# Wisconsin Behavioral Health "System" Challenges *and* Opportunities - Presentation to the WAFCA Leadership Summit

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Rick Immler MD

# Goals of Discussion

- In 30 minutes (because your insurance only covers that much…):
- Worry you with a few stories ☹
- Shock you (exposure therapy) with brief look at data and history ☹ ☹!!
- Provide Cognitive Reframing – Center, Mindfulness, Zen~~~
- Recommend Behavioral therapy – RISE-UP Together!!
- Motivate you – GO!!
- AND Thank-you for all that you do!

# Story – Success but Not Sustained

Success, Demise *and* Survival of Northwoods Alliance for Children and Families

- Human Service Center – also dramatic reduction in out of home placement and hospitalization through Wraparound Model –$200,000 saved by Oneida County Social Services **returned to general County fund – *no monies to sustain program – it closed when Grant ended***
- North Central Health Care —– sustained by early version of CCS – Close collaboration with Marathon County DSS associated with marked reduction in out of home placements 2000-2010

# Sorry, Lucy moved to another state

# Story – Unintended Consequences

900% increase 2011-17 in State Hospital use by Multicounty system

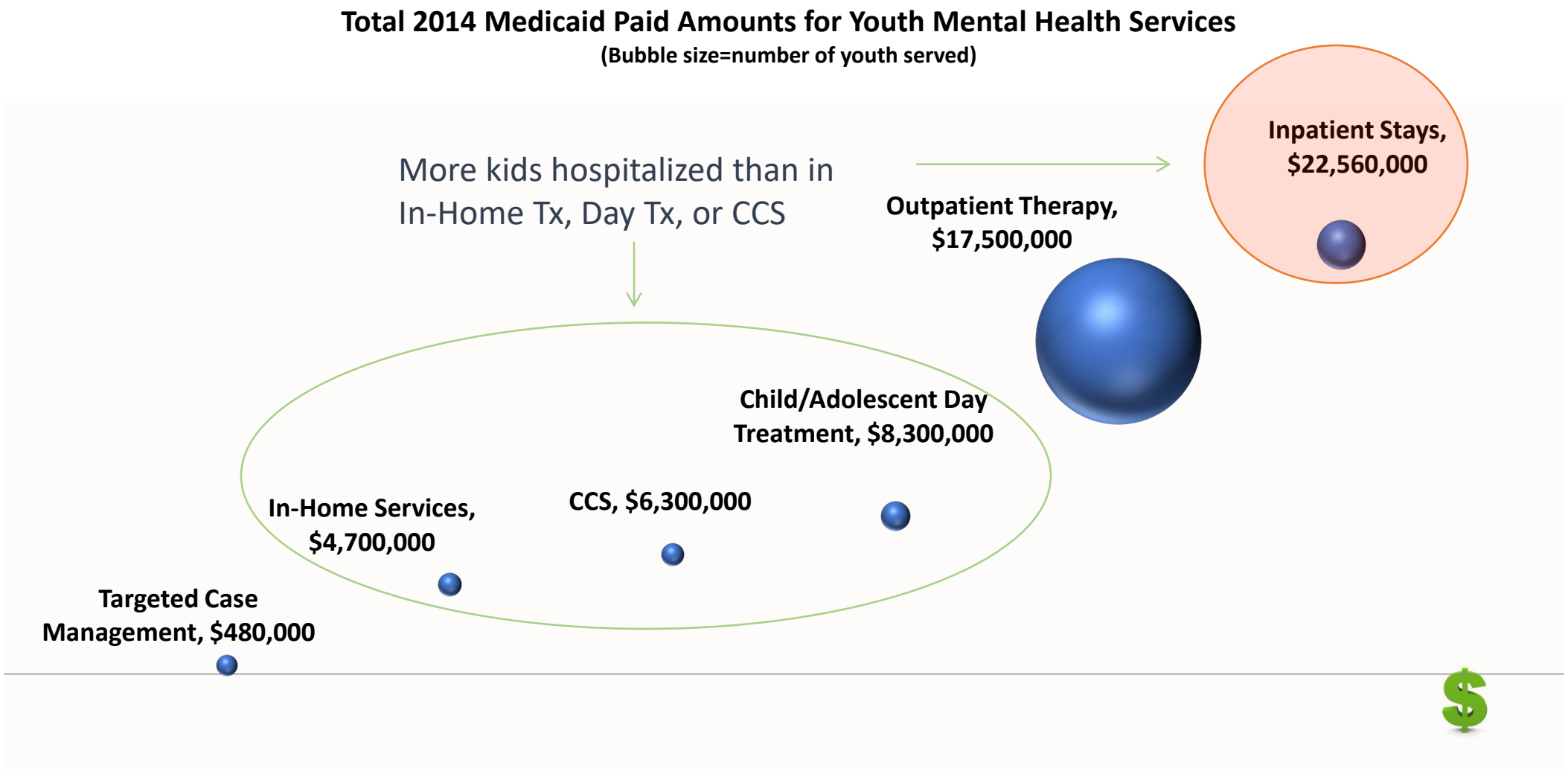
- Well-functioning CSP (Assertive Community Treatment Model) dramatically diminished 2014-15 when **CCS County $ picked up by the State**
- Over 200 High Need Consumers moved from CSP to CCS
- Subsequent increase in hospitalizations (20x for youth at WMHI)
- Loss of experienced staff with institutional memory
- Currently in many year rebuilding process

