ASSESSING THE FINANCIAL OUTLOOK OF MILWAUKEE COUNTY'S BEHAVIORAL HEALTH DIVISION

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Public Policy Forum
moving the region forward

ABOUT THE PUBLIC POLICY FORUM

Milwaukee-based Public Policy Forum – which was established in 1913 as a local government watchdog – is a nonpartisan, nonprofit organization dedicated to enhancing the effectiveness of government and the development of southeastern Wisconsin through objective research of regional public policy issues.

EDITOR'S NOTE

This report was undertaken as part of a technical assistance project commissioned by the Milwaukee County Department of Health and Human Services (DHHS) for the purpose of enhancing the department's understanding of fiscal trends and challenges faced by its Behavioral Health Division (BHD), and advising it on strategies for maximizing the opportunities presented by the Affordable Care Act. The research for this report was conducted from April through September 2012, and the report was delivered to the department in October 2012.

Subsequent to the report's delivery, the authors met several times over several months with County officials to discuss and review the report's findings and those of a complimentary report written by Community Advocates' Public Policy Institute. Although the report is of a technical assistance nature, it is being published now for broad consumption because of its relevance to public deliberations about the future of Milwaukee County's Mental Health Complex. Though the research in this report is now nearly five months old, it remains timely and still speaks accurately to the current fiscal challenges facing BHD. We hope that it will be useful for policymakers, stakeholders and citizens as they consider options for improving mental health care in Milwaukee County.

ACKNOWLEDGMENTS

Report authors would like to thank the leadership and staff of DHHS and BHD for their assistance in providing budget and programmatic information and patiently answering our questions. We especially appreciate the many hours of assistance provided by BHD Administrator Paula Lucey and DHHS Budget Manager Alex Kotze. We would also like to thank Community Advocates and its Public Policy Institute for subcontracting with the Forum to produce this report and for working with us on the overall technical assistance project.

Finally, the Forum would like to acknowledge the generosity of our 2013 Pillars of Public Policy and Sentinels of Civil Conduct, who have made generous grants to support our research in commemoration of our 100th anniversary celebration in 2013.

Pillars of Public Policy: Helen Bader Foundation, Herzfeld Foundation, Northwestern Mutual, Wisconsin Energy Foundation

Sentinels of Civil Conduct: BMO Harris Bank N.A., Baird, Potawatomi Bingo Casino

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INTRODUCTION

The Public Policy Forum has partnered with Community Advocates' Public Policy Institute in a project designed to advise Milwaukee County's Behavioral Health Division (BHD) on ways to strategically prepare for implementation of the Affordable Care Act (ACA). That project was launched in April 2012 with the financial support of BHD and the Milwaukee County Department of Health and Human Services (DHHS).

A central element of planning for ACA implementation is understanding and assessing BHD's current fiscal condition and challenges. The Forum's role in the project was to conduct such an assessment as a means of informing deliberations about possibilities for maximizing revenue impacts associated with ACA. Those may include opportunities to secure health insurance coverage for uninsured individuals currently being served by BHD, and to broaden coverage for those currently covered by the state's Badger Care program or other public funding sources.

The need for an outside, independent assessment of BHD's fiscal condition also was dictated by the mental health redesign process currently being conducted by BHD. That process involves a community-wide planning effort to review findings from several programmatic analyses of mental health services in Milwaukee County (including a comprehensive report by the Human Services Resources Institute co-authored by the Public Policy Forum), and to recommend strategies for implementing redesign initiatives. A particular focus is the need to devise ways to enhance community-based mental health services in conjunction with possible downsizing of BHD's inpatient and nursing home facilities.

Several work groups have been formed by the county's Mental Health Redesign Task Force to address specific areas of programmatic concern, and several broad programmatic recommendations have been issued. Thus far, however, the planning process has not included a component to identify and weave BHD's financial challenges and opportunities into redesign planning. Consequently, another important objective of this report is to provide a baseline fiscal assessment that can be used to inform the mental health redesign process and ensure that programmatic recommendations are accompanied by a fundamental understanding of BHD's current financial constraints and prospects.

After a background section that outlines BHD's general funding and programmatic structure, this paper is divided into four primary sections:

- The first analyzes actual expenditure and revenue data from the 2009-2011 period – broken down by key service areas and revenue sources – to provide perspective on fiscal trends and how they impact BHD's long-term financial picture.

- The second analyzes BHD's fiscal performance during the first several months of 2012 to gain insight into the financial impacts of recent efforts to revamp inpatient services and initiate enhanced community-based services, and how those efforts have affected the division's financial condition and outlook.

- The third analyzes BHD's 2013 requested budget to provide even greater perspective on the challenges posed by recent fiscal trends and the impacts of efforts to initiate one of the key components of mental health redesign – the downsizing of BHD's inpatient and nursing home capacity and the transfer of resulting savings to community-based services.

- Finally, the fourth section ties the three separate pieces of analysis together by offering several overall observations and conclusions.

As noted above, the purpose of this paper is not to critique BHD's fiscal management, but instead to objectively analyze its financial challenges and opportunities so that Milwaukee County budget officials and policymakers – as well as the dozens of public and private sector individuals who are devoting their time to the county's mental health redesign process – will have an independent fiscal assessment with which to consider programmatic changes moving forward.

BACKGROUND

BHD provides a variety of inpatient, emergency and community-based care and treatment to children and adults with mental health and substance abuse disorders. The county's role is dictated primarily by the Wisconsin Statutes, which specifically assign to Milwaukee County government responsibility for the "management, operation, maintenance and improvement of human services" in the county, including mental health treatment and alcohol and substance abuse services (Section 46.21).

Section 51.42 of the Wisconsin Statutes lays out more specifically the mandated role for Milwaukee County pertaining to the provision of behavioral health services:

"The county board of supervisors has the primary responsibility for the well−being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services. This primary responsibility is limited to the programs, services and resources that the county board of supervisors is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds."

The county has interpreted this language as a legal requirement to provide immediate emergency services for persons with mental illness and substance abuse disorders. That interpretation, in turn, has been defined as a requirement that the county also provide a broad range of inpatient, long-term care and outpatient services to indigent persons in order to curtail the need for emergency services and meet the more general statutory language pertaining to well-being, treatment and care. Notably, private health systems and hospitals also have taken into account this interpretation and have considered it to be Milwaukee County's ultimate responsibility to provide for the care of indigent individuals with mental health and substance abuse disorders.

At its Mental Health Complex, Milwaukee County owns and runs an inpatient hospital consisting of five licensed units (one of which is for children and adolescents); two nursing home facilities (a 70-bed nursing home for individuals with complex needs who require long-term treatment and a 72-bed facility for individuals diagnosed with both developmental disability and serious behavioral health needs); a Psychiatric Crisis Service (PCS) that serves persons in need of emergency mental health treatment, more than 60% of whom typically are brought in by law enforcement on an Emergency Detention; a mental health Access Clinic; and an Observation Unit. It also contracts for a wide variety of community-based services, including targeted case management, community support programs, community residential services, outpatient treatment, substance abuse treatment and recovery support, crisis respite, and specialized services for children and adolescents.

