Health Services

Institutions and Mental Health

(LFB Budget Summary Document: Page 232)

LFB Summary Items for Which an Issue Paper Has Been Prepared

Item #	Title
3, 5 & 7	Contracted Mental Health Services and Institutions Reestimates (Paper #375)
9	Mental Health Crisis Service Grants and Emergency Detention Procedures (Paper #376)
10	Consolidate Community Mental Health Programs (Paper #377)

Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

---

May 12, 2015 Joint Committee on Finance Paper #375

Contracted Mental Health Services, and DHS Institutions (Health Services -- Institutions and Mental Health)

[LFB 2015-17 Budget Summary: Page 233, #3, Page 234, #5, and Page 235, #7]

CURRENT LAW

Contracted Mental Health Services

The Department of Health Services (DHS) contracts with organizations to provide competency examinations for individuals that have been charged with a crime, and treatment for persons for whom a court has determined are not competent to stand trial. In addition, the Department contracts with organizations and the Department of Corrections to provide treatment and supervision of persons committed as sexually violent persons (SVPs) under Chapter 980 of the statutes or persons who have been found not guilty of a crime by reason of mental disease, either directly following the court's finding or following release from one of the state's mental health institutes. The costs of these contracts are typically budgeted based on caseload and cost projections. The following paragraphs describe the different types of contracted services.

Outpatient Competency Examination. Chapter 971 of the statutes prohibits courts from trying, convicting, or sentencing an individual if the individual lacks substantial mental capacity to understand the proceedings or assist in his or her own defense. Courts may order DHS to conduct competency examinations, which may be performed either on an inpatient basis by DHS staff at the state mental institutes, or on an outpatient basis in jails and locked units of other facilities by contracted staff. This item would increase funding for contracted examinations.

Treatment to Competency Services. DHS contracts with a vendor to provide outpatient treatment services to individuals who are determined to be not competent to proceed to a criminal trial if a court determines that the individual is likely to be competent within 12 months, or the maximum sentence specified for the most serious offense with which the defendant is charged.

Conditional Release Services. The conditional release program provides treatment to individuals who have been found not guilty by reason of mental disease or defect and are either immediately placed on conditional release following the court's finding, or following release from one of the state's mental health institutes. DHS contracts with five organizations, each of which provides services in one of five regions of the state, to provide these services.

Supervised Release Services. The supervised release program provides community-based treatment to individuals who are found to be sexually violent persons (SVPs) under Chapter 980 of the statutes. SVPs are committed to DHS and provided institutional care at the Sand Ridge Secure Treatment Center in Mauston, but may petition the court for supervised release if at least 12 months have elapsed since the initial commitment order was entered, the most recent release petition was denied, or the most recent order for supervised release was revoked.

Corrections Contract Costs for Supervision. DHS contracts with the Department of Corrections to supervise individuals on conditional and supervised release, and to provide escort and global positioning system (GPS) services to individuals on supervised release.

Base funding for these contracts is $10,729,200 GPR.

Department of Health Services Institutions

DHS operates seven residential institutions, including the three state centers for persons with intellectual disabilities (Central, Northern, and Southern), the state's two mental health institutes (Mendota and Winnebago), the Wisconsin Resource Center (WRC), and the Sand Ridge Secure Treatment Center (SRSTC). Funding to support food costs and variable non-food costs (medical care, drugs, clothing, and other supplies) at these residential institutions are typically budgeted based on population projections and recent cost trends. The funding source for these costs is assigned to GPR and PR appropriations, depending upon the mix of residents. GPR funds services for forensic residents at the mental health institutes and for residents at the WRC and SRSTC, while PR, primarily derived from county payments and Medicaid reimbursement, supports the cost of care for residents who are civil commitments at the mental health institutes, as well as residents at the state centers for persons with intellectual disabilities.

Base funding for variable non-food costs at the facilities is $20,865,000 GPR and $6,680,600 PR, while base funding for food costs is $2,434,600 GPR and $1,176,800 PR.

GOVERNOR

Contracted Mental Health Services. Increase funding by $2,011,100 GPR in 2015-16 and $3,370,400 GPR in 2016-17 to fund projected increases in the costs of competency examinations, restoration to competency treatment, conditional release, and supervised release services for mental health clients served by DHS facilities.

Supplies and Services at DHS Institutions (Variable Non-food). Reduce funding by $1,050,200 (-$2,362,300 GPR and $1,312,100 PR) in 2015-16 and increase funding by $2,107,200 (-$253,100 GPR and $2,360,300 PR) in 2016-17 to reflect estimates of the cost of

providing non-food supplies and services for residents at DHS facilities.

