

Mental Health Funding and Access to Services – August, 2008

Briefing Paper for Secretary Karen Timberlake

Introduction:

For a number of years the Wisconsin Council on Mental Health (WCMH) has identified public sector mental health funding among its legislative priorities. However, attempts to enhance funding through the budget process or through separate legislation have not been successful. In its advisory role to the Department of Health Services (DHS), the WCMH in collaboration with the Wisconsin Counties Human Services Association has developed this briefing paper documenting the current status of public sector funding, the implications for various stakeholders and suggested solutions. It is our hope that this paper can serve as the basis first for dialogue and then for action by the DHS to begin to address the problems that we believe are clearly portrayed in this paper.

I. The Problem: Access to Appropriate, Effective Mental Health Care is Declining

There are numerous reports from around the state about problems people are having accessing community-based mental health services. (See attached letters from La Crosse County Department of Human Services and from the Mental Health Center of Dane County.) According to the DHS' annual community support program (CSP) monitoring report, in 2006 at least 230 persons were on waiting lists for CSP. Persons leaving correctional facilities have major problems in obtaining psychiatric and other services. The Medicaid benefit Comprehensive Community Services (CCS) is not available in all major counties and is available in only 22 out of the 72 counties currently. The FFY 2008-2009 Adult Mental Health Plan projects a 2.8% decrease in access to adult mental health services. [Note: This information does not include data for persons enrolled in Family Care or a Medicaid managed care program.]

Children with emotional disturbances and their families also have significant problems in accessing mental health services. Currently only 42 out of 72 counties have Integrated Service Programs or Coordinated Service Teams to serve children with serious emotional disturbances. The FFY 2008-2009 Child Mental Health Plan reported that access to mental health services for children and their families decreased 14.3% in FFY 2007. [Note: This information does not include data for children enrolled in a Medicaid managed care program.]

A recent study by the Wisconsin Counties Human Services Association further documents access issues across services and age groups (see full survey summary in Attachment 1). With 24 counties reporting (mostly medium to small counties geographically representing all regions of the state and not including Dane or Milwaukee) at least 684 people were waiting for services, with the largest number waiting for psychiatric services and individual, family, couples or group therapy. 72% of those waiting for any service were age 18-59.

The data here on access to psychiatry services is further supported by a recent report to the Children and Youth Committee of the Wisconsin Council on Mental Health. This report found that Wisconsin is one of 35 states with less than the national average of child/adolescent (C/A) psychiatrists. Further, with 8.2 C/A psychiatrists per 100,000 youth Wisconsin is well below the modeled number required from optimal care for 14.4 per 100,000.

II. Funding system: Trends in three major funding sources –Medicaid, Community Aids, County Tax Levy—put increasing strain on local levy.

A. Medicaid

Wisconsin funds a wide array of mental health services in its Medicaid program. However, the following services require county matching funds instead of state match from GPR: community support programs (CSP), crisis intervention, comprehensive community services (CCS), targeted case management, some of the children’s long-term support waiver slots and in-home treatment for adults. These are the services targeted to persons with the most serious mental illnesses.

Other mental health services, such as outpatient psychotherapy and psychiatry services, are state-matched but access problems exist due to reimbursement levels which continue to be well below what is available from other payers. There was a recent rate increase for psychiatrists; the effect on access to care will need to be monitored to determine if it has a positive impact. However, even with this rate increase the Medicaid rate is believed to be less than half of what is paid by private payers.

Until the approval of the Community Options and Recovery (COR) waiver and the Money Follows the Person grant, waiver services have not been available for adults in the target group of mental illness (Note: The Children’s Long-Term Support Waiver program does serve some children who have a serious emotional disturbance (SED)). Persons with mental illness and co-occurring developmental disability, physical disability or infirmities of aging have been served through the existing community-based services waivers but the packages of services have not been designed to meet their needs.

Through the SSI Managed Care initiative many persons with mental illness are now receiving their health care services through HMOs. However, the county matched mental health services have remained fee for service, thus causing coordination of care issues.

B. Community Aids

Community Aids, state funding to the counties for human services, funds services for the following target groups: mental illness, substance abuse, developmental disabilities, physical disabilities, elderly, child abuse and neglect, juvenile delinquency, and children and families. Thus, persons with mental illness are just one group that receives funding from this source.