The total expenditure budget for BHD in 2012 is $188 million, making it the second largest organizational unit in Milwaukee County government after the Family Care program's Care Management Organization (CMO). BHD's 2012 property tax levy is $61 million, again ranking it second after the Office of the Sheriff. Other key revenue sources are state/federal revenue and direct reimbursement from patient care.

BHD also is one of the county's largest functions in terms of individuals served. For example, on an annual basis, BHD typically handles close to 4,000 inpatient and 13,000 PCS admissions, provides or administers services to more than 2,000 individuals in case management programs, and administers community-based substance abuse services to more than 4,500 individuals.

Finally, BHD is the second largest county organizational unit in terms of its number of employees (first is the sheriff), with 810 full-time equivalent employees (FTEs) budgeted in 2012.

BHD FISCAL TRENDS

Five-Year Comprehensive View

Table 1 shows BHD's actual expenditure, revenue and FTE history from 2007 to 2011. For ease of comparison, expenditures and revenues for the County Health Programs Division (CHP) have been subtracted from these figures for 2010 and 2011. CHP was formerly a separate organizational unit in the county budget but was moved under the jurisdiction of BHD in 2010. The division once housed the General Assistance Medical Program (GAMP) but today consists only of the Emergency Medical Services (EMS) program and is now known as the EMS division.

Table 1: BHD actual expenditures and revenues, 2007-2011

	2007	2008	2009	2010	2011
Personal Services w/out fringe	46,989,819	48,480,607	48,219,354	45,225,202	46,382,064
Employee fringe benefits	28,154,850	28,231,671	27,801,100	31,864,059	31,990,379
Services	9,843,915	10,084,964	9,661,202	16,936,471	19,394,747
Commodities	7,857,374	8,187,375	9,703,573	6,235,906	7,079,988
Other charges*	71,835,699	73,111,172	77,179,643	75,129,393	74,371,405
Debt and depreciation	-	-	-	-	-
Capital outlay	127,715	82,792	63,672	77,706	325,256
Capital contra	-	-	-	-	-
County service charges	38,239,417	41,409,987	38,185,131	37,784,722	40,421,891
Abatements	(31,329,741)	(34,523,950)	(32,732,183)	(32,681,691)	(35,170,135)
Total Expenditures	**171,719,048**	**175,064,618**	**178,081,492**	**180,571,767**	**184,795,596**
Direct revenue	63,542,361	57,361,571	60,144,434	60,278,188	61,355,869
State and federal revenue	62,415,021	58,353,670	59,686,856	61,227,168	61,584,993
Indirect revenue	2,101,285	10,700,698	8,958,796	9,932,388	10,002,135
Total Revenues	**128,058,667**	**126,415,939**	**128,790,086**	**131,437,744**	**132,942,996**
Property Tax Levy	**43,660,381**	**48,648,679**	**49,291,406**	**49,134,023**	**51,852,600**
FTE positions	**877**	**891**	**851**	**802**	**817**

Source: BHD BRASS fiscal reports

* Other charges is the biggest expenditure line item because it includes the division's huge portfolio of service contracts with community-based providers for services ranging from outpatient psychiatric care, to case management, to substance abuse treatment.

This high-level view of BHD's five-year fiscal trends reveals several observations and questions, including the following:

- BHD's total expenditures increased by $13 million (7.6%) over the five-year period (which certainly is respectable given the general rate of health care inflation), while its non-property tax revenues increased by only $5 million (3.8%), producing a need for an $8 million (19%) increase in its property tax levy allocation. What is the cause of this discrepancy between the rate of growth of costs versus non-property tax revenues, and is the division's continued reliance on property taxes to fill the gap sustainable?

- Despite substantial increases in fringe benefit and other personnel costs countywide, BHD has kept those costs in check by reducing FTEs. Presumably, that has occurred largely because of initiatives during this period to contract out housekeeping, dietary and other services, which is reflected by the increased expenditures for services in 2010 and 2011. Are there additional strategies that might be pursued to keep a lid on personnel costs in future years, or must BHD's challenged revenue streams absorb annual pay and benefit increases in future years that will be similar in magnitude to other county departments?

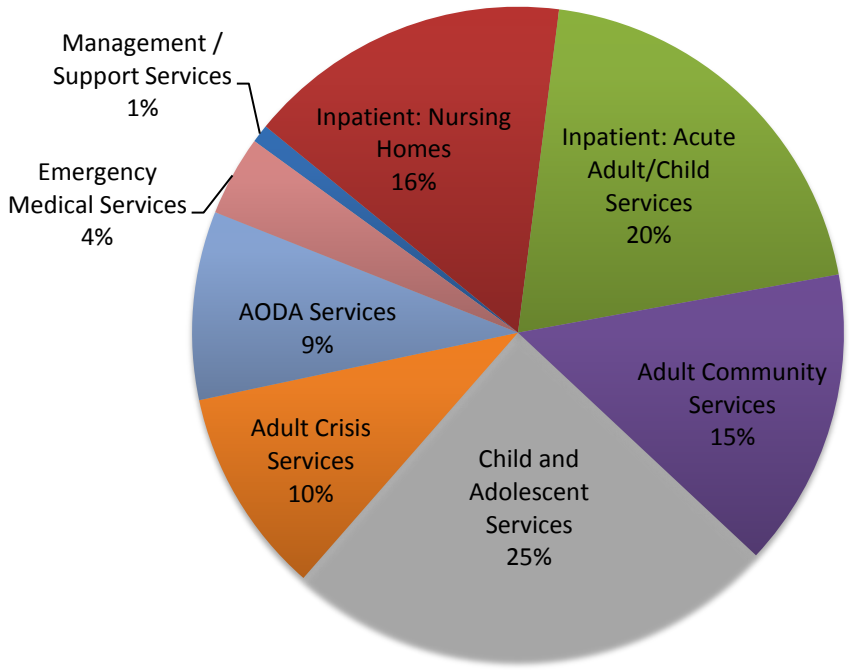
- Given the rate of health care inflation, can an entity that exists largely to provide or secure health care services for indigent individuals on behalf of the state and federal governments survive financially when its state and federal revenue streams are stagnant?

Three-Year Focused View

Expenditures

In Milwaukee County's published budget documents, BHD's budget is broken down into eight distinct cost centers: Management/Support Services; Nursing Facility Services; Acute Adult/Child Inpatient Services; Adult Community Services; Child and Adolescent Services; Adult Crisis Services; AODA Services; and Emergency Medical Services. The share of BHD's expenditure budget devoted to each of those cost centers in 2011 is shown in **Figure 1**.

Figure 1 – BHD 2011 expenditures by cost center



Source: Actual 2011 breakdown taken from BHD's 2013 Requested Budget narrative

For the purposes of this analysis, we focus only on four of the eight BHD cost centers that are directly relevant to the county's mental health redesign planning. The four that are excluded are Child and Adolescent Services, which essentially consists of BHD's Wraparound program, a comprehensive array of community-based behavioral health services for children and adolescents that are administered under an innovative reimbursement system using state and federal funding (and involving no county property tax levy); AODA services, which also involve limited county property tax levy (because of various federal and state grant revenues) and which largely rely on dedicated funding streams that fall outside of the purview of mental health redesign planning[1]; EMS, which also falls outside of the purview of mental health redesign; and Management and Support Services, which comprises only a small portion of BHD's direct expenditure budget.[2]

Subtracting those programs leaves us with four cost centers totaling approximately $117 million in budgeted expenditures in the 2012 budget that are the subject of this analysis. Those cost centers also account for about 91% of BHD's total budgeted property tax levy, making them the critical areas for trend analysis and deliberation in the context of the county's structural deficit and annual budgetary pressures.

