SECTION VII. POTENTIAL MODELS AND PATHWAYS FOR SYSTEM REFORM

A. Framework for the Development of Models/Pathways

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

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

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

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

B. Guiding Principles

The Steering Committee identified a set of principles to guide and inform the development of the models/pathways for funding the public MH/SA system. These principles, initially identified in May 2009, were finalized and adopted by the Steering Committee in September 2009. The six principles identified by the Steering Committee include:

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

The intent of these guiding principles is clarified by the comments and discussion points of the Steering Committee and included in **Table 1**:

SECTION VII. POTENTIAL MODELS AND PATHWAYS FOR SYSTEM REFORM

Table 1
Guiding Principles for the Development of MH/SA Models/Pathways

Guiding Principles	Comments/Discussion Points from Steering Committee
Strong Consumer Role	• Greater implementation of consumer-focused, recovery-oriented services. • Consumer involvement in discussions about models/pathways.
Future County Role or Choice	• Choice in model/participation in system. • Some counties may prefer limited or no participation in system. • Future of state/county cost sharing may impact the role counties want to have. • Counties have a key leadership role and responsibility due to the statutory language of Chapter 51 and the level of local property tax dollars supporting the MH/SA system. • Important to have county flexibility to support services within available resources. • Identify county "building blocks" (e.g., other human services and human service-related functions counties perform) and which responsibilities counties wish to maintain (due to the impact of MH/SA on these other county services). • Address and remove barriers to multi-county service cooperation: o Review regional service approach prior to creation of Chapter 51 and the creation of the MH/SA/DD system (e.g., regionally funded inpatient). o Examine why the existing the multi-county approach for MH/SA services has had varying levels of success. o Identify challenges in regionalizing services like CCS and CSP that require local teams and involvement in the community.
Uniform Benefit Package	• Define the core services available statewide. Previously, the Kettl Commission and Visions Committee stressed the importance of establishing a core service definition. Family Care has a stated benefit; other states are defining core benefits for MH/SA services. The definition of core services will impact the level of county funding, which does not now support uniformity because of differences in local priorities and availability of funding. • Recognize that consumers may change county of residence based on the services that are available in different counties. • Examine the state's plans for implementing the federal parity legislation for MH/SA services. • Include inpatient hospitalization in the benefit package to properly align financial incentives and prevent service fragmentation.
Alignment and Compatibility with Medicaid	• Recognize that Medicaid is and will continue to be a major source of funding. • Medicaid/CMS wants to achieve uniformity and is concerned with the lack of uniformity and consistency in Wisconsin's county-based system, which provides different funding levels and service offerings. The willingness of Medicaid/CMS to tolerate Wisconsin's system is becoming a larger issue of concern. • How can Medicaid become a better payer of MH/SA services (i.e., Medicaid maximization)?

Guiding Principles	Comments/Discussion Points from Steering Committee
State Incentives to Support Change	• What types of incentives can the state provide to ensure change occurs and the system supports the benchmark goals more effectively (i.e., equitable access, accountability for outcomes, equitable and affordable funding, and service efficiency)? • Given fiscal constraints and the shift of MH/SA costs to counties, counties will need to make adjustments in budgets that will impact services and result in layoffs. • Recognize that additional state financial participation may follow defined expectations for certain types and level of services (such as prevention and early intervention) and for processes (such as quality improvement and more centralized intake). • Need to find a new model to share fiscal responsibility that creates joint ownership, improves the system and moves efforts forward. o Attempts to work around issues tend to get bogged down in who funds the services. If each side has a more proportionate share of money in the system (e.g., sharing of match), a more collaborative approach may occur that achieves better outcomes. o If counties and the state change how they fund MH/SA services (with both parties sharing in the financial responsibility), shared incentives will improve the system. o If the state expects counties to implement services like CCS and crisis in order to prevent and divert from inpatient placements, cost sharing incentives need to be addressed. CCS roll-out is cumbersome and yet fiscal responsibility for the federal match for Medicaid is entirely the responsibility of the county.
Alignment and Compatibility with Health Care Reform and Related Initiatives	• Future of MH/SA system needs to be aligned with health care reform initiatives. • If the public MH/SA system does not keep up with other health care reform efforts, MH/SA services may be marginalized and/or omitted. • Address incorporation of managed care principles, such as use of utilization management, global budgeting tools, service authorization models, etc. • Integrate MH/SA services and physical health care.