# Concerning Trends and Data, Is there Accountability?

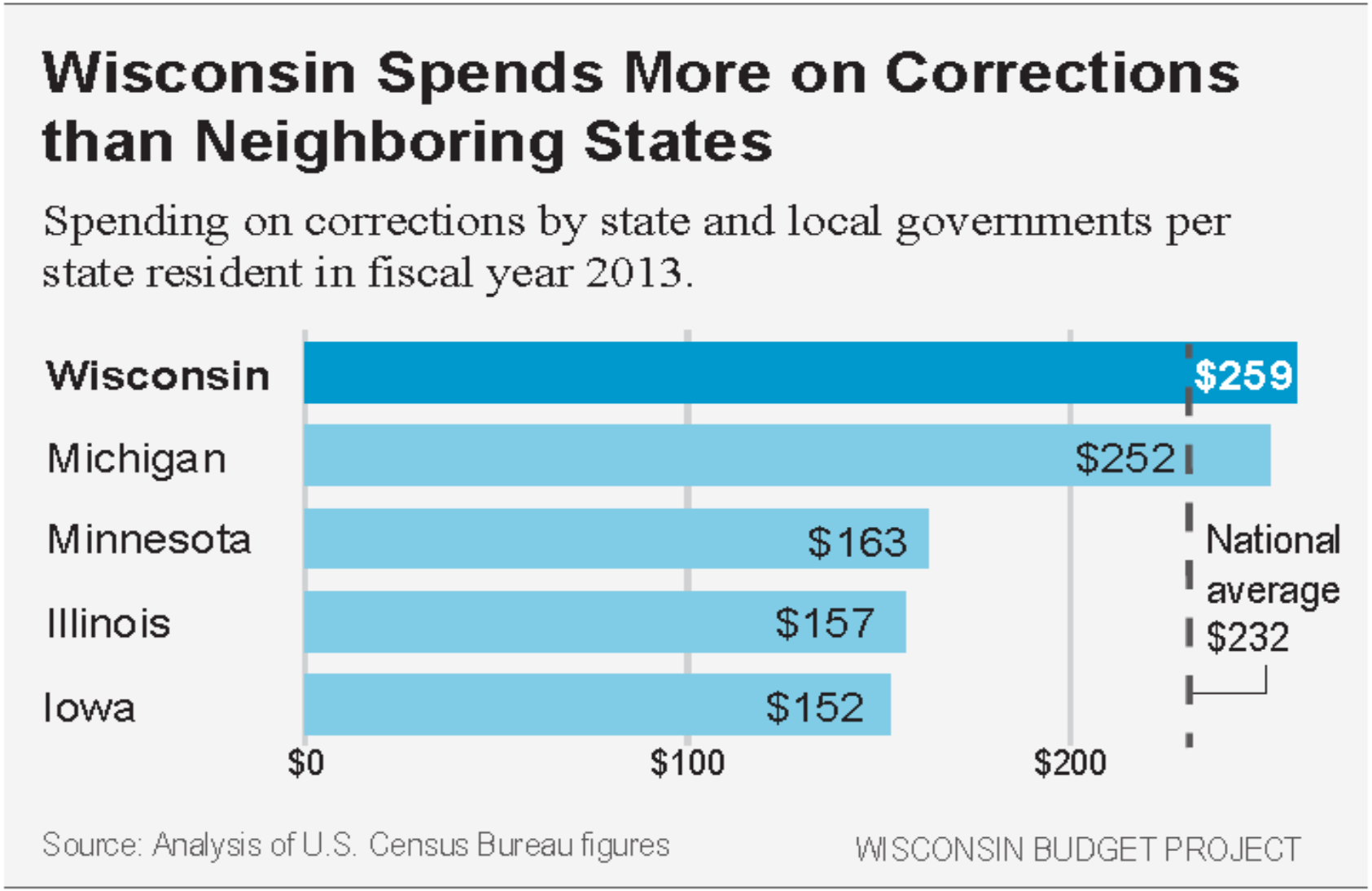
- *Separate PPT with Data to Follow*
- Overuse State Hospitals, Prison, Jails (Consuming GPR and Property Taxes)
- Deaths by Suicide
- Death by Overdose
- Out of Home Placements for Youth
- Untreated behavioral Health needs
- Limited Early Intervention and Prevention Opportunities