To further explore those areas of BHD's budget, we conducted a detailed examination of the last three years of actual expenditure and revenue data, broken down by the four primary categories of mental health services that will be most impacted by ACA and that are the primary subject of adult mental health redesign efforts: inpatient, nursing homes, psychiatric crisis services, and community services. It is important to note that the first three categories relate primarily to services that are conducted onsite at BHD's Mental Health Complex, while the fourth category consists of services that are provided either by BHD or contracted providers in the community. This is an important distinction in the context of mental health redesign, which is focused in part on shifting additional BHD services from the Mental Health Complex into community settings.

For purposes of our analysis, we further break down the four primary service categories into subcategories, as described below:

- **Inpatient** – This category is broken down into the subcategories of acute adult inpatient, which encompasses services associated with BHD's four licensed inpatient units (current combined average daily census of about 70 patients); and child and adolescent inpatient, which encompasses services associated with BHD's single Children's and Adolescent Inpatient Unit (CAIS – current average daily census of about seven patients).

- **Psychiatric Crisis Services (PCS)** – This category encompasses services associated with BHD's mental health emergency room, which admits about 13,000 patients per year; its

[1] While mental health and AODA services traditionally have been funded under distinct revenue streams and have existed as distinct program areas in BHD's budget, a new initiative aimed at coordinating service delivery for the substantial percentage of BHD consumers who suffer from co-occurring disorders may alter that paradigm in the future.

[2] Management and support services are a substantial cost in BHD's budget, but the costs for those services are spread out among BHD's various cost centers. This dynamic receives considerable discussion in the final section of this report, which explains how management and support costs are distributed to distinct operational areas in BHD's budget, thus impacting the financial status of those areas of operation.

onsite mental health access clinic and observation unit; and its mobile crisis teams, which directly support onsite crisis operations. We exclude community-based crisis respite beds and crisis resource centers operated by community agencies, as well as other community-based crisis services that are typically included in this service category by BHD. Instead, those services are shown as an independent line item under the community services category. We organize the services in this manner to isolate crisis-related expenditures that are occurring primarily at the Mental Health Complex versus those that are taking place at community-based sites.

- **Nursing Homes** – This category is broken down per BHD's two long-term care facilities located at its Mental Health Complex: Hilltop, which provides care to individuals with a dual diagnosis of developmental disability and serious behavioral health conditions (current average daily census of about 64 patients); and Rehab Central, which serves individuals who have complex and interacting medical, rehabilitative and psychosocial needs (current average daily census of about 66 patients).

- **Community Services** – This category is broken down into six primary categories of community-based mental health services: Day Treatment, which provides therapeutic services on an outpatient basis to about 13 patients daily; Community Support Program (CSP), which provides high-intensity case management services to more than 1,300 people with chronic mental illness annually; Targeted Case Management (TCM), which provides medium-intensity case management services to more than 1,200 people annually; Service Access to Independent Living (SAIL), which is the centralized intake assessment unit at BHD that assesses the needs of individuals and facilitates their access to community-based services and supports; community-based crisis services, which during the 2009-2011 timeframe consisted largely of three eight-bed crisis stabilization centers and a community-based crisis resource center; and "Other community services," which contains all other BHD-administered mental health community services not included in the five categories above, including community-based residential facilities, outpatient treatment, and prevention and intervention services.

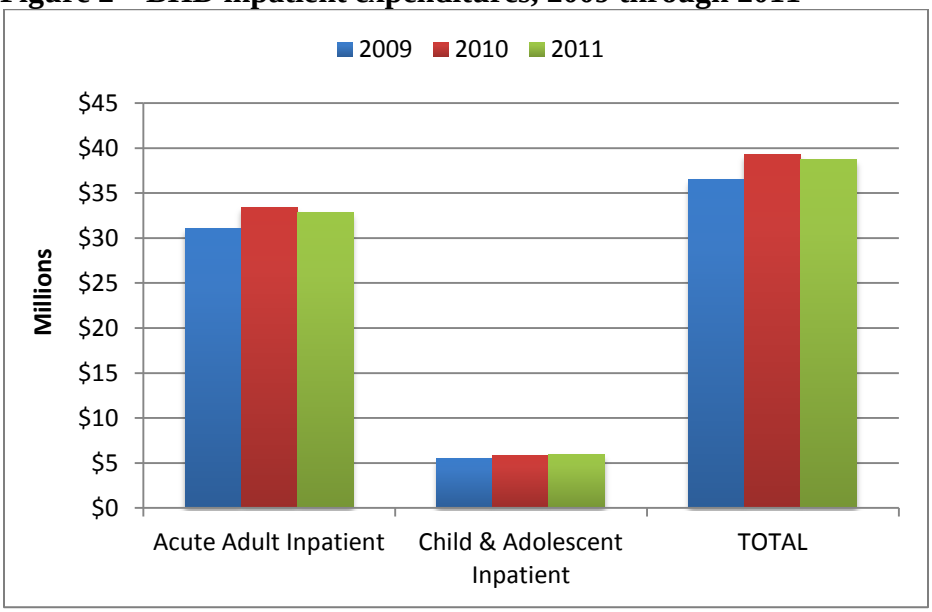
Table 2 shows actual expenditures for these programs and services for the 2009-2011 timeframe, while **Figures 2**, **3, 4** and **5** depict those expenditure totals in a series of bar graphs.

Table 2 – BHD expenditures in "four key service areas" (inpatient, PCS, nursing home and community services), 2009-2011

	2009	2010	2011	*2009-2011 Change*	
INPATIENT					
Acute Adult Inpatient	31,034,465	33,418,023	32,789,264	*1,754,798*	*5.7%*
Child & Adolescent Inpatient	5,455,167	5,845,757	5,939,470	*484,303*	*8.9%*
TOTAL	**36,489,632**	**39,263,779**	**38,728,733**	***2,239,101***	***6.1%***
PSYCHIATRIC CRISIS SERVICES					
TOTAL	**16,656,843**	**16,870,442**	**18,962,747**	***2,305,905***	***13.8%***
NURSING HOME					
Hilltop	15,200,977	15,349,238	16,691,928	*1,490,952*	*9.8%*
Rehab Central	13,689,632	13,303,236	14,311,442	*621,810*	*4.5%*
TOTAL	**28,890,609**	**28,652,474**	**31,003,370**	***2,112,761***	***7.3%***
COMMUNITY SERVICES					
Day Treatment	2,175,128	1,904,575	2,182,728	*7,600*	*0.3%*
CSP	9,407,231	9,854,590	10,178,138	*770,907*	*8.2%*
TCM	4,826,990	4,349,195	4,132,733	*-694,257*	*-14.4%*
SAIL	3,939,731	3,660,956	3,442,126	*-497,604*	*-12.6%*
Community-based crisis services	520,644	1,100,935	739,530	*218,886*	*42.0%*
Other community services	7,944,084	7,532,043	8,606,986	*662,902*	*8.3%*
TOTAL	**28,813,808**	**28,402,295**	**29,282,242**	***468,434***	***1.6%***
TOTAL BHD EXPS	**110,850,892**	**113,188,991**	**117,977,093**	***7,126,201***	***6.4%***

