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.