Food at DHS Institutions. Reduce funding by $23,100 (-$90,200 GPR and $67,100 PR) in 2015-16 and increase funding by $95,100 (-$17,600 GPR and $112,700 PR) in 2016-17 to reflect estimates of the cost of providing meals for residents in the 2015-17 biennium.

DISCUSSION POINTS

1. This paper provides a reestimate of contracted mental health services costs, and variable non-food and food costs at DHS institutions. Reestimates are based primarily on updated population and caseload projections.

2. In developing a reestimate of contracted mental health services, the administration relied on caseload trends from the past several years for the various contracted services. Several more months of caseload data is now available for conditional release and supervised release services, allowing for a reexamination of the costs associated with these contracts. The administration's estimates for the supervised release caseload still appear reasonable. However, recent trends in the number of individuals placed on conditional release suggest that the caseload projections for the 2015-17 biennium are too high. The administration assumed that the conditional release caseload would increase from 313 in 2013-14 to 329 in 2014-15 and to 345 and 361 in the two years of the biennium. Through March, conditional release caseload in 2014-15 is down slightly from 2013-14 and so a downward revision in the 2015-17 estimates is warranted. From the current caseload of approximately 312, the condition release caseload is now projected to grow to 324 in 2015-16 and to 336 in 2016-17. This adjustment reduces estimated contractual costs by $377,300 GPR in 2015-16 and $458,500 GPR in 2016-17.

3. Based on more recent population data, some revisions to the non-food and food costs at the DHS institutions are warranted. Population increases at the WRC and the SRSTC have exceeded the administration's previous estimates and will have the effect of increasing costs. These increases are offset slightly by downward population adjustments at the mental health institutes. In addition, the population at the Southern Wisconsin Center is revised downward slightly. The following table compares the budget population estimates at each of the institutions with the updated estimate.

Comparison of Population Estimates at DHS Facilities

	Bill Estimate		Current Estimate		Difference	
Facility	2015-16	2016-17	2015-16	2016-17	2015-16	2016-17
Mendota Mental Health Institute	303	303	300	300	-3	-3
Winnebago Mental Health Institute	207	215	205	215	-2	0
Wisconsin Resource Center	371	380	385	385	14	5
Sand Ridge Secure Treatment Center	353	353	367	373	14	20
Central Wisconsin Center	240	240	240	240	0	0
Northern Wisconsin Center	13	13	13	13	0	0
Southern Wisconsin Center	147	147	144	144	-3	-3
Total	1,634	1,651	1,654	1,670	20	19

4. In addition to the population reestimate, an adjustment to medical costs at the Northern Wisconsin Center is warranted, to more closely align the rate of increase to estimates for other supplies and services. This adjustment reduces the estimated PR funding requirements.

5. The combination of population adjustments and the adjustment to the medical cost inflationary increase results in the following funding changes: (a) increases of $330,100 GPR in 2015-16 and $424,300 GPR in 2016-17 and decreases of $312,500 PR in 2015-16 and $954,600 PR in 2016-17 for variable non-food costs; and (b) increases of $42,900 GPR in 2015-16 and $41,100 GPR in 2016-17 and decreases of $8,500 PR in 2015-16 and $8,700 PR in 2016-17 for food costs.

6. The following table summarizes the fiscal estimates discussed in the previous points by item and fund source.

	2015-16	2016-17
GPR		
Mental Health Contracts	-$377,300	-$458,500
Variable Non-Food	330,100	424,300
Food	42,900	41,100
GPR Total	-$4,300	$6,900
PR		
Variable Non-Food	-$277,200	-$917,200
Food	-8,500	-8,700
Total	-$285,700	$925,900

MODIFICATION

Make the funding modifications as shown in the table under Point #6 above to reflect reestimates of the cost for contracted mental health services and variable non-food and food costs at DHS institutions.

	Change to Bill
GPR	$2,600
PR	- 1,284,300
Total	- $1,286,900

Prepared by: Jon Dyck

Legislative Fiscal Bureau

One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

---

May 12, 2015 Joint Committee on Finance Paper #376

Mental Health Crisis Service Grants and Emergency Detention Procedures (Health Services -- Institutions and Mental Health)

[LFB 2015-17 Budget Summary: Page 236, #9]

CURRENT LAW

Chapter 51 of the statutes establishes the state's policies for the care and treatment of persons with mental illness. Included in Chapter 51 are procedures for the emergency detention of those who are believed to be mentally ill, chemically dependent, or developmentally disabled, and who evidence a substantial probability of causing physical harm to themselves or to others. Generally, only a law enforcement officer may initiate the emergency detention process, and may take a person into custody only if: (a) the person is believed to be unable or unwilling to cooperate with voluntary treatment; and (b) taking the person into custody is the least restrictive alternative appropriate to the person's needs.