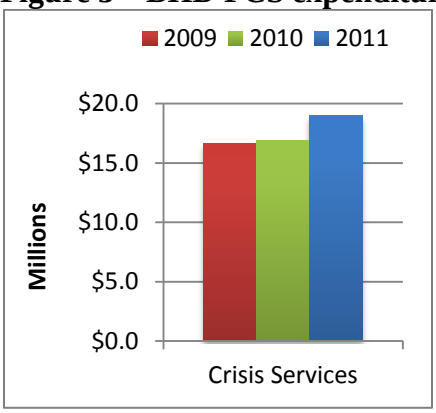
Source: BHD BRASS fiscal reports; BHD's report on community services branch contract expenditures by service area

Figure 2 – BHD inpatient expenditures, 2009 through 2011



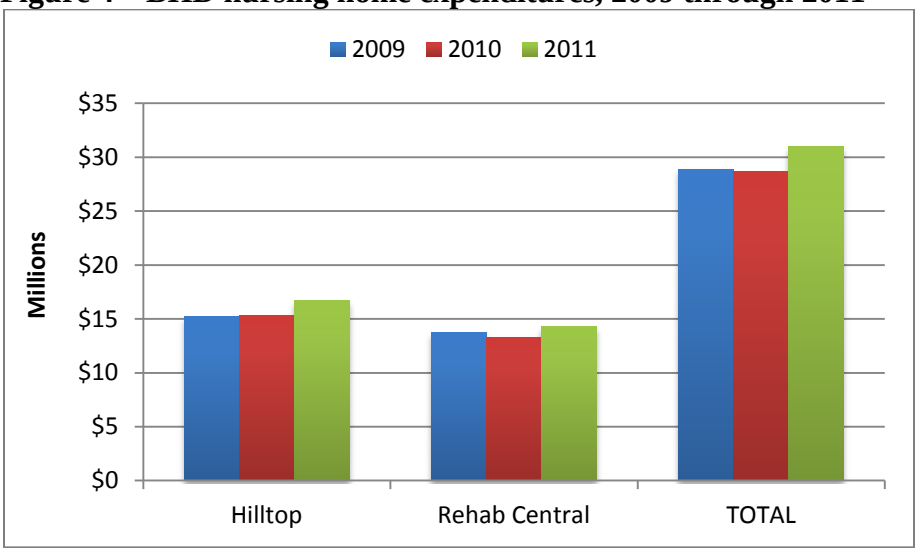
Source: BHD BRASS fiscal reports

Figure 3 – BHD PCS expenditures, 2009 through 2011



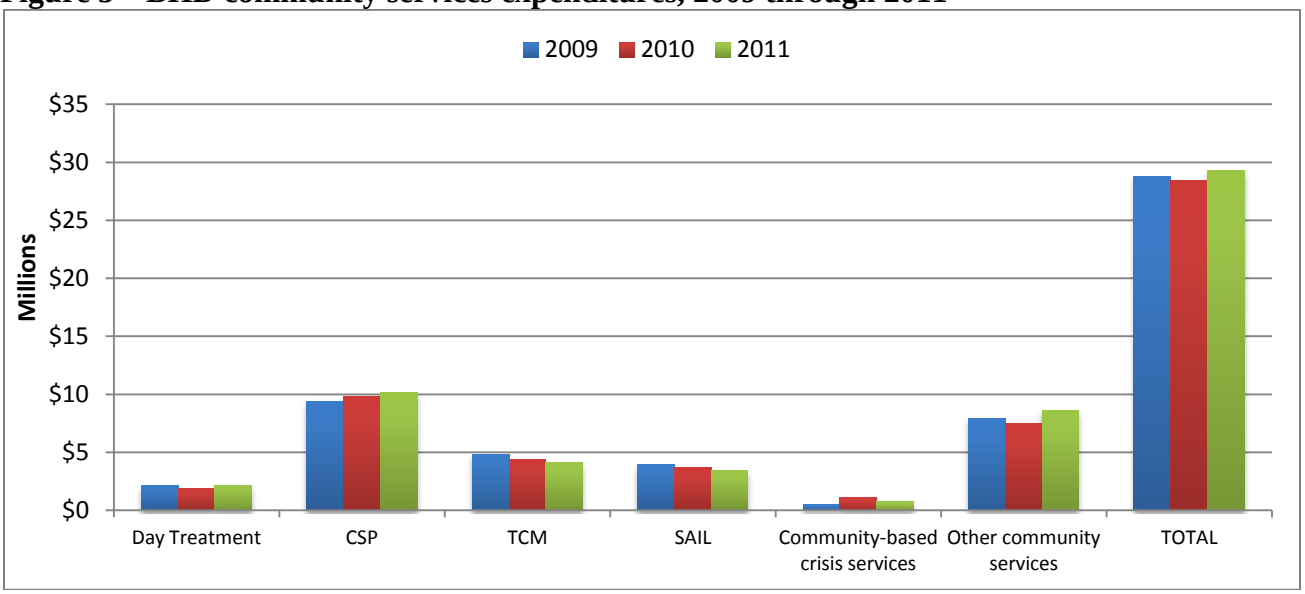
Source: BHD BRASS fiscal reports

Figure 4 – BHD nursing home expenditures, 2009 through 2011



Source: BHD BRASS fiscal reports

Figure 5 – BHD community services expenditures, 2009 through 2011



Source: BHD BRASS fiscal reports; BHD's report on community services branch contract expenditures by service area

Examining BHD's inpatient, PCS, nursing home, and community-based services expenditures from this perspective reveals that all four service categories experienced expenditure increases in the 2009-2011 timeframe. It is worth noting, however, that inpatient, PCS, and nursing home expenditures rose at a faster rate than those for community services (6.1%, 13.8% and 7.3% for inpatient, crisis and nursing homes respectively, versus 1.6% for community services). In fact, we see that expenditures for the three service areas that largely comprise Mental Health Complex operations increased 8.1% over the period.

That finding is not surprising given the context in which BHD was operating during the three-year period.[3] In early 2010, a patient incident at the Mental Health Complex led to an investigation by the federal Center for Medicare and Medicaid Services and a threat to cut off federal reimbursement to BHD, which was lifted shortly thereafter following a series of physical and programmatic improvements. Those improvements involved considerable increases in security, physical plant improvements and enhanced one-on-one staffing levels, as well as increased expenditures in the 2011 budget for major maintenance ($500,000), new clinical positions ($1.9 million), quality assurance/staff education ($562,000), and overtime ($675,000). Those expenditure increases were allocated across several service categories within the Mental Health Complex, including PCS and Hilltop (where the patient incident occurred). In addition, since 2009, BHD has been working to restore its Joint Commission accreditation, an undertaking that involves several physical and staffing improvements to its onsite operations.

