State of Wisconsin
Department of Health Services

Scott Walker, Governor
Kitty Rhoades, Secretary

April 1, 2014

The Honorable Scott Fitzgerald
Majority Leader
Wisconsin Senate
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State Capitol
P. O. Box 7882
Madison, WI 53707-7882

The Honorable Robin Vos
Speaker of the Assembly
Wisconsin State Assembly
Room 211 West
State Capitol
P. O. Box 8953
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The Honorable Chris Larson
Minority Leader
Wisconsin Senate
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The Honorable Peter Barca
Minority Leader
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Room 201 West
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The Honorable Luther Olson, Senate Co-Chair
Joint Legislative Council
Room 319 South
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The Honorable Erik Severson, Chair
Speaker's Task Force on Mental Health
Wisconsin State Assembly
Room 221 North
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The Honorable Joan Ballweg, Assembly Co-Chair
Joint Legislative Council
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The Honorable Sandy Pasch, Vice-Chair
Speaker's Task Force on Mental Health
Wisconsin State Assembly
Room 119 North
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Dear Senator Fitzgerald, Speaker Vos, Senator Larson, Representative Barca, Senator Olson, Representative Ballweg, Representative Severson, and Representative Pasch:

Last fall, Representatives Severson and Pasch asked the Department to investigate the State of Iowa's recent mental health care system redesign for possible lessons for Wisconsin's own mental health reform efforts. The Department's report was to inform a possible Joint Legislative Council study about Iowa's experience.

Over the last several months, Department staff have researched the Iowa reforms and interviewed Iowa Department of Human Service staff, county officials, and legislative staff.

The Department finds that the Iowa reforms may offer guidance for Wisconsin, but it is too early in the implementation to draw conclusions. In addition, the Iowa system is different from Wisconsin in several key ways. Despite these differences, it would be beneficial to monitor Iowa's ongoing implementation to determine if it improves outcomes and achieves efficiencies. However, we believe Governor Walker's approach of providing counties incentives to regionalize their mental health delivery systems will prove more effective than Iowa's mandatory regionalization approach. Attached is the Department's report.

Please contact me if you have any questions about this report or would like to discuss it further.

Sincerely,

K. Rhoades

Kitty Rhoades
Secretary

Enclosure

Iowa Redesign of Adult Disability Services
Analysis by the Wisconsin Department of Health Services
April 2014

The Speaker's Task Force on Mental Health included in its Final Report the recommendation that a Legislative Council Special Committee be established to study Iowa's transition from a county-based to a regional public mental health system. Further, the Task Force requested that the Department of Health Services (DHS) undertake an investigation into the Iowa mental health care redesign and report back to the Legislature and the Joint Legislative Council Co-Chairs on its findings by March 2014. In the report, DHS is asked to state whether the department has been able to collect sufficient information to properly analyze and assess the Iowa transition. DHS submits this report to fulfill this request.

Department staff have researched the Iowa reforms by reviewing the large volume of written material available as well as interviewing Iowa Department of Human Service staff, county officials, and legislative staff. The Department finds that the Iowa reforms may offer lessons for Wisconsin, but it is too early in the implementation to draw conclusions. In addition, the Iowa system is different from Wisconsin in several key ways. Most significantly, Iowa already delivers mental health and substance abuse services to Medicaid enrollees through a state-wide health management organization, which continues under the reform legislation. The new county-based regional system will focus on serving non-Medicaid individuals only. By contrast, in Wisconsin, counties serve both Medicaid and non-Medicaid consumers and are important providers of Medicaid mental health services. Despite these differences, it would be beneficial to monitor Iowa's ongoing implementation of the regional delivery system for non-Medicaid individuals to determine if it improves outcomes and achieves efficiencies.

Background

During the 2011 Legislative Session, Iowa enacted legislation that included provisions to redesign the state's Adult Disability Services system, including the mental health system. Senate File 525 specified legislative intent of a system redesign to include: shifting the financial responsibility for the non-federal share of adult disability services provided under Medicaid from the county to the state; reorganizing the adult disability services system for non-Medicaid services from a county-administered system to a regionally-administered system that provides multiple local points of access to adult disability services regardless of funding (both Medicaid and non-Medicaid funded); changing the financial responsibility for publicly-funded services from the county of legal settlement to the county of residence; and meeting the needs of consumers of disability services in a responsive and cost-effective way. In addition, Senate File 525 established a workgroup process led by the Department of Human Services to inform the Mental Health and Disability Services committee in developing a redesigned system. Initial redesign legislation was developed through this process.

