nine provide services directly, with two contracting out some or most TCM services.
• Community Support Program (CSP)	9	• One has a non-MA certified CSP. • Two have Assertive Community Treatment (ACT) teams.
• Comprehensive Community Services (CCS)	6	• Three, including the two largest counties, do not have CCS due to administrative and funding concerns.
• Children's Wraparound or Coordinated Service Teams (CSTs)	9	• Seven provide all services directly.
• Drop-In Center or Clubhouse	5	
Other Services:		
• Peer Support/Peer Specialist Services	6	• Two reported extensive use of peer support, including in the inpatient setting.

Service Array	# Reporting Available Services	Additional Information
• Recovery Support Services	5	• Services include transportation, child care, vocational services, transitional housing, spiritual counseling services, financial management, help maintaining housing, help connecting with medical health care services, etc.
• Residential Services/Group Homes	9	
• AODA Residential Treatment	8	• One reported available treatment but outside the county.
• AODA OWI Assessment	9	
• AODA Intensive Supervision/OWI Multiple Offender Program	8	
• Work-Related Services	8	
• MH/SA Services to County Jail Inmates	8	
• MH and/or Drug Courts	4	• Three reported having a drug court only; one has both; and one is trying to implement a drug court.

Services for which there is the largest unmet need reported:

- Outpatient services
  - Psychiatrist and nurse time, especially to prescribe and manage medications
  - Child psychiatry services
  - Wait times of up to 3-6 months
  - Limited choice for indigent consumers
  - Providers willing to accept Medicaid reimbursement rates
- Crisis services
  - Mobile crisis services
  - Timely follow-up to crisis
  - Crisis beds
  - Crisis diversion beds for those with substance abuse issues
- Inpatient services
  - Community inpatient capacity
  - Alternative inpatient facility that is less costly than the state mental health institutes

- Substance abuse services
    - Service capacity for those with painkiller addictions
    - Cognitive behavioral element in substance abuse treatment
- Early intervention and prevention services.
- Support services (e.g., vocational, peer support) to help avoid treatment and crisis.
- Services for those with less persistent and serious mental illness (i.e., those lower on the priority list).
- Services for those that are dually diagnosed with mental health, physical health and substance abuse issues, especially those addicted to pain medication.
- Services for nursing home residents with dementia and behavioral issues that cannot be safely managed in a nursing home setting.

Strategies reportedly used by counties to address lack of service capacity and funding for MH/SA:

- Focus on services for Medicaid eligible population.
- Maximize clinic billings for Medicaid reimbursement.
- Establish billable targets for CSP and outpatient services and monitor staff productivity. Two county systems reported use of billable targets for outpatient and community programs.
- Reduce no-show rate for outpatient services.
- Use NIATx process improvement techniques to achieve better MH/SA outcomes.
- Focus on short-term interventions, since the system lacks capacity to place everyone in need in longer-term programs.
- Cut services and lack the ability to expand services to address unmet needs.
- Use telehealth to stretch psychiatric resources and provide better access to consumers.
- Use groups so consumers can get into therapy more quickly.
- Develop crisis diversion options and work closely with law enforcement to divert individuals from inpatient settings (e.g., try to convert emergency detentions to voluntary placements).
- Develop managed care wraparound programs (i.e., Dane and Milwaukee counties which have managed care wraparound programs for children report that MH/SA issues for children are better addressed with an improved continuum of services than in the adult system).

D. Mental Health and Substance Abuse System Responsibilities

Breadth of county responsibilities:

- In addition to treatment services, counties have broad responsibility for various other areas that are performed to support individuals with MH/SA needs.

- Counties in the targeted review reported whether county MH/SA staff, other county staff and/or contracted staff is responsible for various MH/SA system responsibilities. The results are summarized in **Table 3**. Other county staff, within or outside of the county's human services structure, is often responsible for performing functions in these areas that support the county's MH/SA service system.

Table 3 – MH/SA System Responsibilities for Nine Selected County MH/SA Systems

Area of Responsibility	# Provided by County MH/SA Staff	Provided by Other County Staff	# Contracted Out
Information and Assistance regarding MH/SA Services	9	• Aging & Disability Resource Center (ADRC) • Aging • Children and Families • Developmental Disabilities/Disability Services • Economic Support • Law Enforcement • Social Services	3
Crisis Response – Voluntary for Emotional Distress • Receive calls/triage • Respond to calls/situations • Determine funding for service needs • Refer to services/ follow-up	9	• Children and Families • Developmental Disabilities • Elder Abuse (Area Agency on Aging) • Law Enforcement • Social Services	4
Crisis Response – Involuntary • Consult with law enforcement on emergency detention and/or substance use detox • Payment processing for emergency detention and/or substance use detox • Train law enforcement • Report to state	8	• Children and Families • Corporation Counsel • Developmental Disabilities • Operations/Support – Contract Management	3
Protective Services/Treatment – Voluntary • Receive and triage reports	5	• ADRC • Aging • Adult Protective Services	1

Area of Responsibility	# Provided by County MH/SA Staff	Provided by Other County Staff	# Contracted Out
• Investigate and report to state regarding adults and elders at risk • Assess level of treatment/ services needed to achieve stability • Provide informal resolution through service supports and short-term services (including case management) • Identify funding for services • Review and closure of cases		• Children and Families • Developmental Disabilities/Disability Services • Elderly Services • Long-Term Support • Operations/Support – Contract Manager	
Intake/Assessment for Individuals without Resources • Intake and assessment • Determine functional eligibility – MH/AODA functional screen and/or LTC functional screen • Identify funding for services • Initial case management and referrals	9	• ADRC • Children and Families • Developmental Disabilities • Economic Support • Long-Term Support • Operations/Support – Accounts Receivable and Contract Manager • Social Services	3
Provision/Payment of MH/AODA Services and Treatment • Provide inpatient and outpatient services • Provide other services (i.e., TCM, CCS, CSP, day treatment, residential services)	8	• Children and Families • Developmental Disabilities • Family Care MCO • Human Services Justice Sanctions Unit for AODA • Operations/Support – Contract Manager	7
Involuntary Services • Court assessment and documentation for commitment or protective placement services under Chapters 51 and 55, Wis. Stats. • Court hearing processes and periodic review required for individuals protectively placed • Authorize and pay for services when client resources are not available • Recruit, train and pay guardians (when resources are not available from the individual's estate) • Monitor commitment and settlement agreements • Process 3rd party petitions	8	• ADRC • Adult Protective Services • Aging • Children and Families • Corporation Counsel • Disability Services • Long-Term Support • Operations/Support – Contract Manager • Protective Payee Unit	4

E. Accountability for Outcomes

Approaches to ensure effective treatment and good consumer outcomes:

- Counties identified a number of different techniques, including:
    - Providing regular communication and coordination with providers to ensure implementation of effective treatment approaches.
    - Allowing training for county staff and/or provider staff on EBPs, such as motivational interviewing.
    - Using internally-applied SAMHSA fidelity scales to assess fidelity of programs to the EBPs.
    - Including recovery principles and implementing a recovery model for MH/SA services.
    - Reporting on outcomes in public documents, such as annual reports.
    - Embedding outcome measures in data systems for systematic and regular reporting.
    - Identification of best practices in request for proposal (RFP) documents for specific services.
    - Including outcome measures and targets in provider service contracts, so counties pay for results as opposed to service units.
    - Ending contracts with some providers due to lack of documentation on outcomes.
    - Contracting only with state-certified providers, and reviewing EBP fidelity implementation with certifiers of programs.
    - Incorporating some outcome-based measurement processes from SA services into the MH area.

- Counties reported significant variations in the pace with which they have implemented recovery principles. Some reported they are in the infancy of this change, while others have more completely embraced recovery principles in a range of MH/SA services, including inpatient services.

- Counties also reported significant variations in the pace of implementing EBPs and ensuring fidelity to the EBP models, with some counties reporting more widespread implementation than others. One county reported that most of the SAMHSA EBPs are challenging for smaller counties with a limited population base.

- Most counties reported not yet aggregating consumer outcome data and/or limited use of data to inform system changes, quality improvement efforts and/or budget allocation decisions. Some reported beginning to aggregate data to establish a baseline against which future data can be evaluated and system improvements can be made.
    - Most counties do not have the resources for comprehensive data collection and evaluation.
    - Smaller providers lack the infrastructure to evaluate outcomes.
    - Identification of system and service quality issues is easier in a smaller system where the group of consumers is known.
    - It is difficult to track all emergency detentions and those diverted from inpatient.

- Most counties reported inaccuracies in the Human Services Reporting System (HSRS) data because of data entry problems and inconsistency. Several noted better accuracy with the long-term care waiver data because the data is tied to billing and funding, whereas HSRS for MH/SA data is not.

F. Impact of Managed Care Initiatives

Impact of Family Care on Public MH/SA System:

- The business infrastructure (e.g., provision of administrative and other supportive services) between county long-term care and MH/SA programs is intertwined and will have a large impact once Family Care is implemented. Several counties in which the Family Care program has been implemented indicated a significant loss of revenue for agency overhead and administration. Some counties reported increased interest in organizational consolidation of county human services agencies and functions due to infrastructure changes. For counties that continue to be a major service provider to the Family Care MCO, the business structure impact of Family Care on other county human service functions is reduced.

- A key question for counties that will be seeing the return of their county contribution to Family Care over the next five-year period is whether county boards will allow these dollars to be used for human services or for other county purposes.

- Some counties reported mixed experience with Family Care, with some consumer needs being addressed efficiently by Family Care MCOs, but some decisions being driven more by cost than consumer need. These decisions are disruptive to the consumer (e.g., when a Family Care member is pulled out of a placement that has been effective). Some of these issues are more specific to particular Family Care teams and not the MCO as a whole.

- There no clear incentive for the Family Care MCOs to review the total MH/SA needs of the consumer and provide comprehensive care management and care coordination. This is because Family Care does not pay for crisis and inpatient services. Several counties suggested including comprehensive MH/SA services in the Family Care benefit, especially for inpatient MH/SA services. Most counties indicated that the exclusion of inpatient services (and also crisis services) from the Family Care benefit has caused problems and represents a major system flaw. Counties report disincentives for Family Care MCOs to do more timely discharge planning, since they are not responsible for the cost of inpatient care. An incentive to do quality, comprehensive care planning would be for all the funding (including crisis and inpatient) to follow the person.

- While Family Care MCOs are required to manage member risks, one county reported getting adult protective service referrals for Family Care members in residential settings.

- Some counties felt that CSP should not be part of the Family Care benefit, because Family Care requires that CSP services be unbundled, resulting in a lack of support for system management from Family Care MCOs. This has a negative impact on Family Care members who require CSP services and raises concerns that CSP for Family Care members will not use

the true CSP model. These counties felt it would be better to take CSP out of Family Care and leave it as a card (FFS) service or require MCOs to treat CSP as an intact service.

- One county questioned the efficiency of adding another layer to CSP by having CSP in the Family Care benefit and, therefore, adding the involvement of Family Care MCOs to service administration.

- One county felt that the state should provide clarity as to which entity (county or MCO) has primary responsibility for a consumer in CSP.

- One county reported a good working relationship and coordination between the Family Care MCO and the county CSP, which are located in the same building.

- One county reported all the long-term care waiver clients that were formerly enrolled in CSP have never returned to CSP since Family Care was implemented; the county wonders what happened to these individuals.

- One county pointed to lack of service coordination with the Family Care MCO regarding Family Care members with developmental disabilities and mental health issues, in part due to the MCO's lack of familiarity with that target population.

- Some counties expressed concern that some individuals with MH/SA issues who receive long-term care waiver services are not functionally eligible for Family Care. These individuals are now dependent on county funding for continued services or will fall through the cracks of the two systems.

Impact of BadgerCare Plus and SSI Managed Care on Public MH/SA System:

- Several counties stressed the importance of having integrated HMO and community mental health.

- Counties reported mixed experiences coordinating MH/SA services with managed care organizations and there is significant variation among the targeted counties regarding their working relationships with Medicaid HMOs. The counties that reported the most positive working relationships tended to be those county MH/SA systems that have preferred provider arrangements with the MCOs for the counties to provide some or most MH/SA services.

- Several counties reported a great deal of confusion for MH/SA consumers who transitioned to several different HMOs for SSI Managed Care.

- For some enrollees in Medicaid managed care programs, the MH/SA services provided are no longer local.

- The more limited MH/SA benefits provided under the BadgerCare Plus Core expansion are not expected to adequately address the needs of the consumers served by the county system and, therefore, will not have a significant impact on the county system. In addition,

the inclusion of psychiatric service coverage under the BadgerCare Plus Core expansion will have limited efficacy if not combined with other outpatient therapy services.

- One county expressed concern about the impact on consumer continuity of services and the impact on crisis and inpatient services when individuals transition from the county MH/SA system to BadgerCare Plus Core expansion and have to visit different psychiatrists (and/or face longer wait times for psychiatric services).

- Expansion of Medicaid managed care programs does not ensure individuals have access to services if there is not an adequate pool of providers willing to accept Medicaid rates.

- The MH/SA population served by counties has more complex needs that require strong case management and service outreach as opposed to more limited, clinically-based services provided by HMOs and covered under the Medicaid managed care programs.

- With more and more children and family health care under care management, the state should require HMOs to adopt evidence-based practices for MH/SA treatment and monitor outcomes more closely.

- Four counties reported prior authorization and billing problems when Medicaid HMOs have not paid counties adequately or in a timely fashion for MH/SA services provided to enrollees. One of the counties indicated that prior authorization and billing issues (with the Medicaid HMOs concerning outpatient services) are the most significant portion of their write-offs when they do not get paid.

- One county reported that up to 25 percent of individuals receiving county inpatient services are enrolled in Medicaid HMOs and that there is a fairly significant inpatient recidivism rate for these enrollees. There is a concern that individuals cycle back through the inpatient system, because the HMO care management model is not adequate for the higher-need population.

G. Impact of Other Initiatives and Changes

Impact of Wisconsin Medicaid Cost Report (WIMCR):

- Most counties raised concerns about the lack and unpredictability of funding through WIMCR and the difficulty to have confidence and trust when the state failed to sunset WIMCR as originally proposed.

- Several counties raised concerns about the apparent lack of transparency in how the WIMCR allocation methodology is used and the funding allocated between counties.

- Several counties expressed a desire to return to the Community Services Deficit Reduction Benefit (CSDRB), which preceded WIMCR. CSDRB allowed counties to claim local funding for the nonfederal share of Medicaid. It should be noted that the Wisconsin County Human Service Association (WCHSA) has recommended discontinuing WIMCR and instead

permitting counties to return to the direct claiming of Medicaid under CSDRB or an equivalent program, based upon individual county expenditures and experience.

Impact of Comprehensive Community Services (CCS):

- Counties that have not implemented CCS indicated that they did not see a cost-benefit to implementation because of the system change required and the increased paperwork and administrative workload that would be involved.

- Larger county systems expressed concern about the entitlement nature of the CCS benefit and the inability to financially sustain that approach.

- Some counties indicated they have already maximized Medicaid revenues and observed little financial benefit to implementing CCS. Others perceived CCS as an opportunity to integrate the recovery-based philosophy in their services.

- For counties that have implemented CCS, most reported implementation going more slowly than expected. Concerns identified include training needs, documentation requirements, a more restrictive service approach and significant delays in the rate approval process. There has been a great deal of administrative and bureaucratic exchanges between counties and the state regarding billing and reporting issues.

- Some counties expressed concern that the administrative workload requirements of CCS mean less time is spent providing direct services to consumers.

- One county reported CCS implementation was better than expected and indicated a willingness to train others in CCS implementation.

- Some smaller counties lack the community resources to offer the full service array covered by CCS.

1915(i) State Plan Amendment:

- Several counties expressed interest in the proposed 1915(i) state plan amendment for community recovery services, and see this as a potentially more flexible and beneficial option than CCS. Advantages identified include the non-entitlement nature of the 1915(i) benefit and the potential ability of counties to maintain wait lists, receive funding for residential services, and experience less onerous administrative requirements and service restrictions than under CCS.

- Some counties expressed caution and wariness about the proposal and are assuming a “wait and see” approach until they have a better idea of whether the benefits will offset the administrative burden to counties.

H. Impact and Use of Funding Sources

Medicaid funding:

- Several counties indicated a strong focus on getting eligible individuals with mental health issues on Medicaid, but noted the smaller role Medicaid plays as a funding source for individuals with substance abuse issues.

- Some counties indicated a continuing effort to maximize Medicaid revenue, including improving the billing and collections processes that are often challenged by fragmented computer systems. One county emphasized the importance of a robust computer system for outpatient billing and working closely with clinical staff in order to successfully maximize Medicaid revenues and ensure that they are billing for all eligible costs.

- A few counties emphasized the desire to implement every possible Medicaid program benefit, as long is it is good for the consumer and makes sense financially for the county.

- There was considerable variation in the relative percentage of the Medicaid funded population that counties reported serving in their MH/SA systems. A few counties reported the percentage of MH/SA consumers with Medicaid funded services in the 13-15 percent range. Several others reported a Medicaid funded population in the 30-50 percent range. One county estimated that up to 65 percent of its MH/SA service population is Medicaid funded. While these variations may indicate differences in how counties estimate their Medicaid funded population across programs, they may also indicate differences in how counties maximize Medicaid funding for MH/SA services.

State funding:

- Most counties noted that there is county and federal support for MH/SA services, but a lack of commensurate state support.

- Many counties reported that their increased county levy support for MH/SA services is a direct result of the lack of state funding.

- Several counties have not raised rates to providers due to flat or decreasing state funding. Instead they are purchasing fewer services with the same or reduced revenues. Flat or declining provider rates are negatively impacting overall service capacity.

Local funding:

- Most counties reported using local property levy dollars and Community Aids Basic County Allocation (BCA) interchangeably to fund MH/SA services.

- Some counties reported an approach that used local levy dollars only as a last resort to fund MH/SA services.

- One county system reported less reliance on the county levy due to the impact of the transitional payment from Family Care implementation.

- One smaller county reported large fluctuations in county levy from year-to-year due to the unpredictability and level of institutional placement costs.

- Counties reported increases in the uninsured population due to the economic downturn and job losses. Most counties reported that the indigent population (i.e., those without Medicaid or other insurance) comprises from 50-59 percent of the population they serve in their MH/SA systems.

- Some counties fund non-Medicaid eligible individuals in CSP to prevent more costly inpatient placements.

Private insurance funding:

- Most counties indicated that private insurance was not a major revenue source for the publicly funded MH/SA system. Some indicated this was a declining source of revenue.

- While counties indicated that they try to maximize use of private insurance for outpatient services, the benefit limits (e.g. lifetime and episode limits) associated with private health plans impact the usefulness of private insurance to support those in the county MH/SA system and impede the ability of consumers to access necessary services.

- One county noted the disruption in treatment plans for consumers who transfer from a private insurance provider to a county provider.

I. Reform Effort Considerations

Issues to Address in Reform Effort

Issues identified by the targeted counties that should be addressed in a potential effort to reform the financing and delivery of MH/SA services are arranged thematically by major benchmark goal and include:

<u>Equitable Access to Services</u>

- Consumers who need MH/SA services should have an earlier and more appropriate service response than crisis and inpatient services.

- Chapter 51 should be re-written to make it easier for individuals to receive services. There needs to be a more cost-effective, prevention-based approach that does not require hospitalization.

- Regionalization of services is being driven by providers that need to serve a greater base and more counties in order to survive financially.

- There needs to be a better response, including service options and financial incentives, to serve the ever-increasing population with dementia and aggression, and prevent these individuals from being placed at the state institutes.
- Provider capacity for the higher cost, specialized services (e.g., psychiatric services) is a challenge, especially in more rural counties. Demand for more limited services drives up the cost to counties.

- Counties are seeing increases in the indigent (uninsured and underinsured) population with MH/SA needs.

- Wisconsin should evolve from the CSP model of a long-term intensive program to a more comprehensive and flexible service array that promotes self-sufficiency and recovery.

Accountability for Outcomes

- The correctional population should be included in MH/SA reform efforts.