[3] We were curious about whether increases in BHD's share of Milwaukee County "legacy costs" (i.e. costs related to the county's pension and retiree health care obligations) were a major contributor to the expenditure increases in the predominantly county-staffed functions housed at the Mental Health Complex , but our analysis showed that BHD's overall legacy benefits actually decreased from $15.2 million in 2010 to $14 million in 2011.

At the same time, BHD took several steps during that period to reduce Mental Health Complex-related overhead costs in an effort to offset the expenditure increases cited above, including initiatives to outsource both dietary and housekeeping services. In fact, had it not been for those initiatives, the total increases observed for inpatient, PCS and nursing home services from 2009 to 2011 would have been at least $2 to $3 million higher.

The fact that these key mental health service areas were granted a nearly $7 million increase during a time when Milwaukee County was struggling with severe budgetary challenges may have reflected the intense scrutiny under which the division was operating during this period. Indeed, it could be argued that the county had little choice but to invest additional resources given the attention of state and federal regulators and the general public.

A key question today is whether annual increases of this magnitude can be sustained, and whether they need to be. To the extent that BHD was able to use this "opportunity" to shore up its staffing levels and physical plant at the Mental Health Complex, then it is possible that the need for future annual increases in the 4% range for services at the Complex will diminish. If that is the case, then the county as a whole may experience some limited relief, or it is possible that resources that would have been targeted for onsite operations could be shifted to community-based services.

On the other hand, given general trends in health care inflation and the fact that BHD now has taken advantage of some of its biggest opportunities for overhead reductions, it may not be possible for the county to avoid annual increases of this magnitude to maintain appropriate service quality without significant changes to Mental Health Complex operations. In future sections of this report, we will examine how BHD grappled with this issue in its 2012 budget and 2013 budget request.

Locally Allocated Resources

The use of total expenditure data to analyze how BHD cost trends are impacting Milwaukee County's overall finances is somewhat limited by the fact that many of the inpatient, nursing home and community services provided by BHD are supported (at least in part) by cost-based reimbursement from federal funding sources like Medicaid and Medicare. Consequently, depending on the reimbursement rates established by the federal and state governments, at least some of the annual inflationary cost increases associated with those services are matched by increases in outside revenue, thus decreasing the negative impact on the county's bottom line.

It is important, therefore, to examine trends in the use of locally allocated resources to support mental health services, as it is the competition for those limited resources among the county's various functions that dominates annual budget deliberations. The property tax levy is by far the county's largest source of locally allocated funding at $275 million in the 2012 budget. Other major revenue streams that are allocated at the discretion of the county executive and county board are the sales tax ($64 million) and state shared revenue ($31 million).

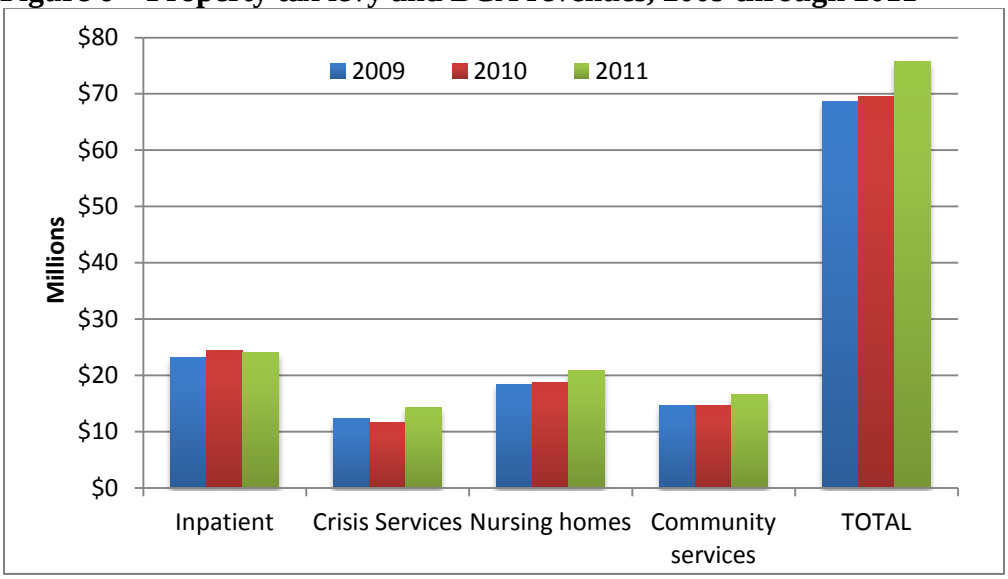
Under the county's budget methodology, those revenue sources are blended in that the total amount of property tax levy that is shown in departmental budgets actually includes *all* non-

departmental revenues. While the specifics of this allocation methodology are complicated and not directly germane to this analysis, what is most relevant is that given the numerous and varied demands on the county's limited locally allocated sources of revenue (which only comprise about 30% of its overall budget), the need for increased property tax levy allocations to meet growing costs for mental health services creates a significant financial challenge.

An analysis that only tracks BHD's annual property tax allocations as a means of assessing that challenge will not take into account, however, the interplay in BHD's budget between property tax levy and its Basic County Allocation (BCA) from the state's Community Aids program. Community Aids is a source of somewhat flexible funding provided by the State of Wisconsin that can be used at counties' discretion for certain *health and human services* programs and services. In 2012, Milwaukee County will use about two-thirds of its $35 million BCA allocation to support BHD programs and services, with the remainder allocated to other DHHS divisions.[4] BCA is combined with property tax levy in this analysis because BHD uses these sources interchangeably to pay for services that are not covered with other forms of reimbursement or grant revenue.

In **Figure 6**, we show the combined property tax levy and BCA dedicated to the four major mental health service areas in the 2009-2011 timeframe. This analysis shows increases in combined levy and BCA for all four service areas during the period, with an $800,000 increase for inpatient, $2.1 million for crisis services and $2.5 million each for nursing homes and community services. Combined, the four services experienced an 11.7% increase in property tax/BCA expenditures from 2009 to 2011, or an average of about 5.8% per year.