# Another way to look at it:

## Medicaid Amount Paid x Number of Kids Served

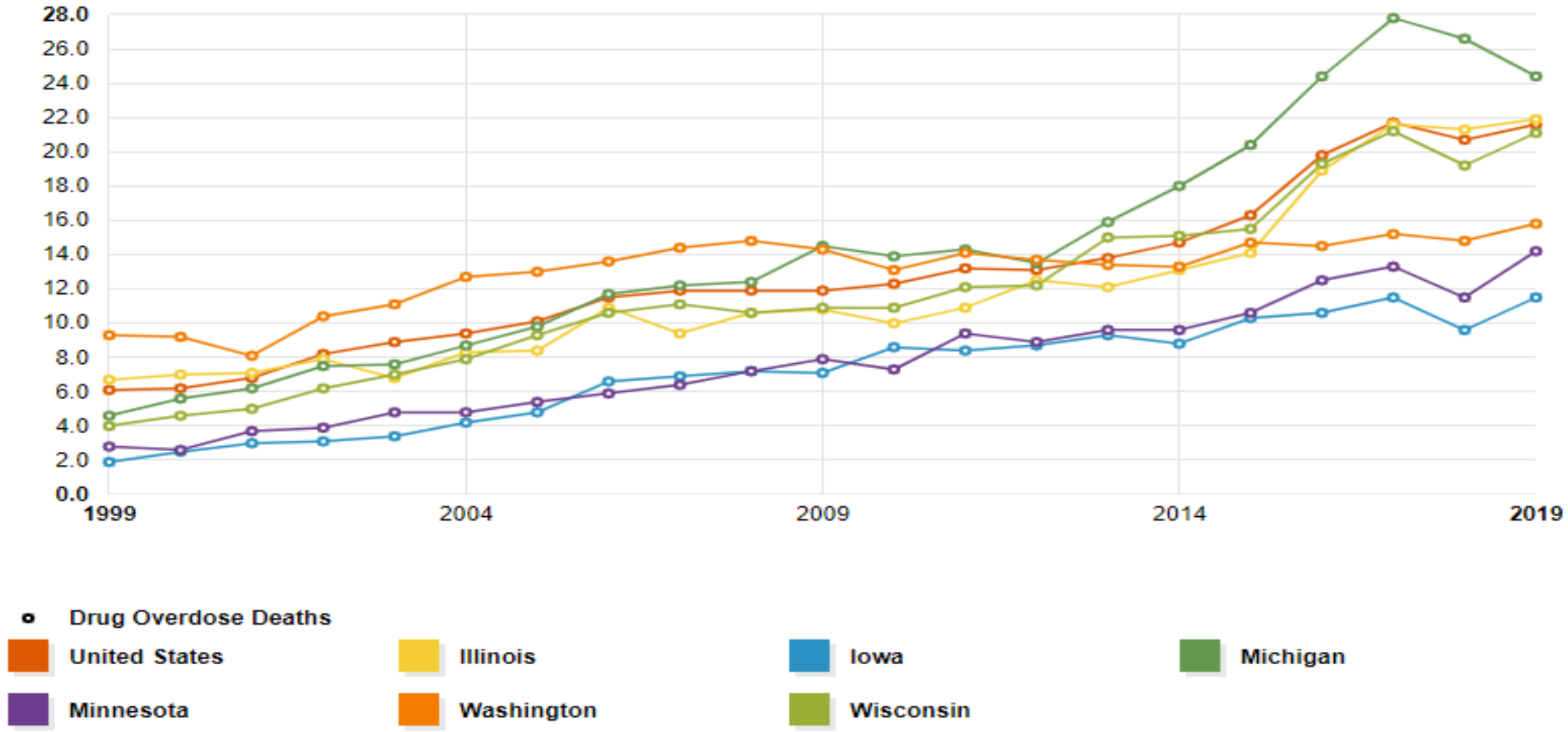


# Long Term Effect of Policy Decisions



# If We’re Going to Get Ahead – What Vision Might Let It Happen?

# What is possible based on a State's Changes – OD Rates



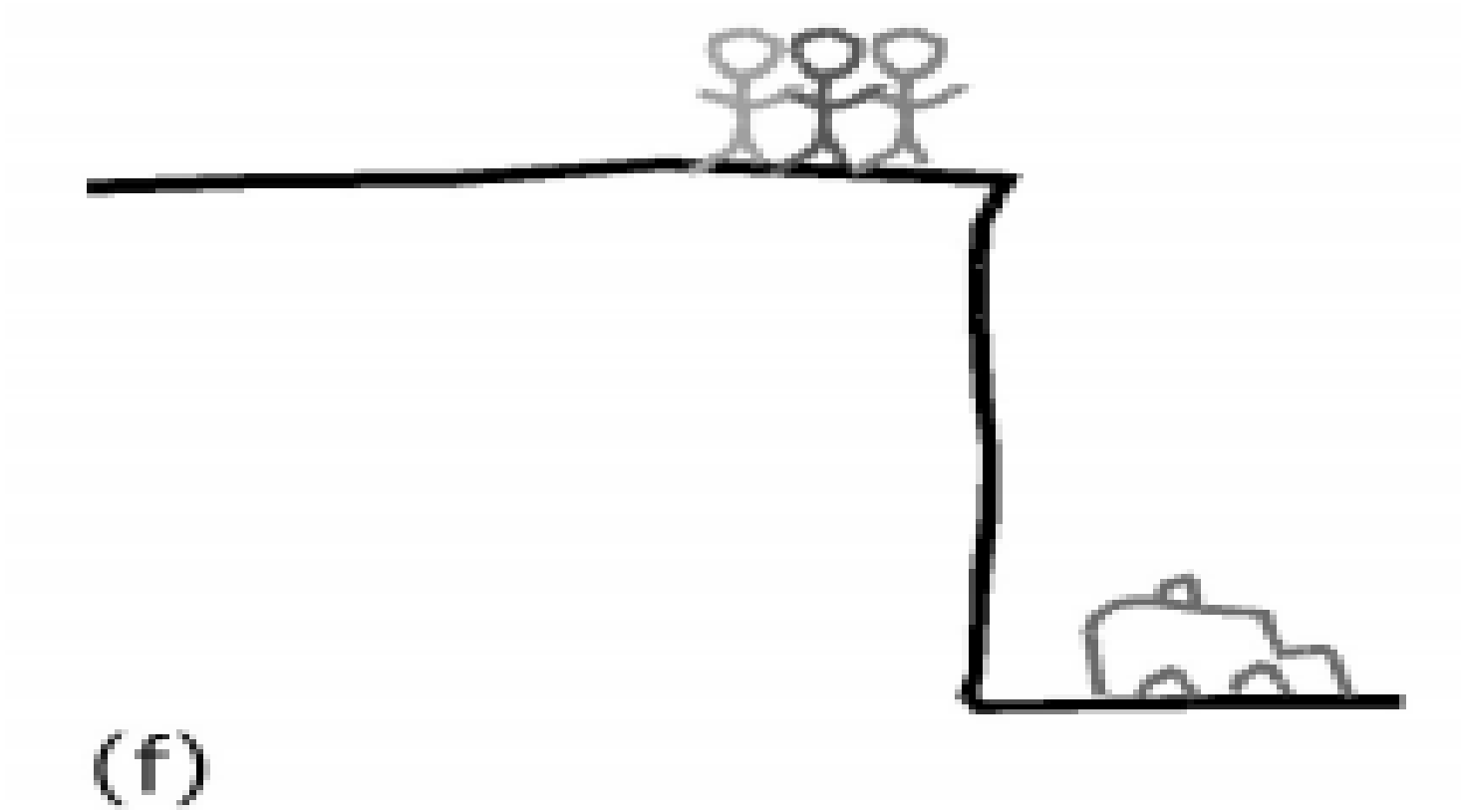
# From the Introduction of Chapter 51

- 51.001 **Legislative policy**. (1) It is the **policy of the state to assure the provision of a full range of treatment and rehabilitation services** in the state for all mental disorders and developmental disabilities and for mental illness, alcoholism and other drug abuse. **There shall be a unified system of prevention of such conditions and provision of services which will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs,** and movement through all treatment components to assure continuity of care, within the limits of available state and federal funds and of county funds required to be appropriated to match state funds.

# Wisconsin has History of County Responsibility (So does Minnesota)

- Wisconsin is like New England – Local County Authority (3000 Units)
- State Government promised to collect Income Taxes, Return monies to Counties but stopped indexing to inflation 30 years ago
- Deinstitutionalization of Long-Term Facilities 1960 – 1990s
- Wis Chapter 51 – County Responsibility including for Cost of State Hospital Use (full cost for 22-64)
- **Expectation of Counties as Safety Net** – But Mandated to be a Primary Provider Beyond Crisis