- There is a concern that both the state and Medicaid managed care organizations (including Family Care MCOs) are shifting high cost services to the counties.

- Reform should include shared consequences for all systems (i.e., county and managed care systems) involved in a consumer's care when one system makes a mistake.

- Mental health standards should be updated in a timely fashion and all inpatient providers should be required to adopt recovery principles and evidence-based practices.

- Reform should move to a performance-based MH/SA service delivery system, with counties buying value and getting results, not simply contributing funding.

- There should be a greater focus on evidence-based treatments for MH/SA services provided by HMOs to the Medicaid population.

Equitable and Affordable Funding

- The publicly funded MH/SA service system should be financially sustainable, and the current system, with the heavy reliance on county funding, is not. The county property tax levy is not a sustainable funding source for MH/SA services.

- The publicly funded MH/SA system still invests a lot of resources in inpatient care. A more balanced funding structure that provides greater incentives to provide prevention and early intervention and build community services would allow a return on investment from other related systems, such as corrections.

- The state should fund high costs placements at state institutes. There is a misaligned incentive regarding when the county is responsible for paying the cost of placements at state institutes. There is no financial incentive for the state institutes to move individuals to a less restrictive setting. Aside from the financial strain these placements put on county

budgets and community services, it is difficult to manage these cases from a distance. Some state screening should occur so that those with the most significant mental health issues and/or criminal histories become the responsibility of the state.

- There is a great deal of concern that the recent state budget provision to make counties responsible for the placement costs of youth and elderly in the state institutes will further burden an already stressed and underfunded county MH/SA system.

- Medicaid rates are not adequate and result in fewer providers and reduced provider capacity to serve Medicaid eligible individuals.

- Medicaid and private insurance pays a small portion of actual county service costs.

- The property tax levy should not fund human services, but rather services related to property.

- The state should be responsible for providing the nonfederal share of Medicaid funded services.

- If additional resources are not available, the state should change its expectations for counties and/or modify its approach.

- Counties providing MH/SA services to other counties should be able to bill counties outside of their service area for the difference between the Medicaid rate and the actual cost of care. This would encourage more regionally-funded service delivery, and would be consistent with how the state institutes bill counties for the cost of care. The counties receiving such regionally-provided services could provide payment to the state, which could, in turn, provide payment to the county provider of MH/SA services.

- Mental health and substance abuse services should be better integrated. The entire MH/SA system is fragmented regarding funding and services. Funding needs to be more flexible to serve those who are dually diagnosed. While funding can be redirected, there should be better integration of different funding streams and requirements.

- The risk management aspect of operating in an underfunded system is a concern if staff burns out and makes mistakes that harm consumers.

- It is more critical for reform to address the lack of funding for MH/SA services as opposed to the system structure.

- There needs to be more money to accompany mandates placed on county MH/SA systems.

- Certain services, such as crisis intervention/diversion and inpatient, should be fully funded by the state.

- Reform should explore possible Medicaid funding solutions for the adult population and include additional opportunities to provide Medicaid coverage of MH/SA services. If

Medicaid could cover the costs of those aged 21 to 64 in an inpatient setting, counties could draw down the federal share of Medicaid, which would have a significant positive impact on the system's financial viability and available resources for community services.

Efficiency of Service Delivery

- Regulations are out-of-date and not flexible to address system fragmentation. Also, programs sometime require multiple assessments when data could simply be updated.
- Rule and statutory changes need to parallel reform efforts.
- Reform should streamline requirements and processes (e.g., billing and rate-setting processes) for certified programs.
- Regional delivery of MH/SA services may work as long as local community connections are not lost. It is important to include collaborative efforts among counties in a reform initiative.

Lessons Learned from Past Reform Efforts

The targeted counties identified the following lessons learned from past state human services reform efforts in Wisconsin (Family Care expansion, Mental Health Redesign, CCS, etc.) that can help inform future efforts to reform the publicly funded MH/SA system:

Process and Approach to Reform Effort – Lessons Learned

- There needs to be a clear vision for the reform effort and identified interfaces with other related state and county systems.
- The state should establish all requirements and parameters of reform initiatives before reform is implemented (e.g., CCS became more restrictive as it was implemented and there were a lot of unresolved issues when Family Care began to expand).
- The state should be more transparent in the reform process and fully disclose potential impacts, concerns and issues.
- Data should inform and drive the reform effort.
- Reform works best when the state allows stakeholder involvement and provides a broad outline of the reform effort, giving counties appropriate incentives and the ability to fill in the details.
- Pilot programs (e.g., Family Care and CCS) rarely go to scale and expand successfully without becoming more bureaucratic and without losing their uniqueness.
- Communication regarding various reform efforts has varied, with the state providing more information for the expansion of Family Care and comparatively little for the rollout of SSI Managed Care.

- It is important for counties and the state to have a dialogue about the facts of a new initiative, without editorial comment.

- Counties that have successfully implemented reform initiatives could provide training funded by the state to other counties during implementation.

- Standardizing or consolidating computer operations to support the reform effort needs to occur before reform is implemented. Standardized technology and adequate technology support should be part of reform plan. This did not occur with Family Care.

- Reform should bring about greater standardization of operating practices (e.g., standardized information provided to counties by ADRCs).

- There is a need to look at more robust solutions to system reform and stop implementing "band-aid" approaches.

Structure and Roles - Lessons Learned

- Reform needs to address all the functions that counties perform. Otherwise, remaining functions will not have adequate funding. For example, under Family Care, counties have certain responsibilities (e.g., guardianships, adult protective services) and do not have the funding to support them. One county reported scheduling reviews for persons under protective placement orders at the same time as long-term care waiver visits. In the past, the costs were born by the waiver programs. However, this can no longer occur, since Chapter 55 reviews and guardianships are not included in the Family Care program.

- There is a significant misalignment of incentives in the current system that is managed at the state level but funded at the local level. It is marked by a lack of clarity regarding what is and what is not mandated by the state.

- Reform sometimes adds more complexity and layers to the system rather than less.

- Counties can serve MH/SA consumers more multi-dimensionally due to greater flexibility than consumers who have insurance and those whose cases are highly managed. Highly managed cases can become a limiting factor in securing the necessary and appropriate services.

- A concern with multi-county systems is the loss of individual county control and identity, but the opportunities include better cooperation, standardization and use of limited resources.

Funding – Lessons Learned

- The state always underestimates the cost and impact to counties of human services reform, with counties experiencing the negative effects of reform. Before future reform efforts are implemented, there needs to be a better understanding of the associated costs and savings, as well as the service implications.

- Counties are closely watching what is happening with Family Care to see if people are being served and if the program is costing less than the prior system.

- Reform of the MH/SA system cannot occur with just Medicaid funding – all funding sources need to be included for sufficient resources.

- Counties will be reluctant to transfer their county property tax contributions for MH/SA services to fund state reform.

- Financing reform should align funding with program expectations and responsibility. Reform also should provide incentives to promote quality services and diversion from deep-end services.

- It is very challenging to identify the true cost of services per consumer, given the funding and service fragmentation inherent in the MH/SA system.

A. Overview of National Trends

While a review of the literature examined for this study reveals numerous trends that currently influence or have the potential to influence public MH/SA systems, three trends, in particular, are likely to have an increasing impact in shaping the future financing of these systems.

Preference for Integrated Care Models

- Payer and consumer preference for integrated services is growing and integrated care initiatives are being implemented and/or proposed in various states.
- Integrated care can result in better coordinated care and outcomes for consumers, as well as administrative simplification and reduced costs for payers of MH/SA services.
- Integration has different meanings and can be defined as integration between one or more of the following:
    - Mental health and substance abuse services
    - MH/SA and physical health care services
    - MH/SA and other human services and disability support services

Role of Medicaid as a Major Funding Source for MH/SA Services

- Medicaid is the largest single source of financing for mental health services and the second largest payer for substance abuse services.
- Given the dominance of Medicaid as a funding source, there may be a shift away from other funding sources, including state general purpose and block grant dollars. The disadvantage to this funding shift is the eligibility and service limits of Medicaid. Other funding sources may provide more funding flexibility to address comprehensive service needs for a broader population.
- Medicaid expansion has resulted in more individuals with MH/SA issues being eligible for Medicaid funded services. However, given the lack of providers in some areas who are willing to accept Medicaid rates, consumers may still lack adequate access to certain covered services, such as psychiatric services and traditional outpatient services.

Financial Incentives and Value-Based Purchasing for MH/SA Services

- Increasingly, payers of MH/SA services and other human services are focusing on strategies to purchase value and to get better results for the funding allocated.
- The focus on performance-based contracting and accountability for consumer outcomes are part of the trend to purchase value as opposed to simply purchasing units of service.

- In addition, the inclusion of incentives in funding strategies is intended to support and reward systems that implement best practice approaches and achieve improved outcomes.

B. Federal Initiatives and Potential Changes

Public MH/SA systems are also impacted by changes in federal law and regulations. The passage of federal parity legislation for MH/SA and eventual federal health care reform efforts may result in changes that impact the availability and funding for publicly financed MH/SA services. With potentially greater health insurance coverage of MH/SA services through public and private health plans, both parity legislation and health care reform legislation have the potential to decrease demands on safety net provider systems, such as county MH/SA systems. While the specific impacts of these initiatives on Wisconsin's public MH/SA have not been analyzed, this section identifies the key components of the initiatives and their potential impact.

Mental Health and Substance Abuse Parity

- MH/SA parity seeks to equalize MH/SA benefit coverage with physical health benefit coverage, thereby recognizing the importance of MH/SA services as an integral part of most medical conditions. MH/SA parity means that benefits coverage for MH/SA benefits must be at least equal to the coverage provided for physical health benefits. Therefore, any financial requirements and treatments limitations applied to MH/SA benefits cannot be more restrictive than those for physical health benefits. In the past, some health plans have applied higher patient cost sharing and more restrictive treatment limitations to MH/SA benefits than for physical health care benefits.

- The **Mental Health Parity and Addiction Equity Act of 2008** (MHPAEA) substantially increases the mental health benefits protection afforded under the federal Mental Health Parity Act of 1996, which only required parity coverage for lifetime and annual dollar limits and did not apply to substance abuse service benefits. Effective January 1, 2010, MHPAEA requires all group health plans with 50 or more employees to comply with the parity requirements. This means the amount a group health plan covers for physical health benefits, it must also cover for MH/SA benefits.

Impact of Parity on Medicaid

- MHPAEA addresses parity in a variety of settings and programs, including Medicaid health plans and the children's health insurance program (CHIP), thus impacting the BadgerCare Plus and SSI managed care programs (but not Medicaid fee-for-service programs).

- <u>Medicaid Health Plans</u>

    - If a state chooses to cover MH/SA services through Medicaid health plans, these plans must be in compliance with the current law under the Mental Health Parity Act of 1996 *(Ref.* 42 USC s.1396u-2 (b)(8)).
    - If mental health benefits are covered by the Medicaid contract, then all Medicaid managed care organizations must comply with the requirements of MHPAEA and provide for parity for MH/SA benefits.

- Children's Health Insurance Program (CHIP)

  - Legislation in 2009 reauthorizing CHIP now requires parity. The previous provision to allow states to develop "benchmark equivalent plans" for mental health was eliminated.
  - As of 2008, CHIP applied to 7.4 million children nationally; it is estimated to reach 11 million children by 2013.

- Medicaid Fee-for-Service

  - MHPAEA does not apply to fee-for-service arrangements because the State Medicaid Agency does not meet the definition of a "group health plan," as defined in HIPAA. Section 1932(b)(8) of the Social Security Act (as added by section 4704(a) of the Balanced Budget Act of 1997).
  - The Federal law specifically requires Medicaid managed care organizations to comply with mental health parity by treating them, for that purpose, like health insurance issuers offering group health insurance coverage (as those terms are defined in HIPAA).

- Parity Exemptions

  - The exemptions from the parity provisions in MHPAEA (e.g., exemption for groups with less than 50 employees and cost exemptions in certain situations) apply only to group health plans and to insurance products sold to those plans.
  - The exemptions are not available to Medicaid managed care plans because they are furnishing services in connection with a state Medicaid program, which is not a group health plan. The parity requirements of MHPAEA apply to Medicaid managed care organizations without exemptions.

Status of Parity Regulations

- A Request for Information (RFI) regarding the MHPAEA was published in Volume 74 of the Federal Register (April 28, 2009) by the U.S. Department of Labor (Employee Benefits Security Administration), U.S. Department of Health and Human Services (Centers for Medicare and Medicaid Services), and the Internal Revenue Service. Comments were due by May 28, 2009, and more than 400 groups, government organizations and individuals provided input.

- The federal government is expected to issue its parity regulations by January 2010 when the law is slated to go into effect. It is expected that the regulations will clarify key questions regarding Congressional intent about MH/SA scope of services, medical management deductibles and treatment limitations.

Federal Health Care Reform

Debate continues at the federal level about how to reform the health care system. Achieving comprehensive health care reform has emerged as a leading priority of the President and many members of Congress. Various proposals seek to address health insurance access and affordability, health care costs and/or quality of care issues.

Expansion of Medicaid:

- Each of the major reform proposals contain provisions for expansion of public programs, including expanding Medicaid to all individuals (children, pregnant women, parents and adults without dependent children) with incomes up to either 133 percent or 150 percent of the federal poverty level (FPL), depending on the proposal.

- Other provisions included in reform proposals require premium assistance to certain Medicaid beneficiaries with access to employer-sponsored insurance, and an increase in the federal medical assistance percentage (FMAP).

Insurance Reforms – Sample Provisions from Different Health Reform Proposals:

- No lifetime and annual benefit limits.

- No coverage exclusion for pre-existing conditions or rejection of applicants for coverage based on their health status.

- Limits on premium rate variation, with no variation on the basis of health status.

- Guaranteed issue and renewal.

MH/SA Protections:

- Both the Senate and House reform proposals, America's Affordable Health Choices Act of 2009 (House Tri-Committee) and the Affordable Health Choices Act (Senate HELP Committee), contain key MH/SA provisions, including strong protections for parity coverage under the health reform.

- Other provisions included in reform proposals require health plans to provide MH/SA and rehabilitation and habilitation services, and require health plans to provide coverage of MH/SA treatment at parity. Initially, there was concern by advocacy groups that the protections afforded by the MHPAEA could be lost in reform proposals unless parity for MH/SA treatment was specifically addressed. And, the proposed requirement that health plans provide MH/SA coverage is a significant achievement, since the current parity law does not require group health plans to cover MH/SA treatment. It only requires that if they cover MH/SA treatment, it has to be at parity with physical health benefits.

SECTION VI. REVIEW OF SELECTED STATES

A. Background to Other State Review

The study included five states other than Wisconsin to gain an understanding of each respective state's MH/SA models and efforts to reform the financing and structure of publicly funded MH/SA services:

- Minnesota
- New Mexico
- North Carolina
- Ohio
- Oregon

Before selecting the five states, the MH/SA Infrastructure Steering Committee reviewed comparative information gathered from available national and state data sources. This information is included in the table in **Appendix C.** While various factors were considered by the Steering Committee when selecting these five states, key considerations included:

- Minnesota and Ohio have county-based human service systems that are often compared to Wisconsin. However, both have more experience with multi-county approaches to MH/SA funding and service delivery than Wisconsin does.

- New Mexico and North Carolina have both implemented significant reforms in funding MH/SA services, and these reforms have been the topic of numerous studies. New Mexico, while a state-administered system, represents a bold initiative to consolidate various funding streams for MH/SA across many state agencies into one entity. North Carolina implemented significant changes to almost every aspect of its MH/SA system and offers many lessons from its experience with reform.

- Oregon is moving toward greater integration of MH/SA and physical health care, and is considered a leader in the implementation of evidence-based practices.

To gain an understanding of these other state systems and reform efforts, the project team reviewed extensive background information from state sources, independent evaluations and national data. Interviews were also conducted with various individuals to gain a more balanced and comprehensive perspective on the respective reform efforts. The project team interviewed representatives of the appropriate state mental health and substance abuse agencies and representatives of consumer and county system advocacy. The list of state officials and organizational representatives interviewed is included in **Appendix C.** Also, the summaries of the interviews with representatives of MH/SA consumer system advocacy from each of the five states are in **Appendix C**.

TMG would like to thank the representatives from the other states for participating in this study, and for sharing their perspectives and information regarding their respective MH/SA systems.

B. Key Lessons Learned from Other State Reform Efforts

Despite the differences in approach and scope of system reform in the five states included in this study, there were several overall and recurring themes that can serve as lessons learned for Wisconsin and other states that are contemplating reform efforts. The key lessons learned are summarized in this section.

Process and Approach to Reform Effort – Key Lessons Learned:

- Recognize that **leadership is critical** – both executive and legislative.
- Continue to **hold the vision and goals** of reform, in spite of changes in staff and leadership.
- Establish an extensive, **comprehensive and inclusive planning** process involving all the system stakeholders to minimize the risk of creating a reform design that harms a fragile consumer population.
- Make sure reform is **consumer-focused**. Ensure that better consumer outcomes drive the system and that consumers benefit from the reform effort.
- **Demonstrate clear results** of changes – show changes that have meaning in people's lives.
- **Manage expectations** – understand the breadth and depth of what reform will entail; the more significant the change, the longer it will take to implement.
- Give reform time to be successful – **stage reform** and show results instead of trying to do everything at once. Do not take on **too much change at once** because of the impact it will have on service capacity and workforce, as well as the difficulty in assessing the impact of individual changes and taking corrective action.
- **Pilot reform** – do not try to reform the entire state at once.
- Find **compromise solutions** that move system toward reform goals.
- Implement a **core benefit set** and any changes to benefits first.
- Address **service capacity and workforce issues** – these are critical, especially when moving to a uniform benefit package that may require greater service capacity and different types of services.
- Ensure **data informs and shapes the reform effort** and helps evaluate the impact of reform.

Structure and Roles in Reform – Key Lessons Learned:

- Focus attention on **how services are provided and funded** and entities function within "boxes," as opposed to how many "boxes" there are.

- Consider potential **implications of profit motive** of private entities in public managed care system. Non-profit managed care organizations (MCOs) may work better (Minnesota's experience), since it is difficult to align profit motive with goals of the public system (North Carolina's experience).

- Ensure that people **do not lose managed care plan eligibility or fall through the public safety net** because they are uninsured.

- Provide **flexibility for business entities** (i.e., counties, MCOs, Mental Health Organizations (MHOs)) to partner and establish the regions and structure for collaboration that they choose.

Funding Reform – Key Lessons Learned:

- Recognize that the **influx of new dollars** increases the likelihood of a successful reform effort. Publicly funded MH/SA service systems are typically underfunded, with not enough dollars to move to a capitated rate structure, even if all funding streams are combined.

- Allocate **funding by regions** to help support regional service planning.

- Base funding, at least in part, on **performance measures and incentives** to support system goals.

- Address **inequities in funding and service access**. If a significant portion of overall funding is determined through a competitive process or relies on local financial contribution, inequitable funding and service access will occur.

- Address the **full costs of reform** effort and address these with sufficient resources (e.g., North Carolina initially established a trust fund to support reform during economic downturns).

- Build **cross-system funding capacity**.

Service Integration in Reform – Key Lessons Learned:

- Include **MH/SA care reform as part of the larger health care reform effort**. If MH/SA is not included, it will be a silo.

- Recognize the **difficulty and need to address system fragmentation** if there are multiple agencies, requirements and funding streams.

C. Other State Reform Efforts

Minnesota – State Reform Effort

Most of Minnesota's reform came from the work of the **Minnesota Mental Health Action Group (MMHAG)**. MMHAG is a broad-based planning work group begun in 2003. Its work resulted in the Governor's Mental Health Initiative in 2007, which had strong bipartisan support.

Reform goals:

The MMHAG identified four high priority goals to implement the Road Map for Mental Health System Reform in Minnesota (June 2005). The MMHAG was charged with transforming the mental health system to better serve children and families, and to improve quality and efficiency. The high priority goals included:

- Measure quality and performance by implementing streamlined and standardized measurement tools across the system to produce useful quality data.
- Develop a new financing and payment model for mental health services in which funding follows the consumer.
- Reduce system complexity and improve ease of access by promoting communication and coordination and continuity of care between providers.
- Create a consumer-centered system by using consumer principles and guidelines to evaluate system improvements.