Figure 6 – Property tax levy and BCA revenues, 2009 through 2011

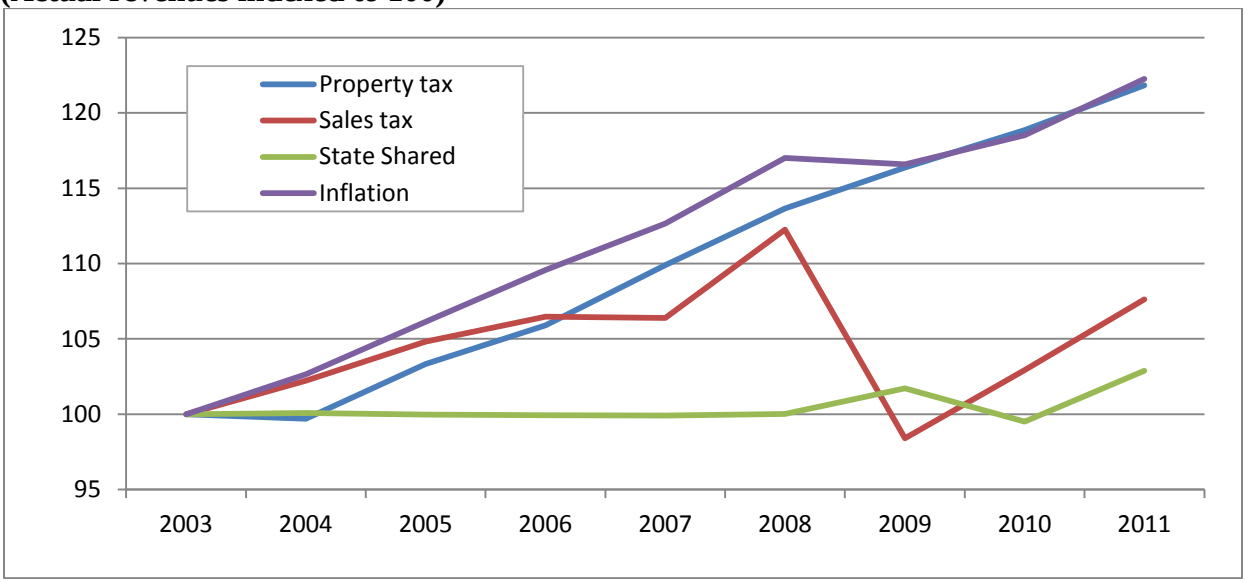


Source: BHD BRASS fiscal reports

[4] The county gradually has shifted a greater proportion of its BCA to BHD during the past five years, as the allocation used to be roughly split between BHD and other DHHS divisions. This is in part because program responsibilities in other parts of DHHS have diminished with the state's takeover of the Income Maintenance function. The County's total BCA allocation has been largely flat for most of the past decade, and has actually declined in recent years because of the Income Maintenance shift and a 10% cut in the 2011-13 State budget.

On its face, even an annual increase in local mental health care-related expenditures in the 6% range should not raise eyebrows in light of the magnitude of overall health care inflation in southeast Wisconsin and the nation. For Milwaukee County government, however, such annual increases are quite problematic, as the county's major sources of locally-allocated revenues that support such expenditures – the property tax, sales tax, and state shared revenue – generally have lagged even general inflation, as shown in **Figure 7**.

Figure 7: Milwaukee County local tax revenues, shared revenue, and inflation, 2003 to 2011 (Actual revenues indexed to 100)



Source: Milwaukee County Department of Administrative Services

Patient Care Revenue

To gain further insight into why such substantial increases in property tax/BCA allocations were required to support mental health services over the three-year period, we next examine the other major revenue source that supports BHD's mental health programs and services: reimbursement revenue from state, federal and commercial insurance sources that is directly linked to services provided. **Table 3** shows the amounts and sources of "patient care" revenue received by all BHD programs and services during the 2009-2011 timeframe,[5] while **Figure 8** shows each source as a proportion of BHD's total patient care revenue pie.

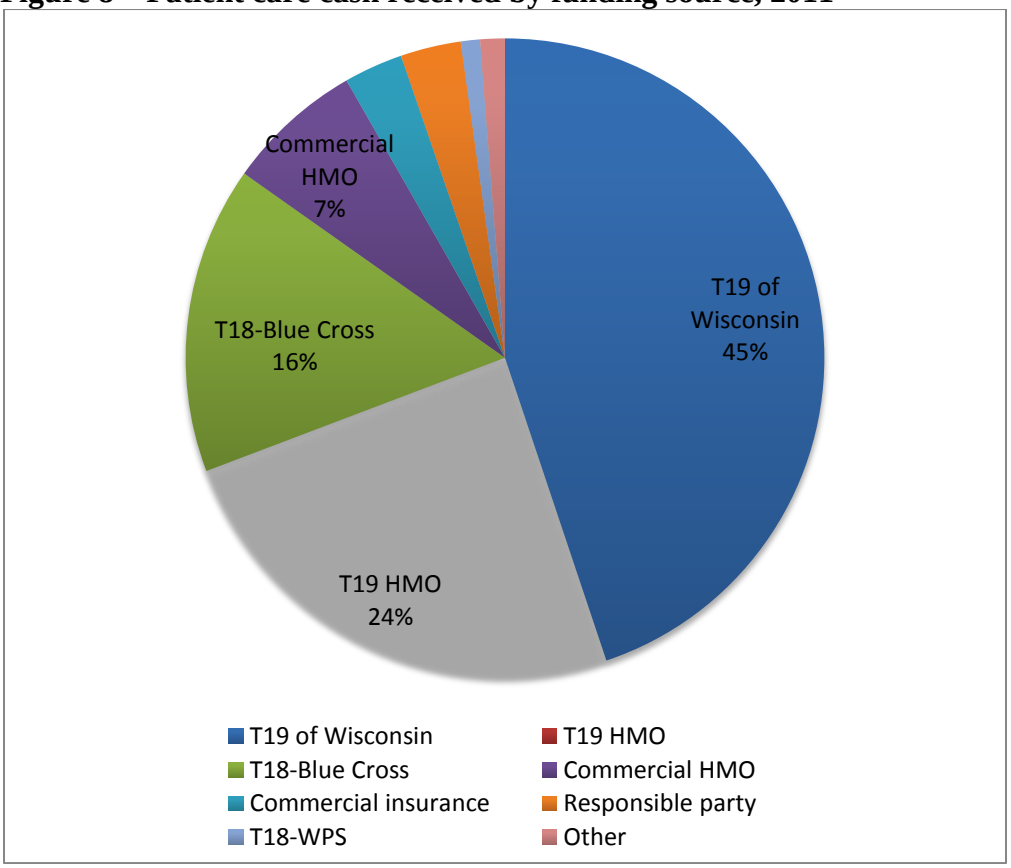
[5] It is important to note that the annual figures cited in this table reflect the cash received in each respective year, but not necessarily the year in which the service was provided.

Table 3 – BHD patient care revenue, 2009 through 2011

Funding source	2009	2010	2011
T19 of Wisconsin	15,019,389	16,298,445	14,718,765
T19 HMO	5,776,795	6,267,783	7,997,044
T18-Blue Cross	4,483,380	4,635,423	5,105,472
Commercial HMO	2,096,014	1,700,714	2,277,934
Commercial insurance	1,188,006	1,191,066	979,821
Responsible party	1,081,616	1,065,721	1,005,125
T18-WPS	381,260	425,838	318,453
Other	282,796	544,038	409,585
	30,309,256	**32,129,028**	**32,812,199**

Source: BHD 2011 & 2012 quarterly Fiscal and Program Dashboard reports

Figure 8 – Patient care cash received by funding source, 2011



Source: BHD 2011 & 2012 quarterly Fiscal and Program Dashboard reports

The largest source of patient care revenue is the Medicaid program (T19). BHD receives Medicaid revenues directly from the state for patients who are Medicaid-eligible, and from private HMO's that manage the care of Medicaid-eligible individuals under contract with the state. The second largest source is T18, which refers to the federal Medicare program.