**So our public MH *County* "system" is crisis oriented and based on program eligibility – but funding is changing!**



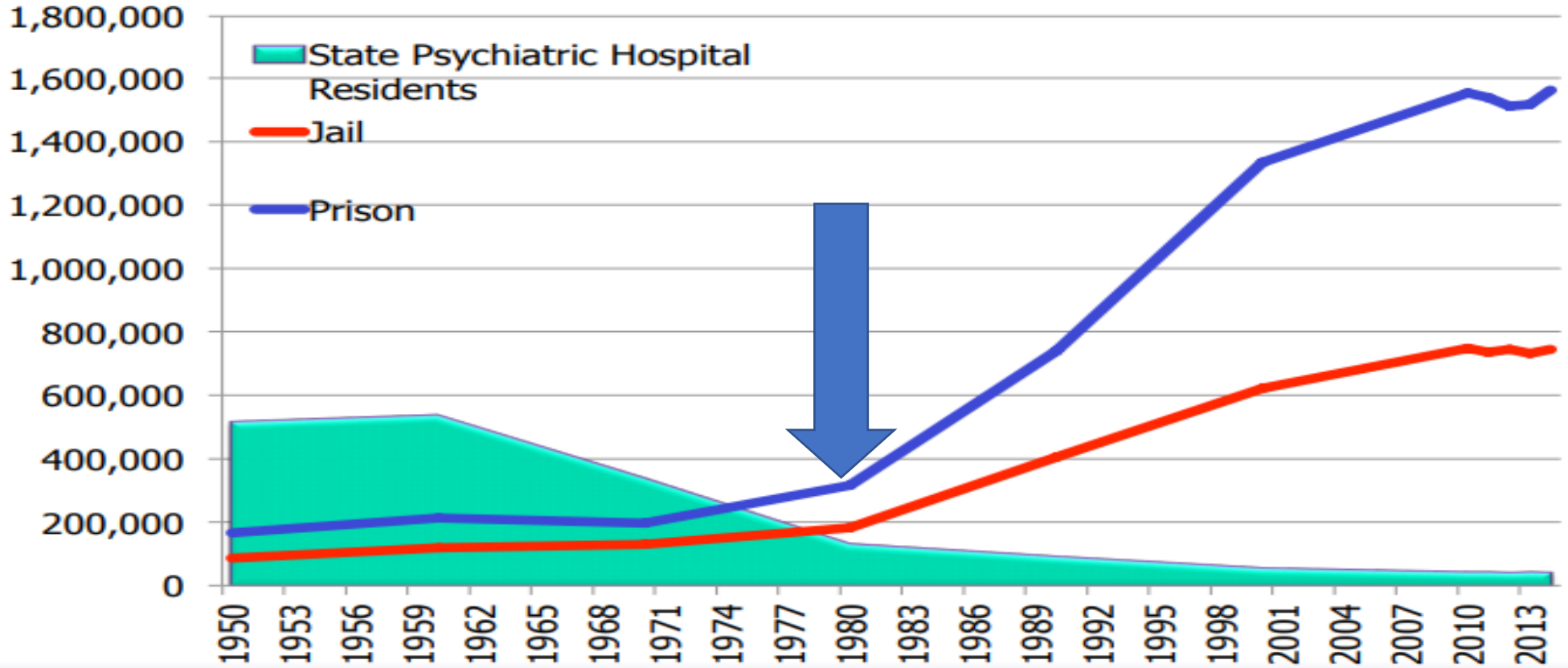
# History, County Responsibility and Medicaid: 1990-2009

- **Major Growth of Medicaid portion of funding**
- **Loss of Private Sector Mental Health** resources in Wisconsin (poor Medicaid and insurance reimbursement, increased uninsured)
- **Shortage of Psychiatry** (at one-point in past 15 years, highest % of unfilled Psychiatry Shortage Areas)
- **Difficulty Generalizing** EBP (PACT, Mendota JTU, DBT, FEP)
- **Great Variability** in County Services, Outcomes, Costs and Lack of Transparency
- **Dramatic Rise** in Jail (Property Tax) and Prison (GPR) Use (3x) and Costs