Key elements included:

- Development of a **comprehensive mental health benefit set** for all publicly funded mental health services.
- Creation of **Preferred Integrated Networks (PINs)** used to provide integrated mental and physical health care and coordination with county social services for adults with serious and persistent mental illness. PINs are also for children with severe emotional disturbances who are currently enrolled in managed care programs (prepaid health plans). PINs are partnerships between health plans and community human services departments. These partnerships will create a "social model" HMO that will be at-risk for all health, pharmaceutical, mental health and social services offered. Funding is combined from several sources to create a braided funding methodology. The primary goals of this reform effort as identified by state officials are to provide better integration and less fragmentation between mental and physical health care and to promote a greater focus on prevention.
- **Infrastructure investment** that has linked state grants (awarded to counties through a competitive bid process) to certain goals the state wanted to achieve, including capacity building for crisis, housing and children's services, as well as development of evidence-based and best practices.

Proposed human services structural redesign:

- Governor's redesign proposal seeks to create a **regional human services delivery system** composed of 15 service delivery areas (SDAs) to simplify administration of human services and integrate services around the needs of individuals and families.

- Counties' counterproposal, named the **State County Results Accountability and Service Delivery Redesign**, has a goal of creating systems change through finance reform, shared performance accountability and structural redesign that gives counties flexibility to organize themselves as single or multi-county systems.

Other reform efforts:

- Responsibility and funding for **mental health targeted case management** for those enrolled in prepaid health plans were recently moved from counties to MCOs based on recommendations from a statutorily mandated study.

- 1996 legislation created county **adult mental health initiatives (AMHI),** which encourage counties to plan regionally and led to the closure of four state hospitals. This included the redeployment of state hospital staff and resources to community-based services and the transition to ten, 16-bed community MH/SA hospitals. The community hospitals do not serve forensic patients who have been committed as mentally ill and dangerous; these individuals are served at a state security hospital.

- 1993 legislation created **local children's mental health collaboratives** to better coordinate care between multiple service systems for children with severe emotional disturbances or those at risk. Counties, schools, local mental health providers and juvenile corrections are mandatory partners to provide integrated and coordinated services, and to pool resources and design services. Parents and public health and other community-based organizations also participate.

Minnesota – Structure and Roles

- Minnesota is a county-based system of 87 counties operating 84 distinct mental health systems and three joint human services systems in 16 regions. The regions are also referred to as county adult mental health initiatives, and were designed to increase the provision of cross-county mental health services. Counties could create their own regions; these were not delineated by the state.

- Minnesota also has county-based health care purchasing entities that are joint powers authorities using a capitated funding approach.

- Minnesota has separate state divisions for mental health and substance abuse, children's mental health services and Medicaid, but all are in the Department of Human Services (DHS). Minnesota's DHS includes the Adult Mental Health Division, the Children's Mental Health Division and the Chemical Health Division. A global budgeting approach in Minnesota's DHS ensures good working relationships between divisions, including Medicaid. In addition, the Adult Mental Health Division has a Medicaid fiscal policy specialist.

- Minnesota contracts with three types of organizations for delivery of Medicaid funded health services, including MH/SA services:

  - Six HMOs, which must be non-profit corporations in Minnesota;
  - Three county-based purchasing entities, which are a hybrid of county social services and HMO-like managed care; and
  - Eleven tribal governments.

Minnesota – Funding

- State mental health funding and some substance abuse funding is allocated to the regions, which then distribute funding to the counties based on regional service plans.

- Grants to counties are based on established criteria (including population, performance measures, and some competitive features).

- Infrastructure investment of $31 million (some from inpatient system savings and reductions) targeted grants distributed through competitive RFP to counties to expand service capacity and support EBPs and best practice approaches for ensuring consumer outcomes.

- New investments in mental health funding augmented rather than replaced current funding by requiring maintenance of effort for counties equal to prior years' average expenditures.

- Pending state plan amendment for peer support specialist and to bundle costs for Assertive Community Treatment (ACT), intensive residential services, and case management. It was challenging to get CMS to approve bundled rates.

- Minimum 15 percent county maintenance of effort requirement for substance abuse services funded through the state-operated, county-administered Consolidated Chemical Dependency Treatment Fund (CCDTF); other funding sources are federal block grant dollars and state appropriations.

Minnesota – Integration Initiatives

<u>Mental Health and Substance Abuse Service Integration</u>:

- Co-Occurring Systems Improvement Grant supports efforts for funding dual licensures and training. The challenge is how to braid and integrate federal funding

- Mental health and substance abuse services are in separate organizational structures at the local and state levels.

- Substance abuse services are not generally part of mental health reform initiatives.

Mental Health and Physical Health Care Integration:

- New public/private partnership through the establishment of three Preferred Integrated Networks (PINs) in locally-defined service areas. PINs are demonstration projects that will enroll individuals who have a serious and persistent mental illness and children with severe emotional disturbance, who would otherwise be served through the fee-for-service Medicaid program. The PIN initiative is expected to cover approximately 40 percent of the state's MA population.

- PINs use county/MCO model to integrate care with roles and responsibilities defined in local partnership agreements.

- Focus of the PINs is on prevention, integration with physical health, and decreasing system fragmentation.

Minnesota – Stakeholder Perspectives

Consumer Advocacy Perspectives:

- The latest National Alliance on Mental Illness (NAMI) state report card (2006) indicates that the state is "working hard to chart a course for reform" and has a "foundation for progress." Strengths cited in the report include: investments in mental health system infrastructure to improve access; strong vision for state mental health system; creation of a uniform benefit package, and bi-partisan legislative support for changes. Problems cited in the NAMI report include: workforce shortages and transportation needs in rural areas, disparities in access to services, and demand for housing and employment supports that exceeds capacity.

- MMHAG had broad-based consumer involvement in reform planning.

- Important to ensure that better consumer outcomes drive system reform, and that consumers benefit from the reform effort.

- Reform has made system more consumer-focused (e.g., shift from state hospitals to community services; use of peer specialists; implementation of EBPs).

- Important to include MH/SA as integrated part of health care reform, not simply as an add-on.

- Consumer advocacy involvement had a meaningful impact in allowing voluntary consumer enrollment in PINs. Consumers can self-select enrollment in PIN or remain in fee-for-service system.

- Voluntary regional funding approach has resulted in better use of limited resources to serve the most people. Prefer regional funding so there is a better flow of available funding between counties in a region.

- Cost efficiency (not cost cutting) was goal of reform.

- Inequitable funding for and access to services, as well as provider shortages, are very problematic for consumers.
- Not serving dually diagnosed consumers properly because of fragmented organizational structures at state and county levels; integration occurs at provider level.
- Service integration between various systems, including corrections, is an issue.
- Constituency that supports mental health is more active than substance abuse advocacy.

County System Perspectives:

- Maintenance of effort requirement for new mental health funding limits county flexibility to best meet needs across all county programs; it is also difficult to calculate county maintenance of effort and identify county expenditures for services.
- Reliance on county funding and the way the system is financed contributes to access and equity issues.
- Reasons for human services regionalization include administrative simplification, cost savings, efficiencies and improved ease for the state to work with counties through fewer regional entities.
- Counties developed an alternative redesign proposal that focuses on how to operate inside the boxes, rather than on how many boxes there are. Form should follow function.
- Critical to provide flexibility to counties regarding how they organize and structure themselves to meet reform goals.
- Important to ensure there are checks and balances in the system, and that incentives are aligned so that people do not become ineligible in the prepaid programs and become dependent on county services because they are uninsured.
- Vital to involve county representatives in reform. State officials have the appropriate policy perspective and local officials have the operational savvy needed to ensure reform can be implemented as intended.
- Policy issues should be defined and their impact known at the operational level before reform is implemented. Otherwise, there is a risk of harming consumers.

Minnesota – Lessons Learned

- MMHAG was very broad-based and ensured front-end support for reform initiative.
- Need to bring all parties/stakeholders together to address concerns, even if it is a laborious process.
- Be willing to compromise when possible.
- Need to move dollars for service provision quickly to support reform.

- Think about community infrastructure first and the impact that changes will have on demand for services.
- There is a lack of overall funding for capitated payment approach, even if all funding streams are combined. Influx of new dollars helped when moving to managed care approach.
- Capitated payment approach offers much greater flexibility than a fee-for-service system.
- Business entities involved in Minnesota's managed care plans are non-profit, which is perceived as positive.

Minnesota – Continued Challenges

- Developing capacity at local level. Lack of housing and employment programs and transportation needs in rural areas. Provider workforce shortages, especially in rural areas.
- Addressing continuity of care issues between inpatient and community-based services; fragmentation exists between counties and MCOs especially regarding discharge from inpatient.
- State budget deficits and underfunding of MH/SA services. Trying to maximize federal stimulus dollars and advocate for exempting MH/SA services from budget cuts to counteract these challenges.
- How to braid and integrate federal dollars is a challenge.

New Mexico – State Reform Effort

In 2002, the **Behavioral Health Needs and Gaps in New** Mexico report found the system to be fragmented, lacking evidence-based practices and deficient in consumer and family participation in service planning and implementation. Fragmentation of the state's system involved multiple provider systems, multiple service definitions and numerous data systems, along with duplication of effort and infrastructure at the state and local levels. In 2004, legislation created a single statewide statutory entity to oversee the MH/SA delivery system. The legislation also requires state agencies and resources involved in MH/SA treatment and recovery to work as one entity in an effort to improve services in the New Mexico.

Reform goals:

The primary goals of this reform effort as identified by state officials were to simplify and streamline services, reduce bureaucracy, and facilitate oversight and accountability, while at the same time promoting recovery.

Key elements included:

- **Behavioral Health Purchasing Collaborative** that is made up of 15 state agencies and the Governor's office, which creates a virtual department across these agencies. An interagency policy-making body forms the steering committee of the Collaborative. It includes the Secretary of Human Services as one of the co-chairs and the secretaries of Health and Children and Families alternating as the other co-chair.

- **Cabinet level director** of the Collaborative is the CEO, the "behavioral health czar," and the director of the Behavioral Health Services Division. Other agencies involved in the Collaborative allocate staff to the Collaborative and specific projects.

- **Cross-system financing** to blend and braid dollars from 15 state agencies.

- Establishment of a **statewide entity (SE)** under contract with the Collaborative to manage the publicly funded MH/SA system for the Collaborative.

- Identification of a **single set of service definitions** (one of first tasks of reform effort).

- **Local collaboratives** designed to create and sustain partnerships among consumers, families, advocates, local agencies and community groups.

- Collaborative is required to provide **annual reports** to the legislature regarding progress on strategic plans and goals, and information on service provision and program operations.

New Mexico – Structure and Roles

- Behavioral Health Services Division (formerly with the New Mexico Health Department) joined with the New Mexico Human Services Department in 2007. It is one of five divisions in the Human Services Department, including Medicaid. The Behavioral Health Services Division is responsible for overall management of the Behavioral Health Purchasing Collaborative. The design group of the Collaborative has met every week since 2003. The Purchasing Collaborative has several cross-agency teams for contract oversight, administrative services, quality and evaluation, and training and research. It also has cross-agency teams working on initiatives such as supportive housing, core services, service definitions, cultural competence and early intervention.

- The Purchasing Collaborative contracts with a single statewide entity that includes all MH/SA services and funding except for state hospitals and certain substance abuse services. As of July 2009, the new statewide entity is OptumHealth. Performance issues involving services and IT systems were identified in an external quality review of the organization that served as the statewide entity for the previous four years. The Purchasing Collaborative is required to bid the statewide entity contract every four years.

- The statewide entity contracts with a network of providers to deliver MH/SA services via five county regions and one statewide virtual region for Native Americans. Regional offices of the statewide entity include peer and family specialists.

- Fifteen single and multi-county local collaboratives, based on state judicial districts, are intended to be strong local voices to guide service planning. They are advisory to the state and SE only and have no service provision function.

- New Mexico had a state/regional system before reform and transitioned to a state collaborative and single statewide entity approach. Before reform, five regional coordinating councils, operating as an arm of the state, developed plans and managed MH/SA services. No local tax levy funding was part of the system.

- Most of the 33 counties in New Mexico have no real role in MH/SA services, with a few providing special projects through their county indigent fund. However, funding and responsibility for some substance abuse services remains with the counties.

New Mexico – Funding

- Goal of reform was to inventory various agency expenditures for MH/SA services and to blend and braid funding, in order to maximize resources across various funding streams.

- No local funding and very little state general purpose dollars support the cross-system financing of MH/SA services included in the Collaborative.

- No new dollars funded the Collaborative and reform; instead existing resources were reallocated to community-based services.

- The Collaborative, through the Human Services Department, submits a separate, consolidated MH/SA budget request.

- State Collaborative staff funded by Transformation State Incentive Grant (TSIG) will need to be sustained when grant ends.

- State funding for statewide entity tries to incentivize recovery-based services through a higher rate.

- Community reinvestment dollars criteria are tied to recovery and resiliency goals (more traditional healing projects).

- Hospital costs are outside of the statewide entity contract, but this has not created adverse incentives for inpatient placement.

- Funding for Driving While Intoxicated services is not including in the statewide entity contract, with assessment and treatment dollars administered by counties.

New Mexico – Integration Initiatives

- New Mexico Medical Assistance Division contracts with MCOs to manage both primary and MH/SA care for individuals in Medicaid managed care and fee-for-service programs.

- Collaborative promotes a systems-of-care approach for children's services administered by the New Mexico Department of Children, Youth and Families.

- Statewide entity requires that MH/SA subcontractors establish continuity of care for individuals in the criminal justice system.

New Mexico – Stakeholder Perspectives

Consumer Advocacy Perspectives:

- Latest NAMI state report card (2006) indicates the "Collaborative has the potential to become a national model, but so far, it is only a potential." Strengths cited in the NAMI report include: integrated dual diagnosis treatment services and expansion of other EBPs; number of consumer-run programs and peer supports; and mental health services to veterans. Problems noted in the NAMI report include: lack of funding, major service shortages and difficulties serving those in isolated, rural regions.

- 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 more funding options for services to consumers.

- 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 rural areas.

- There is great variation in how the local collaboratives are run and organized, especially with regard to consumer involvement.

- Consumers initially liked the idea of the local collaboratives and thought their voice would have an impact on the 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, as well as encourage a dialogue between consumers/peers and providers.

- Make sure consumers understand their role in the reform effort and/or design their role, and have the necessary training and other supports so they can effectively carry out their role in the reform effort.

- Consumers have been effective in advocating for more consumer-run services and in expressing concerns with the previous SE, which resulted in contract changes.

County System Perspectives:

- Counties play no significant role in the publicly funded MH/SA system in New Mexico.

New Mexico – Lessons Learned

- Important to develop a statewide system of MH/SA, despite limited state resources, insufficient and inappropriate balance of services, and multiple, disconnected advisory groups and processes.

- Focus on transparency and participation in the reform effort. Resist temptation to work in isolation. Involve local communities, and be clear about local role and expectations in reform effort.

- Pursue systems of care approach for reform.

- Maintaining the reform vision and goals is ongoing and needs to transcend changes in state staff. Need constant reminders to help overcome inertia and barriers to change.

- Recognize critical role of strong leadership at all levels (Governor, Secretary, legislative, staff and stakeholder levels).

- Understand business realities and implement financial incentives for what you are trying to achieve. Need to have rigorous oversight and monitoring of contract with statewide entity to enforce contract provisions.

- Show clear results of reform effort in a way that demonstrates the changes have meaning in people's lives. Use shared outcomes as a unifying force to support the reform effort.

- Collaboration is challenging and time-consuming.

New Mexico – Continued Challenges

- Demand for services vastly exceeds capacity. Lack of service capacity in rural/frontier areas – every area is designated as disadvantaged in state. Workforce and resource shortages. Lack of crisis services.

- Still a very fragile system that is underfunded.

North Carolina – State Reform Effort

North Carolina included MH/SA reform in 2001 legislation. The legislation was promoted by an active legislature and key legislators and resulted from findings of numerous studies that indicated higher state institutional use. The reform effort was included in the State Plan 2001 – Blueprint for Change developed by the Department of Health and Human Services (DHHS).

Key elements of the 2001 reform included:

- **Enhanced Service Package** for mental health, substance abuse and developmental disability services designed to leverage federal funding and improve service array.

- **Divestiture of public system** – counties would no longer be the provider of services.

- Creation of **Local Management Entities (LMEs)** as agencies of local government area authorities or county programs**.**

- **State agency reorganization** by functional areas as opposed to target groups.

Additional legislation in 2006 further defined the function and authority of LMEs and established a state **Consumer and Family Advisory Committee** (state CFAC) and **Consumer and Family Advisory Committee**s (CFACs) at each LME.

Reform goals by stakeholder category were identified by the state:

- *For consumers*: greater choice, no wrong door, greater input into the system, community- based services, and services focused on rehabilitation and prevention.
- *For providers*: greater role in shaping the system, system standardization/statewide uniformity, creation of a public/private partnership for service delivery and training.
- *For the state*: system uniformity, fiscal stability, system-wide accountability, collaboration among stakeholders, employment of EBPs and improved system management.

Some successes of reform noted by state officials:

- Performance-based contracting with LMEs.
- More adoption of evidence-based practices.
- Implementation of statewide system of care for children and more integration between children's mental health and substance abuse services.
- More person-centered focus, due to influence of developmental disability (DD) service approach on MH/SA services.
- More open and formal mechanisms for consumer and family involvement.
- Reversed tide of community inpatient closures.
- Attempting to right-size service providers and develop more comprehensive providers so consumers do not need to change providers as their service needs change.
- Providers are required to become nationally accredited; no state licensure. LME endorsement process is also required.

Challenges and unintended consequences of reform:

- State downsized state hospitals at the same time local inpatient units were closing; North Carolina is trying to develop a more robust crisis system.
- Delay in CMS approval for benefit set resulted in provider uncertainty and capacity issues.
- More growth in lower level services because of MCO profit motive.
- Funding mismanagement by LMEs.

North Carolina – Structure and Roles

- All three disability groups (MH, SA and DD) are under same state agency and same local entity structure. North Carolina Department of Health and Human Services includes the Division of the Mental Health, Developmental Disabilities and Substance Abuse Services and the Division of Medical Assistance. Both divisions planned for and implemented reform, which culminated with the 2001 state plan.

- Before reform occurred there were 40 area programs (all but 15 were multi- county programs) that served 100 counties. The area programs were separate entities of local government and contracted with outside providers. They also provided some services using county employees. The reform effort has created the 24 LMEs that currently exist, with further consolidation of LMEs recommended. LMEs must cover a population of at least 200,000 or a five-county area. Most LMEs cover multiple counties, but some larger counties have single-county LMEs. LMEs are political subdivisions of the state (e.g., employees included in state retirement system). LMEs are formed through intergovernmental agreement between counties.

- As a result of reform, the service management function was separated from service provision. Service delivery was privatized, with LMEs responsible for management of services and not service provision. The management functions LMEs provide include: general administration, business management and accounting, claims processing, information management and analysis, provider relations and support, access (screening/triage/referral), service management, consumer affairs/satisfaction, quality management and outcomes evaluation. Counties could be providers to the LMEs. While LMEs do not typically provide direct services (aside from initial screening and some crisis services), LMEs can receive approval from the state to provide certain treatment services, if sufficient private providers do not exist in a given area.

- While most MH/SA services are provided through private providers under contract with LMEs, the state directly offers services through the four state psychiatric hospitals and the three Alcohol and Drug Treatment Centers (ADATCs).

- North Carolina went from an office/clinic-based to a community-based model of care (e.g., intensive in-home and ACT model).

- Each LME establishes a consumer and family advisory committee (CFAC) as a self-governing and self-directed organization that advises the area authority or county program in its service area regarding the planning and management of the local public MH/DD/SA system.

North Carolina – Funding

- North Carolina went from a grant-based funding approach pre-reform to a fee-for-service (FFS) approach.