During the 2012 Legislative Session, Iowa enacted legislation to implement the redesign of the state's Adult Disability Services system. This legislation, Senate File 2315 and Senate File 2336, included changes to the administration and financing of publicly-funded adult mental health and disability services. The Adult Disability Services redesign included the following major provisions: 1) Regionally-

administered service system; 2) Required core service domains for non-Medicaid funded services; 3) Residence-based definition for county financial responsibility; and 4) State financial responsibility for the non-federal share of Medicaid adult disability services.

Regional Service System

Counties are required, under the redesign legislation, to form regions for the administration of adult disability services. Regions are required to have: at least three contiguous counties; at least one community mental health center or federally-qualified health center with providers capable of providing mental health services; availability of inpatient psychiatric services within reasonably close proximity; capacity to provide core services; and a regional administrator structure with clear lines of accountability. Regions are subject to Department of Human Services (DHS) approval. Counties can apply for exemption from the regional formation requirement. If the exemption is approved, however, the county must still comply with all requirements applicable to a region.

Specific requirements for regional governance, finances and development of a regional services management plan are also included in the legislation (Senate File 2315). Counties are required to provide core services as of July 1, 2013.

Core Services

The redesign legislation specifies non-Medicaid core service domains the regional service system is required to provide. These services include:

- Treatment services – assessment and evaluation, mental health outpatient therapy, medication prescribing and management, and inpatient mental health
- Basic crisis response – 24-hour access to crisis response, evaluation and personal emergency response
- Support for community living – home health aid, home and vehicle modifications, respite and supportive community living
- Support for employment – day habilitation, job development, supported employment, prevocational services
- Recovery oriented services – family and peer support
- Service coordination – case management and health home
- Sub-acute and crisis services – facility-based sub-acute services, as specified in the legislation, and community-based sub-acute services, and a crisis pilot.

Regions will provide additional core services when funding is available. These expanded core services include:

- Comprehensive crisis response – 24 crisis hotline, mobile response, and crisis residential services
- Sub-acute services – facility-based and community-based services
- Justice involved services – jail diversion, crisis intervention training for law enforcement, and civil commitment prescreening

- Evidence based practices – positive behavior support, assertive community treatment, and peer self-help drop in centers.

Eligibility for regional services is limited to adults (18 and over, with certain exceptions), who are non-Medicaid eligible or uninsured and are in need of mental health or intellectual disability services. A standardized assessment is used to determine eligibility for individual services.

Individuals with an income of less than 150% of federal poverty limit are not required to pay co-pays or other fees for services. Individuals with incomes above 150% of federal poverty level may receive services with approved co-pay and sliding fee schedules. In addition, individuals must meet resource limitation rules and if eligible for federally funded services or other support, apply for that support.

The legislation states the intent to evaluate providing services to individuals with developmental disabilities and brain injury in the future. A region may provide assistance to other disability service populations subject to available funding and can implement waitlists for services as a financial management tool.

Residency

The redesign legislation changed the county financially responsible for publicly-funded services from the county of legal settlement to the county of residence. This change includes individuals who are homeless. Individuals maintain residency in the county in which they last resided when receiving services in a different location, such as a hospital or nursing facility among other locations. This includes individuals from out-of-state. This change was made throughout Iowa Code.

State funding of Medicaid services

The redesign legislation directed the state to assume financial responsibility from the counties for the non-federal share of certain Medicaid services including: the Intellectual Disabilities Waiver, Habilitation Services, Intermediate Care Facilities for Individuals with Intellectual Disabilities, and State Resource Centers. Services previously covered by counties cost the state $240.9 million in FY 13.

To fund this shift in Medicaid costs to the state, Senate File 2336 redirected $190.0 million in existing funding previously distributed to counties and appropriated an additional $50 million in new GPR for this purpose. The state did, however, appropriate $11.6 million in supplemental funding to 26 counties that needed additional funding for services in FY 13.

Senate File 2315 also created a new county mental health tax levy and established a method to equalize non-Medicaid service funding across counties. The mental health levy was set at the existing county levy total of $125.8 million and then converted into a per capita rate of $47.28. Counties whose per capita tax levy was above the new limit were required to lower their levy to the new rate. Counties whose levy was below the per capita limit would receive equalization payments from the state to reach the per capita rate. Equalization payments of $29.8 million were made to 54 counties in FY 14; 45 counties were required to lower their levy limit by a total of $10.8 million. The legislation enacted this

funding system for two fiscal years, FY 14 and FY 15. Unless acted upon by the legislature and Governor the measure will be repealed at end of FY 15.