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

C. Common Elements

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

SECTION VII. POTENTIAL MODELS AND PATHWAYS FOR SYSTEM REFORM

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

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

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

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

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

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

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

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

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

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

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

D. Overview of Models/Pathways

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

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

Model A – County-Based System

- Fund continuation of current single county and optional multi-county systems with incentives to address the four benchmark goals.

- Model A provides the least structural change to the current financing and delivery of MH/SA services. The state would continue to fund single county and multi-county systems, as is currently the case. However, the level of state financial participation would increase, combined with a commensurate increase in accountability for outcomes. This model clearly ties increased funding to greater accountability. Three potential pathways under which Model A could operate are described below.

- *Potential Pathways for Model A:*

  A.1. Greater state financial participation.

  > The state could provide greater financial participation tied to county implementation of evidence-based programs or other best practices. For example, to encourage statewide adoption of effective program models such as CCS or crisis services, the state could provide the nonfederal share of Medicaid funding that is currently required of counties.

  A.2. State elevation of Medicaid.

  > The state could assume the administrative responsibility and nonfederal share of all MA-funded MH/SA services. Like the Ohio reform proposal to "elevate" Medicaid administration to the state level, this would require the state to fund the nonfederal share of all MA-funded programs that is currently the responsibility of the counties,

such as crisis intervention, case management, CSP, CCS, and outpatient MH/SA services provided in a home or community-based setting. Under this pathway, the state, and not the counties, would fund the nonfederal share of these programs.

The intent of this pathway would be to create greater uniformity of funding, service provision and MA administrative responsibilities such as claims processing, while freeing up county dollars previously allocated to fund the nonfederal MA share. These funds would then be used by counties to support non-MA funded services. Given the pressures on counties to fund MH/SA services to a growing indigent population, this pathway could offer the most direct relief to financially-strapped counties.

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

This proposed pathway simply recognizes the political and fiscal reality that there may not be sufficient resources to implement the previous two pathways or any of the other three models and pathways. In the absence of greater state financial participation, the implementation of financing and structural reform would be compromised. Therefore, this pathway reflects the reality that if funding is not enhanced, new service delivery expectations would not be implemented. For example, if counties continue to fund the nonfederal share of certain MA-funded MH/SA programs, then the implementation of these services should continue to be a county option and not a requirement.

Model B – County Collaborative System

- Fund consortium of counties for specific services (e.g., crisis, inpatient) and/or functional areas (e.g., planning, access/intake, administrative/back office duties, provider network development, workforce development and training) with incentives to address the four benchmark goals.

- Model B is based off of Model A, but encourages the development of alliances between counties to collaborate on MH/SA specific services and/or functional areas. The current regional crisis grants provide a good example of this model, and how it could be expanded to other collaborative efforts. The state would provide funding for counties to plan and implement collaborative approaches that could include providing services to a multi-county area (e.g. crisis line, crisis beds, inpatient services) and/or performing certain functions on a multi-county basis (e.g., access/intake, administrative, workforce development and training).

- *Potential Pathway for Model B:*

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

Without implementing any changes to the county governance structure for MH/SA services, counties could more formally establish the scope and parameters of specific

county collaborative efforts through intergovernmental agreements or service provider contracts.

Model C – Multi-County System

- Fund mandatory multi-county system structure with incentives to address the four benchmark goals.