- There was no new funding for reform, with the expectation that reallocation of resources from inpatient and administrative savings would be sufficient.

- There are no LME financial incentives to limit use of state hospitals, which is a continuing problem since the state funds these placements.

- Generally, local funding in the MH/SA system is a relatively small portion of total LME revenues at about 6 percent, with some larger counties contributing 25 to 35 percent of LME revenue.

- In 2009, local match for Medicaid was assumed by the state (previously it had been 85 percent state and 15 percent county for the nonfederal share).

- County commissioners endorsed original reform legislation and were critical of the system before reform.

North Carolina – Integration Initiatives

MH/SA Service Integration:

- Integration occurred through the new service definition and through consolidation of service providers who can provide both mental health and substance abuse services.

Mental Health and Physical Health Care Integration:

- In 2005, the state initiated a collaborative approach to mental health and primary care integration in four pilot sites. Under this model, MH/SA professionals are located within primary care facilities, and MH/SA services are integrated with primary care through screening, assessment, brief supportive counseling, therapy, case management, medication monitoring and coordinated team care. A goal of the pilots is to overcome inadequate access to MH/SA services and manage the mental and physical health needs of Medicaid enrollees identified by the state. The state provides a per member per month rate that is split between the primary care practice and the LME. The four pilot projects are being implemented by Community Care of North Carolina. Community Care networks are organized regionally and are expected to collaborate and partner with their local LMEs. The state is looking to match up LME geography with that of Community Care to achieve better service alignment. According to a report by Health Management Associates, the pilots cover approximately 20 percent of the state population.

Integration with Other Systems:

- A children's system of care is being implemented. School-based child and family teams identify needs and refer to appropriate agencies. Children can receive mental health services through either the MH/SA or child welfare system. The child welfare system is county operated by county departments of social services, but works well with the LMEs.

- County-run jails use a uniform screening tool for mental health and LMEs are required to review incarceration logs daily.

North Carolina – Stakeholder Perspectives

Consumer Advocacy Perspectives:

- The latest NAMI state report card (2006) indicates that North Carolina's reform initiatives were "changing too much, too fast, resulting in an increasingly disorganized environment." Strengths cited in the report include: integrated physical and mental health care pilot program, state feedback to physicians about their prescribing patterns, and improving access to Medicaid consumers by reinstating their Medicaid benefits after incarceration. Problems cited in the NAMI report include a need to: restore confidence and order to overall system, improve state hospitals and restore program funding cuts.

- Reform was partially due to the stories heard by legislators that consumers were not being served.

- Consumers supported reform effort and participated in reform planning. There were consumer representatives on the Blueprint for Change taskforce. Consumers 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, moving focus from hospital to community-based services and greater consumer voice).

- Reform has potential to make the system more consumer-focused. The building blocks are in place, but it has not yet been achieved. Implementation takes longer than expected.

- There was too much attention focused on governance (i.e., "who's in charge"), as opposed to the services provided. Consumer outcomes have gotten lost in the rush to administer and manage the system.

- The reviews regarding the performance of consumer and family advisory committees (CFACs) at each LME has been mixed; some are seen as very effective and others are not.

- The system has stabilized in the past year.

- There is better monitoring of provider performance since reform.

- Before reform, substance abuse services were a small part of the overall service mix; reform improved access to substance abuse services. Reform also increased the level of state funding for substance abuse; prior to reform, it relied more on federal funding.

- Privatization has been positive for substance abuse workforce development because it broke the reliance on the county salary structure and increased compensation for licensed substance abuse workforce.

- Now there is a major momentum toward integrated MH/SA and physical health care, which would not have been possible under the county system.

- There has been 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.

- Privatization (divestiture of the public programs run by counties) was a significant shift that resulted in many changes in provider groups, failure of providers, etc. ("providers failed by the 100s"). This issue goes to the core of the importance of continuing the relationship between consumers and service providers. In the past, consumers could always default to the public system if they had problems getting their medications; that was no longer the case after privatization. There was a loss of the public safety net and no statutory provision to protect people under privatization. The public system lost case management capacity due to privatization.

County System Perspectives:

- The divestiture of public service capacity had a negative impact on consumer access to services.

- Counties were not involved in design of reform, but participated once options had been developed. One option considered was a state system with private providers.

- Alignment in regions was determined by counties.

- Main driver of reform seemed to be the desire to cut administrative overhead.

- Important to establish a collaborative planning process and partnership based on trust, as well as a common vision of what reform is trying to achieve.

- Do not try to implement changes to service array and system structure at the same time, because it brings about too much uncertainty. Implement change methodically and sequentially so the impact of each can be assessed.

- Future of the system is looking to greater consolidation, and fewer (but better qualified and more comprehensive) providers.

North Carolina – Lessons Learned

- Do not try to change everything at once. Better to sequence reform and show incremental results.

- Better to slow down changes regarding who delivers the service until the service array has been determined and approved. It took the state about two years to develop and gain approval for the new service definition.

- Give reform time to be successful and manage expectations. The more significant the change, the longer it will take to implement. The constant stream of system changes between 2003 and 2006 (e.g., multiple policy revisions, new processes, new legislation and new responsibilities) did not provide the opportunity to fully adapt.

- Resources devoted to the reform effort to ensure sufficient service capacity were not adequate. The inpatient downsizing plan moved dollars to community-based services; however, the expectation

that institutional resources and administrative overhead savings could be reallocated to expand services proved erroneous.

- Need adequate state staffing and knowledge to implement reform. Not adequately staffed at state level to roll-out reform. State agency had slimmed down substantially pre-reform and needed greater knowledge base in dealing with private providers and understanding how the profit motive drove reform in a direction that was not healthy for the public system.

- Moving from a predominantly government-operated MH/SA system to a private system had unintended consequences, namely greater growth in lower level services due to the profit motive of a privatized system.

A legislative program evaluation in July 2008 found that compromised system controls and the pace of change negatively impacted the implementation of the reform effort, including utilization and cost overruns. Key issues noted in the evaluation included:

- Pace of implementation – Delays in securing federal approval of the new service array meant DHHS had three months to implement the new service set. Work with CMS began in 2004, but CMS did not approve the new service array until December 2005 and the new service array went into effect in March 2006. As divestiture of area programs occurred; the provider network intended to replace it was not yet fully operational and not willing to commit to delivering an array of unapproved services. DHHS was concerned that consumers would fall through the cracks, so it allowed for greater policy flexibility (i.e., conditional endorsements of providers and relaxing of authorization requirements) during the transition, which had unintended consequences.

- Insufficient forecasting and monitoring – DHHS did not adequately forecast costs or utilization, and did not have a baseline against which to measure system performance and assess utilization and expenditures. Utilization of the new services grew faster than expected. Some, like community support services, which accounted for 90 percent of enhanced services, grew very rapidly. Subsequent reviews found that $60.8 million was paid to providers for 4.7 million units of community support services that were not medically necessary. DHHS says that the lack of experience with a public/private model of service delivery and the paradigm shift introduced by reform made forecasting challenging.

- Information not organized for decision-making – Performance goals and measures were not established for the service array at the outset.

North Carolina – Continued Challenges

- State focus is on stabilizing the system. Current strategic objectives listed in the 2007-2010 state plan include:

    - Establish and support a stable and high quality provider system with an appropriate number and choice of providers of desired services.
    - Continue development of comprehensive crisis services.
    - Achieve more integrated and standardized processes and procedures.

  - Improve consumer outcomes related to housing, education and employment.

- Too few service providers in some areas, especially where geography (e.g., mountains, water and swamps) makes service access challenging. Focus is on working more closely with indigenous partners and creation of more mobile services.

- Based on outside study, there is a further need to develop LME competencies and improve performance. Imperative for LME data systems to provide accurate, timely data to manage and oversee services for all levels of care, especially for high cost and complex cases.

Ohio – State Reform Effort

In March 2009, the Governor introduced the **Ohio Mental Health and Alcohol and Other Drug System Sustainability Plan.** The reform effort is focused on financing and structural changes to the MH/SA services funded by Medicaid.

Reform goals:

The overarching goal of this reform effort, as stated in the March 2009 plan, is to design a system that optimizes consumer access, statewide consistency, administrative efficiency, compliance with federal Medicaid requirements and most importantly, sustainability.

Key elements included:

- **Elevate/move Medicaid administration** for MH/SA services from counties to state agency level to ensure appropriate statewide monitoring of Medicaid expenditures and to ensure that covered services are available and administered statewide, as federally required.

- Provide **quality incentives to service providers** through a fee schedule instead of a cost-based/reconciliation funding approach.

- Develop a **framework for core services** (to include treatment, prevention and recovery support) that allows consumers appropriate availability and quality.

- Define **service scope, duration and benefit package**. Re-balance and target resources to those in the greatest need.

- Provide more equitable funding through a **revised formula**.

- **Decrease administrative burdens** on service providers and increase flexibility through deregulation involving changes to legislation, rules, policies and/or technology.

Other reform efforts:

- In 2005, Ohio received a SAMHSA Mental Health **Transformation State Incentive Grant** (TSIG) to support a number of initiatives designed to transform the system of mental health services. It also supports the **Office of Systems Transformation** in the Ohio Department of Mental Health (ODMH).

- Ohio's **Transitions Work Group** provides broad stakeholder input to state reform proposals and oversees the TSIG-related activities, which are designed to increase the availability of mental health services to consumers.

- In the 2005 state budget bill, the Ohio Department of Jobs and Family Services expanded MA coverage so that most MA fee-for-service transitioned to MA managed care. The state **Behavioral Health and Managed Care Collaborative** was created to resolve issues impacting coordination of care for MA managed care members with MH/SA needs.

- **Coordinating Centers of Excellence** (CCOEs) and networks provide technical assistance and data analysis for implementation of evidence-based and other best practices. Federal block grant funds, as well as other grant and foundation funding, support CCOEs. Most CCOEs have contracts with universities, which provide staff resources.

- **Hospital to community transition** initiative in the 1980s was based on the Wisconsin model.

- **Regional funding** of certain services. The state is seeking statutory authority to fund more than one multi-county board for specific projects in an effort to gain administrative efficiencies.

Ohio – Structure and Roles

- Ohio has two separate state agencies for MH and SA: the Ohio Department of Mental Health (ODMH) and the Ohio Department of Alcohol and Drug Addiction Services (ODADAS). Ohio is one of the few states with a separate, cabinet level AODA agency. Ohio also has separate state agencies for developmental disabilities (the Ohio Department of Developmental Disabilities) and children and family services (the Department of Job and Family Services), which includes the state's Medicaid agency.

- The Office of Systems Transformation in the Ohio Department of Mental Health has provided leadership and staff support for the state's system transformation effort.

- Ohio has a state-supervised, county-administered system of 50 local mental health and/or substance abuse boards serving 88 counties. Most boards are combined Alcohol, Drug Addiction and Mental Health Services Boards (46), and four are separate Mental Health Services Boards and Alcohol and Drug Addiction Boards. Twenty of the local boards are multi-county.

- Local boards are prohibited from providing direct services; instead they are required to plan and administer funds and contract with service providers

- MH/SA boards are relatively few compared to the total number of county human services agencies (over 230) for other populations.

- The state has focused on implementing utilization management and better service integration at the provider level, as opposed to creating another administrative layer to manage care.

Ohio – Funding

- Local boards need to seek voter approval for local property tax levies to fund MH/SA and other local services. Most of Ohio's 88 counties have voter-approved local levies for MH/SA services. In 2008, three counties had a levy in effect for mental health services only (not substance abuse), and 14 counties had no levy in effect for either mental health or substance abuse services.

- Boards are responsible for funding both community and inpatient (including state hospital) placements. This change was adopted from the Wisconsin system.

- MH/SA system relies heavily on county funds for the nonfederal share of Medicaid and for services to the non-Medicaid eligible population. About 30 percent of revenues are from county funds.

- State initiative moves Medicaid administrative duties from counties to the state (ODMH and ODADAS). This was proposed to free up local dollars to finance other local needs (availability of non-MA funded services is a large problem) and to achieve efficiencies and statewide oversight in administering Medicaid at the state level. Currently, local boards are only pass-through entities for Medicaid, with no pre-authorization of services. Local boards are beginning to look at cost outliers through utilization review.

- State is also looking to revise an outdated formula for state funding that is based on prevalence data, history of hospitalization and county population. The revised formula would distribute funds based on need and where individuals are receiving services. Implementation of the revised formula would occur with no new funding, but rather through a reallocation of existing funds (some counties would gain and some would lose).

Ohio – Integration Initiatives

<u>Mental Health and Substance Abuse Service Integration</u>:

- Coordinating Centers of Excellence (CCOEs) promote intersystem collaboration and work with local boards to implement EBPs, including an EBP for dually diagnosed individuals. CCOEs work with local boards to implement and evaluate EBPs.

<u>MH/SA and Physical Health Care Integration</u>:

- State initiative to elevate Medicaid administration to the state level is expected to help support the integration of MH/SA with all health care services funded by Medicaid.

- Ohio is also considering the possibility of a more comprehensive MH/SA benefit in managed health care plans; some MH/SA services are currently carved out of the publicly funded Community Health Plan. It is difficult to serve the high need MH/SA population in managed care plans.

- MCOs are required to coordinate with local MH/SA providers. Pursuant to Medicaid managed care contract language, the Ohio Department of Jobs and Family Services (ODJFS) requires coordination of MH/SA services between Medicaid managed care programs and the publicly funded community MH/SA system. A state work group, the **Behavioral Health and Managed Care Collaborative**, tries to

address issues and problems that impact the appropriateness, timeliness, and/or quality of care coordination services delivered to Medicaid managed care members who have MH/SA needs and/or receive care from public MH/SA systems. The state collaborative includes representatives of advocacy groups, associations and provider organizations, county boards, managed care plans, service providers and state agencies (ODADAS, ODJFS, and ODMH).

Ohio – Stakeholder Perspectives

Consumer Advocacy Perspectives:

- Latest NAMI state report card (2006) indicates that Ohio's "status as a leader on mental health has slipped ….budget cuts and policy decisions threaten mental health services, and burdens on criminal justice and emergency response systems are significant." Strengths cited in the report include:

  - EBPs such as ACT, Integrated Dual Disorders Treatment (IDDT) and supported employment,
  - Leadership on jail diversion (56 of 88 counties have jail diversion programs) and community re-entry services, and
  - Consumer and family involvement in design and delivery of services (including an innovative, consumer-staffed toll-free phone system that provides information and resources).

  Problems cited in the NAMI report include:
  - System underfunding,
  - Need to improve coverage of uninsured persons and non-Medicaid services (due to county prioritization of services that are Medicaid funded), and
  - Need to increase inpatient capacity (due to downsizing of public and private inpatient beds).

- Consumers and advocates for developmental disability services are more vocal and more state funding goes to that target group as opposed to MH/SA services.

- Coalition for Healthy Communities, representing about 30 different statewide groups involved in consumer advocacy, is involved in the systems change discussion.

- Reform is not generally driven by consumers, but by local boards and providers.

- Advocates favor moving responsibility for the nonfederal share of Medicaid to the state from the local boards to help with local funding inequities and shortfalls, and to put MH/SA care on par with physical health care.

- Accountability for consumer outcomes has improved.

- State agency leadership recognizes 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 this model, with

most of the funding directed to services for the seriously mentally ill. Ideal system would fully embrace the recovery model and adequately fund it.

- CCOEs have been successful in promoting integration of physical and MH/SA care through integration pilot programs. Centers are primarily focused on mental health services; substance abuse is not generally included except in one Center that is focused on co-occurring disorders.

- There needs to be a shared vision for the reform effort, as well as leadership at the state level 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 it is not necessary for all the staff currently associated with local boards (which do not provide direct services) to be involved. It is unlikely that local boards will ever be eliminated due to the level of local funding they provide to the system.

- Ideal system would integrate physical and MH/SA care.

- While Ohio is sometimes held up as a model, it still has a long way to go for its 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.

<u>County System Perspectives:</u>

- The only significant funding increases for the MH/SA system in the past few years have been from local levy dollars. State has learned to count on local levy to finance the system.

- State provides counties with increased percentage of federal match, since counties currently pay for nonfederal share of Medicaid.

- There are large disparities in per capita funding between counties (ranges from $12 to $40 per capita).

- Consumers have to navigate duplicate systems – managed care system and community system of care – to get their MH/SA needs addressed.

- Coordination of care issues exist between MCOs and local boards.

- Local boards have been involved in system changes and input has been valued by the state.

- There is a desire for more state control, which puts a strain on the relationship between the state and counties.

- Any state contemplating reform should look at long-term picture and goals – where does it want to go?

Ohio – Lessons Learned

- Important to give stakeholders time and opportunity to react. This was a bigger issue with the counties feeling that they were not aware of and/or fully involved in the proposed changes to Medicaid administration. It is important to involve counties at the beginning of reform efforts.

- Need to have a strong communication plan for the reform effort. There is always room for improvement in areas of communication and stakeholder input.

- Transitions Work Group has helped to get stakeholder input and build broad support for reform efforts.

Ohio – Continued Challenges

- Availability of non-Medicaid funded services is a challenge, with these services eroding over time as counties have tended to allocate their resources to funding the nonfederal share of Medicaid. Counties have also had difficulty providing these match resources for Medicaid.

- Provider capacity is a concern, and some providers are now out of business.

- Work force concerns include loss of direct care workers to other systems (veterans and federal health centers).

- Ohio's MH/SA System Sustainability Plan outlines several challenges the plan is intended to address, including:

    - Outdated funding formula based on historical prevalence data and/or county population demographics.
    - Reliance on local levy funds to meet Medicaid match.
    - Inability of providers to benefit from increases in efficiency.
    - Inherent inequities resulting from varying service levels for consumers based on county of residence.

Oregon – State Reform Effort

The Oregon reform effort was initiated by the Department of Health Services and a legislative committee after several studies. The main reform proposal is to establish an **Integrated Management and Service Delivery System Demonstration Project** for integrating MH/SA services and physical health care. The system change will also focus on an integrated service management and payment system. These two changes are expected to result in a simpler, more efficient use of state, federal and local resources and better services to those in need.

A work group of representatives from the Oregon Department of Human Services (DHS) and provider and health plan organizations provided the foundation for the development of initiatives to integrate MH/SA and primary care. Areas addressed by the work group included:

- Key factors considered in the development of the recommendations (population to be served, barriers to integration, and current opportunities).

- Principles and goals for effective linkage/integration (system principles, design, finances, outcomes, and quality).

- Recommendations (design and implementation process, financing and payment, and next steps).

Reform goals:

Two recent legislatively funded reports, one on the mental health system and one on the substance abuse services system, identified the complicated structure of the mental health and addiction systems in Oregon. Both reports recommended changing the system to an integrated funding and service model that will:

- Provide consistent service throughout the state
- Consolidate funding
- Regionalize services
- Make the system more transparent
- Gain efficiencies in utilization of resources

The integrated care initiative is designed to increase the availability, access and quality of MH/SA services and to improve health outcomes and access to primary care. The goal is for consumers to be served in the most natural environment possible and for use of institutional care to be minimized.

Key elements of the integrated care initiative include:

- By June 30, 2011, DHS is directed to establish two or three **regional demonstration projects for integrated physical health care and MH/SA services** and fund an integrated management entity or other local collaborative structure with a single point of accountability for the delivery of integrated services. DHS is required to work with willing local mental health authorities, mental health organizations, fully capitated health plans, federally qualified health clinics, and community MH/SA providers to develop these integrated management and services systems.

- Existing funds administered by DHS (state, federal, Medicaid and other) will be administered through an integrated management entity or other collaborative structure. DHS is required to **consolidate administration and financing** of state and federal funding to support the integrated care systems.

- **Comprehensive services** include medical care (preventive, routine, acute and specialty care) and a full continuum of MH/SA services including, but not limited to: peer-delivered services, detoxification, acute and sub-acute mental health services, residential treatment, outpatient, and supported housing and employment.