The procedures and requirements applying to emergency detention in Milwaukee County are different than those used in other counties. In Milwaukee County, the law enforcement officer who takes a person into custody must transport the person to a treatment facility. Upon arrival at the facility, the treatment director of the facility has 24 hours to determine if the person meets the criteria for detention (excluding time needed to evaluate and treat a non-psychiatric medical condition). In all other counties, the county department of human services (or other county agency responsible for mental health programs) must agree for the need for detention before a law enforcement proceeds with the detention. In order to approve detention, the county must reasonably believe that the individual will not voluntarily consent to evaluation, diagnosis, and treatment. If approved, the officer is required to transport the person to a treatment facility, if the facility agrees to take the person, or to a state treatment facility. The treatment director of the facility is not required to determine whether the emergency detention criteria have been met within any specified time period, but must discharge the person when, upon the advice of the treatment staff, he or she determines that the criteria are no longer met. In all counties, the person may not be held in detention for a period exceeding 72 hours from the time that the

person was taken into custody, exclusive of Saturdays, Sundays, and legal holidays. During this period, a court may hold a probable cause hearing for involuntary civil commitment, which may result in continued detention pending a final commitment hearing.

The law enforcement officer who initiates a detention must complete a statement detailing the individual's actions leading to the decision to take the person into custody. In all counties except for Milwaukee County, this statement is delivered to the treatment facility and to the court, which initiates the probable cause hearing process. In Milwaukee County, the statement is delivered to the treatment facility, but is not filed immediately with the court. Only if the treatment staff determine that the criteria for emergency detention are met within the 24-hour time limit is the statement filed with the court.

Under a pilot program that applies only in Milwaukee County and that will expire after May 1, 2016, certain mental health professionals employed by, or under contract with, the Milwaukee Behavioral Health Division, or their designees may take a person into custody for the purposes of emergency detention.

GOVERNOR

Provide $1,500,000 PR in one-time funding in 2015-16 for DHS to distribute as grants to counties for mental health crisis services. Funding for these grants would be budgeted in a current program revenue appropriation that supports the Department's institutional operations.

Make the following statutory changes, effective on July 1, 2016:

Crisis Assessments. Modify provisions related to the emergency detention of persons for reasons of mental illness, drug dependency, or developmental disability to specify that a county human services department may not approve the detention of a person unless a physician who has completed a residency in psychiatry, a licensed psychologist, or a mental health professional has performed a crisis assessment on the individual and agrees for the need for detention.

Emergency Detention Procedures in Milwaukee County. Repeal provisions that establish special procedures for emergency detention in Milwaukee County and repeal a pilot program for alternative emergency detention procedures in Milwaukee County.

DISCUSSION POINTS

1. The bill would provide $1,500,000 for making one-time grants for crisis services, but would not specify how the funding would be distributed, nor would it establish specific criteria or requirements. The Department of Health Services indicates that the funds would be distributed to assist counties in complying with some of the bill's statutory changes related to emergency detention. Of the proposed statutory changes, one would affect all counties, while two others would affect Milwaukee County only. The following points describe the proposed statutory changes, as well as their relationship to the grant funding, in more detail.

Crisis Assessment Requirement for All Counties

2. Since 2010, law enforcement officers have been required to get approval from the county department of human services prior to transporting a person to a treatment facility for the purpose of emergency detention, a change that was made with the intent of ensuring that emergency detention was used only in cases where all of the statutory criteria are met. Counties use different models to comply with this requirement. Some counties have 24-hour mobile crisis teams composed of mental health workers to respond to crisis situations, allowing for an in-person assessment for potential emergency detention cases. Others have some crisis team capacity, but do not have sufficient capacity to respond to all situations on a 24-hour basis, meaning that approval is sometimes given by telephone. In still other counties, the approval for emergency detention is provided primarily by telephone correspondence.

3. All counties are required to have an emergency mental health services program. At a minimum, emergency programs must offer 24-hour crisis telephone service and 24-hour in-person service on an on-call basis. In order to receive reimbursement under the state's medical assistance (MA) program or private insurance, an emergency mental health services program must have additional features, such as a mobile crisis team that is available for at least eight hours per day, walk-in services, and short-term voluntary or involuntary hospital care when less restrictive alternatives are not sufficient to stabilize an individual experiencing a mental health crisis.

4. Currently, 63 counties have emergency service programs that meet the MA program standards (or are served by a multi-county certified program) and nine counties (Bayfield, Buffalo, Douglas, Dunn, Iron, Pepin, Taylor, Trempealeau, and Washburn) do not have such a program. Three of the counties that do not currently have a certified program (Buffalo, Dunn, and Pepin) are currently seeking certification, while the other six counties are not currently taking actions toward MA certification.