- Model C represents a more significant departure from the current funding and governance structure for county MH/SA service systems. While a multi-county governance structure is an option under current statutes, this model would mandate the implementation of multi-county systems statewide. Three potential pathways under which Model C could operate are described below.

- *Potential Pathways for Model C:*

C.1. Create multi-county MH/SA systems through Chapter 51 statutory framework.

The state could fund mandatory multi-county MH/SA systems that would be created under similar statutory parameters for creating the current optional multi-county systems found in Section 51.42, Wisconsin Statutes. The statutory language is included in **Appendix D** for reference. Responsibility for the funding and governance of these multi-county systems would be similar to the three existing multi-county systems, with individual counties maintaining a financial and governance role in these systems.

C.2. Create multi-county MH/SA systems through Family Care statutory framework.

The state could fund mandatory multi-county MH/SA systems that would be created under similar statutory parameters for creating Family Care districts (i.e., long-term care districts) found in Section 46.2895, Wisconsin Statutes. The statutory language is included in **Appendix D** for reference. Responsibility for the funding and governance of a multi-county system under a district model approach would transfer the financial risk and governance from individual counties to a new risk-bearing entity, which would be under contract with the state for the provision of publicly funded MH/SA services. Under this pathway individual counties would be absolved of financial risk and all current statutory responsibilities for providing MH/SA services.

C.3. Integrate MH/SA programs and all remaining county human services functions into broader multi-county human services systems.

The state could fund integrated multi-county human services systems that combine MH/SA and other human services under the governance of a multi-county or district governance model. Current statutory language allowing counties to establish multi-county human services systems can be found in Section 46.23, Wisconsin Statutes. The statutory language is included in **Appendix D**. The statewide expansion of regional managed care for long-term care services under Family Care allows for the potential for regionalization of MH/SA, child welfare, income maintenance services and even

county public health services. This creates an opportunity to create broader multi-county human services delivery systems and avoid greater system fragmentation that may occur if some service systems are multi-county and others remain single-county based.

Model D – Public/Private Integrated Care System

- Fund demonstration projects of public/private partnerships that integrate MH/SA and physical health care with incentives to address the four benchmark goals.
- Model D also represents a more significant departure from the current funding and governance structure of the county MH/SA services system. The intent of this model is to achieve integration of all publicly funded MH/SA services and physical health care. This model represents a growing trend to view individuals' health needs more holistically and create service delivery structures that integrate all health services provided. Four potential pathways under which Model D could operate are listed below.
- *Potential Pathways for Model D:*

D.1. Single or multi-county MH/SA systems work in contractual partnerships with HMOs.

Counties or, more likely, multi-county systems could develop partnerships with HMOs to coordinate care management of MH/SA and physical health care services.

D.2. HMOs contract with single or multi-county MH/SA systems.

HMOs could contract with counties or, more likely, multi-county MH/SA systems to provide all MH/SA services and coordinate care management.

D.3. Public or private MH/SA managed care organizations provide MH/SA services and coordinate physical health care with HMOs.

The public or private MH/SA MCOs would be under contract with the state for the provision of publicly funded MH/SA services. Under this pathway, individual counties would be absolved of financial risk and all current statutory responsibilities for providing MH/SA services.

D.4. HMOs provide fully-integrated MH/SA and physical health care services.

HMOs could provide fully-integrated MH/SA and physical health care services, with counties transferring all financial risk and governance to the HMO as the risk-bearing entity. The HMO would be under contract with the state for the provision of publicly funded MH/SA services. Under this pathway, individual counties would be absolved of financial risk and all current statutory responsibilities for providing MH/SA services.

E. Model Framework Grids

The tables that follow on the next pages highlight the key characteristics, and pros and cons of each of the four major models. These tables are not intended to provide exhaustive descriptions of each model, but rather provide a basic framework for developing a common understanding of the key elements of each model. The ability of each model to address the four benchmark goals is also included to provide a common understanding of which models may be more effective in addressing the benchmark goals and why. Finally, the tables reference experiences with a particular model from the other states included in this study (i.e., Minnesota, New Mexico, North Carolina, Ohio and Oregon) that could help inform the future development of a similar model or pathway in Wisconsin.