- DHS is required to consult with system stakeholders to:

- Develop **specific, measurable outcomes** for consumers receiving services from the integrated systems.
- Develop **financial incentives** for selected outcomes.
- Ensure meaningful **consumer and family involvement** throughout development and implementation of the integrated systems.

- The intent of the integrated care reform effort is to initiate demonstration projects in areas of the state where there is **sufficient readiness and collaboration among local partners**, in order to gain the experience necessary for the initiative to eventually spread to other areas of the state. DHS is required to report progress to the legislature in two years. DHS will report on the impact and status of the projects and provide recommendations for continuation and expansion, including the proposed budget and policies needed for statewide expansion.

- The legislature's intent is to **reinvest savings** realized from the integrated care reform back into the system to improve service capacity, quality and oversight.

Other reform efforts:

- **Oregon Children's System Change Initiative** (OSCI) – The statewide wraparound project, was initiated through a Governor's order and report in 2007 that called for implementation of a system of care approach to the delivery of MH/SA services and supports for children and families. After studying Milwaukee's wraparound program, Oregon is implementing a wraparound approach designed to increase the number of children receiving community- vs. facility-based care.

- **Mental Health Carve Out** – Approximately 15 years ago, the Oregon Health Plan included MA-funded physical health services and substance abuse services provided by fully capitated health plans (HMOs). Since physical health plans were less familiar with comprehensive mental health services, mental health care was carved out at the time and managed by mental health organizations (MHOs), which are regional MCOs that subcapitate payment to community mental health programs (CMHPs).

- **EBP Implementation** – Oregon is considered a national leader in the adoption of evidence-based practices, and began an EBP fidelity pilot project in 2007 to provide the Addictions and Mental Health Division with information about the effectiveness of EBPs.

Oregon – Structure and Roles

- The Addictions and Mental Health (AMH) Division is located within the Oregon Department of Human Services, which also includes divisions for children, adults, families; seniors and people with disabilities; the Division of Medical Assistance (State Medicaid Agency); and public health-related offices. The Addictions and Mental Health Division includes an Office of Mental Health and Addictions Medicaid Policy.

- MH/SA services are available in all 36 counties through 32 community mental health programs (CMHPs) or a county commission-designated substance abuse provider. CMHPs directly provide services or contract with private nonprofit agencies and are responsible for planning and

coordinating local systems of care. CMHPs have statutory responsibility for providing services within available state and local funding.

- The Division of Medical Assistance (DMAP) administers the Oregon Health Plan (OHP), which includes the state's Medicaid and children's health insurance programs. While OHP covers both physical and MH/SA services, DMAP does not oversee mental health services. The AMH Division contracts with nine multi- and single-county MHOs to manage the mental health services funded by OHP, but the services are carved out of OHP and locally administered by these MHOs. OHP funds mental health services through MHOs and substance abuse services through fully capitated health plans for consumers who are Medicaid-eligible. In this way, mental health services are "carved out" of the OHP and substance abuse services are "carved in."

- Eight of the MHOs are county-based groups. Six of the nine MHOs serve multi-county areas ranging from three to 13 counties.

- MHOs generally do not provide direct services. They instead contract with private providers and counties (CMHPs). MHOs are responsible for inpatient placement, excluding state hospitals. MHOs have management responsibilities, including monitoring and oversight of provider contracts. MHOs reportedly derive their real authority through the counties that are part of their governance.

- Under the reform initiative, the potential configuration of integrated care demonstration projects could include partnerships between MHOs and HMOs or could consist of HMOs (fully capitated health plans) providing all the physical and MH/SA services.

- The county role would still include local planning and involvement in prevention services, civil commitment process, and services unique to a county that would not be included in the MCO-provided services. Some counties are talking to MCOs about services they can provide in an integrated care model.

- The initial reform proposal was to go from 32 county community mental health programs (CMHPs) serving 36 counties to approximately 10 regional MCOs to provide integrated care. The demonstration project initiative is a compromise.

Oregon – Funding

- Previous studies estimated that Oregon's system is significantly underfunded by more than $500 million on a biennial basis.

- MH/SA services are provided through financial assistance agreements with counties (non-Medicaid population), contracts with managed care MHOs in the Oregon Health Plan (Medicaid population) and direct contracts with regional, statewide or specialized service providers.

- State general funds for non-residential services are allocated to counties using a block grant approach. Capitated mental health services for persons who are Medicaid eligible are administered through contracts between the AMH Division and MHOs. MHOs are responsible for inpatient services, excluding services provided at the state hospitals. All other non-capitated services are administered through contracts to the counties and direct contracts to services providers for

community hospitals for acute psychiatric care and a small number of residential programs. AMH is responsible for the state-operated psychiatric hospitals, Oregon State Hospital and the Blue Mountain Recovery Center.

- AMH is responsible for the oversight and management of all state funded community mental services. AMH provides funding to local mental health authorities (LMHAs) that have statutory responsibility for providing services to the extent that funding is available. LMHAs use a combination of AMH funding and county and municipal dollars to ensure programs are delivered locally through either community mental health programs (CMHPs) or mental health providers. CMHPs provide services to individuals who do not qualify for OHP, but who are still in need of publicly provided services.

- Only a handful of counties provide local funding to support MH/SA services. There is no county match for Medicaid. Some contribute more and others do not contribute any local funds. While local funding for MH/SA is not significant, county elected officials are influential in terms of what occurs in the system.

- Providers should be incentivized based on goals that are established (i.e., reduction in inpatient admissions). Better data and information results from connecting data to how organizations get paid (e.g., performance-based contracting). The current payment system provides very little incentive for providers to move consumers to greater self-sufficiency. In the reformed system, providers will get paid for achievement of goals, not for keeping consumers in programs.

- Proposed state allocation over the biennium will support the integrated care demonstration projects, including start-up and an independent evaluation.

Oregon – Integration Initiatives

<u>MH/SA and Physical Health Care Integration:</u>

- The state is moving to a fully integrated model. This does not mean that everyone will walk through the same door for services; rather that consumers have a way to get all their health care needs met in an integrated fashion.

- Integrated demonstration projects will include integration of mental health and substance abuse services.

- Integration models could include:

    - MCOs that are fully capitated health plans and that carve in comprehensive MH/SA services.
    - MHOs that will cover physical health care to become fully capitated plans.
    - MCOs and MHOs that may merge.

Oregon –Stakeholder Perspectives

Consumer Advocacy Perspectives:

- Latest NAMI state report card (2006) indicates that Oregon "has many pockets of excellence, yet services can vary significantly between counties and regions. Oregon has a reputation for innovation in its Medicaid program and health care in general, but the same cannot be said for mental health care." Strengths cited in the report include:

  - Emphasis on EBPs (one of first states in the country to adopt an EBP-supported employment model) and recovery-focused care,
  - Availability of an Early Assessment and Support Team (EAST) program for outreach and early intervention to young adults,
  - Emphasis on housing for persons with serious mental illness, and
  - Development of peer supports.

  Problems cited in the NAMI report include:
  - Lack of uniformity of access and services throughout the state and persistent challenges with system navigation for consumers and families,
  - Limited access to treatment for non-MA eligible population other than crisis services,
  - Growth in emergency room, jail, prison and forensic ward admissions for those with mental illness, and
  - Need for appropriate community placements for those in state hospitals.

  According to the NAMI report, advocates have called for development of services that promote integration of MH/SA and physical health care services.

- Reform efforts have become more consumer-focused, but only through the involvement of consumer advocates. For example, the state codified formal consumer participation to require a minimum 20 percent mental health consumer membership in any public body that discusses mental health issues. This requirement does not apply to substance abuse issues.

- Consumers favor integrated care model, but it remains to be seen how outcomes will be tracked for the proposed demonstration projects.

- MH/SA services are automatically part of health care reform discussions in the state due to their cost implications.

- The Children's Change Initiative has resulted in improvements for children with MH/SA issues; and the children's system is moving toward better integration due to the wraparound approach.

- There are large variations in funding throughout the state; some counties do not spend any local dollars or provide services beyond the MA funded Oregon Health Plan services and crisis services funded by the general fund.

- Reform efforts that result from budget cuts are generally not well thought out, and do not involve system stakeholders in finding solutions.

- 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 mental health/addiction service providers as to what integrated care means.

- For states pursuing service integration between physical and MH/SA care, it is important that state staff has the contracting experience to ensure the necessary collaboration takes place in an integrated care model.

County System Perspectives:

- Oregon had numerous studies of its MH/SA system, and people will read into those studies what they would like. Some studies began with pre-conceived ideas of what should happen.

- The problem with the current system is underfunding and not structure. The current system is chronically underfunded. The funding deficit is estimated at half a billion dollars based on actual cuts that have occurred and the cost of funding an ideal system with a full array of services (as identified in a baseline study). There is not enough money in the Medicaid mental health carve out to join with the Oregon Health Plan in the future (i.e., to carve in mental health services that are currently provided by county-based mental health organizations or MHOs).

- There is not enough funding to coordinate the system pieces from a consumer perspective due to county funding differences and overall underfunding.

- Services are very fragmented and uneven. Level of coordination between service systems varies greatly between counties, and depends on past working relationships.

- There are concerns about what will happen to civil commitment, crisis, community-based, prevention and wraparound services that fully capitated health plans do not want to provide.

- Stakeholders have different ideas of what regionalization and integration mean.

- Getting to a more equitable system could involve more state funding going to counties and equalization of funding around certain services, such as acute care and crisis.

- Reform efforts need to be developed and discussed in a public process.

- Need to provide flexibility for counties – one model does not fit all.

- Current system has multiple structures that are not well-coordinated.

- Counties should retain a local planning role and voice. Service planning should be locally-driven (bottom up, not top down). Current local planning process works well with good local participation.

- Some NAMI representatives have suggested a brokerage system instead of the current county system for mental health, which would be similar to the system used for adult consumers with developmental disabilities.

Oregon – Lessons Learned

- It is preferable to reach compromise with demonstration projects instead of having confrontation over statewide expansion.

Oregon – Continued Challenges

- Great variation in availability of mental health services from one county to another.
- Service penetration rate of only 40 percent for mental health and 25 percent for substance abuse services (60 percent are in hospitals, corrections, are homeless, etc.).
- Lack of safe and affordable housing for individuals with mental illness due to stigma surrounding mental illness and its impact on locating facilities in communities.
- Trend that consumers are increasingly accessing care through higher cost inpatient and emergency services.
- Challenges in funding Oregon Health Plan due to state budget shortfalls.
- Lack of accountability regarding how state funds provided to the counties by AMH are being used. An antiquated client process monitoring system is being used, and very few people are knowledgeable about it.
- Need to improve accountability and access to uniform services, which is not possible with 32 different political entities.
- Counties have a strong say in the system even though most do not contribute significant funding. Counties are also experiencing financial pressures from declining revenues.
- Focus on utilization management in residential programs to reduce reliance on institutional placements. Otherwise the institutional budget will consume all available funding for community services.
- Need to get better utilization management that results in more people being served within existing resources.
- It is a challenge to reconcile the different focus of MH/SA and Medicaid areas. The focus of the former is to provide services, and the focus of latter is to control costs.

D. Other State Benchmark Goals and Data

Rather than collecting detailed financial and program information from each of the five states, the study utilized readily available data sources from national organizations. Using information collected from these sources ensures that at minimum, states were responding to a consistent set of questions and that the resulting information was reported in a consistent format. There is a significant amount of national information available for mental health program administration, financing, and service utilization. Unfortunately, similar information regarding substance abuse is not as readily available and is therefore not included in this section.

There are two primary sources of mental health information. The first is the National Association of State Mental Health Program Directors Research Institute (NRI). According to the NRI Web site, the organization is highly regarded within the mental health community and is seen as a national leader in the sharing and dissemination of new data, research, and information on mental health. NRI has been successful in obtaining responses to annual inquires and requests for data, making it the most complete source for information regarding the infrastructure of mental health services.

Annually, NRI collects data and produces state profiles with the latest and most complete information on the activities of State Mental Health Agencies (SMHAs). The profiles provide descriptions of each SMHA's organization and structure and other key measures. The state profiles from the most recent three years available (2004 to 2006) were used to show how Wisconsin compares to the five states included in this study. The tables presented on the following pages also include comparisons to national averages.

The other source of information used to collect comparative information for mental health services in the other states is the U.S. Department of Health and Human Services Substance Abuse and Mental Health Services Administration's (SAMHSA) National Mental Health Information Center. SAMHSA's National Mental Health Information Center has created a system to ensure uniform reporting of state level data to describe public mental health systems. The Uniform Reporting System was created to assist in the collection of such information. SMHAs annually report information to SAMHSA, and the most recent three years available (2004 to 2006) have been included in this report.

While this information allows for a side-by-side view of the data for Wisconsin and the other selected states, readers of this report should be cautioned that the intent of presenting this data is not to make positive or negative comparisons between the states. Each state has its own unique statutory and regulatory environment that governs who is served by the SMHA. States also can operate under various Medicaid waivers that can impact the number of consumers served and how those services are funded. Further, the information in the tables should not be used to measure the level, intensity or quality of services provided in each of the states.

Total and Per Capita Mental Health Agency Expenditures

Table 1 provides a summary of the total expenditures for state mental health agencies in the five states as well as Wisconsin. The table also includes a comparison of the per capita expenditures to better equalize the information across the states and their varying expenditure levels and size.

Table 1 – Summary of Total and Per Capita State Mental Health Agency Expenditures

State	2004				2005				2006			
	Total Expenditures	National Rank	Per Capita Expenditures	National Rank	Total Expenditures	National Rank	Per Capita Expenditures	National Rank	Total Expenditures	National Rank	Per Capita Expenditures	National Rank
Minnesota	$618,836,158	13	$121.37	13	$669,275,671	13	$130.60	13	$721,046,541	11	$139.96	12
New Mexico [1, 3]	52,534,100	49	$27.78	51	46,400,000	51	$24.23	51	49,400,000	46	25.58	48
North Carolina [1, 2]	419,001,458	21	$49.64	45	1,027,800,736	5	$119.82	14	1,111,927,787	5	126.78	14
Ohio	733,534,314	10	$64.06	36	757,733,206	11	$66.10	37	781,342,833	10	68.22	35
Oregon [2]	218,411,658	31	$60.79	37	434,558,178	22	$119.48	15	432,300,000	23	117.22	17
Wisconsin	522,281,277	16	$94.82	19	579,728,296	16	$104.90	20	600,446,346	16	107.81	20
Average of Targeted States (excluding Wisconsin)	**$408,463,538**		**$64.73**		**$587,153,558**		**$92.05**		**$619,203,432**		**$95.55**	
National Average (excluding Wisconsin)	**$533,673,104**		**$98.06**		**$576,343,867**		**$103.41**		**$620,216,745**		**$113.46**	
Wisconsin Above/(Below) National Targeted Average	**27.9%**		**46.5%**		**-1.3%**		**14.0%**		**-3.0%**		**12.8%**	
Wisconsin Above/(Below) National Average	**-2.1%**		**-3.3%**		**0.6%**		**1.4%**		**-3.2%**		**-5.0%**	

Notes:

[1] Medicaid revenues for community programs are not included in SMHA-controlled expenditures (New Mexico 2005 & 2006; North Carolina 2004).

[2] SMHA-controlled expenditures include funds for mental health services in jails or prisons (North Carolina 2006; Oregon 2004).

[3] Children's mental health expenditures are not included in SMHA-controlled expenditures (New Mexico 2004, 2005 & 2006).

Source: NASMHPD Research Institute, Inc., "Funding Sources and Expenditures of State Mental Health Agencies", 2004, 2005, and 2006.

Key findings from this information show:

- Wisconsin's SMHA controlled expenditures have ranked 16th nationally in the most recently reported years.
    - Wisconsin's total mental health expenditures increased 15.0 percent between 2004 and 2006, compared to the national average of 16.2 percent.
    - Wisconsin's total mental health expenditures were an average of 1.6 percent below the national average.
    - Wisconsin's total mental health expenditures were an average of 7.9 percent above the other comparative states average, but below in both 2005 and 2006.
- Wisconsin's SMHA controlled per capita expenditures have ranked 19th and 20th nationally in the most recently reported years.
    - Wisconsin's total mental health per capita expenditures increased 13.7 percent between 2004 and 2006, compared to the national average of 15.7 percent.
    - Wisconsin's total mental health per capita expenditures were an average of 2.3 percent below the national average.
    - Wisconsin's total mental health expenditures were an average of 24.4 percent above the other comparative states average, but dropped significantly in both 2005 and 2006 when compared to 2004.

Per Capita Expenditures and Percentage of Total Expenditures by Service Setting

Table 2 provides a summary of the total per capita expenditures and the percentage of each state SMHA's total expenditures by service setting. This includes a breakdown of costs for inpatient settings as well as residential settings.

Table 2 – Summary of Per Capita State Mental Health Agency Expenditures and Percentage of Total Expenditures by Service Setting

2004	Inpatient [4]		Residential (24 hr) Service		Less Than 24 hr Service		Other Services		Research, Training & Admin.		Total	
	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures
Minnesota	$47.81	29.4%	$14.78	17.3%	$58.18	47.8%	$0.00	3.9%	$0.60	1.5%	$121.37	100%
New Mexico [3]	9.71	34.9%	1.32	4.8%	16.75	60.3%	0.00	0.0%	0.00	0.0%	$27.78	100%
North Carolina [1]	33.71	67.9%	0.96	1.9%	0.00	0.0%	14.96	30.1%	0.00	0.0%	$49.64	100%
Ohio	17.64	27.5%	4.06	6.3%	39.82	62.2%	0.00	0.0%	2.53	4.0%	$64.06	100%
Oregon [2]	30.51	50.2%	13.27	21.8%	15.45	25.4%	0.44	0.7%	1.11	1.8%	$60.79	100%
Wisconsin	32.81	34.6%	8.45	8.9%	53.28	56.2%	0.00	0.0%	0.29	0.3%	$94.82	100%
Average of Targeted States (excluding Wisconsin)	**$27.88**	**40.8%**	**$6.88**	**10.2%**	**$26.04**	**42.0%**	**$3.08**	**5.8%**	**$0.85**	**1.3%**	**$64.73**	**100%**
National Average (excluding Wisconsin)	**$34.36**	**38.3%**	**$15.22**	**13.2%**	**$38.43**	**38.3%**	**$8.75**	**8.3%**	**$3.43**	**2.8%**	**$98.06**	**100%**
Wisconsin Above/(Below) National Targeted Average	**17.7%**	**-15.1%**	**22.9%**	**-12.5%**	**104.6%**	**33.9%**	**-100.0%**	**-100.0%**	**-65.8%**	**-76.3%**	**46.5%**	
Wisconsin Above/(Below) National Average	**-4.5%**	**-9.7%**	**-44.5%**	**-32.5%**	**38.6%**	**46.9%**	**-100.0%**	**-100.0%**	**-91.5%**	**-89.2%**	**-3.3%**	

Notes:

[1] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[2] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[3] Children's mental health expenditures are not included in SMHA-controlled expenditures.

[4] Inpatient includes state mental health institutes and community programs institutes.

Source: NASMHPD Research Institute, Inc., "Funding Sources and Expenditures of State Mental Health Agencies" 2004.