5. Under the bill, all counties would be required to provide a crisis assessment prior to the transport of a person to a treatment facility. The Department indicates that it is the intention that crisis assessments would generally be conducted by a mental health professional on a face-to-face basis or using some mode of distance technology, such as videoconferencing. Department staff believe that having a face-to-face crisis assessment would allow a more thorough review of each individual's needs, and would reduce inappropriate emergency detentions. Individuals who do not meet the criteria for emergency detention, but who are experiencing a crisis may then be more likely to be referred to community-based treatment options and support, such as crisis centers, peer supported resources, and psycho-social rehabilitation programs. Although face-to-face assessments would be the goal, the Department indicates that telephonic approval may still be appropriate in some circumstances. The policies for crisis assessment would be established by administrative memorandums.

6. Since the bill would require a crisis assessment prior to any emergency detention decision, every county would need to have a 24-hour crisis service capable of providing this type of approval. Counties that do not currently have an MA-certified emergency mental health services program would likely need to allocate additional resources toward developing emergency services capacity (although they may not need to have all elements necessary for MA certification). In

addition, some counties that have an MA-certified emergency mental health services program may not have sufficient capacity in their programs to comply with the proposed crisis assessment requirement. These counties would also need to invest additional resources into crisis services.

7. The Department indicates that the $1,500,000 in crisis assessment grants would be distributed to assist counties in complying with the crisis assessment requirement. Counties that do not meet MA certification as well as counties that do not have sufficient crisis assessment capacity would be eligible for funds, and counties could cooperate to create regional programs. The Department would plan on using an application or request for proposal process for allocating funding.

8. Although the bill would provide funding with the intent of increasing counties' capacity for emergency mental health services, it would be provided on a one-time basis and so counties may need to devote their own resources to meet any ongoing need. However, since one of the goals of the policy would be to reduce the use of emergency detention, it is possible that some counties may be able to shift resources away from inpatient services toward community-based services, including crisis services.

9. Not all counties may be able to offset additional crisis services costs with savings associated with a reduction in the use of emergency detention, at least in the short term. That is, maintaining a 24-hour crisis service capability that is sufficient to meet the demand may require more ongoing funding than any resulting ongoing savings. Furthermore, just having a 24-hour crisis services capability may not be sufficient to achieve the desirable outcomes. Persons who have mental health crises may need other services, such as access to psychotherapy or other outpatient treatment, supported housing, targeted case management, employment support, or other psychosocial rehabilitation services. If there are not sufficient community-based services to provide ongoing care, persons that may be diverted from emergency detention initially may continue to experience mental health crises.

10. Advocates of community-based services assert that there are other benefits associated with avoiding unnecessary emergency detention, even if this may require additional investment of resources. Since the process of emergency detention can be traumatic for someone undergoing a mental health crisis, the use of community-based services is preferable when possible. This is particularly true in cases involving a lengthy trip to a facility that accepts persons in crisis. [Many times persons must be taken to Winnebago Mental Health Institute, near Oshkosh, if there is no hospital that is able and agrees to accept them.] Law enforcement agencies also favor increasing the diversion to community-based facilities, since the process of transporting a person to an emergency detention facility often involves considerable law enforcement officer time.

11. Subsequent to the introduction of the bill, the Department of Administration submitted a budget erratum related to the persons who are authorized to conduct a crisis assessment and the setting for the assessment. As introduced, the bill would permit the county department to approve the detention only if a physician who has completed a residency in psychiatry, a licensed psychologist, or a mental health professional has performed a crisis assessment on the individual and agrees with the need for detention. The administration has requested that this provision be modified to state that a county department may approve the detention only if a mental health

professional, as defined by the Department, has performed a crisis assessment in a setting other than a psychiatric hospital on the individual and agrees with the need for detention. If the Committee adopts the Governor's provision with respect to emergency detention procedures, this provision could be modified to reflect the Governor's intent [Alternative A1].

Milwaukee County Emergency Detention Procedure

12. In Milwaukee County, law enforcement officers transport persons whom they believe meet the criteria for emergency detention to Psychiatric Crisis Services (PCS) at the Milwaukee County Mental Health Complex (unless the person has a non-psychiatric medical condition that first must be treated at a general hospital). Once at the facility, PCS staff must determine whether the person meets the criteria for detention within 24 hours of the time that the person was taken into custody, exclusive of any time that the person had to be evaluated and treated for a non-psychiatric medical condition. Only if the person is determined to meet the criteria for emergency detention is the person detained and is case filed with the court.

13. The 24-hour rule, also known as the treatment director supplement (TDS), has been part of the Milwaukee County procedure for several decades, and is intended to ensure that individuals who are experiencing a crisis and who are transported to PCS, but who do not meet the criteria for emergency detention, are discharged or are provided other treatment.