# Mental Illness and Substance Abuse Contributing to Incarceration

Analytics Improving Behavioral Health℠

## Residents in State Psychiatric Hospitals, Jails, and Prisons, 1950 to 2014



# So Where Do We Put our Resources and What is the “System”?

**Figure 13: Sectors of Mental Health Providers and Insurers in Wisconsin**

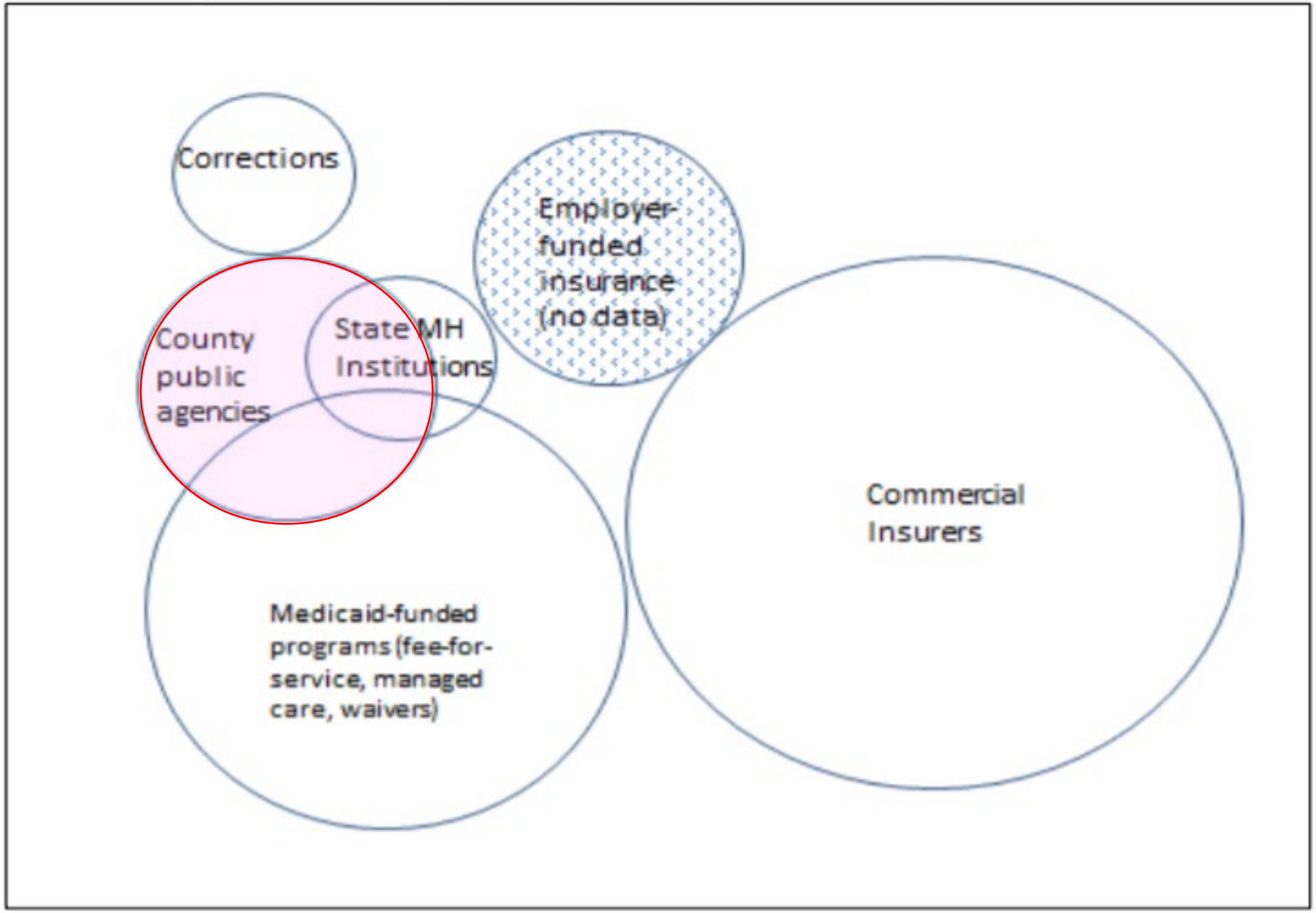


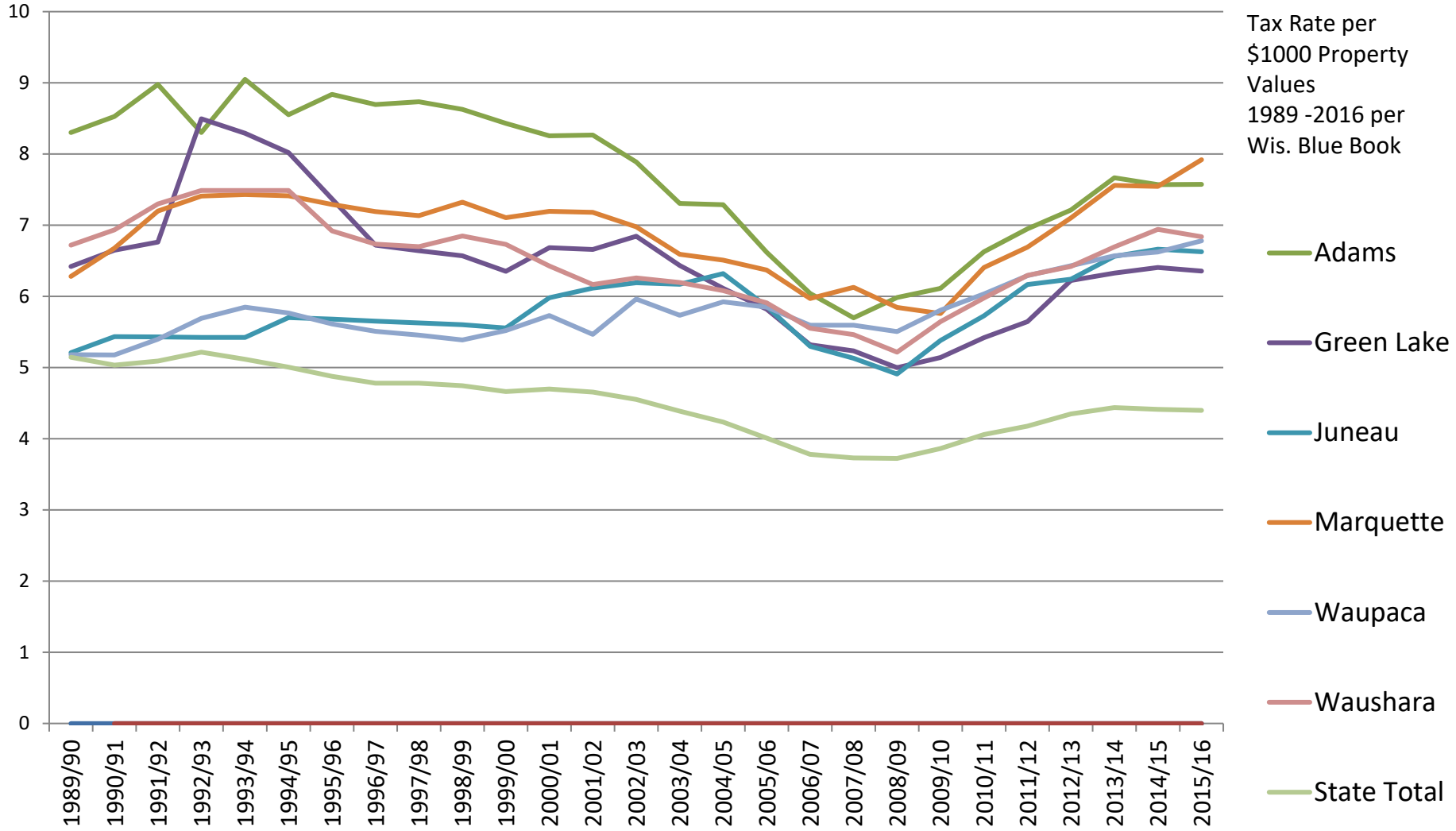
**Table 18: Mental Health Disorder Prevalence and County-Authorized Mental Health Service Participants, Wisconsin, 2015**

| | Mental Health Prevalence - Any Mental Illness | | County-Authorized Mental Health Service Participants Served - 2015 | |
|---|---|---|---|---|
| | Number | Percent | Number | Percent |
| Female | 615,592 | 60% | 30,942 | 50% |
| Male | 410,067 | 40% | 30,336 | 50% |
| Total | 1,025,659 | 100% | 61,278 | 100% |
| | | | | |
| Age 0-17 | 271,871 | 26% | 10,407 | 17% |
| Age 18-24 | 122,251 | 11% | 7,170 | 12% |
| Age 25-49 | 374,112 | 35% | 26,089 | 42% |
| Age 50 and over | 297,266 | 28% | 17,619 | 29% |
| Total | 1,065,501 | 100% | 61,285 | 100% |
| | | | | |
| White | 911,968 | 84% | 48,651 | 82% |
| African American | 56,087 | 5% | 5,446 | 9% |
| Hispanic | 55,372 | 5% | 2,147 | 4% |
| American Indian | 10,759 | 1% | 1,175 | 2% |
| Asian | 18,815 | 2% | 699 | 1% |
| Hawaiian/Pacific Islander | 280 | 0% | 49 | 0% |
| Multiracial | 26,728 | 3% | 1,226 | 2% |
| Total | 1,080,009 | 100% | 59,393 | 100% |