2005	Inpatient [4]		Residential (24 hr) Service		Less Than 24 hr Service		Other Services		Research, Training & Admin.		Total	
	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures
Minnesota	$53.91	41.3%	$13.95	10.7%	$62.05	47.5%	$0.00	0.0%	$0.68	0.5%	$130.60	100%
New Mexico [1,3]	11.33	46.8%	0.00	0.0%	12.90	53.2%	0.00	0.0%	0.00	0.0%	$24.23	100%
North Carolina [1,2]	36.03	30.1%	20.95	17.5%	56.62	47.3%	4.25	3.6%	1.97	1.6%	$119.82	100%
Ohio	18.05	27.3%	4.03	6.1%	41.45	62.7%	0.00	0.0%	2.57	3.9%	$66.10	100%
Oregon [2]	32.60	27.3%	22.90	19.2%	24.50	20.5%	36.06	30.2%	3.41	2.9%	$119.48	100%
Wisconsin	41.06	39.1%	9.09	8.7%	54.53	52.0%	0.00	0.0%	0.21	0.2%	$104.90	100%
Average of Targeted States (excluding Wisconsin)	**$30.38**	**35.3%**	**$12.37**	**10.4%**	**$39.50**	**47.2%**	**$8.06**	**5.6%**	**$1.73**	**1.5%**	**$92.05**	**100%**
National Average (excluding Wisconsin)	**$35.86**	**37.7%**	**$15.55**	**13.3%**	**$40.41**	**37.1%**	**$9.76**	**10.5%**	**$3.07**	**2.5%**	**$103.41**	**100%**
Wisconsin Above/(Below) National Targeted Average	**35.1%**	**10.7%**	**-26.5%**	**-16.1%**	**38.0%**	**10.2%**	**-100.0%**	**-100.0%**	**-87.8%**	**-86.8%**	**14.0%**	
Wisconsin Above/(Below) National Average	**14.5%**	**3.7%**	**-41.5%**	**-34.8%**	**34.9%**	**40.2%**	**-100.0%**	**-100.0%**	**-93.2%**	**-91.9%**	**1.4%**	

Notes:

[1] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[2] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[3] Children's mental health expenditures are not included in SMHA-controlled expenditures.

[4] Inpatient includes state mental health institutes and community programs institutes.

Source: NASMHPD Research Institute, Inc., "Funding Sources and Expenditures of State Mental Health Agencies" 2005.

Table 2 - Continued– Summary of Per Capita State Mental Health Agency Expenditures and Percentage of Total Expenditures by Service Setting

2006	Inpatient [4]		Residential (24 hr) Service		Less Than 24 hr Service		Other Services		Research, Training & Admin.		Total	
	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures	Per Capita Expenditures	% of Total Expenditures
Minnesota	$58.96	42.1%	$14.23	10.2%	$66.04	47.2%	$0.00	0.0%	$0.73	0.5%	$139.96	100%
New Mexico [1, 3]	11.50	44.9%	0.00	0.0%	14.08	55.1%	0.00	0.0%	0.00	0.0%	$25.58	100%
North Carolina [2]	37.28	29.4%	21.95	17.3%	60.61	47.8%	4.99	3.9%	1.94	1.5%	$126.77	100%
Ohio	18.16	26.6%	4.33	6.3%	42.97	63.0%	0.00	0.0%	2.76	4.1%	$68.22	100%
Oregon	36.12	30.8%	24.27	20.7%	22.59	19.3%	31.21	26.6%	3.04	2.6%	$117.23	100%
Wisconsin	40.14	37.2%	10.89	10.1%	56.63	52.5%	0.00	0.0%	0.16	0.1%	$107.81	100%
Average of Targeted States (excluding Wisconsin)	**$32.40**	**35.2%**	**$12.96**	**10.8%**	**$41.26**	**47.5%**	**$7.24**	**5.1%**	**$1.69**	**1.5%**	**$95.55**	**100%**
National Average (excluding Wisconsin)	**$39.40**	**36.2%**	**$20.46**	**9.9%**	**$50.39**	**43.5%**	**$27.32**	**8.0%**	**$3.80**	**2.3%**	**$113.45**	**100%**
Wisconsin Above/(Below) National Targeted Average	**23.9%**	**5.8%**	**-15.9%**	**-6.2%**	**37.3%**	**10.6%**	**-100.0%**	**-100.0%**	**-90.6%**	**-93.2%**	**12.8%**	
Wisconsin Above/(Below) National Average	**1.9%**	**2.8%**	**-46.8%**	**2.0%**	**12.4%**	**20.7%**	**-100.0%**	**-100.0%**	**-95.8%**	**-95.7%**	**-5.0%**	

Notes:

[1] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[2] SMHA-controlled expenditures include funds for mental health services in jails or prisons.

[3] Children's mental health expenditures are not included in SMHA-controlled expenditures.

[4] Inpatient includes state mental health institutes and community programs institutes.

Source: NASMHPD Research Institute, Inc., "Funding Sources and Expenditures of State Mental Health Agencies" 2006.

Key findings from **Table 2** include:

- Wisconsin's SMHA controlled per capita expenditures for inpatient services have represented between 35 percent and 39 percent of total expenditures between 2004 and 2006.
    - Wisconsin's total inpatient per capita expenditures increased 22.3 percent between 2004 and 2006, compared to the national average of 14.7 percent.
    - Wisconsin's total inpatient expenditures were an average of 25.6 percent above the national average.
    - Wisconsin's total inpatient expenditures were an average of 4.0 percent above the other comparative states average.

Per Capita Revenues by Source

The NRI annual state mental health profiles also collects information on the sources of revenue utilized by SMHAs to fund services. **Table 3** provides a summary of the per capita revenues by source as well as the percentage of revenues each source contributes to the total.

Key findings from **Table 3** include:

- Wisconsin's SMHA controlled total per capita revenues increased from just under $95 in 2004 to nearly $108 in 2006, a 13.7 percent increase.
    - The average increase for the other five selected states increased at a rate of 51.8 percent, due primarily to a large increase in North Carolina which was implementing reforms of its system during this period.
    - The average increase nationally was 16.5 percent.

- Wisconsin's SMHA controlled general state funds increased from just over $24 per capita in 2004 to nearly $55 in 2006, a 126.7 percent increase. This increase is primarily due to a change in reporting methodology between 2004 and 2005 (when the Human Services Revenue Report was initiated). The revenues reported for community administered programs experienced a large increase due to the existence of a more accurate reporting source for DHS to collect this information.
    - The average increase for the other five selected states increased at a rate of 14.5 percent.
    - The average increase nationally was 12.3 percent.
    - Based on the percentage of total revenue, Wisconsin's SMHA controlled general state funds was between 11 percent and 12 percent above the national average in 2005 and 2006.

- Wisconsin's SMHA controlled funding from Medicaid increased from just under $19 per capita in 2004 to just over $26, a 40.9 percent increase. Again, this increase is primarily due to the more accurate source for DHS to collect information from the counties.
    - The average increase for the other five selected states increased at a rate of 118.9 percent, due primarily to large increases for both North Carolina and Oregon, both of which were implementing system reforms during this period.
    - The average increase nationally was 22.5 percent.

  - Based on the percentage of total revenue, Wisconsin's SMHA controlled Medicaid funds increased from 19.7 percent in 2004 to 24.5 percent in 2006, but this was significantly below the national averages of 41.4 percent in 2004 and 43.5 percent in 2006.

- Only three states (including Wisconsin) reported local government revenue as a source for funding SMHA controlled mental health services. Wisconsin's percentage of revenue from local funding was approximately 20 percent of all SMHA controlled revenues.

  - The average percentage nationally was approximately 1 percent.

Table 3 – Summary of Per Capita State Mental Health Agency Revenues by Source

2004	State General Funds		Total Medicaid [4]		Medicare		Other Federal		CMHS MH Block Grant		Local Government		Other Revenues		Total SMHA Revenue	
	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues
Minnesota	$49.40	40.7%	$52.87	43.6%	$0.80	0.7%	$1.22	1.0%	$4.33	3.6%	$7.08	5.8%	$5.67	4.7%	$121.38	100%
New Mexico [3]	21.63	81.5%	2.12	8.0%	0.11	0.4%	2.17	8.2%	0.21	0.8%	0.00	0.0%	0.32	1.2%	$26.55	100%
North Carolina [1]	37.95	76.4%	5.13	10.3%	3.03	6.1%	1.01	2.0%	2.52	5.1%	0.00	0.0%	0.00	0.0%	$49.64	100%
Ohio	37.36	55.2%	26.69	39.4%	1.04	1.5%	1.37	2.0%	1.12	1.7%	0.00	0.0%	0.15	0.2%	$67.72	100%
Oregon [2]	31.65	52.1%	27.14	44.6%	0.64	1.1%	1.17	1.9%	0.19	0.3%	0.00	0.0%	0.00	0.0%	$60.79	100%
Wisconsin [5]	24.13	25.4%	18.66	19.7%	1.00	1.1%	1.25	1.3%	0.13	0.1%	0.00	0.0%	49.67	52.4%	$94.84	100%
Average of Targeted States (excluding Wisconsin)	**$35.60**	**61.2%**	**$22.79**	**29.2%**	**$1.12**	**2.0%**	**$1.39**	**3.0%**	**$1.68**	**2.3%**	**$1.42**	**1.2%**	**$1.23**	**1.2%**	**$65.21**	**100%**
National Average (excluding Wisconsin)	**$43.47**	**47.4%**	**$37.96**	**41.4%**	**$1.74**	**1.9%**	**$1.37**	**1.5%**	**$1.79**	**2.0%**	**$0.73**	**0.8%**	**$4.69**	**5.1%**	**$91.75**	
Wisconsin Above/(Below) National Targeted Average	**-32.2%**	**-58.4%**	**-18.1%**	**-32.6%**	**-11.2%**	**-46.0%**	**-9.6%**	**-56.4%**	**-92.4%**	**-94.1%**	**-100.0%**	**-100.0%**	**3949.3%**	**4204.5%**	**45.4%**	
Wisconsin Above/(Below) National Average	**-44.5%**	**-46.3%**	**-50.8%**	**-52.4%**	**-42.7%**	**-44.5%**	**-8.7%**	**-11.7%**	**-92.9%**	**-93.1%**	**-100.0%**	**-100.0%**	**959.0%**	**924.7%**	**3.4%**	

Notes:

[1] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[2] SMHA-Controlled Expenditures include funds for mental health services in jails or prisons.

[3] Children's mental health expenditures are not included in SMHA-controlled expenditures.

[4] Total Medicaid includes State Medicaid and Federal Medicaid matches.

[5] Local Government revenues included in Other Revenues category in 2004 report.

Source: NASMHPD Research Institute, Inc., "Funding Sources and Expenditures of State Mental Health Agencies" 2004.

2005	State General Funds		Total Medicaid [4]		Medicare		Other Federal		CMHS MH Block Grant		Local Government		Other Revenues		Total SMHA Revenue	
	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues
Minnesota	$53.97	41.3%	$59.24	45.4%	$0.72	0.6%	$1.23	0.9%	$3.73	2.9%	$6.36	4.9%	$5.35	4.1%	$130.60	100%
New Mexico [1, 3]	20.63	82.8%	2.40	9.6%	0.10	0.4%	0.47	1.9%	0.10	0.4%	0.00	0.0%	1.20	4.8%	$24.91	100%
North Carolina	36.89	30.8%	71.94	60.0%	3.29	2.7%	1.13	0.9%	0.30	0.3%	4.15	3.5%	2.11	1.8%	$119.81	100%
Ohio	37.77	53.9%	28.70	40.9%	1.21	1.7%	1.33	1.9%	0.90	1.3%	0.00	0.0%	0.18	0.3%	$70.10	100%
Oregon	33.71	28.2%	82.29	68.9%	0.00	0.0%	1.21	1.0%	0.41	0.3%	0.00	0.0%	1.84	1.5%	$119.46	100%
Wisconsin	55.33	52.8%	24.52	23.4%	1.03	1.0%	1.23	1.2%	0.04	0.0%	20.55	19.6%	2.19	2.1%	$104.89	100%
Average of Targeted States (excluding Wisconsin)	**$36.59**	**47.4%**	**$48.91**	**45.0%**	**$1.07**	**1.1%**	**$1.07**	**1.3%**	**$1.09**	**1.0%**	**$2.10**	**1.7%**	**$2.14**	**2.5%**	**$92.98**	**100%**
National Average (excluding Wisconsin)	**$46.65**	**47.0%**	**$42.22**	**42.5%**	**$1.82**	**1.8%**	**$1.35**	**1.4%**	**$1.71**	**1.7%**	**$1.02**	**1.0%**	**$4.54**	**4.6%**	**$99.31**	
Wisconsin Above/(Below) National Targeted Average	**51.2%**	**11.3%**	**-49.9%**	**-48.0%**	**-3.2%**	**-9.7%**	**14.5%**	**-12.3%**	**-96.7%**	**-96.7%**	**877.7%**	**1075.6%**	**2.5%**	**-16.4%**	**12.8%**	
Wisconsin Above/(Below) National Average	**18.6%**	**12.3%**	**-41.9%**	**-45.0%**	**-43.3%**	**-46.3%**	**-8.6%**	**-13.4%**	**-97.9%**	**-98.0%**	**1909.0%**	**1802.1%**	**-51.8%**	**-54.4%**	**5.6%**	

Notes:

[1] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[2] SMHA-Controlled Expenditures include funds for mental health services in jails or prisons.

[3] Children's mental health expenditures are not included in SMHA-controlled expenditures.

[4] Total Medicaid includes State Medicaid and Federal Medicaid matches.

Source: NASMHPD Research Institute, Inc., "Funding Sources and Expenditures of State Mental Health Agencies" 2005.

Table 3 continued – Summary of Per Capita State Mental Health Agency Revenues by Source

2006	State General Funds		Total Medicaid [4]		Medicare		Other Federal		CMHS MH Block Grant		Local Government		Other Revenues		Total SMHA Revenue	
	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues	Per Capita Revenues	% of Total Revenues
Minnesota	$57.67	41.2%	$64.21	45.9%	$0.78	0.6%	$1.32	0.9%	$3.57	2.6%	$7.30	5.2%	$5.12	3.7%	$139.97	100%
New Mexico [1,3]	30.60	80.8%	3.74	9.9%	0.08	0.2%	1.45	3.8%	0.31	0.8%	0.00	0.0%	1.68	4.4%	$37.85	100%
North Carolina [2]	37.21	29.4%	77.50	61.1%	3.64	2.9%	1.25	1.0%	0.22	0.2%	4.47	3.5%	2.50	2.0%	$126.78	100%
Ohio	40.28	55.1%	28.90	39.5%	1.24	1.7%	1.34	1.8%	1.25	1.7%	0.00	0.0%	0.14	0.2%	$73.14	100%
Oregon	38.10	32.5%	75.08	64.1%	0.00	0.0%	1.08	0.9%	0.65	0.6%	0.00	0.0%	2.30	2.0%	$117.22	100%
Wisconsin	54.71	50.7%	26.29	24.4%	1.11	1.0%	1.20	1.1%	0.81	0.7%	21.78	20.2%	1.90	1.8%	$107.80	100%
Average of Targeted States (excluding Wisconsin)	**$40.77**	**47.8%**	**$49.89**	**44.1%**	**$1.15**	**1.1%**	**$1.29**	**1.7%**	**$1.20**	**1.2%**	**$2.35**	**1.7%**	**$2.35**	**2.4%**	**$98.99**	
National Average (excluding Wisconsin)	**$48.84**	**45.7%**	**$46.50**	**43.5%**	**$2.19**	**2.0%**	**$1.37**	**1.3%**	**$1.94**	**1.8%**	**$1.08**	**1.0%**	**$5.01**	**4.7%**	**$106.92**	
Wisconsin Above/(Below) National Targeted Average	**34.2%**	**6.2%**	**-47.3%**	**-44.7%**	**-2.9%**	**-3.0%**	**-6.7%**	**-34.5%**	**-32.6%**	**-35.3%**	**825.4%**	**1055.7%**	**-19.0%**	**-27.8%**	**8.9%**	
Wisconsin Above/(Below) National Average	**12.0%**	**11.1%**	**-43.5%**	**-43.9%**	**-49.1%**	**-49.5%**	**-12.1%**	**-12.8%**	**-58.4%**	**-58.7%**	**1918.2%**	**1901.8%**	**-62.0%**	**-62.3%**	**0.8%**	

Notes:

[1] Medicaid revenues for community programs are not included in SMHA-controlled expenditures.

[2] SMHA-Controlled Expenditures include funds for mental health services in jails or prisons.

[3] Children's mental health expenditures are not included in SMHA-controlled expenditures.

[4] Total Medicaid includes State Medicaid and Federal Medicaid matches.

Source: NASMHPD Research Institute, Inc., "Funding Sources and Expenditures of State Mental Health Agencies" 2006.

Penetration Rates and Utilization

SAMHSA's Uniform Reporting System (URS) reports information on the penetration rates for mental health services controlled by SMHAs. The URS reports also show utilization rates for various service settings. **Table 4** provides a summary for Wisconsin and the five selected states showing penetration rates for 2004 through 2006 as well as utilization rates per 1,000 of the total population for various service settings. This data differs from the data of consumers served for Wisconsin found in **Section III. Wisconsin's Public Mental Health and Substance Abuse System** of this report, because the penetration rate data in **Table 4** only includes data for mental health funding controlled by the state mental health agency (SMHA).

Table 4 – Summary of Mental Health Penetration Rates and Utilization by Service Settings per 1,000 Population for SMHAs

State	2004				2005				2006			
	Penetration Rate	Community Utilization	State Hospital Utilization	Other Psychiatric Inpatient	Penetration Rate	Community Utilization	State Hospital Utilization	Other Psychiatric Inpatient	Penetration Rate	Community Utilization	State Hospital Utilization	Other Psychiatric Inpatient
Minnesota	15.79	15.72	0.44	0.08	16.61	16.52	0.47	0.07	31.37	30.88	0.50	2.35
New Mexico	29.17	27.73	1.38	0.04	37.33	33.58	0.54	1.24	37.40	33.49	0.54	1.22
North Carolina	35.53	35.29	0.60	1.49	27.84	26.46	1.35	0.02	26.26	25.15	1.07	0.04
Ohio	26.44	n/a	n/a	n/a	26.97	n/a	n/a	n/a	28.01	n/a	n/a	n/a
Oregon	30.02	24.43	0.45	1.56	29.66	19.11	0.43	1.70	28.31	22.81	0.43	1.61
Wisconsin	15.74	15.24	0.94	1.44	15.28	14.52	0.96	1.10	16.42	15.88	1.02	1.23
Average of Targeted States (excluding Wisconsin)	27.39	25.79	0.72	0.79	27.68	23.92	0.70	0.76	30.27	28.08	0.64	1.31
National Average (including Wisconsin)	19.88	18.58	0.59	1.42	20.14	19.01	0.60	1.43	20.69	19.15	0.59	1.51
Wisconsin Above/(Below) National Targeted Average	-42.5%	-40.9%	31.0%	81.7%	-44.8%	-39.3%	37.6%	45.2%	-45.8%	-43.5%	60.6%	-5.7%
Wisconsin Above/(Below) National Average	-20.8%	-18.0%	59.3%	1.4%	-24.1%	-23.6%	60.0%	-23.1%	-20.6%	-17.1%	72.9%	-18.5%

Notes:
Data includes only services provided directly by or contracted through state mental health agencies.
n/a = Data not reported.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), Division of State and Community Systems Development (DSCSD), Uniform Reporting System (URS) Output Tables 2006, 2007 and 2008.

Key findings from this data include:

- The penetration rate for individuals served through Wisconsin's SMHA controlled services increased from 15.74 per 1,000 of the total population in 2004 to 16.42 per 1,000 population in 2006.
    - Wisconsin's penetration rate was on average 21.9 percent below the national average over the three year period.
    - Wisconsin's penetration rate was on average 44.4 percent below the average of the other comparative states.
- The utilization rate for individuals served in the community through Wisconsin's SMHA controlled services increased from 15.24 per 1,000 of the total population in 2004 to 15.88 per 1,000 population in 2006.
    - Wisconsin's utilization rate for individuals served in the community was on average 19.6 percent below the national average over the three year period.
    - Wisconsin's utilization rate for individuals served in the community was on average 41.2 percent below the average of the other comparative states.

- The utilization rate of state hospitals for individuals served through Wisconsin's SMHA controlled services increased from 0.94 per 1,000 of the total population in 2004 to 1.02 per 1,000 population in 2006.

    - Wisconsin's utilization rate of state hospitals for individuals was on average 64.1 percent above the national average over the three year period.
    - Wisconsin's utilization rate of state hospitals for individuals was on average 43.1 percent above the average of the other comparative states.

- The utilization rate of other psychiatric inpatient facilities for individuals served through Wisconsin's SMHA controlled services decreased from 1.44 per 1,000 of the total population in 2004 to 1.23 per 1,000 population in 2006.