14. 2013 Act 203 transferred primary oversight of mental health policy and budgeting from the Milwaukee County Board to a newly-established Milwaukee County Mental Health Board. In addition, the act required DHS to arrange for a programmatic audit of mental health services in the County. To comply with this requirement, DHS contracted for an assessment of the Milwaukee County Behavioral Health Division, and, following the completion of the assessment, developed several recommendations for changes to the delivery of Milwaukee County mental health services. Among these recommendations was that the state consider changes to align the emergency detention process in Milwaukee County with other Wisconsin counties. The bill, by eliminating the TDS requirement, would implement this recommendation. Milwaukee County would then also be subject to the bill's provision requiring that a crisis assessment be conducted prior to transport for emergency detention.

15. Milwaukee County indicates that the proposed changes may not necessarily change the procedure that the county currently uses if the assessment conducted at PCS is deemed sufficient to comply with the bill's crisis assessment requirement. However, if the bill would require a face-to-face assessment to be conducted in the field by a mobile crisis team, rather than at PCS, the county estimates that it would need to spend an additional $2.7 million annually to expand mobile crisis capacity.

16. As with the proposed change to the emergency detention procedures affecting all counties, it is presumed that Milwaukee County would have to invest in additional community-based emergency crisis services, but that this could involve shifting resources away from institutionalized care.

17. The Act 203 Milwaukee County behavioral health system assessment notes that the

County has made progress transitioning from inpatient services to community-based care. Between 2010 and 2014, for instance, the number of inpatient admissions at the Behavioral Health Complex declined by over 40%, allowing the Complex to reduce the number of staffed beds at the facility. At the same time, the County has expanded the use of mobile crisis teams, enhanced existing psycho-social rehabilitation services, and expanded crisis resource centers.

18. Although community-based mental health resources can allow some individuals to avoid more expensive inpatient care, the transition from a heavy reliance on emergency detention and inpatient care to community-based care is not necessarily possible without investing additional resources in the system as a whole. In its recommendations, DHS notes that despite the reduction in the number of staffed beds at the Behavioral Health Complex, there are continuing, fixed costs associated with maintaining the aging facility. In addition, the facility must maintain enough bed capacity to serve as a safety net hospital in cases where there is no other alternative.

19. Mental health advocacy groups have long been in support of reducing reliance on emergency detention in Milwaukee County, as well as in other counties, as they believe that emergency detention is traumatizing and counterproductive. Consequently, these advocates are in favor of putting in place procedures, like an up-front crisis assessment, that result in diverting individuals who are experiencing crisis to other treatment and support options if emergency detention is not necessary. However, in testimony before the Assembly Committee on Mental Health Reform, representatives of the Milwaukee Mental Health Task Force (a coalition of advocacy organizations and providers) warned that there are not sufficient community-based resources, including mobile crisis teams, to sufficiently address the demand for crisis assessment and diversion in Milwaukee County. They indicated, furthermore, that there is a danger that if the law is changed without these resources in place, then persons experiencing a mental health crisis may be more likely to be placed in jail. The Task Force recommends, therefore, that additional community-based treatment and support services be developed before the law is changed.

Milwaukee County Emergency Detention Pilot Program

20. The Milwaukee County emergency detention pilot program was authorized under 2013 Act 235, which took effect on April 10, 2014. Supporters of the program asserted that allowing mental health professionals to initiate an emergency detention would reduce the number of crisis situations requiring law enforcement involvement. They also claim that mental health professionals are trained to recognize when crisis situations can be deescalated and to know when alternatives to emergency detention are appropriate. Finally, they note that avoiding law enforcement involvement reduces the stigmatization and trauma associated with emergency detention. Some advocates for persons with mental illness opposed the change, indicating that they feared the authority to initiate emergency detention by mental health professionals would be misused in situations that would otherwise be managed with less restrictive intervention. They also indicated that there were not sufficient resources for mobile crisis teams to allow the pilot program to adequately address the needs in Milwaukee County.

21. The bill would eliminate the Milwaukee County emergency detention pilot program, in response to the Department's Act 203 recommendation to align the Milwaukee County procedures with those used in other counties.

22. Under Act 235, the pilot program was intended to be a time-limited demonstration of alternative emergency detention methods. The program is set to expire on May 1, 2016, after which time the Legislative Audit Bureau (LAB) is required to conduct a performance evaluation audit of the program. The audit must include an evaluation of the feasibility and likely outcomes of continuing the pilot program in Milwaukee County, or of expanding the program to other counties or statewide, but additional legislation would need to be enacted to authorize such an extension or expansion.