Model A – County-Based System	
Description of Model	• Fund continuation of current single county and optional multi-county systems with incentives to address the four benchmark goals.
Services/Benefits Provided	• Comprehensive core benefit package for publicly funded MH/SA services with potential for greater state financial participation and/or state assumption of financial responsibility for Medicaid funded services depending on the pathway selected.
Service Area	• Continuation of current single county and optional multi-county service areas.
Governance Structure	• Continuation of single and optional multi-county stand-alone systems through existing statutory provisions.
Funding Structure and Sources	• State funding allocated to existing single and optional multi-county systems to reward counties for adopting best practices. • Core services provided would be based on available funding following statewide eligibility criteria (Visions Proposal funding concept). • Mix of funding sources would change to greater state financial participation for Medicaid services and less reliance on county funding in the future.
Service Delivery Structure	• No change to service delivery structure with continuation of public and private provision of services primarily through single county and existing multi-county systems. • Provider network development primarily built on single county and existing multi-county systems.
Alignment and Coordination with Other Related Systems	• Long-Term Care – Challenges coordinating with regional Family Care MCOs to address the MH/SA needs of those in the long-term care system. • Children's System (child welfare and schools) – Children's services largely organized around a county structure, so structural alignment could indicate better potential for service coordination. • Corrections (state corrections and county jail systems) – County jails governed by a county structure, so structural alignment could indicate a greater potential for service coordination.
Coordination and Integration of MH/SA and Physical Health Care	• Challenges would occur integrating MH/SA and physical health care needs due to limitations inherent in a relatively small (single county) population base. However, coordination between behavioral and physical health care systems may be feasible and encouraged through state incentives and/or modifications to HMO contract language for managed care programs. • There would be challenges coordinating MH/SA services between counties and HMOs due to fragmentation between county/community-based and HMO provided MH/SA services.

Model A – County-Based System	
Ability and Incentives to Support Benchmark Goals	• Equitable Access – Development of core benefit package and statewide eligibility criteria with appropriate financial incentives to achieve implementation statewide would improve access and service portability. • Accountability for outcomes – Given differences in service array, funding and program administration, accountability for consumer outcomes will vary greatly among county systems. • Equitable and affordable funding – Inequitable funding likely to continue in system with 67 single or multi-county systems with significant reliance on local funding. • Service efficiency – Difficult to reduce duplicative administrative structures and gain efficiencies among single county systems.
Pros – Benefits of Model	• Least disruption to existing governance and service delivery structure. • Greater potential to coordinate care with other county-based systems, such as child welfare, courts, jails and social services. • Provides greater state financial participation to help address current funding, service level and service quality inequities among different county systems. • With greater state financial participation to fund Medicaid services, counties could have greater fiscal capacity to fund the non-Medicaid, uninsured population.
Cons – Challenges of Model	• Consumer access to services limited to what county-based systems provide. • Unlikely that sufficient state funding would be provided to equalize current inequities in county-funded services among 67 county systems. • Medicaid concerns regarding equitable access to services and service uniformity would continue and future Medicaid funding may be jeopardized. This would occur unless the state assumes financial responsibility and administration of Medicaid services, which are currently funded, in part, by counties.
Other State Experiences	• Minnesota county-based system with allocation of targeted funding through a competitive state grant process to support the service delivery infrastructure, including expanding service capacity and developing best practice approaches. • Ohio county-based system with individual board levies; 88 counties and 234 human service agencies, including 50 MH/SA boards. • Ohio reform effort to elevate Medicaid administration to the state level and assume responsibility of the nonfederal share of Medicaid from counties.