    - Wisconsin's utilization rate of other psychiatric inpatient facilities for individuals was on average 13.4 percent below the national average over the three year period.
    - Wisconsin's utilization rate of other psychiatric inpatient facilities for individuals was on average 40.4 percent above the average of the other comparative states.

Readmission Rates to Mental Health Inpatient Facilities

SAMHSA also requests information from states regarding the readmission rates within 30 and 180 days of a discharge from a mental health inpatient facility. **Table 5** provides a summary of 2004 through 2006 information for Wisconsin and the other five states showing the readmission rates to state hospitals at 30 and 180 days, as well for readmissions within 30 days to any inpatient mental health facility.

Table 5 – Summary of Readmission Rates to Inpatient Mental Health Facilities within 30 and 180 Days

State	2004			2005			2006		
	State Hospital 30-days	State Hospital 180-days	Any Inpatient 30-days	State Hospital 30-days	State Hospital 180-days	Any Inpatient 30-days	State Hospital 30-days	State Hospital 180-days	Any Inpatient 30-days
Minnesota	7.2%	18.9%	8.4%	7.4%	18.4%	8.9%	7.9%	19.5%	15.4%
New Mexico	7.0%	7.4%	12.4%	9.2%	17.5%	9.2%	7.7%	17.4%	14.0%
North Carolina	12.0%	21.8%	n/a	12.1%	25.1%	n/a	10.9%	23.1%	n/a
Ohio	11.7%	25.6%	n/a	11.6%	23.3%	n/a	10.7%	23.0%	n/a
Oregon	7.4%	14.9%	14.7%	3.7%	14.3%	12.3%	3.5%	11.8%	10.6%
Wisconsin	14.9%	29.0%	9.7%	12.5%	27.2%	9.5%	16.3%	30.5%	11.1%
Average of Targeted States (excluding Wisconsin)	9.1%	17.7%	11.8%	8.8%	19.7%	10.1%	8.1%	19.0%	13.3%
National Average (including Wisconsin)	9.1%	19.3%	13.9%	9.4%	19.9%	14.2%	9.3%	21.3%	14.7%
Wisconsin Above/(Below) National Targeted Average	64.5%	63.7%	-18.0%	42.0%	37.9%	-6.3%	100.2%	60.9%	-16.8%
Wisconsin Above/(Below) National Average	63.7%	50.3%	-30.2%	33.0%	36.7%	-33.1%	75.3%	43.2%	-24.5%

Notes:
Data includes only services provided directly by or contracted through state mental health agencies.
n/a = Data not reported.

Source: Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Mental Health Services (CMHS), Division of State and Community Systems Development (DSCSD), Uniform Reporting System (URS) Output Tables 2006, 2007 and 2008.

- Readmission rates to state hospitals within 30 days for individuals served through Wisconsin's SMHA controlled services ranged between 15 percent and 16 percent.

    - Wisconsin's readmission rate to state hospitals within 30 days was on average 57.3 percent above the national average over the three year period.
    - Wisconsin's readmission rate to state hospitals within 30 days was on average 68.9 percent above the average of the other comparative states.

- Readmission rates to state hospitals within 180 days for individuals served through Wisconsin's SMHA controlled services ranged between 27 percent and 30 percent.

    - Wisconsin's readmission rate to state hospitals within 180 days was on average 43.4 percent above the national average over the three year period.
    - Wisconsin's readmission rate to state hospitals within 180 days was on average 54.2 percent below the average of the other comparative states.

- Readmission rates to any inpatient facility within 30 days for individuals served through Wisconsin's SMHA controlled services ranged between 9 percent and 11 percent.

    - Wisconsin's readmission rate to any inpatient facility within 30 days was on average 29.3 percent below the national average over the three year period.
    - Wisconsin's readmission rate to any inpatient facility within 30 days was on average 13.7 percent below the average of the other comparative states.

Utilization of Evidence-Based Services and Innovative Practices

NRI prepares annual state profiles that provide descriptions of the SMHA's organization and structure, services, eligible populations, emerging policy issues, numbers of consumer served, fiscal resources, consumer issues, information management systems, and the research and evaluation they conduct. The profiles also include information from the states as to which evidence-based services are provided by SMHA funded agencies. **Table 6** provides a summary of the responses Wisconsin and the other five states provided to NRI in 2007.

Table 6 – Implementation of Evidence-Based Services and Evidence-Based and Innovative Practices

	Wisconsin	Minnesota	New Mexico	North Carolina	Ohio	Oregon
Evidence-Based Services						
Assertive Community Treatment (ACT)	**P**	P	P	S	P	P
Supported Employment	**P**	P		P	P	P
Family Psychoeducation	**P**			P	P	P
Integrated MH/SA Services	**P**	P		P	P	P
Self-Management	**P**	S		P	P	P
Supported Housing	**S**	S		S	P	P
Consumer-Operated Services	**S**	S		P	P	P
Multisystemic Therapy (Conduct Disorder)		P		P	P	P
Therapeutic Foster Care		P		S	P	P
Functional Family Therapy				P	P	P
Medication Algorithms (Schizophrenia)					P	P
Medication Algorithms (Bipolar Disorder)					P	
Source: NRI Report, October 2008.	P – Implemented in **parts** of the state; S – Implemented **statewide**					

There were a total of 12 evidence-based services listed by the states, with Wisconsin listing seven. Only Ohio reported implementing all 12, but only in parts of the state. Both Minnesota and North Carolina reported three evidence-based services are offered statewide, while Wisconsin reported two that were statewide – supported housing and consumer-operated services.

SECTION VII. POTENTIAL MODELS AND PATHWAYS FOR SYSTEM REFORM

A. Framework for the Development of Models/Pathways

Various factors were considered in the development of possible models for financing the public MH/SA service system. These included:

- The guiding principles established by the Wisconsin MH/SA Infrastructure Study Steering Committee.
- The experience of Wisconsin and other states implementing different models.
- The national trends impacting the financing and delivery of publicly funded MH/SA services.

The purpose of the model development was to identify potential major models available for consideration, but not to recommend any particular model. Pathways were developed for each model, representing different approaches or strategies that could be used to implement a particular model.

The project team was directed to consider all major models (except for a state-administered system model) during discussions about the scope of the study with Department of Health Service (DHS) officials and members of the Study Steering Committee. A state-administered model was excluded from consideration because of Wisconsin's strong county-based MH/SA system tradition and the apparent incompatibility in moving to a fully state-administered system in light of that tradition. In addition, transferring all MH/SA responsibilities from counties to the state would be impractical and not financially feasible because of the extensive infrastructure costs and planning such a transfer would require. However, in two of the potential models, there are pathways that would allow counties to opt out of the responsibilities associated with administering MH/SA services

B. Guiding Principles

The Steering Committee identified a set of principles to guide and inform the development of the models/pathways for funding the public MH/SA system. These principles, initially identified in May 2009, were finalized and adopted by the Steering Committee in September 2009. The six principles identified by the Steering Committee include:

- Strong Consumer Role
- Future County Role or Choice
- Uniform Benefit Package
- Alignment and Compatibility with Medicaid
- State Incentives to Support Change
- Alignment and Compatibility with Health Care Reform and Related Initiatives

The intent of these guiding principles is clarified by the comments and discussion points of the Steering Committee and included in **Table 1**:

SECTION VII. POTENTIAL MODELS AND PATHWAYS FOR SYSTEM REFORM

Table 1
Guiding Principles for the Development of MH/SA Models/Pathways

Guiding Principles	Comments/Discussion Points from Steering Committee
Strong Consumer Role	• Greater implementation of consumer-focused, recovery-oriented services. • Consumer involvement in discussions about models/pathways.
Future County Role or Choice	• Choice in model/participation in system. • Some counties may prefer limited or no participation in system. • Future of state/county cost sharing may impact the role counties want to have. • Counties have a key leadership role and responsibility due to the statutory language of Chapter 51 and the level of local property tax dollars supporting the MH/SA system. • Important to have county flexibility to support services within available resources. • Identify county "building blocks" (e.g., other human services and human service-related functions counties perform) and which responsibilities counties wish to maintain (due to the impact of MH/SA on these other county services). • Address and remove barriers to multi-county service cooperation: o Review regional service approach prior to creation of Chapter 51 and the creation of the MH/SA/DD system (e.g., regionally funded inpatient). o Examine why the existing the multi-county approach for MH/SA services has had varying levels of success. o Identify challenges in regionalizing services like CCS and CSP that require local teams and involvement in the community.
Uniform Benefit Package	• Define the core services available statewide. Previously, the Kettl Commission and Visions Committee stressed the importance of establishing a core service definition. Family Care has a stated benefit; other states are defining core benefits for MH/SA services. The definition of core services will impact the level of county funding, which does not now support uniformity because of differences in local priorities and availability of funding. • Recognize that consumers may change county of residence based on the services that are available in different counties. • Examine the state's plans for implementing the federal parity legislation for MH/SA services. • Include inpatient hospitalization in the benefit package to properly align financial incentives and prevent service fragmentation.
Alignment and Compatibility with Medicaid	• Recognize that Medicaid is and will continue to be a major source of funding. • Medicaid/CMS wants to achieve uniformity and is concerned with the lack of uniformity and consistency in Wisconsin's county-based system, which provides different funding levels and service offerings. The willingness of Medicaid/CMS to tolerate Wisconsin's system is becoming a larger issue of concern. • How can Medicaid become a better payer of MH/SA services (i.e., Medicaid maximization)?

Guiding Principles	Comments/Discussion Points from Steering Committee
State Incentives to Support Change	• What types of incentives can the state provide to ensure change occurs and the system supports the benchmark goals more effectively (i.e., equitable access, accountability for outcomes, equitable and affordable funding, and service efficiency)? • Given fiscal constraints and the shift of MH/SA costs to counties, counties will need to make adjustments in budgets that will impact services and result in layoffs. • Recognize that additional state financial participation may follow defined expectations for certain types and level of services (such as prevention and early intervention) and for processes (such as quality improvement and more centralized intake). • Need to find a new model to share fiscal responsibility that creates joint ownership, improves the system and moves efforts forward. o Attempts to work around issues tend to get bogged down in who funds the services. If each side has a more proportionate share of money in the system (e.g., sharing of match), a more collaborative approach may occur that achieves better outcomes. o If counties and the state change how they fund MH/SA services (with both parties sharing in the financial responsibility), shared incentives will improve the system. o If the state expects counties to implement services like CCS and crisis in order to prevent and divert from inpatient placements, cost sharing incentives need to be addressed. CCS roll-out is cumbersome and yet fiscal responsibility for the federal match for Medicaid is entirely the responsibility of the county.
Alignment and Compatibility with Health Care Reform and Related Initiatives	• Future of MH/SA system needs to be aligned with health care reform initiatives. • If the public MH/SA system does not keep up with other health care reform efforts, MH/SA services may be marginalized and/or omitted. • Address incorporation of managed care principles, such as use of utilization management, global budgeting tools, service authorization models, etc. • Integrate MH/SA services and physical health care.

Key among the principles identified by the Steering Committee is a desire for individual county choice regarding the role of counties in a particular model. County representatives on the Steering Committee acknowledged that the future of state/county cost sharing may impact the role counties want to have in a future MH/SA services system, with some counties preferring limited to no county participation in the system.

C. Common Elements

It was important to begin the model/pathways development with an understanding of the underlying assumptions for all of the models. Based on the guiding principles identified by the Steering Committee, the lessons learned from other state reform efforts and the feedback from counties participating in the targeted county review, a set of elements emerged that would apply to all the major models considered.

SECTION VII. POTENTIAL MODELS AND PATHWAYS FOR SYSTEM REFORM

The following elements are assumed to be common for all of the major models identified in this section and therefore are not repeated for each of the model descriptions:

- All models address the four benchmark goal areas, but in different ways and to different degrees, through **incentives to ensure appropriate alignment of system goals**, including appropriate use of and responsibility for community-based and inpatient services. All models assume **greater state financial participation** to achieve implementation of the benchmark goals. The four benchmark goal areas for the models to finance the public mental health/substance abuse services system are:

    - Equitable access to services
    - Accountability for consumer outcomes
    - Equitable and affordable funding
    - Service efficiency

- All models include **publicly funded MH/SA services** to a defined eligible population, which can include Medicaid and non-Medicaid eligible individuals, those with serious and persistent mental illness and others that the publicly funded MH/SA system may be serving.

- All models include the development of a **comprehensive core benefit package** for publicly funded MH/SA services that is driven by functional and financial **eligibility criteria that are consistent throughout the state**. In addition, services to individuals that do not meet the statewide eligibility criteria could be provided based on local choice and available resources.

- All models maintain and seek to improve **quality MH/SA services** that are recovery-oriented, consumer-driven and focused.

- All models include approaches for **better coordination and integration between MH/SA and physical health care services**, ranging from co-location of services, to facilitation of referrals for services across systems, to joint planning and financing of services.

- All models maintain a **local service planning role** that includes effective **consumer/family involvement** in service planning.

- All models have a continued county role or **county choice** in a continued role for providing and funding MH/SA services.

- All models recognize the **breadth of responsibilities** (in addition to the provision of treatment services) that counties perform to support individuals who have MH/SA needs, including information and assistance, law enforcement crisis response, intake and assessment, protective services and court-related services. All models also acknowledge that these **need to be addressed in any reform effort**.

- All models incorporate **principles of managed care and performance-based contracting**, such as utilization management; effective data collection, reporting and analysis; a focus on consumer outcomes; and payment for meeting performance expectations.

D. Overview of Models/Pathways

Four major models for financing the public MH/SA services system are identified in this section, along with potential pathways for implementing the models. It is helpful to consider the models on a continuum, with Model A reflecting the least amount of change to system financing and governance, and Model D representing the greatest amount of change to system financing and governance. While Model C, the multi-county system, would represent significant change from the current single county systems, the establishment and existence of multi-county systems is not new to Wisconsin.

It is also important to recognize that the models are not mutually exclusive. For example, Model A (the continuation of the current single and multi-county system) is the foundation for Model B, the county collaborative system. Further, the success of county collaboratives formed under Model B could give rise to the creation of additional multi-county systems under Model C. Finally, Model A and Model C can be considered in conjunction with demonstration projects implementing Model D, the public/private integrated care system. However, establishing partnerships with private health care organizations for an integrated care model will likely be easier if the service area reflects the multi-county areas (Model C) within which most HMOs (health plans) operate.

Model A – County-Based System

- Fund continuation of current single county and optional multi-county systems with incentives to address the four benchmark goals.

- Model A provides the least structural change to the current financing and delivery of MH/SA services. The state would continue to fund single county and multi-county systems, as is currently the case. However, the level of state financial participation would increase, combined with a commensurate increase in accountability for outcomes. This model clearly ties increased funding to greater accountability. Three potential pathways under which Model A could operate are described below.

- *Potential Pathways for Model A:*

  A.1. Greater state financial participation.

  The state could provide greater financial participation tied to county implementation of evidence-based programs or other best practices. For example, to encourage statewide adoption of effective program models such as CCS or crisis services, the state could provide the nonfederal share of Medicaid funding that is currently required of counties.

  A.2. State elevation of Medicaid.

  The state could assume the administrative responsibility and nonfederal share of all MA-funded MH/SA services. Like the Ohio reform proposal to "elevate" Medicaid administration to the state level, this would require the state to fund the nonfederal share of all MA-funded programs that is currently the responsibility of the counties,

such as crisis intervention, case management, CSP, CCS, and outpatient MH/SA services provided in a home or community-based setting. Under this pathway, the state, and not the counties, would fund the nonfederal share of these programs.

The intent of this pathway would be to create greater uniformity of funding, service provision and MA administrative responsibilities such as claims processing, while freeing up county dollars previously allocated to fund the nonfederal MA share. These funds would then be used by counties to support non-MA funded services. Given the pressures on counties to fund MH/SA services to a growing indigent population, this pathway could offer the most direct relief to financially-strapped counties.

A.3. In the absence of greater state financial participation, changes to funding approach or service delivery expectations would not be implemented.

This proposed pathway simply recognizes the political and fiscal reality that there may not be sufficient resources to implement the previous two pathways or any of the other three models and pathways. In the absence of greater state financial participation, the implementation of financing and structural reform would be compromised. Therefore, this pathway reflects the reality that if funding is not enhanced, new service delivery expectations would not be implemented. For example, if counties continue to fund the nonfederal share of certain MA-funded MH/SA programs, then the implementation of these services should continue to be a county option and not a requirement.

Model B – County Collaborative System

- Fund consortium of counties for specific services (e.g., crisis, inpatient) and/or functional areas (e.g., planning, access/intake, administrative/back office duties, provider network development, workforce development and training) with incentives to address the four benchmark goals.

- Model B is based off of Model A, but encourages the development of alliances between counties to collaborate on MH/SA specific services and/or functional areas. The current regional crisis grants provide a good example of this model, and how it could be expanded to other collaborative efforts. The state would provide funding for counties to plan and implement collaborative approaches that could include providing services to a multi-county area (e.g. crisis line, crisis beds, inpatient services) and/or performing certain functions on a multi-county basis (e.g., access/intake, administrative, workforce development and training).

- *Potential Pathway for Model B:*

  B.1. Use intergovernmental agreements to establish scope and parameters of county collaboration.

  Without implementing any changes to the county governance structure for MH/SA services, counties could more formally establish the scope and parameters of specific

county collaborative efforts through intergovernmental agreements or service provider contracts.

Model C – Multi-County System

- Fund mandatory multi-county system structure with incentives to address the four benchmark goals.

- Model C represents a more significant departure from the current funding and governance structure for county MH/SA service systems. While a multi-county governance structure is an option under current statutes, this model would mandate the implementation of multi-county systems statewide. Three potential pathways under which Model C could operate are described below.

- *Potential Pathways for Model C:*

  C.1. Create multi-county MH/SA systems through Chapter 51 statutory framework.

  The state could fund mandatory multi-county MH/SA systems that would be created under similar statutory parameters for creating the current optional multi-county systems found in Section 51.42, Wisconsin Statutes. The statutory language is included in **Appendix D** for reference. Responsibility for the funding and governance of these multi-county systems would be similar to the three existing multi-county systems, with individual counties maintaining a financial and governance role in these systems.

  C.2. Create multi-county MH/SA systems through Family Care statutory framework.

  The state could fund mandatory multi-county MH/SA systems that would be created under similar statutory parameters for creating Family Care districts (i.e., long-term care districts) found in Section 46.2895, Wisconsin Statutes. The statutory language is included in **Appendix D** for reference. Responsibility for the funding and governance of a multi-county system under a district model approach would transfer the financial risk and governance from individual counties to a new risk-bearing entity, which would be under contract with the state for the provision of publicly funded MH/SA services. Under this pathway individual counties would be absolved of financial risk and all current statutory responsibilities for providing MH/SA services.

  C.3. Integrate MH/SA programs and all remaining county human services functions into broader multi-county human services systems.

  The state could fund integrated multi-county human services systems that combine MH/SA and other human services under the governance of a multi-county or district governance model. Current statutory language allowing counties to establish multi-county human services systems can be found in Section 46.23, Wisconsin Statutes. The statutory language is included in **Appendix D**. The statewide expansion of regional managed care for long-term care services under Family Care allows for the potential for regionalization of MH/SA, child welfare, income maintenance services and even

county public health services. This creates an opportunity to create broader multi-county human services delivery systems and avoid greater system fragmentation that may occur if some service systems are multi-county and others remain single-county based.

Model D – Public/Private Integrated Care System

- Fund demonstration projects of public/private partnerships that integrate MH/SA and physical health care with incentives to address the four benchmark goals.

- Model D also represents a more significant departure from the current funding and governance structure of the county MH/SA services system. The intent of this model is to achieve integration of all publicly funded MH/SA services and physical health care. This model represents a growing trend to view individuals' health needs more holistically and create service delivery structures that integrate all health services provided. Four potential pathways under which Model D could operate are listed below.

- *Potential Pathways for Model D:*

  D.1. Single or multi-county MH/SA systems work in contractual partnerships with HMOs.

  Counties or, more likely, multi-county systems could develop partnerships with HMOs to coordinate care management of MH/SA and physical health care services.