# County Financial Challenges

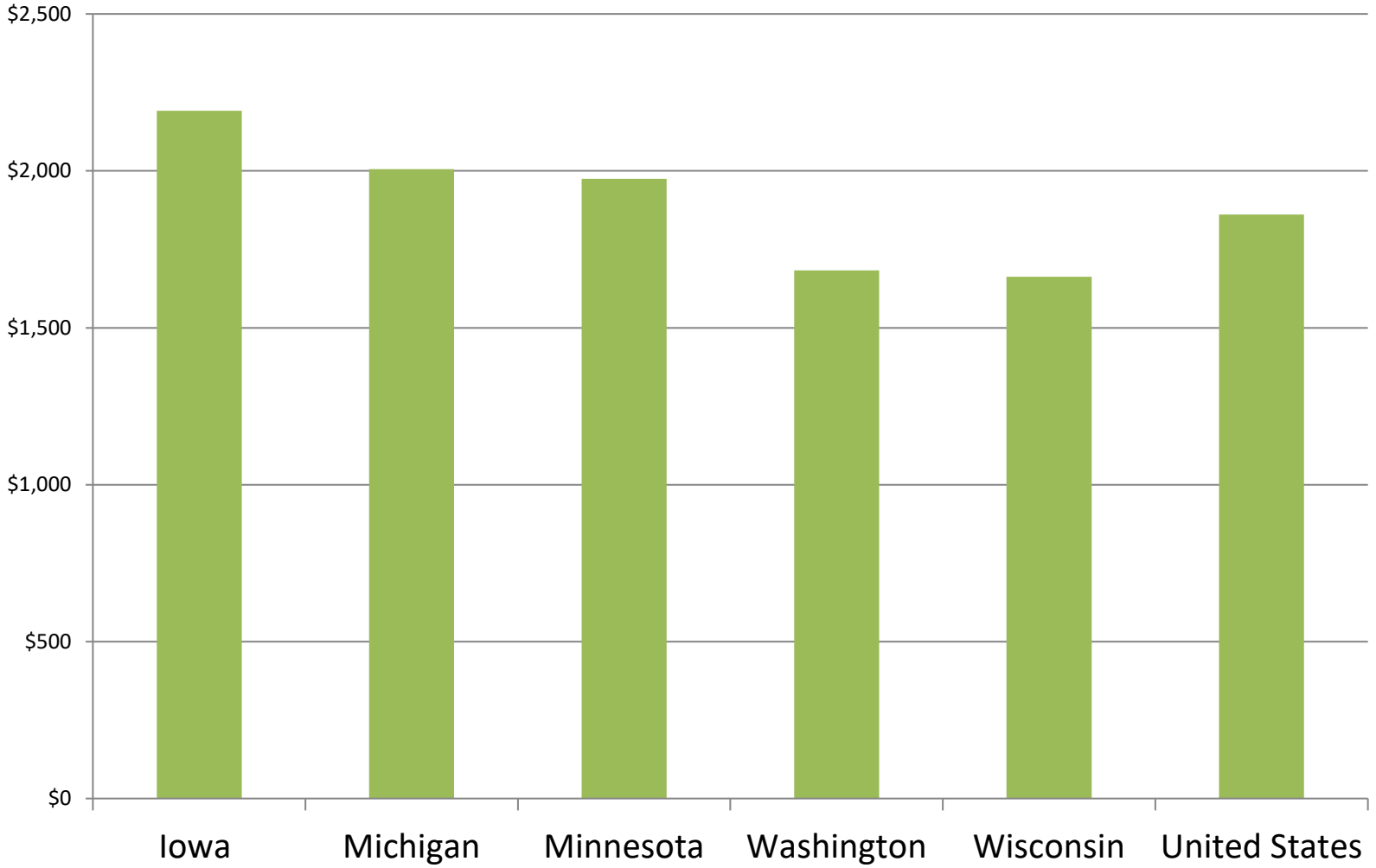
- Very limited or frozen revenues from Tax Levy for HSD/BH, PH, **Law Enforcement (consumers largest proportion property taxes)**
- County Tax Levies vary significantly across the state
- **Shared Revenues/ Basic County Allocation essentially flat (so reduced by inflation) for over 20 -30 years – and vary from county to county**
- **Wis Local Government receives less Federal funds than neighboring States and the US average**

# Tax Rates for CWHP Counties 50% more than State Average



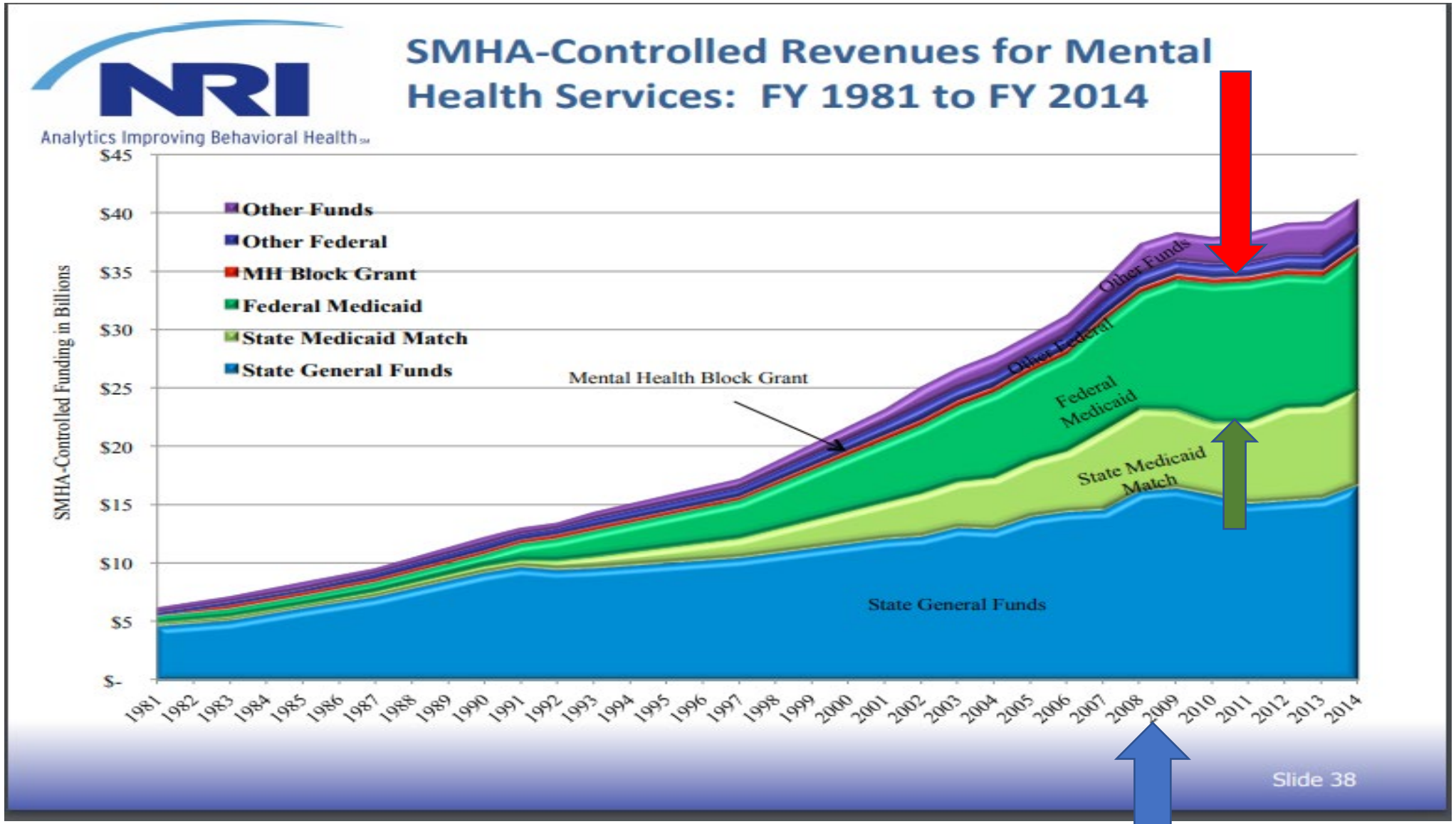
# In 2011-12 Wisconsin Captured Less Federal Revenue