Model B – County Collaborative System	
Description of Model	• Fund consortia of counties for specific services (e.g., crisis, inpatient) and/or functional areas (e.g., planning, access/intake, administrative/back office duties, provider network development, workforce development and training) with incentives to address the four benchmark goals. • Build upon the foundation of Model A - County-Based System, to encourage further county collaboration through financial incentives.
Services/Benefits Provided	• Services specific to the areas identified for collaboration by the counties involved and/or as specified by the state through a Request for Proposal process.

Service Area	• Continuation of current single county and optional multi-county services areas (Model A) with implementation of voluntary county collaborative systems statewide.
	• Development of county collaborative systems would include geographic configurations that are based on county preference for one or more of the following:
	  o Historical working relationships among counties
	  o Provider network service areas
	  o Family Care regions
	  o Other areas defined by the counties and/or the state

Governance Structure	• Continuation of current statutory governance structure for single or optional multi-county systems. • Voluntary implementation of county collaborative systems through intergovernmental agreements between counties. • Individual counties would develop collaborative systems that have responsibility for the specific area(s) selected for collaboration (crisis services, inpatient services, administrative and business support, provider network development, workforce development and training, etc.). • Counties could create a collaborative decision making body that is limited in scope and authority to the specific areas and approach identified for collaboration.
Funding Structure and Sources	• The mix of funding sources would adjust to greater state financial participation for collaborative systems and less reliance on county funding in the future. • State funding for identified service(s) would be allocated to collaborative boards that, in turn, distribute resources based on collaborative service planning. • Remaining core services outside of the collaborative would be based on available funding following statewide eligibility criteria (Visions Proposal funding concept).

Model B – County Collaborative System	
Service Delivery Structure	• Continuation of public and private provision of services as defined by the collaborative. • No change to service delivery structure for areas not included in the scope of the collaborative, with continuation of public and private provision of services primarily through single county and existing multi-county systems (Model A).
Alignment and Coordination with Other Related Systems	• Long-Term Care – Challenges coordinating with regional Family Care MCOs to address the MH/SA needs of those in the long-term care system unless multi-county collaborative systems align geographically with Family Care MCO regions. • Children's System (child welfare and schools) – Children's services largely organized around a county structure, so structural alignment could indicate potential challenges for service coordination. • Corrections (state corrections and county jail systems) – County jails governed by a county structure, so structural alignment could indicate potential challenges for service coordination.
Coordination and Integration of MH/SA and Physical Health Care	• Greater capacity to potentially integrate with physical health care would be available because of a larger multi-county population base for certain service areas. This base may be better aligned with larger HMO service areas, which also tend to be multi-county. • Challenges coordinating MH/SA services between multi-county collaboratives, single county and optional multi-county MH/SA systems and HMOs would occur due to additional structural complexity and fragmentation.
Ability and Incentives to Support Benchmark Goals	• Equitable access to services – Development of core benefit package and statewide eligibility criteria with appropriate financial incentives to achieve implementation statewide would improve access and service portability. This also can be enhanced within multi-county collaborative areas depending on the scope of the collaborative efforts. • Accountability for outcomes – Given differences in service array, funding and program administration, accountability for consumer outcomes will still vary greatly among counties involved in multi-county collaborative systems. • Equitable and affordable funding – There would be some potential to achieve more equitable funding within collaborative multi-county areas depending on the scope of the collaborative efforts. • Service efficiency – There would be some potential to achieve administrative and program efficiencies with broader infrastructure base for multi-county collaborative systems.
Pros – Benefits of Model	• Relatively little disruption to county governance and service delivery structure since creation of collaborative systems and changes to service delivery structure would be at county discretion. • Creates mechanism for multi-county collaboration, with an opportunity to learn about which areas are more likely to benefit from a multi-county approach. • Provides greater state financial participation to help address current funding inequities and provides potential for greater access to equitable services by multi-county area for selected services or functions.