The change to the Community Aids Basic County Allocation is difficult to measure over time as some of these funds have been “carved out” to the Bureau of Milwaukee Child Welfare and the Family Care pilot counties. A report by the Wisconsin Counties Association suggests that since

1986 the gap between actual state funding of community aids and what would have been available with inflationary increases is about \$185m. They note that between 2005 and 2006 alone while community aids remained flat funded county tax levy for human services increased from \$394m to \$416m. (see Attachment 2). Since costs for health care have increased and since in many areas demand has increased as well, community aids covers a shrinking share of human service costs. This also means that less money is potentially available for mental health services. This has caused significant problems for counties since this is one of the funding sources they use for match for the Medicaid mental health services that require county match. In many cases this has led to lack of availability of services to which people are entitled.

The upcoming redirection of Community Aids funds for Family Care expansion and the new Department of Children and Families may further affect the availability of Community Aids to fund mental health services.

C. County Tax Levy

In 2005, counties provided \$113,634,682 in tax levy funds for mental health services for over 97,000 people; this amounted to 30.83% of the funding for mental health services provided through the counties. Counties provided more tax levy funding for mental health services than for any other disability group. For example, the tax levy for developmental disabilities was \$71,075,396; for delinquent youth it was \$68,676,955; for the elderly it was \$26,105,804.

The required county match for the Medicaid services requiring match is currently \$35,476,543. the majority of this being for community support programs and crisis intervention. However, this does not include the local overmatch that is provided for some of these services or the cost to serve those individuals who are not Medicaid eligible.

The requirement for county match for Medicaid mental health services, the decreases in Community Aids, and the lack of availability of waivers for this population has led to this very significant county use of property tax funds for mental health services.

Additionally, it should be noted that the mental health system is impacted by all target groups served by the county. If a person who has a developmental disability, degenerative brain disorder (e.g., dementia), substance use disorder, exhibits challenging behaviors and requires an emergency detention/inpatient psychiatric hospitalization or crisis services, the funding for the services comes from the mental health system, irrespective of the person's diagnosis. Given that the number of persons who experience dementia will increase significantly in the next several decades, the need for mental health services, particularly crisis and inpatient services, and funding for persons from other target groups will increase significantly.

III. There are a Number of Adverse System Consequences Created by the Current Funding Structures

The lack of state match for Medicaid funded mental health services and the reliance on county tax levy has a number of adverse consequences.

- It contributes to inequities in availability of services across the state; the willingness and ability of the county to provide funding determines whether individuals in a particular county will have access to needed services.
- It has created a problem in many counties as they have met their tax levy limits. Once these limits are met, no more funding may be available for mental health or any other county provided services.
- It has created a ceiling for the county matched services. This has been a particular problem for CSP where waiting lists exist, even for persons who are entitled to receive the service under Medicaid. There are also concerns about how it will impact the ability of counties to take advantage of new state funding for the children's long-term support waivers.
- It has led to reluctance of some counties to become involved in the Comprehensive Community Services benefit. Dane and Milwaukee Counties have refused to participate to date in large part due to concerns about having to provide the matching funds for a program which persons meeting the eligibility requirements may be entitled to receive. In the long run, this may create problems for the state in meeting the Medicaid statewideness requirement.
- It impedes the development of managed care programs. Because of the dollars involved in providing the state match, CSP, CCS, and crisis services have remained fee for service in the areas where managed care is being provided for persons on SSI. This creates potential duplication of services or coordination of care problems. When the state tried to develop a mental health managed care system in the late 1990s, the effort was thwarted in part due to the large amount of county funding and the achievements of the county mental health system in reducing institutional costs for the Medicaid program resulting in projections of low capitation rates.

IV. The Current Funding Structures Result in Persons with Mental Illnesses Using More Costly or Inappropriate Services and Systems

If persons with serious mental illness do not receive adequate and effective community based services, they frequently end up using services that are more costly, such as inpatient mental health services at a state mental health institute or other hospital, or are in other parts of the human services systems not designed to meet their needs, including the child welfare or corrections system.

A. Inpatient services

Inpatient civil admissions at the two state mental health institutes have gone from 2,204 in 2004 to 2,682 in 2007. For the past two years, the adult units have been over 90% capacity for all but one month; many months have been over 100% capacity. This increased inpatient utilization has contributed to a county request for funding for inpatient care in 2007 Assembly Bill 509.

Medicaid funded inpatient episodes for youth and adults have risen from 6,893 in 2003 to 7,403 in 2006, an approximately 7% increase.

According to a report by Wisconsin Family Ties mental health hospitalization rates for Wisconsin children increased by 17% between 1997 and 2003.