23. Although the bill would end the pilot program prior to when it was initially scheduled to expire, it would not eliminate the requirement for LAB to conduct a performance evaluation. If the intent is to eliminate the program in order to have all counties use the same procedures, then the Committee could also eliminate the requirement for LAB to conduct an evaluation, on the grounds that no additional study is necessary [Alternative C2]. On the other hand, a case could be made that there has been insufficient time to evaluate the impact of the pilot program, and that it should be allowed to continue until the currently-scheduled end date [Alternative C3]. Under this alternative, the Legislature could make a determination on the future emergency detention policies used in Milwaukee County as well as the rest of the state based on LAB's performance evaluation.

General Considerations on Statutory Changes and Crisis System Grants

24. The Wisconsin Council on Mental Health, which advises the Governor and Legislature on mental health policy matters, has recommended that all of the changes to the emergency detention law be removed from the budget bill. The Council takes the position that emergency detention procedures are complex policy issues, and that any potential modifications should be considered in separate legislation. For similar reasons, the Wisconsin Counties Association (WCA) has also recommended that the emergency detention provision be removed from the bill. WCA indicates that it would prefer that any changes to the emergency detention procedures be formulated after discussion with a workgroup composed of counties, advocates, consumers, public defenders, law enforcement, and other interested parties. If the Committee agrees that the changes to the emergency detention should be considered outside of the budget bill deliberations, or only after more discussion with interested parties, these provisions could be removed from the bill [Alternatives A2, B2, and C3].

25. The Department makes the case that the changes in the bill reflect evidence-based practice and are supported by research evaluations, the Milwaukee County behavior health services audit, as well as feedback from stakeholders.

26. Even if the statutory changes to the emergency detention procedure are removed from the bill, the Committee could decide to retain the $1,500,000 in emergency system grants, on the grounds that additional funding would allow counties to increase crisis services team capacity in preparation for any future change to the emergency detention procedures [Alternative D1]. Funding for the grants would be provided from unexpended balances in the Department's PR appropriation for the mental health institutes. Revenues in this appropriation are received as payments from counties, private insurance, and the MA program for the institutes' programs.

27. The Committee may decide that without statutory changes to the emergency detention

system, there is no need to provide additional funding for counties to change their emergency crisis systems at this time [Alternative D2]. Additional funding could be provided at a later time if statutory changes are enacted as part of separate legislation.

ALTERNATIVES

A. Crisis Assessment Requirement Prior to Emergency Detention

1. Approve the Governor's recommendation to require that counties conduct a crisis assessment prior to approval of transport for the purposes of emergency detention (modified to reflect the administration's intent as described in Point 11).

2. Delete provision (retain current law procedure).

B. Milwaukee County Emergency Detention Procedure

1. Approve the Governor's recommendation to eliminate current law provisions that establish special procedures for emergency detention in Milwaukee County (the 24-hour rule).

2. Delete provision (retain current law procedure).

C. Milwaukee County Emergency Detention Pilot Program

1. Approve the Governor's recommendation to delete a current law pilot program that authorizes certain mental health professionals to take a person into custody for the purposes of emergency detention in Milwaukee County.

2. Approve the Governor's recommendation to delete the pilot program, but modify the bill to also delete a requirement that the Legislative Audit Bureau conduct an evaluation of the pilot program.

3. Delete provision (retain pilot program).

D. Crisis Service Grants

1. Approve the Governor's recommendation to provide one-time funding of $1,500,000 PR in 2015-16 for mental health crisis service grants for counties.

2. Delete provision.

ALT D2	Change to Bill
PR	- $1,500,000

Prepared by: Jon Dyck

Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

---

May 12, 2015 Joint Committee on Finance Paper #377

Consolidate Community Mental Health Programs (Health Services -- Institutions and Mental Health)

[LFB 2015-17 Budget Summary: Page 237, #10]

CURRENT LAW

The Department of Health Services (DHS) provides grants to counties for community-based mental health services under several programs that were established in the late 1980s as an alternative to institutional care for persons with serious and persistent mental illness.

The treatment funds for mentally ill persons program (s. 46.266 of the statutes) requires DHS to allocate funding to county human service agencies for the care of persons living in a nursing home or intermediate care facility that is classified as an institute for mental disease (IMD) or for community-based care of mentally ill persons meeting certain criteria. The amount of funding provided to counties is based on the number of persons eligible for mental health services in the IMD or relocated to community-based care. The relocation services for individuals with mental illness program (s. 46.268 of the statutes) requires the Department to distribute not more than $830,000 in each fiscal year for community-based services for persons with mental illness and who are not eligible for services under the community integration program. The combined total based funding for these two programs is $8,013,700.