Model B – County Collaborative System	
	• Concerns regarding equitable access to services and service uniformity could be more effectively addressed by multi-county area, but only for the services selected for collaboration and not on a statewide basis. • Greater capacity to achieve efficiencies and expand expertise in administrative and program operations, but only for the services or functions selected for collaboration and not on a statewide basis. • Expansion of service delivery boundaries consumers currently face in accessing services, but only for the services selected for collaboration and not on a statewide basis.
Cons – Challenges of Model	• Unlikely that collaborative structure would serve to address current inequities between county systems, although more equitable funding could likely result within collaborative service areas or functions. • Medicaid concerns regarding equitable access to services and service uniformity would continue and future Medicaid funding may be jeopardized.
Other State Experiences	• Minnesota regional funding initiative that distributes funding to regions and then distributes dollars based on regional service planning. • New Mexico local collaboratives that help guide service planning for state-administered MH/SA system.

Model C – Multi-County System	
Description of Model	• Fund mandatory multi-county MH/SA systems with incentives to address the four benchmark goals.
Services/Benefits Provided	• Comprehensive core benefit package for publicly funded MH/SA services, with potential to include services under Family Care program.

Service Area	• Expansion of multi-county systems statewide.
	• Development of multi-county systems would include geographic configurations that are based on minimum population requirements and one or more of the following:
	    o Historical working relationships among counties
	    o Provider network service areas
	    o Family Care regions
	    o Other areas defined by the counties and/or the state

Governance Structure	• Statewide expansion of mandatory multi-county MH/SA systems through stand-alone MH/SA systems or integration of MH/SA and all remaining county human services functions into multi-county human services systems depending on the pathway selected. • Delegation of individual county governance to separate multi-county boards that have policy and budget authority per existing state statutes. Each county could determine its role in the multi-county system. This role could range from a system governance role based on representation on a multi-county board, to a purchasing role as a contractor of services from a multi-county system, or no role if financial and service responsibility is transferred to a risk-bearing entity (similar to a Family Care district). • Creation of a local planning and liaison function with each participating county in the multi-county system to ensure coordination with other related systems in the individual counties and provide a communication link between individual counties and a multi-county system.
Funding Structure and Sources	• State funding allocation by mandatory multi-county systems that, in turn, distribute resources based on multi-county service planning. • Core services provided would be based on available funding following statewide eligibility criteria (Visions Proposal funding concept). • Greater state financial participation for Medicaid services and less or no reliance on county funding in the future.
Service Delivery Structure	• Continuation of public and private provision of services, but through a defined multi-county/regional provider network. • Creation of local satellite offices throughout the multi-county service area. • Determination of which services would be shared and provided centrally and which would be provided through a decentralized service structure.

Model C – Multi-County System	
Coordination and Integration of MH/SA and Physical Health Care	• Greater capacity to potentially integrate with physical health care because of a larger multi-county population base that may be better aligned with larger HMO service areas, which also tend to be multi-county. • Greater capacity to potentially coordinate MH/SA services between multi-county systems and HMOs due to less fragmentation between MH/SA services that are multi-county/community-based and HMO provided (resulting from implementation of a comprehensive core MH/SA benefit package).
Ability and Incentives to Support Benchmark Goals	• Equitable access to services – Development of core benefit package and statewide eligibility criteria with appropriate financial incentives to achieve implementation statewide. • Accountability for outcomes – Greater consistency in service array, funding and program administration would result in less variance in consumer outcomes within multi-county systems and potentially between multi-county systems. • Equitable and affordable funding – Greater ability to achieve more equitable funding within multi-county areas and statewide, which will help alignment with Medicaid goals. • Service efficiency – Greater ability to achieve administrative and program efficiencies with broader infrastructure base.
Pros – Benefits of Model	• Provides a larger financial base to help address current funding inequities and potential for greater consumer access to equitable and more diverse services by multi-county area. • The larger financial base helps spread risk for high cost cases that can disproportionately and significantly impact individual county budgets. • Medicaid concerns regarding equitable access to services and service uniformity could be more effectively addressed by statewide expansion of multi-county systems. • Greater capacity to achieve efficiencies and expand expertise in administrative and program operations due to broader multi-county infrastructure base.
Cons – Challenges of Model	• Major change to governance, funding and service delivery structure that has the potential to disrupt consumer access to services and service effectiveness if change is not well-planned and implemented. • Challenge in determining how to equitably address the level of individual county funding and future funding responsibility for multi-county systems. • Unlikely that sufficient state funding would be provided to equalize current inequities between multi-county systems, although more equitable funding would likely result within multi-county systems. • Challenges in creating effective governance and operational structures for counties to form multi-county systems, including the need to overcome barriers and issues that have precluded counties from exercising the option to create multi-county systems under current statutory provisions. These barriers include county reluctance to turn over program and financial control to a multi-county system. There have also been past concerns of counties in multi-county systems about the program and financial operations of those systems and/or the compatibility of service philosophy and approach between counties in a multi-county system.