B. Impact on Corrections

The Department of Corrections estimates that approximately 28% of its inmates have mental illnesses requiring treatment. This has led to significant increases for the need for mental health staff including a new facility for women with mental illness. Persons with mental illness who are released from prison tend to return within the first two years; 56% are back in a correctional facility within 5 years. However, if adequate community treatment and support were provided this number could be significantly reduced. This has been the experience with the DHS' conditional release program that serves persons who have committed a crime but were found not guilty due to mental disease or defect.

While Wisconsin does not have data on the number of persons with mental illness in county jails, national estimates are that 64% have mental health problems. Of these individuals 74% have a co-occurring substance abuse problem.

C. Impact on Family Care and Partnership Programs

Persons with mental illness make up approximately 40% of the persons being served through Family Care; the percentage is higher for Partnership participants. They are higher utilizers of residential and institutional services than those without mental illness being served in these programs and thus cost approximately 35% more. This may be due to lack of adequate community mental health services in these programs as well as in the county system in general.

D. Impact on Children's Services

National studies indicate that 50% of children in the child welfare system have mental health problems. Wisconsin is in the process of piloting a screening program to gather this data from county child welfare programs. A Wisconsin study of parents of children involved in county child welfare services found that 40% have mental illness.

The Department of Corrections reports that 44% of the boys at Lincoln Hills School and 56.5% at Ethan Allen School and all of the girls at Southern Oaks Girls School are seen by clinical services twice a month or more. 36% of the boys at Lincoln Hills, 26% at Ethan Allen and 78% of the girls at Southern Oaks are receiving psychotropic medications. In addition there are

specialized mental health programs for boys at the Mendota Juvenile Treatment Center and for girls at Southern Oaks.

According to the Wisconsin Department of Public Instruction 56% of children with serious emotional disorders do not graduate from high school, the highest percentage of any disability group.

V. Possible Solutions

There are a number of potential solutions to address the issues identified in this paper. While some may not require new GPR funds it is unreasonable to believe that significant progress can be made addressing the current inequities without the infusion of new state dollars. These dollars cannot come from other sources that currently fund mental health or disability services.

A. The following are the solutions that we see as having the highest probability of directly addressing the current burden that counties are experiencing and, as a result, enhancing access to community-based services. However, in order to result in enhanced access it would be beneficial for some or all of the savings from implementation of any of these solutions to be retained in the mental health system. The mechanism for doing this while appropriately balancing this goal of increased access with county needs for flexibility would have to be subject to further discussion. The fact that most counties have been willing to “take up the slack” to date provides some level of assurance that this is achievable.

- 1) State pick up of the county match for CCS, CSP, crisis services, targeted case management, and in-home treatment for adults.

Options for implementation:

- Pick up the entire county match; require counties to use saved funds for mental health services
- Phase in over time, for example, state picks up increasing % of the match as was done with the Family Care program in the last budget; require counties to continue to use saved funds for mental health services.
- Freeze county contribution with state picking up future match; require counties to continue to use funds for mental health services.

Picking up 25% of the current county contribution would require about \$9m. GPR.

- 2) Eliminate Wisconsin Medicaid Cost Reporting (WIMCR) and return to Community Services Deficit Reduction Benefit (CSDRB) so that counties instead of the state receive the federal funds for mental health services with a requirement that counties use the funds to provide mental health services.
- 3) Pursue a 1915(i) Medicaid state plan amendment to fund mental health services. This program permits states to offer certain home and community-based services to eligible

persons as an optional benefit under the State Medicaid Plan. Persons served under this program do not need to meet an institutional level of care threshold; instead, individuals must meet the needs-based criteria established by the State, in addition to the financial eligibility criteria prescribed by federal requirements. As part of the benefit, the state must conduct independent eligibility determinations and assessments and provide individualized plans of care. This is not an entitlement program and can be limited by total enrollees and geographically.

Options for implementation:

- Milwaukee County only.
- Other counties.
- All counties.

In order to ensure that this option best meets the needs of consumers, providers and counties it is critical that there be strong stakeholder involvement in development of the state plan amendment and the benefit.

Funding: While we have made the argument in this paper that the current state match requirements are increasingly onerous to counties, counties recognize that because there are services that can be covered under this state plan amendment that are not currently covered under Medicaid they can draw down federal revenue to replace current county expenditures. Additionally, the ability to limit slots allows counties to manage the program within available resources without the risks imposed by an open-ended entitlement. Therefore 1915(i) can feasibly work as a county-matched program. However, the preference would be to have a combination of state and county funded slots as is done in other waiver programs.