## Per Capita Funding from Federal Revenue Sources

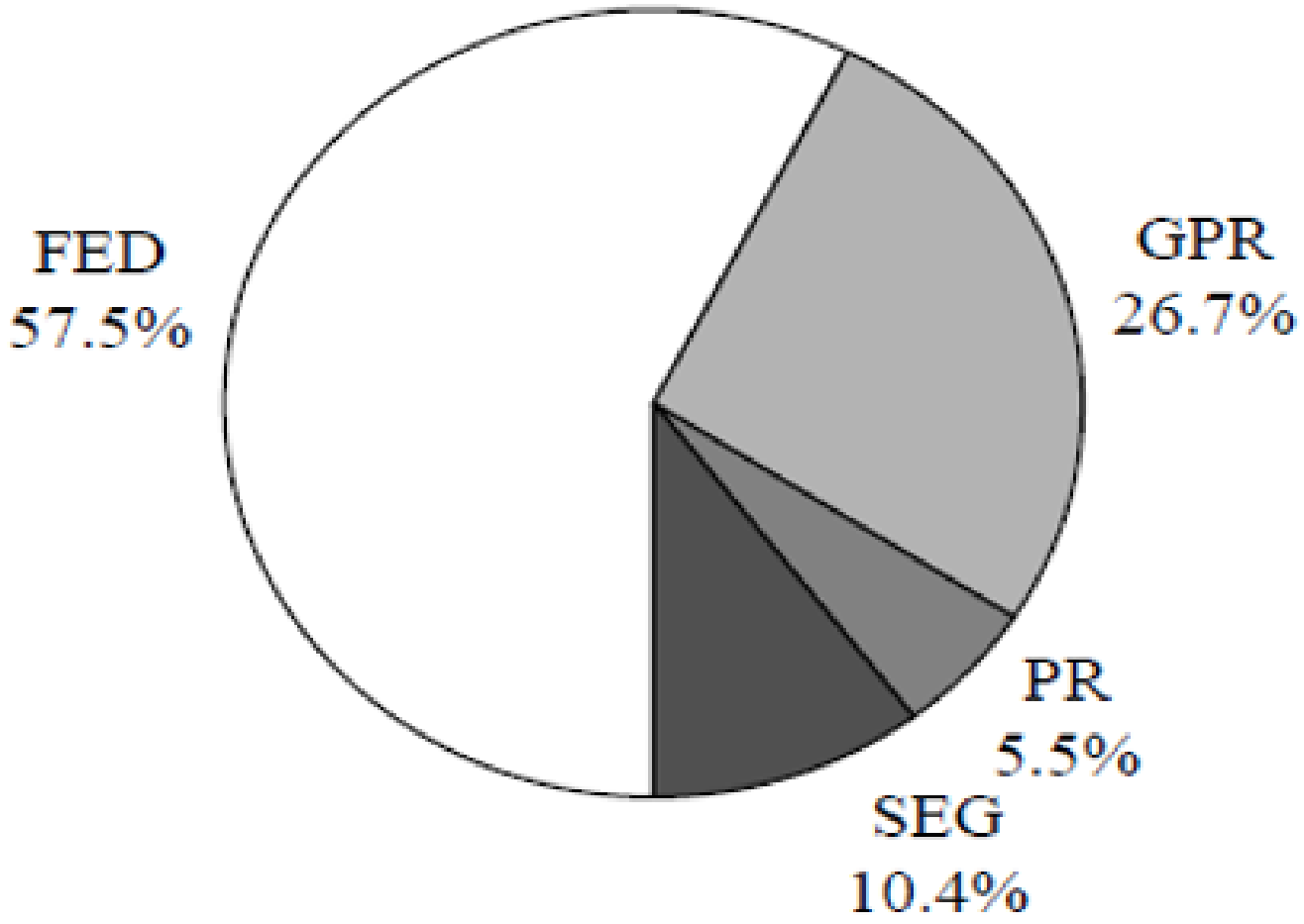


| Origin of Funds – DHS - In Thousands | Source of Funds | Abused Neglected Children | Adults & Elderly | Alcohol/ Other Drug Abuse | Children & Families | Delinquent & Status Offender | Dev Disabilities | Mental Health | Physical & Sensory Disability | Total in $ thousands |
|---|---|---|---|---|---|---|---|---|---|---|
| Community Aids BCA | GPR & Fed | $15,856 | $12,863 | $12,115 | $6,524 | $5,534 | $14,740 | $105,857 | | $174,419 |
| Children's LT Support | GPR & Fed | | | | | | $52,802 | | | $68,115 |
| Medical Assistance FFS | GPR & Fed | | | | | | $14,374 | $278,083 | | $304,455 |
| WIMCR | Fed | | | | | | | $29,707 | | $34,312 |
| Other | GPR & Fed | | $10,345 | $24,705 | | | $21,525 | $39,896 | | $105,195 |
| Total DHS | | $17,978 | $24,140 | $45,051 | $12,822 | $8,338 | $106,513 | $462,988 | $8,657 | $686,486 |
| DCF | GPR & Fed | $44,744 | $986 | $1,561 | $24,223 | $79,219 | $2,983 | $6,269 | $270 | $160,255 |
| County | Tax Levy & Shared Revenue | $93,941 | $22,535 | $21,336 | $43,170 | $59,088 | $34,963 | $181,631 | $3,753 | $460,416 |
| Total All | | $167,729 | $85,416 | $87,633 | $87,209 | $176,222 | $153,458 | $698,555 | $13,807 | $1,470,029 |