Model C – Multi-County System	
	• Implementation of multi-county systems may be more challenging in Wisconsin, which has larger county boards than other states that have adopted a more regional governance, service and funding model. • Mechanisms for local involvement in service planning and for coordination with other related systems that are largely county-based would need to be developed. • Challenges in addressing other county responsibilities that support and/or impact the MH/SA service system, such as the court-related functions and law enforcement response function. All related MH/SA areas of responsibility would need to be addressed in a multi-county system to ensure necessary functions are still appropriately performed and funded. • Challenges in creating a new operating structure capable of effectively collecting and analyzing data necessary to manage a multi-county system.
Other State Experiences	• Minnesota's regional initiative to consolidate county human services departments into regional authorities, called service delivery authorities (SDAs). • North Carolina's Local Management Entities (LMEs). (24 LMEs serve 100 counties, and further consolidation and regionalization is being recommended). • Ohio's multi-county boards. (50 boards serve 88 counties; 20 of the boards are multi-county). • Oregon's nine regional Medicaid managed care Mental Health Organizations (MHOs) (eight regional MHOs are run by county groups and one is run by a physicians group) contract with 33 community mental health programs (CMHPs).

Model D – Public/Private Integrated Care System	
Description of Model	• Fund demonstration projects of public/private partnerships that integrate MH/SA and physical health care with incentives to address the four benchmark goals.
Services/Benefits Provided	• Comprehensive MH/SA benefit package (community-based, inpatient and outpatient services) and physical health benefit package (acute and primary care), with potential to include long-term care services under Family Care program.
Service Area	• Implementation of public/private integrated care systems statewide. • Development of public/private integrated care systems would include geographic configurations that are based on minimum population requirements and one or more of the following: o Historical working relationships among counties o Provider network service areas, including existing HMO service areas o Family Care regions o Other area defined by the counties and/or the state
Governance Structure	• Implementation of demonstration projects (voluntary pilot programs) of integrated care systems through new statutory authority. • Delegation of individual county governance to public/private care systems that have broad authority for integrating care.
Funding Structure and Sources	• State funding allocated through capitated payments to public/private demonstration projects and supported by pooling Medicaid and other federal, state and county funding sources. • Potential pathways for funding include: o Single or multi-county MH/SA systems work in a contractual partnership with HMOs to coordinate care management activities for all behavioral and physical health care services. o HMOs contract with single or multi-county MH/SA systems to provide all MH/SA services and the organizations coordinate care management of MH/SA and physical health care services. o Public or private MH/SA managed care organizations provide MH/SA services and coordinate physical health care with HMOs, with the potential for counties to be absolved of financial risk and all current statutory responsibilities for providing MH/SA services. o HMOs provide fully-integrated behavioral and physical health care services, with the potential for counties to be absolved of financial risk and all current statutory responsibilities for providing MH/SA services.
Service Delivery Structure	• Continuation of public and private provision of services as defined by the integrated care system demonstration project. • Development of approaches that integrate MH/SA and physical health care through collaborative arrangements between public and private organizations and blending of funding for all MH/SA services. Integrated care service delivery approaches could include:

Model D – Public/Private Integrated Care System	
	○ Primary care professional(s) embedded (on-site or via telehealth) in community MH/SA setting. ○ MH/SA professional(s) embedded (on-site or via telehealth) in primary care setting. ○ Co-location of community MH/SA and primary care provided by two separate entities. ○ Behavioral and physical health care through one provider entity. ○ Case management of all primary and specialty care by same professional (i.e., medical home model).
Alignment and Coordination with Other Related Systems	• Long-Term Care – Challenges coordinating with regional Family Care MCOs to address the MH/SA needs of those in the long-term care system unless integrated care systems align geographically with Family Care MCO regions. • Children's System (child welfare and schools) – Children's services largely organized around a county structure, so structural alignment could indicate potential challenges for service coordination. • Corrections (state corrections and county jail systems) – County jails governed by a county structure, so structural alignment could indicate potential challenges for service coordination.
Coordination and Integration of MH/SA and Physical Health Care	• Greatest capacity to integrate with physical health care due to direct collaboration and partnership between counties, private MH/SA agencies and HMOs. • Greatest capacity to achieve service integration between county/community-based and HMO-provided MH/SA services.
Ability and Incentives to Support Benchmark Goals	• Equitable access to services – Development of core benefit package and statewide eligibility criteria with appropriate financial incentives and contract enforcement to achieve implementation statewide. • Accountability for outcomes – Accountability for consumer outcomes could be specified in contractual requirements established by the state. • Equitable and affordable funding – Capitated payment structure would address funding inequities inherent in current system and pool resources to comprehensively meet an individual's physical and MH/SA needs. • Service efficiency – Greater capacity to achieve administrative and program efficiencies with broader infrastructure base and relative service and business strengths of private and public entities.
Pros – Benefits of Model	• Provides a larger funding and service base to comprehensively address the behavioral and physical health needs of consumers. • Greater potential for consumers to access care for their physical and MH/SA needs through a number of different locations in a broader service network, which can also help mitigate the stigma associated with accessing MH/SA services. • Greater capacity for coordination of MH/SA care (community-based, outpatient and inpatient) and coordination between behavioral and physical health care. • Medicaid concerns regarding equitable access to services and service uniformity could be more effectively addressed by demonstration project but not on a statewide basis. • Capitated payment structure may provide incentive to fund care that maximizes positive consumer outcomes in the most cost-effective manner, including the provision of preventative care and community-based services.

Model D – Public/Private Integrated Care System	
Cons – Challenges of Model	• Major change to governance, funding and service delivery structure that has the potential to disrupt consumer access to services and service effectiveness if change is not well-planned and implemented. • Challenge in determining how to equitably address the level of individual county funding and future funding responsibility for integrated care systems. • Capitated payment structure may provide incentive to ration necessary MH/SA care, especially more intensive and costly care. • Medically-driven HMO model may be difficult to align with community-based county MH/SA model. • Perception that there will be less opportunity for consumers to participate in the design of a private sector model than a public sector model. • Limited or no ability for the state and affected counties to meet service capacity, if statutorily-created business entity fails and services are no longer available through that entity. • Challenges in creating an operating structure capable of effectively collecting and analyzing data necessary to manage a multi-county system that integrates behavioral and physical health care services.
Other State Experiences	• Minnesota Preferred Integrated Networks (PINs) to demonstrate the integration of physical and mental health services within pre-paid health plans and their coordination with county social services. • North Carolina's Community Care collaborative approach to mental and primary health care integration at four Local Management Entity (LME) pilot sites for Medicaid enrollees that includes shared data systems and common measures to track results. • Oregon integrated care demonstration projects proposed to "carve in" mental health services to the Oregon Health Plan, with substance abuse services already included.