- 4) Address the costs associated with county use of the State Mental Health Institutes for adults. As psychiatric beds in non-State facilities decline, counties are often forced to rely on Institutes to provide services. The goal is to eliminate the burden, especially on smaller counties but present for all counties, which these hospitalizations can create without setting up a system that removes incentives for continuing to develop and provide community based services, when appropriate. Some possible ideas include:
 - a) Require mental health institutes to bill Medicare directly for eligible individuals and accept reimbursement as full payment for services.
 - b) Require mental health institutes to bill counties the average Medicaid reimbursement rate with GPR funds covering the difference between this amount and the cost of care.
 - c) Develop a mechanism for sharing risk/costs associated with individuals requiring long stays at the Institutes.

B. The following solutions represent more targeted approaches to enhancing access to community-based services that would have a direct fiscal impact.

- 1) Develop and fund a pilot re-entry program for persons with mental illness leaving state prisons or WRC, based on the Conditional Release Program. The cost would depend upon the size of the pilot program.
- 2) Increase funding for children's mental health programs as proposed in 2007 Assembly Bill 700. These increases phase in funding to counties and tribes that do not currently have coordinated service teams and provide funds for training and technical assistance and peer advocacy. AB700 allocated \$1.5m for this initiative.
- 3) Increase reimbursement for psychiatry services to more closely approximate reimbursement under private insurance coverage. Psychiatry services are extremely difficult to find in many areas of the state, and in many of those there is no real choice of providers for Medicaid recipients.

C. The following solutions are not primarily fiscal but may have fiscal impacts.

- 1) Improve mental health services in Family Care and Partnership. Over 40% of individuals in these programs have mental illnesses. Requirements for specialized mental health services, providers, and training must be included in the Family Care contracts.
- 2) Explore expanding Family Care eligibility to include persons with serious and persistent mental illness.
- 3) Increase use of peer supports and informal supports, including reimbursement for peer support services under Medicaid.
- 4) Enact Mental Health Parity for private insurance in Wisconsin.
- 5) Allow greater regionalization of services such as CCS.
- 6) Expand use of telehealth to address psychiatric services in rural areas and for specialized populations (children, elderly).

ATTACHMENT 1

Numbers by Age - Waiting for Any Type of Mental Health Services 24 Counties Reporting

	# of Counties reporting	Under age 17	18 –59 yrs of age*	Over age 60*	TOTALS
Community Support Program	7		77	6	83
Comprehensive Community Services	5	38	7 10-25*	2	47
SED Waivers - CLTS	4	48	1		49
Day Treatment Services		1			1
Psychiatric Services	9	53	229	3	285
Individual, Family, Couples and Group Therapy Services	7	41	149	7	197
Psychological Testing	2	16	3		19
Wrap-Around	1	3			3

Additional Comments:

- Psychiatric Services are 6-12 week wait for clients who were detained and 4-6 months for all others.
- Don't keep wait lists but 6-8weeks to see psychiatrist
- Psychiatrist is capped for admissions –so unknown waiting
- Psychiatrist not taking new intakes
- Scheduling for outpatient 1 month out and for psychiatrist 5-6 weeks
- Psychiatrist not taking any new clients other than emergencies-outpatient clinic appointments 6 to 8 weeks out for scheduling.
- Counties reporting no wait list for any services 14

*Pending certification of CCS program

Number of Inpatient Hospitalization by Age Group

2006 or 2007 Data	Under age 22	22-64 yrs of age	65 – plus	All Other Counties Reporting in Aggregate	Totals
Total Inpatient Hospitalizations	688	2808	125	266	3887
Number of Emergency Detentions or Involuntary Commitment Orders	655	1874	139	1792	4460

Dollars Spent by Age Group*

2006 or 2007	Under age 22	22-64 yrs of age	65 and over	Aggregate only data	TOTALS
	523,101 (8 counties)*	5,175,720 (9 counties)*	14,159 (4 counties)*	9,140,097 (13 counties)*	14,853,077

*Counties vary in how they track data i.e. some counties reported on child/adult, some reported on all three age categories and some counties only reported total dollar expenditures.

Comments:

- For children’s crisis the formula for funding needs to increase to provide an incentive to serve children in the community.
- For adults we have not had waiting lists however we are studying how to limit services and how to evaluate who we serve in order to use our funds to support those at most risk as our priority.
- Access to Mental Health services in rural northern Wisconsin is extremely difficult to provide to area residents. Current contractual provider may reduce or eliminate contract.
- Long waits for appointments leads to an increase in emergencies.
- There are few providers specifically trained in children’s services. No child psychiatrist available.
- Increased prescription of psychotropic medications for children, including by family physicians.
- Our region is lacking in inpatient beds for both adults and children.
- Very short of psychiatrists as a result increase in Emergency Detentions.