Analysis

The Iowa legislation makes changes to a state mental health system very different from the one in Wisconsin, in several respects. Because of these important structural differences in how services are delivered and funded, and the array of services available to individuals with mental illness, it is challenging to evaluate Iowa's redesign efforts in the context of Wisconsin's mental health system.

First, mental health services in Iowa remain part of a larger adult disability services system, which includes long term care services for individuals with intellectual and developmental disabilities. The reform converts the funding for the non-federal share of Medicaid services to this population from county funded to state funded. Wisconsin already funds these long term care services at the state level through the Family Care or IRIS programs in most counties.

Table I: Iowa Adult Disability System

	Pre-Reform		Reform
	Mental Health	Intellectual Disabilities	Mental Health/Intellectual Disabilities
Medicaid	Magellan (MCO) State funded	County match State pay Private service delivery	County no longer involved
Non-Medicaid	County pay County funded	County pay County funded	Funding equalized Required regionalization Uniform benefits package

Service Delivery

Mental health services in Iowa are delivered through a managed care organization or through county/region-contracted providers depending on whether the service is provided under Medicaid or non-Medicaid core benefits. Medicaid-funded mental health services in Iowa are "carved out" from other physical health care services provided under Iowa's Medicaid program and are administered through a single managed care company, Magellan Behavioral Healthcare of Iowa. Non-Medicaid mental health services are administered by regions in Iowa. Regions in Iowa serve an administrative and care management role in the delivery of non-Medicaid funded mental health services. Regions contract with providers to provide mental health services to individuals not enrolled in Medicaid.

In Wisconsin, Medicaid-funded mental health services are included in the overall health care benefits provided under the state's Medicaid programs, both through fee-for-service and managed care payment methods. Wisconsin state law provides that counties have legal and financial responsibility for the mental health needs of their residents and state Medicaid policy recognizes that responsibility. As such, counties are an integral part of the mental health service delivery system serving as providers to Medicaid eligible and non-Medicaid populations, in addition to performing other administrative and

care coordination functions. Counties in Wisconsin contract for services as well, but are often a main provider of services in the county.

Funding

Under the reform, mental health services in Iowa are funded by Medicaid for Medicaid enrollees and county mental health tax levy for non-Medicaid enrollees. Services provided under Medicaid are funded by federal dollars, with the non-federal share of expenses funded by the state of Iowa. Non-Medicaid mental health services are funded by an equalized per capita county mental health tax levy. The reform legislation designates funding generated by the levy is to be used to provide legislatively-prescribed core mental health benefits, with exceptions.

In Wisconsin, the non-federal share of Medicaid-funded mental health services can be the responsibility of either the state or county. Non-Medicaid services are county-funded, predominately using Community Aids allocations from the state and/or county tax levy. Each county is able to tailor the level of funding and array of services, with some exceptions, to meet the mental health needs of its residents.

Iowa's new per capita funding mechanism will sunset in FY 2015 without legislative action, creating uncertainty in the source and level of funding regions will have available to provide non-Medicaid core mental health services. Enacting a similar funding mechanism in Wisconsin, where counties both fund and provide mental health services, could destabilize not only funding but the provision and availability of services in the state's mental health system.

Community-Based Mental Health Services

It appears that Iowa provides a less robust array of mental health services than Wisconsin in many respects. Medicaid-funded services in Iowa do not include the flexible package of wrap around services provided in many counties through psychosocial rehabilitation programs such as Wisconsin's Comprehensive Community Services (CCS) and other services such as crisis intervention. Iowa's non-Medicaid core services, those required to be provided by regions, are already provided by Wisconsin counties. Expanded core services, those services that will be provided by Iowa regions once funds become available, include services many Wisconsin counties already provide, such as mobile crisis, crisis intervention training, and peer based recovery centers.

While access varies across the state, Wisconsin provides a comprehensive array of mental health services through Medicaid and county-funded services. Community mental health services provided in Wisconsin include Crisis Services, Community Support Programs (CSP), Comprehensive Community Services (CCS), Community Recovery Services (CRS), Targeted Case Management, and mental health outpatient services. These programs provide a continuum of community mental health services available to treat the full range of acuity of mental health diagnosis and functional limitations for individuals. Providing services in the community decreases the likelihood that an individual will require more costly, intensive services such as those provided at the state mental health institutes and through crisis services, resulting in savings to counties and decreases in utilization of inpatient and other acute health services, including Medicaid services.

Summary

Untreated mental illness can have wide ranging consequences, including poorer employment and educational outcomes and higher demands on the criminal justice, correctional, juvenile justice, child welfare, and primary and acute health care system. Access to mental health services, including psychosocial rehabilitation services, can ameliorate these negative outcomes and reduce costs.

