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# **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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### 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.

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- 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.

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### 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

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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).



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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:

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- 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.

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- 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

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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.

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- 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.

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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 .