In **Table 4**, we isolate patient care revenue that collectively stemmed only from inpatient, PCS, nursing home, and community services, and show those three-year revenue trends in comparison to the other major sources of revenue that support those services. **This table shows the essence of BHD's fiscal challenge: the growth in patient care and "other" revenues did not keep pace with BHD's mental health expenditure needs over the 2009-2011 period, thus necessitating a $7.8 million increase in property tax/BCA expenditures during the period**.[6]

Table 4 – BHD major revenue sources supporting four key service areas, 2009-2011

	2009	2010	2011	*Change*
Property tax levy	45,218,046	47,040,830	53,358,487	*8,140,442*
BCA	21,723,931	21,624,670	21,412,170	*-311,761*
Patient care revenue	26,888,697	27,784,854	28,564,170	*1,675,473*
Other	14,990,968	15,187,181	13,274,236	*-1,716,732*
TOTAL	**108,821,642**	**111,637,535**	**116,609,063**	***7,787,422***

Source: BHD BRASS fiscal reports

As is the case with nearly all public and private health care providers that serve low-income populations, the amount of patient care revenue received by BHD is far less than the cost of services provided. This discrepancy is based on four primary factors: 1) a sizable percentage of BHD's clients lack any form of insurance coverage and the means to pay for services out of their own pockets; 2) not all of the services provided by BHD are eligible for reimbursement from Medicaid, Medicare or private insurance plans; 3) even for those services that are covered, public and private insurance plans often do not reimburse at rates that reflect BHD's costs; and 4) for various reasons linked to the proficiency of its billing capabilities, BHD has not been able to collect all reimbursement to which it is entitled.

Figures 9 and **10** provide additional perspective by breaking down BHD's inpatient and crisis admissions by health insurance payer source. This information shows that about 13% of all patients admitted to inpatient units and 26% admitted to PCS lack any form of health insurance. In addition, another 8% of inpatient admissions have Medicaid coverage but fall between the ages of 21 and 64, which means that BHD cannot receive reimbursement because of its "IMD exclusion" (discussed in greater detail below).

[6] Other revenues include a variety of miscellaneous revenue sources, including federal Community Options Program (COP) funds, state grants, reimbursement from the Wisconsin Medicaid Cost Report (WIMCR) program, Potawatomi revenue, and Institute for Mental Disease revenue from the state that reflects the cost of serving certain patients in the community who otherwise would qualify for inpatient/nursing home care.

Figure 9: Inpatient admissions by health insurance payer source, 2011

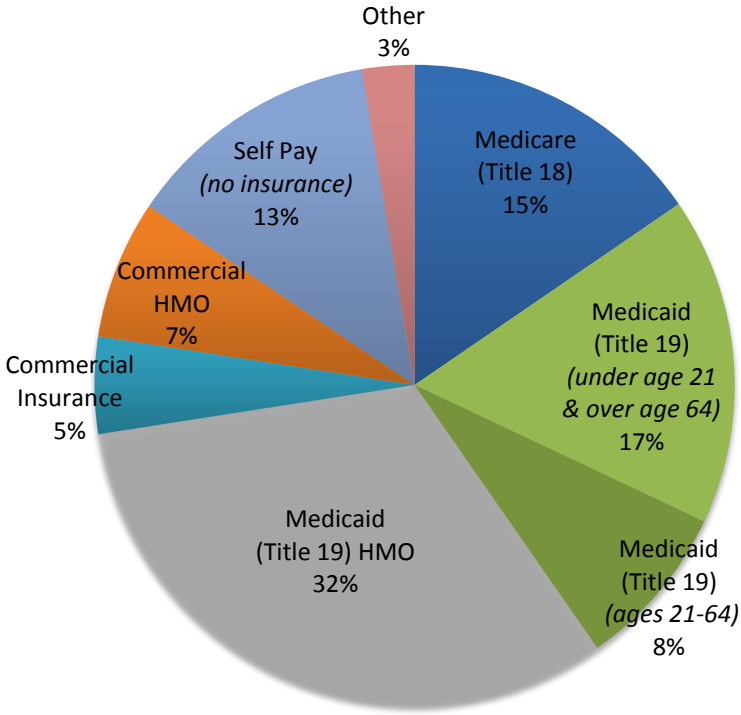
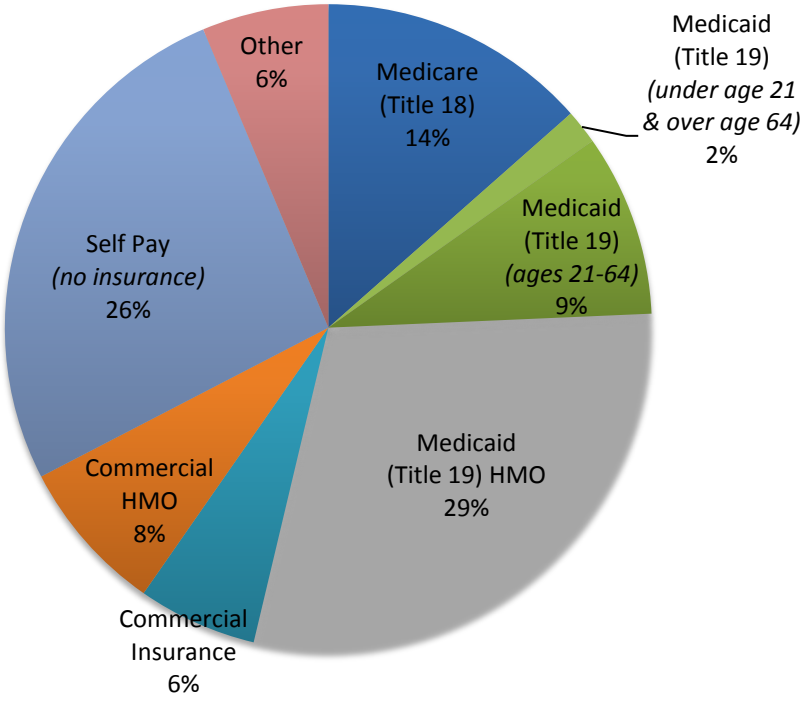
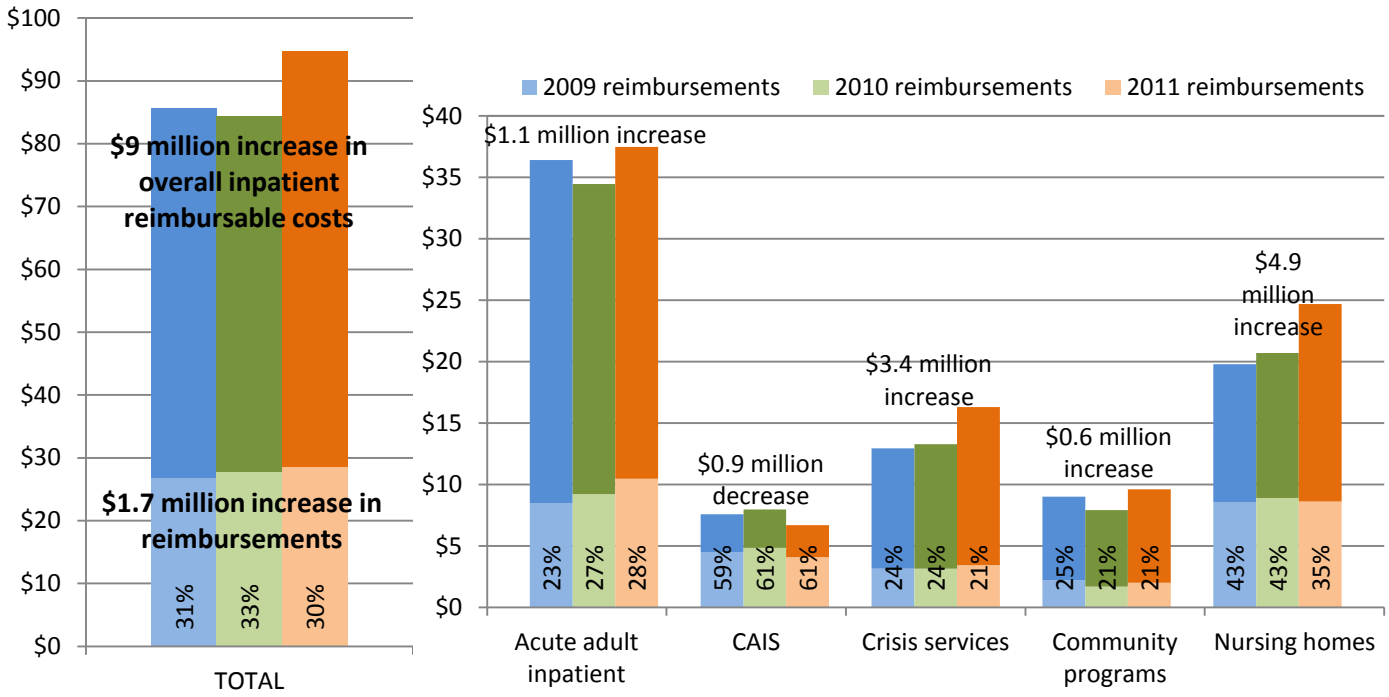