The Department's community support program and psychosocial services appropriation funds grants to counties for providing community-based mental health treatment to persons with severe and persistent mental illness. Base funding in the appropriation is $3,757,500.

GOVERNOR

Consolidate base funding for community mental health services by repealing several programs and funding allocations and transferring base funding from these programs to a funding allocation under the state's community aids program, effective January 1, 2016. (A

summary of these transfers is shown under Discussion Point 1.)

Repeal the treatment funds for mentally ill persons program and the relocation services for individuals with mental illness program. Delete references to these two programs in the DHS mental health treatment services appropriation and specify, instead, that this appropriation may be used to support mental health treatment services at a county-operated institution for mental disease as selected by the Department ($1,551,500 on an annualized basis). Currently, the only county-operated institution for mental disease is the Trempealeau County Health Care Center.

Repeal the community support programs and psychosocial services appropriation, effective June 30, 2016, and delete all statutory references to that appropriation, including a provision that authorizes the DHS to transfer unexpended moneys from this appropriation at the end of the fiscal year to the Department's appropriation for grants for community programs to be used for supported employment opportunities for individuals who are severely disabled.

Expand the statutory purpose of community aids program to explicitly include community mental health services. Require DHS to distribute not less than $24,348,700 in each fiscal year for community mental health services. Provide that in 2015-16, the first fiscal year of the consolidation, the Department may distribute one-half of that amount ($12,174,350), after January 1, 2016.

DISCUSSION POINTS

1. The bill would combine two mental health institutional relocation programs and one psychosocial rehabilitation program into a new community aids program for community mental health services. Statutory provisions governing the usage of funds under these programs would be eliminated and replaced with a general requirement that the funds be distributed to counties for community mental health programs. In addition to the funding from the eliminated programs, other funding would be transferred from the community options program (COP), in an amount that approximates the annual use of COP funding for program participants receiving community-based mental health and substance abuse services. The following table shows the appropriation changes associated with the program consolidation. The institutional relocation programs are funded from the "mental health treatment services" appropriation.

Proposed Funding Transfers for the Creation of Community Mental Health Services Grants

Appropriation	2015-16	2016-17
Mental Health Treatment Services	-$4,006,800	-$8,013,700
Community Support Programs and Psychosocial Services	-1,878,800	-3,757,500
Community Options Program (Mental Health/Substance Abuse)	-6,288,800	-12,577,500
Community Aids -- Community Mental Health Services	$12,174,400	$24,348,700

2. The program consolidation would begin in calendar year 2016. Since the existing programs would continue in 2015, only one-half of the full annualized transfers would occur in fiscal year 2015-16.

3. The following points provide a brief description of the programs proposed for consolidation.

Mental Health Institutional Relocation Programs

4. The creation of relocation programs in the late 1980s was in response to a federal determination that several county-operated nursing homes met the definition of an institution for mental disease (IMD). Under federal law, federal Medicaid funds may not be used to reimburse IMDs for care provided to persons between the ages of 21 and 64. Consequently, the state funding was provided to assist counties in moving residents of these facilities to community-based mental health treatment programs, if appropriate.

5. Originally, the funding in these programs was intended as one-time assistance to allow relocation of persons with mental illness from IMDs to the community. In the succeeding years, the program was modified to allow funds to be used on an ongoing basis for community-based services for persons who otherwise may require institutional care.

6. Thirty counties currently receive funds from one or both of the IMD relocation programs. The amount of funding that each county receives remains the same from year to year, and is tied to the original formula-based relocation calculation.

7. Although the funding received under the relocation programs is still being used by counties to support persons in community-based mental health services, the circumstances have changed. Instead of supporting specific individuals relocated from institutional care to community-based services, persons in need of such services are given a direct placement into community programs that the funding supports (although some may be placed in these programs from institutions). Because of the change in circumstances, some of the specific statutory requirements for the use of funds are no longer pertinent to current uses of the funding. The Department believes that eliminating the statutory provisions would simplify the administration of grant funding for counties.

Community Support Programs and Psychosocial Services

8. The community support programs and psychosocial services appropriation provides funding for county programs providing supportive services for persons with severe and persistent mental illness. Psychosocial rehabilitation services include coordination of medically-oriented treatments, as well as social, educational, and occupational supports. Although the medical assistance (MA) program provides coverage for MA-eligible individuals who are enrolled in county psychosocial rehabilitation programs, counties vary on the array of services that they provide. The GPR funding provided under the community support program and psychosocial services appropriation is used by counties to provide the non-federal match for mental health services for which counties have the matching responsibility.