  D.2. HMOs contract with single or multi-county MH/SA systems.

  HMOs could contract with counties or, more likely, multi-county MH/SA systems to provide all MH/SA services and coordinate care management.

  D.3. Public or private MH/SA managed care organizations provide MH/SA services and coordinate physical health care with HMOs.

  The public or private MH/SA MCOs would be under contract with the state for the provision of publicly funded MH/SA services. Under this pathway, individual counties would be absolved of financial risk and all current statutory responsibilities for providing MH/SA services.

  D.4. HMOs provide fully-integrated MH/SA and physical health care services.

  HMOs could provide fully-integrated MH/SA and physical health care services, with counties transferring all financial risk and governance to the HMO as the risk-bearing entity. The HMO would be under contract with the state for the provision of publicly funded MH/SA services. Under this pathway, individual counties would be absolved of financial risk and all current statutory responsibilities for providing MH/SA services.

E. Model Framework Grids

The tables that follow on the next pages highlight the key characteristics, and pros and cons of each of the four major models. These tables are not intended to provide exhaustive descriptions of each model, but rather provide a basic framework for developing a common understanding of the key elements of each model. The ability of each model to address the four benchmark goals is also included to provide a common understanding of which models may be more effective in addressing the benchmark goals and why. Finally, the tables reference experiences with a particular model from the other states included in this study (i.e., Minnesota, New Mexico, North Carolina, Ohio and Oregon) that could help inform the future development of a similar model or pathway in Wisconsin.

Model A – County-Based System	
Description of Model	• Fund continuation of current single county and optional multi-county systems with incentives to address the four benchmark goals.
Services/Benefits Provided	• Comprehensive core benefit package for publicly funded MH/SA services with potential for greater state financial participation and/or state assumption of financial responsibility for Medicaid funded services depending on the pathway selected.
Service Area	• Continuation of current single county and optional multi-county service areas.
Governance Structure	• Continuation of single and optional multi-county stand-alone systems through existing statutory provisions.
Funding Structure and Sources	• State funding allocated to existing single and optional multi-county systems to reward counties for adopting best practices. • Core services provided would be based on available funding following statewide eligibility criteria (Visions Proposal funding concept). • Mix of funding sources would change to greater state financial participation for Medicaid services and less reliance on county funding in the future.
Service Delivery Structure	• No change to service delivery structure with continuation of public and private provision of services primarily through single county and existing multi-county systems. • Provider network development primarily built on single county and existing multi-county systems.
Alignment and Coordination with Other Related Systems	• Long-Term Care – Challenges coordinating with regional Family Care MCOs to address the MH/SA needs of those in the long-term care system. • Children's System (child welfare and schools) – Children's services largely organized around a county structure, so structural alignment could indicate better potential for service coordination. • Corrections (state corrections and county jail systems) – County jails governed by a county structure, so structural alignment could indicate a greater potential for service coordination.
Coordination and Integration of MH/SA and Physical Health Care	• Challenges would occur integrating MH/SA and physical health care needs due to limitations inherent in a relatively small (single county) population base. However, coordination between behavioral and physical health care systems may be feasible and encouraged through state incentives and/or modifications to HMO contract language for managed care programs. • There would be challenges coordinating MH/SA services between counties and HMOs due to fragmentation between county/community-based and HMO provided MH/SA services.

Model A – County-Based System	
Ability and Incentives to Support Benchmark Goals	• Equitable Access – Development of core benefit package and statewide eligibility criteria with appropriate financial incentives to achieve implementation statewide would improve access and service portability. • Accountability for outcomes – Given differences in service array, funding and program administration, accountability for consumer outcomes will vary greatly among county systems. • Equitable and affordable funding – Inequitable funding likely to continue in system with 67 single or multi-county systems with significant reliance on local funding. • Service efficiency – Difficult to reduce duplicative administrative structures and gain efficiencies among single county systems.
Pros – Benefits of Model	• Least disruption to existing governance and service delivery structure. • Greater potential to coordinate care with other county-based systems, such as child welfare, courts, jails and social services. • Provides greater state financial participation to help address current funding, service level and service quality inequities among different county systems. • With greater state financial participation to fund Medicaid services, counties could have greater fiscal capacity to fund the non-Medicaid, uninsured population.
Cons – Challenges of Model	• Consumer access to services limited to what county-based systems provide. • Unlikely that sufficient state funding would be provided to equalize current inequities in county-funded services among 67 county systems. • Medicaid concerns regarding equitable access to services and service uniformity would continue and future Medicaid funding may be jeopardized. This would occur unless the state assumes financial responsibility and administration of Medicaid services, which are currently funded, in part, by counties.
Other State Experiences	• Minnesota county-based system with allocation of targeted funding through a competitive state grant process to support the service delivery infrastructure, including expanding service capacity and developing best practice approaches. • Ohio county-based system with individual board levies; 88 counties and 234 human service agencies, including 50 MH/SA boards. • Ohio reform effort to elevate Medicaid administration to the state level and assume responsibility of the nonfederal share of Medicaid from counties.

Model B – County Collaborative System	
Description of Model	• Fund consortia of counties for specific services (e.g., crisis, inpatient) and/or functional areas (e.g., planning, access/intake, administrative/back office duties, provider network development, workforce development and training) with incentives to address the four benchmark goals. • Build upon the foundation of Model A - County-Based System, to encourage further county collaboration through financial incentives.
Services/Benefits Provided	• Services specific to the areas identified for collaboration by the counties involved and/or as specified by the state through a Request for Proposal process.
Service Area	• Continuation of current single county and optional multi-county services areas (Model A) with implementation of voluntary county collaborative systems statewide. • Development of county collaborative systems would include geographic configurations that are based on county preference for one or more of the following: o Historical working relationships among counties o Provider network service areas o Family Care regions o Other areas defined by the counties and/or the state
Governance Structure	• Continuation of current statutory governance structure for single or optional multi-county systems. • Voluntary implementation of county collaborative systems through intergovernmental agreements between counties. • Individual counties would develop collaborative systems that have responsibility for the specific area(s) selected for collaboration (crisis services, inpatient services, administrative and business support, provider network development, workforce development and training, etc.). • Counties could create a collaborative decision making body that is limited in scope and authority to the specific areas and approach identified for collaboration.
Funding Structure and Sources	• The mix of funding sources would adjust to greater state financial participation for collaborative systems and less reliance on county funding in the future. • State funding for identified service(s) would be allocated to collaborative boards that, in turn, distribute resources based on collaborative service planning. • Remaining core services outside of the collaborative would be based on available funding following statewide eligibility criteria (Visions Proposal funding concept).

Model B – County Collaborative System	
Service Delivery Structure	• Continuation of public and private provision of services as defined by the collaborative. • No change to service delivery structure for areas not included in the scope of the collaborative, with continuation of public and private provision of services primarily through single county and existing multi-county systems (Model A).
Alignment and Coordination with Other Related Systems	• Long-Term Care – Challenges coordinating with regional Family Care MCOs to address the MH/SA needs of those in the long-term care system unless multi-county collaborative systems align geographically with Family Care MCO regions. • Children's System (child welfare and schools) – Children's services largely organized around a county structure, so structural alignment could indicate potential challenges for service coordination. • Corrections (state corrections and county jail systems) – County jails governed by a county structure, so structural alignment could indicate potential challenges for service coordination.
Coordination and Integration of MH/SA and Physical Health Care	• Greater capacity to potentially integrate with physical health care would be available because of a larger multi-county population base for certain service areas. This base may be better aligned with larger HMO service areas, which also tend to be multi-county. • Challenges coordinating MH/SA services between multi-county collaboratives, single county and optional multi-county MH/SA systems and HMOs would occur due to additional structural complexity and fragmentation.
Ability and Incentives to Support Benchmark Goals	• Equitable access to services – Development of core benefit package and statewide eligibility criteria with appropriate financial incentives to achieve implementation statewide would improve access and service portability. This also can be enhanced within multi-county collaborative areas depending on the scope of the collaborative efforts. • Accountability for outcomes – Given differences in service array, funding and program administration, accountability for consumer outcomes will still vary greatly among counties involved in multi-county collaborative systems. • Equitable and affordable funding – There would be some potential to achieve more equitable funding within collaborative multi-county areas depending on the scope of the collaborative efforts. • Service efficiency – There would be some potential to achieve administrative and program efficiencies with broader infrastructure base for multi-county collaborative systems.
Pros – Benefits of Model	• Relatively little disruption to county governance and service delivery structure since creation of collaborative systems and changes to service delivery structure would be at county discretion. • Creates mechanism for multi-county collaboration, with an opportunity to learn about which areas are more likely to benefit from a multi-county approach. • Provides greater state financial participation to help address current funding inequities and provides potential for greater access to equitable services by multi-county area for selected services or functions.

Model B – County Collaborative System	
	• Concerns regarding equitable access to services and service uniformity could be more effectively addressed by multi-county area, but only for the services selected for collaboration and not on a statewide basis. • Greater capacity to achieve efficiencies and expand expertise in administrative and program operations, but only for the services or functions selected for collaboration and not on a statewide basis. • Expansion of service delivery boundaries consumers currently face in accessing services, but only for the services selected for collaboration and not on a statewide basis.
Cons – Challenges of Model	• Unlikely that collaborative structure would serve to address current inequities between county systems, although more equitable funding could likely result within collaborative service areas or functions. • Medicaid concerns regarding equitable access to services and service uniformity would continue and future Medicaid funding may be jeopardized.
Other State Experiences	• Minnesota regional funding initiative that distributes funding to regions and then distributes dollars based on regional service planning. • New Mexico local collaboratives that help guide service planning for state-administered MH/SA system.

Model C – Multi-County System	
Description of Model	• Fund mandatory multi-county MH/SA systems with incentives to address the four benchmark goals.
Services/Benefits Provided	• Comprehensive core benefit package for publicly funded MH/SA services, with potential to include services under Family Care program.
Service Area	• Expansion of multi-county systems statewide. • Development of multi-county systems would include geographic configurations that are based on minimum population requirements and one or more of the following: o Historical working relationships among counties o Provider network service areas o Family Care regions o Other areas defined by the counties and/or the state
Governance Structure	• Statewide expansion of mandatory multi-county MH/SA systems through stand-alone MH/SA systems or integration of MH/SA and all remaining county human services functions into multi-county human services systems depending on the pathway selected. • Delegation of individual county governance to separate multi-county boards that have policy and budget authority per existing state statutes. Each county could determine its role in the multi-county system. This role could range from a system governance role based on representation on a multi-county board, to a purchasing role as a contractor of services from a multi-county system, or no role if financial and service responsibility is transferred to a risk-bearing entity (similar to a Family Care district). • Creation of a local planning and liaison function with each participating county in the multi-county system to ensure coordination with other related systems in the individual counties and provide a communication link between individual counties and a multi-county system.
Funding Structure and Sources	• State funding allocation by mandatory multi-county systems that, in turn, distribute resources based on multi-county service planning. • Core services provided would be based on available funding following statewide eligibility criteria (Visions Proposal funding concept). • Greater state financial participation for Medicaid services and less or no reliance on county funding in the future.
Service Delivery Structure	• Continuation of public and private provision of services, but through a defined multi-county/regional provider network. • Creation of local satellite offices throughout the multi-county service area. • Determination of which services would be shared and provided centrally and which would be provided through a decentralized service structure.

Model C – Multi-County System	
Coordination and Integration of MH/SA and Physical Health Care	• Greater capacity to potentially integrate with physical health care because of a larger multi-county population base that may be better aligned with larger HMO service areas, which also tend to be multi-county. • Greater capacity to potentially coordinate MH/SA services between multi-county systems and HMOs due to less fragmentation between MH/SA services that are multi-county/community-based and HMO provided (resulting from implementation of a comprehensive core MH/SA benefit package).
Ability and Incentives to Support Benchmark Goals	• Equitable access to services – Development of core benefit package and statewide eligibility criteria with appropriate financial incentives to achieve implementation statewide. • Accountability for outcomes – Greater consistency in service array, funding and program administration would result in less variance in consumer outcomes within multi-county systems and potentially between multi-county systems. • Equitable and affordable funding – Greater ability to achieve more equitable funding within multi-county areas and statewide, which will help alignment with Medicaid goals. • Service efficiency – Greater ability to achieve administrative and program efficiencies with broader infrastructure base.
Pros – Benefits of Model	• Provides a larger financial base to help address current funding inequities and potential for greater consumer access to equitable and more diverse services by multi-county area. • The larger financial base helps spread risk for high cost cases that can disproportionately and significantly impact individual county budgets. • Medicaid concerns regarding equitable access to services and service uniformity could be more effectively addressed by statewide expansion of multi-county systems. • Greater capacity to achieve efficiencies and expand expertise in administrative and program operations due to broader multi-county infrastructure base.
Cons – Challenges of Model	• Major change to governance, funding and service delivery structure that has the potential to disrupt consumer access to services and service effectiveness if change is not well-planned and implemented. • Challenge in determining how to equitably address the level of individual county funding and future funding responsibility for multi-county systems. • Unlikely that sufficient state funding would be provided to equalize current inequities between multi-county systems, although more equitable funding would likely result within multi-county systems. • Challenges in creating effective governance and operational structures for counties to form multi-county systems, including the need to overcome barriers and issues that have precluded counties from exercising the option to create multi-county systems under current statutory provisions. These barriers include county reluctance to turn over program and financial control to a multi-county system. There have also been past concerns of counties in multi-county systems about the program and financial operations of those systems and/or the compatibility of service philosophy and approach between counties in a multi-county system.

Model C – Multi-County System	
	• Implementation of multi-county systems may be more challenging in Wisconsin, which has larger county boards than other states that have adopted a more regional governance, service and funding model. • Mechanisms for local involvement in service planning and for coordination with other related systems that are largely county-based would need to be developed. • Challenges in addressing other county responsibilities that support and/or impact the MH/SA service system, such as the court-related functions and law enforcement response function. All related MH/SA areas of responsibility would need to be addressed in a multi-county system to ensure necessary functions are still appropriately performed and funded. • Challenges in creating a new operating structure capable of effectively collecting and analyzing data necessary to manage a multi-county system.
Other State Experiences	• Minnesota's regional initiative to consolidate county human services departments into regional authorities, called service delivery authorities (SDAs). • North Carolina's Local Management Entities (LMEs). (24 LMEs serve 100 counties, and further consolidation and regionalization is being recommended). • Ohio's multi-county boards. (50 boards serve 88 counties; 20 of the boards are multi-county). • Oregon's nine regional Medicaid managed care Mental Health Organizations (MHOs) (eight regional MHOs are run by county groups and one is run by a physicians group) contract with 33 community mental health programs (CMHPs).

Model D – Public/Private Integrated Care System	
Description of Model	• Fund demonstration projects of public/private partnerships that integrate MH/SA and physical health care with incentives to address the four benchmark goals.
Services/Benefits Provided	• Comprehensive MH/SA benefit package (community-based, inpatient and outpatient services) and physical health benefit package (acute and primary care), with potential to include long-term care services under Family Care program.
Service Area	• Implementation of public/private integrated care systems statewide. • Development of public/private integrated care systems would include geographic configurations that are based on minimum population requirements and one or more of the following: o Historical working relationships among counties o Provider network service areas, including existing HMO service areas o Family Care regions o Other area defined by the counties and/or the state
Governance Structure	• Implementation of demonstration projects (voluntary pilot programs) of integrated care systems through new statutory authority. • Delegation of individual county governance to public/private care systems that have broad authority for integrating care.
Funding Structure and Sources	• State funding allocated through capitated payments to public/private demonstration projects and supported by pooling Medicaid and other federal, state and county funding sources. • Potential pathways for funding include: o Single or multi-county MH/SA systems work in a contractual partnership with HMOs to coordinate care management activities for all behavioral and physical health care services. o HMOs contract with single or multi-county MH/SA systems to provide all MH/SA services and the organizations coordinate care management of MH/SA and physical health care services. o Public or private MH/SA managed care organizations provide MH/SA services and coordinate physical health care with HMOs, with the potential for counties to be absolved of financial risk and all current statutory responsibilities for providing MH/SA services. o HMOs provide fully-integrated behavioral and physical health care services, with the potential for counties to be absolved of financial risk and all current statutory responsibilities for providing MH/SA services.
Service Delivery Structure	• Continuation of public and private provision of services as defined by the integrated care system demonstration project. • Development of approaches that integrate MH/SA and physical health care through collaborative arrangements between public and private organizations and blending of funding for all MH/SA services. Integrated care service delivery approaches could include:

Model D – Public/Private Integrated Care System	
	o Primary care professional(s) embedded (on-site or via telehealth) in community MH/SA setting. o MH/SA professional(s) embedded (on-site or via telehealth) in primary care setting. o Co-location of community MH/SA and primary care provided by two separate entities. o Behavioral and physical health care through one provider entity. o Case management of all primary and specialty care by same professional (i.e., medical home model).
Alignment and Coordination with Other Related Systems	• Long-Term Care – Challenges coordinating with regional Family Care MCOs to address the MH/SA needs of those in the long-term care system unless integrated care systems align geographically with Family Care MCO regions. • Children's System (child welfare and schools) – Children's services largely organized around a county structure, so structural alignment could indicate potential challenges for service coordination. • Corrections (state corrections and county jail systems) – County jails governed by a county structure, so structural alignment could indicate potential challenges for service coordination.
Coordination and Integration of MH/SA and Physical Health Care	• Greatest capacity to integrate with physical health care due to direct collaboration and partnership between counties, private MH/SA agencies and HMOs. • Greatest capacity to achieve service integration between county/community-based and HMO-provided MH/SA services.
Ability and Incentives to Support Benchmark Goals	• Equitable access to services – Development of core benefit package and statewide eligibility criteria with appropriate financial incentives and contract enforcement to achieve implementation statewide. • Accountability for outcomes – Accountability for consumer outcomes could be specified in contractual requirements established by the state. • Equitable and affordable funding – Capitated payment structure would address funding inequities inherent in current system and pool resources to comprehensively meet an individual's physical and MH/SA needs. • Service efficiency – Greater capacity to achieve administrative and program efficiencies with broader infrastructure base and relative service and business strengths of private and public entities.
Pros – Benefits of Model	• Provides a larger funding and service base to comprehensively address the behavioral and physical health needs of consumers. • Greater potential for consumers to access care for their physical and MH/SA needs through a number of different locations in a broader service network, which can also help mitigate the stigma associated with accessing MH/SA services. • Greater capacity for coordination of MH/SA care (community-based, outpatient and inpatient) and coordination between behavioral and physical health care. • Medicaid concerns regarding equitable access to services and service uniformity could be more effectively addressed by demonstration project but not on a statewide basis. • Capitated payment structure may provide incentive to fund care that maximizes positive consumer outcomes in the most cost-effective manner, including the provision of preventative care and community-based services.

Model D – Public/Private Integrated Care System	
Cons – Challenges of Model	• Major change to governance, funding and service delivery structure that has the potential to disrupt consumer access to services and service effectiveness if change is not well-planned and implemented. • Challenge in determining how to equitably address the level of individual county funding and future funding responsibility for integrated care systems. • Capitated payment structure may provide incentive to ration necessary MH/SA care, especially more intensive and costly care. • Medically-driven HMO model may be difficult to align with community-based county MH/SA model. • Perception that there will be less opportunity for consumers to participate in the design of a private sector model than a public sector model. • Limited or no ability for the state and affected counties to meet service capacity, if statutorily-created business entity fails and services are no longer available through that entity. • Challenges in creating an operating structure capable of effectively collecting and analyzing data necessary to manage a multi-county system that integrates behavioral and physical health care services.
Other State Experiences	• Minnesota Preferred Integrated Networks (PINs) to demonstrate the integration of physical and mental health services within pre-paid health plans and their coordination with county social services. • North Carolina's Community Care collaborative approach to mental and primary health care integration at four Local Management Entity (LME) pilot sites for Medicaid enrollees that includes shared data systems and common measures to track results. • Oregon integrated care demonstration projects proposed to "carve in" mental health services to the Oregon Health Plan, with substance abuse services already included.