Iowa's redesign of its adult disability system, including the mental health system, addresses issues related to service access, funding and administrative structure by establishing core mental health benefits, equalizing county mental health funding through a per capita-based county mental health levy and state assumption of the non-federal share of Medicaid service costs, and requiring regionalization of counties. Wisconsin has utilized regional models across a number of human service programs administered by counties to create administrative and service delivery efficiencies. Unlike Iowa, the geographic organization of regions varies between these programs. Allowing counties to collaborate in different regions for different programs may provide more opportunities to leverage county and community resources and improve service delivery while maximizing administrative efficiencies.

The 2013-15 Biennial Budget adopted the Governor's initiative to fund the non-federal share of CCS costs in an effort to expand CCS statewide and increase consumer access to community mental health services. CCS, like many other mental health services provided by counties, are Medicaid reimbursable services where counties are the sole providers of the service through the Wisconsin Medicaid program. The relationship between the state Medicaid agency and counties as Medicaid providers of a comprehensive array of psychosocial rehabilitation services does not exist in Iowa. In Iowa, the county-state relationship with respect to its adult disability and mental health is limited to the funding of services rather than the service delivery system. As a result, Wisconsin counties are more involved and invested in the delivery of Medicaid and non-Medicaid mental health services and currently maintain a more robust service delivery system. Efforts to compare Wisconsin to regional reforms in other states should consider the further complexity presented by integrating service delivery in addition to funding and administration into regional approaches for mental health service delivery

For example, under the Governor's proposal Wisconsin counties are not required to provide CCS, but can choose to adopt regional CCS models to receive the non-federal share of costs. This approach is more incentive based than the mandated approach used in Iowa. The Department only requires that regions satisfy certain requirements, and counties and tribes can work within these broad requirements to provide CCS through a region to their residents. Counties that have expressed interest in providing CCS on a regional basis represent over 94% of the Wisconsin population. Allowing counties and tribes the flexibility to provide mental health services regionally based on county needs, resources and existing relationships, while ensuring through broad requirements that individuals are appropriately assessed, that a full array of services is available, and that service quality and consumer outcomes are monitored and improved likely represents a regional system better positioned to meet the needs of mental health consumers by strengthening relationships among counties and between the county and state.

Iowa's mental health system redesign has included changes to the funding, administration and available service array to ensure statewide access to services with adequate funding and an efficient administrative structure. These goals are shared by Wisconsin. In fact, Wisconsin counties are in the process of piloting regional administrative and service delivery structures for the provision of mental health and substance abuse services. DHS has engaged two groups of counties (Lacrosse-Jackson-Monroe, and Chippewa-Buffalo-Pepin) that are developing regional service systems for a defined set of mental health and substance abuse benefits. DHS provided these regional pilots with three year planning grants which began in 2013. The grants support a regional service infrastructure and administration that assures core benefits are available to all eligible citizens in the service area. DHS is working with the regional pilots to measure performance and outcomes. Following are the outcomes being measured:

- Equitable and affordable funding for services; including per capita expenditures and average expenditures per client
- Equitable access; documented capacity to provide core benefits, number of people served, wait times between request for service and initial contact
- Efficiency of service delivery; use of community services versus inpatient service, number of emergency detentions, number of detoxification placements
- Improvement in system outcomes; demonstrated financial savings, sustainability of shared services design, consumer involvement
- Improvement in consumer clinical and functional outcomes; consumer satisfaction, aggregate clinical outcomes (i.e. improvement in symptomology, living arrangements, discharge status, etc.).

Based on the outcomes of the two regional pilots, DHS will consider expanding regional service systems through additional grant opportunities and/or technical assistance to interested counties.

Wisconsin has recently assumed funding of the non-federal share of the Medicaid psychosocial rehabilitation services program CCS to expand statewide service access. Counties are required to form regional partnerships in the provision of CCS in order to access the non-federal share from DHS. This effort is supporting greater regionalization of services across the state. As of this writing, sixty two counties have signified intent to provide CCS in regional services systems.

Iowa is still in the process of implementing all aspects of the legislated redesign of its adult disability system. Certain aspects of the redesign have yet to be implemented and it is too early for any outcome data to be available for any implemented changes. It is likely there will be aspects of Iowa's redesign that will be instructive to other states, including Wisconsin, that are looking to improve their mental health and substance abuse services systems. However, in the absence of full implementation and outcome data, it is too early to determine whether Iowa's system redesign will achieve its goals or whether Iowa's experience can inform changes to the mental health and substance abuse service system in Wisconsin.