# Growth of Medicaid for Public MH



# % Total WI MA Spending by Fund Source 2019-20



# Sources of MA Funding

| | 2015-16 | 2016-17 | 2017-18 | 2018-19 | 2019-20 |
|---|---|---|---|---|---|
| GPR | $2,639,662,200 | $2,655,880,600 | $2,911,926,800 | $2,994,609,100 | $2,840,883,900 |
| FED | 4,757,923,700 | 4,934,657,600 | 5,139,834,800 | 5,440,239,600 | 6,127,681,300 |
| PR | 690,577,400 | 973,822,800 | 876,508,000 | 1,070,023,500 | 1,104,533,600 |
| SEG | 594,961,600 | 619,955,400 | 517,811,700 | 611,669,100 | 586,637,500 |
| Total | $8,683,124,900 | $9,184,316,400 | $9,445,331,300 | $10,116,541,300 | $10,659,736,300 |

# Medicaid Expenditures and Participation

| | Expenditures ($ in Millions) | Average Monthly Enrollment |
|---|---|---|
| 2010-11 | $7,181.7 | 1,098,000 |
| 2011-12 | 6,597.2 | 1,112,700 |
| 2012-13 | 7,187.7 | 1,106,800 |
| 2013-14 | 8,070.1 | 1,103,100 |
| 2014-15 | 8,526.2 | 1,130,100 |
| 2015-16 | 8,683.1 | 1,127,700 |
| 2016-17 | 9,184.3 | 1,117,900 |
| 2017-18 | 9,445.3 | 1,113,200 |
| 2018-19 | 10,116.5 | 1,105,400 |
| 2019-20 | 10,659.7 | 1,123,000 |

# MA Benefits by Major Category FY 2019-20 (Millions)

| | |
|---|---|
| **Long-Term Care** | |
| Family Care and Similar Programs | $2,194.6 |
| Nursing Homes and Other Institutions | 791.2 |
| IRIS and Other Waiver Programs | 800.1 |
| Personal Care/Home Health | 258.3 |
| Subtotal | $4,044.2 |
| | |
| **Managed Care for Medical Services** | |
| BadgerCare Plus Managed Care | $1,630.3 |
| SSI Managed Care | 339.2 |
| Subtotal | $1,969.5 |
| | |
| **Fee-for-Service/Other** | |
| Hospitals (Excluding Access Payments) | $504.4 |
| Hospital Access Payments and Supplements | 893.4 |
| Professional and Clinic Services | 834.4 |
| Subtotal | $2,232.2 |

**So, we have many challenges but is there something to help me feel better?**
**YES!**

# 1997 BRC Recommendations: Financing & Organizational Structures

The Commission feels that the **mental health system's design and financing should:**

1. **Merge the three major sources of funding** for mental health services (State Community Aids, County Funds, and Medicaid) in order to provide comprehensive services for mental health treatment, recovery, and prevention and to assure that "**money follows the consumer.**"

2. **Integrate funding for institutional and community services** in order to encourage development of community-based service alternatives.

3. **Enhance incentives to encourage counties to reduce inpatient and nursing home care.**

4. **Maintain and build upon existing linkages between county mental health systems** and other county-coordinated human and "safety net" services, including child welfare, criminal justice, adult protective services, etc.

5. **Maintain and build upon local investments** in community mental health: county funding, county risk bearing, citizen involvement, and natural support networks.

6. **Develop improved data systems to guide decision making as changes in the mental health system are implemented.** Specifically, data needs include: the **per person cost of services funded by community aids, county tax funds, and Medicaid; consumer outcomes; and performance contract details**.

# Goals of the 2009 TMG Study

The goals or benchmarks used to measure the strengths and weaknesses of the Wisconsin system (as well as alternative state models) include:

**(A) equitable access** to service across the state;

**(B) accountability for outcomes**, including the availability of evidence-based programs and the information technology to evaluate outcomes;

**(C) equitable and affordable funding** for services; and

**(D) efficiency** of service delivery.

# TMG Findings in Executive Summary

- There are differences in eligibility and MH/SA benefits coverage among these various managed care programs and plans. While these distinctions exist among the managed care programs and plans, the **variations that exist between the managed care programs and the county-administered MH/SA services are much greater and more significant.**
- One of the study's key findings is that **Wisconsin appears to have two primary and very distinct publicly funded systems that serve individuals with MH/SA issues:** one is the **county-administered** service delivery system, and the other is the **system of Medicaid managed care programs.**

# TMG Findings in Executive Summary continued

- While service eligibility requirements and benefit requirements for the Medicaid managed care programs are clearly defined, specific and consistent, **county-based system service eligibility and coverage are not well defined** and are broad and subject to significant variation among counties. **This results in system complexity, inconsistency and fragmentation, and may lead to conflict between the two systems.**

# Most Recently – Early Phase of Strategic Planning

- Used Logic Model for Survey of WCMH
- What **Outcomes** do we want to see?
- What **Service System Improvements** –
    - **Tertiary** (more complex, higher Needs
    - **Secondary Care** – Outpatient, Easy Access
    - **Primary Prevention**
- What **Structural Improvements** (Funding Models, Workforce, Data/Accountability, Access based on Consumer Need, Not Program Availability)
- What **does the WCMH and the Committees need to achieve our mission?**

# WCMH Focus on Access and Equity

- **Funding**
  - Potential value of **Medicaid Expansion** – improve access
  - Role of **FQHCs** (largely Medicaid supported)
  - **August review of Block Grant for SAMHSA Application**
  - Additional Federal Dollars in **ARPA and Cares Act**
- **Central Role of *Community* for BIPOC**
  - Counties as Central to Chapter 51 but not adequately serving BIPOC consistently
- **Platform and Structural Barriers**
  - Some success with Office of Tribal Affairs
  - New DHS Office of Health Equity

# WCMH Focus on Access and Equity

- **Data / Quality Monitoring**
  - PPS Limitations – County Focused (Smaller Part of Public Funding)
  - Need for Data from Medicaid / PH / DCF / DOC / DSPS – Institutions)
- **Workforce**
  - Support for Local Organizations – e.g., those supporting training
  - AHEC / DSPS / CYC – Annapolis Model
  - BPTR support for Qualified Tx Trainee = QTT
- **Educational Equity** (Value of Culturally Informed Educators, addressing dyslexia and other learning disabilities)

**But if we work together, patiently, persistently.. things can change!**

# Minnesota MH Action Group Areas of Concern 2003-2007

- Provider Shortages
- Stigma
- **Lack of Equitable Access to Services Statewide** – Public Funding follows individual consumer needs and available across the state
- **Payments emphasize programs, not people**
- **Cost shifting -> develop model mental health benefit set**
- **Limited accountability** – establish outcomes for care
- System too complex – coordinate essential services
- Compromised student learning – integrate MH services and ED systems
- **Lack of coordination between public and private systems**

# With Your Support, We Will Have a Comprehensive System. Thanks!