9. There are two components of this appropriation, and all but four counties (Buffalo, Florence, Pepin, and Pierce) receive funding from one or both components. The community support program (CSP) waitlist component was established to allow counties that operated CSPs, but that did not have sufficient capacity for all eligible persons, to offer a modified support program. Currently this component distributes $939,400. The community mental health component distributes $2,818,100 to assist counties with the costs of civil commitments at the state mental health institutes. As with the IMD relocation programs, the distribution in these two components is not necessarily tied to the original distribution. For instance, although the CPS waitlist component funding was originally tied to individuals on CSP waitlists, it no longer has this specific connection.

10. As with the proposed consolidation of IMD relocation programs, DHS believes that the consolidation of the psychosocial rehabilitation services funding would simplify administration of the program since it would eliminate the need for counties to separately account for subcomponents of the program.

Community Options Program

11. The state's community options program (COP) provides home and community-based services for persons who need long-term supportive services to remain in their home or a community residential facility. The program has two distinct components. The COP-waiver (COP-W) program operates under terms of a federal Medicaid waiver. COP-W enrollment is limited to elderly and disabled persons with certain care needs, and is unrelated to mental health. The other component, known as COP-regular (COP-R) is 100% GPR-funded and operates outside the MA program. Under the COP-R component, DHS provides grants to counties for long term care services. Among other purposes, counties may use these funds for services for persons with chronic mental illness or substance use disorders.

12. DHS allocates COP-R funding to each county and the counties determines how to utilize the funds among the target populations. Since COP-R funds may be used to provide services to persons who do not have mental health or substance abuse-related needs, the amount that is allocated by counties for mental health and substance abuse purposes can vary from year to year. The bill would reallocate $12,577,500 of COP-R funding to the community mental health grants program, based on the amount of COP-R funding that counties used for persons with long-term care needs related to mental illness and substance abuse in calendar year 2013.

Discussion of Alternatives

13. The Department indicates that the existing distribution of funds from the consolidated programs would continue in 2016. However, in preparation for the 2017 distribution, DHS would consult with counties and other mental health stakeholders to develop funding allocation policies. The Department indicates that it would seek to promote the use of evidence-based practices to promote positive outcomes, as well as encourage regional cooperation in the delivery of psychosocial rehabilitation programs.

14. With the establishment of new policies for the allocation of community mental health funds, it is possible that the distribution of funding among counties would change. Since a

significant portion of the original funding for these programs was based on formulas or policies that targeted funding to certain counties (such as the relocation of residents from certain county nursing homes), the funding distribution does not reflect current populations of persons in need of community-based mental health care in counties.

15. The Wisconsin Counties Association (WCA) has raised concern regarding the proposed community mental health program consolidation, and has requested that the consolidation provision be removed from the bill [Alternative 3]. WCA notes that although the Department indicates that the 2016 funding distribution would remain the same as in prior years, the variability of COP-R funding means that counties do not know how much they would receive. Furthermore, the counties note that an eventual change to the distribution of these funds would result in some redistribution of funds. Without an increase to the total amount of funding allocated, some counties would see a reduction in their allocation. WCA indicates its preference that any change to these programs be done only after consultation with the counties and mental health stakeholders.

16. Another alternative would be to retain the proposed program consolidation but require the Department to consult with WCA and mental health stakeholders before developing a method for distributing the funds in 2016 and beyond. To ensure Legislative oversight of the distribution method, the Department could be required to submit the plan to the Joint Committee on Finance for approval under a 14-passive review process. The Committee could be given authority to modify the planned distribution if it objects to the Department's proposal [Alternative 2]. This alternative could accomplish the Department's goals of eliminating antiquated statutory language and simplifying the administration of the grant programs, but would give WCA and other stakeholders a formal role in establishing a new distribution formula.

ALTERNATIVES

1. Approve the Governor's recommendation to consolidate mental health programs by eliminating programs and requiring the Department to distribute $24,348,700 in each fiscal year ($12,174,350 in 2016) for community mental health services.

2. Modify the Governor's recommendation as follows: (a) require DHS to consult with the Wisconsin Counties Association and mental health stakeholders before developing a method for distributing community mental health services funds in 2016 and beyond; (b) require the Department to submit a proposed distribution method to the Joint Committee on Finance under a 14-passive review process; and (c) require the Department to use the proposed distribution method, as approved, or as modified and approved by the Committee.

3. Delete provision.

Prepared by: Jon Dyck

HEALTH SERVICES

Institutions and Mental Health

LFB Summary Items for Which No Issue Paper Has Been Prepared

Item #	Title
1	Mental Health Institutes Funding Split
2	Fuel and Utilities
6	Civil Commitment Costs of Nonresidents
8	Mendota Juvenile Treatment Center
11	Office of Children's Mental Health

LFB Summary Item to be Addressed in a Subsequent Paper

Item #	Title
4	Debt Service Reestimate