

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.

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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.

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- 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.

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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.

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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.

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- 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

Mental Health and Substance Abuse Service Integration:

- 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.

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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.

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- 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.

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- 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.

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- **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.

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- 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.

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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.

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- 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 Committees** (CFACs) at each LME.

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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.

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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.

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- 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.

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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.

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- 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

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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.

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- 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).

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- 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.

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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

Mental Health and Substance Abuse Service Integration:

- 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.

MH/SA and Physical Health Care Integration:

- 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

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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 slippedbudget 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

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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.

County System Perspectives:

- 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?

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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:

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- 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:

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- 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

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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

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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

MH/SA and Physical Health Care Integration:

- 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.

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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.

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- 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.

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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.

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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 inquiries 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.

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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.

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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.



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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.



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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.

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- 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.

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Table 3 – Summary of Per Capita State Mental Health Agency Revenues by Source

	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
2004																
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.

	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
2005																
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.



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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 ^{1,3}	\$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.



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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.

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- 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.

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- 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.

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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.