Figure 10: Psychiatric Crisis Service admissions by health insurance payer source, 2011



In **Figure 11**, we show the discrepancy between BHD billable services and patient care revenue collections by showing actual patient care revenue collected by BHD from 2009 through 2011 versus patient care costs for the various categories of mental health services.

Figure 11: Inpatient revenue reimbursement by category, 2009 through 2011



Source: BHD 2011 & 2012 quarterly Fiscal and Program Dashboard reports

Taken together, these figures reinforce the fact that BHD receives patient care reimbursement for only a fraction of its patient care costs, and that reimbursable costs have been growing at a much faster clip than actual reimbursements. Even more important, they also highlight the difficulty the division may have in reversing this problem by showing the sizable percentage of uninsured patients; and the even greater percentage who are covered by Medicaid, which is a funding source that is heavily influenced by the fiscal challenges facing both the federal and state governments.

BHD's largest source of Medicaid reimbursement – shown above as T19 of Wisconsin revenue – consists of several subcategories, the largest of which is reimbursement based on rates established annually by the Wisconsin Department of Health Services (DHS) for emergency, inpatient, nursing home and day treatment services provided to Medicaid-eligible individuals at the Mental Health Complex.[7] As shown in **Table 3** above, BHD's T19 reimbursement from the state increased substantially from 2009 to 2010, but then decreased even more substantially from 2010 to 2011.

[7] BHD and its contract vendors also receive smaller amounts of Medicaid reimbursement on roughly a 60% federal/40% local basis for certain case management and related community services. This revenue is not included in the T19 of Wisconsin revenue category.

Any efforts that BHD might wish to undertake to increase its receipt of T19 revenue from the state are impacted by the following challenges:

- BHD's inpatient operation is classified under federal guidelines as an "Institute for Mental Disease (IMD)," which prohibits it from collecting state Medicaid reimbursement for inpatient services provided to individuals between the ages of 21 and 64, even if those individuals are enrolled in Medicaid. This so-called "IMD exclusion" once prevented BHD from collecting several million dollars of Medicaid revenue per year, though that amount has declined recently because of BHD's ability to collect T19 HMO reimbursement from managed care organizations for individuals served at the Mental Health Complex who are enrolled in one of the state's Medicaid managed care programs.[8]

- The reimbursement rate for various inpatient and emergency procedures is established by the state DHS and can be impacted by the state's own budget challenges. Furthermore, the rate often is established late in the calendar year, which means BHD can be subject to mid-year budget deficits that are beyond its control when the state establishes new reimbursement rates that are lower than anticipated and applies those rates retroactively.

- Certain types of Medicaid eligibility – particularly for components of the Badger Care program – are established by DHS and can impact the number of individuals served by BHD for whom Medicaid reimbursement is even an option.

As will be discussed later in this report, despite these challenges, BHD is taking several steps to enhance its collection of T19 revenue – both directly from the state and federal Medicaid programs, and from the private HMOs that provide managed care services for thousands of Milwaukee County Medicaid recipients. This is a logical undertaking for which the division should be applauded given that it would appear to be the most elastic of BHD's major revenue sources (in contrast to the property tax and BCA) and the one over which it has the greatest internal control. Whether that potential elasticity will allow patient care revenues to grow rapidly enough to meet BHD's mental health expenditure needs is a critical question, as is what additional steps might be taken given the implementation of ACA to bolster those efforts.

[8] The IMD exclusion is predicated on the federal government's concern that local and state governments that run inpatient mental health facilities will inappropriately steer clients into inpatient settings to avail themselves of Medicaid reimbursement, as opposed to serving individuals in the community with services that may not be eligible for similar levels of federal reimbursement.

BHD 2012 ADOPTED BUDGET AND YEAR-TO-DATE EXPERIENCE

BHD's 2012 adopted budget was highlighted by a handful of far-reaching initiatives that reflected a substantial shift in the nature of inpatient operations, a commitment to investing more heavily in community-based services in keeping with the principles of early mental health redesign planning, and a continuation of efforts to shore up both the quality of Mental Health Complex operations and the accuracy of certain key revenue projections.

Table 5 provides an overview of BHD's 2012 budget, as compared to actual spending and revenues in 2011. For the sake of consistency with previous tables in this report, we deduct expenditures and revenues related to Emergency Medical Services.

Table 5: BHD 2012 Adopted Budget and 2011 Actual Expenditures and Revenues

	2011A	2012B
Personal Services w/out fringe	46,382,064	45,085,763
Employee fringe benefits	31,990,379	30,368,100
Services	19,394,747	15,524,539
Commodities	7,079,988	5,949,492
Other charges	74,371,405	78,509,772
Debt and depreciation	-	-
Capital outlay	325,256	410,000
Capital contra	-	-
County service charges	40,421,891	42,526,368
Abatements	(35,170,135)	(37,236,708)
Total Expenditures	**184,795,596**	**181,137,326**
Direct revenue	61,355,869	58,064,298
State and federal revenue	61,584,993	58,019,971
Indirect revenue	10,002,135	9,800,590
Total Revenues	**132,942,996**	**125,884,859**
Property Tax Levy	**51,852,600**	**55,252,467**

Source: BHD BRASS fiscal reports

This broad budgetary snapshot reveals several notable points regarding the manner in which county and BHD officials responded to the fiscal trends observed in the previous three years, as well as the new momentum of mental health redesign planning:

- BHD was able to secure an additional $3.4 million in property tax levy in the 2012 budget. Approximately $3 million of that amount was inserted in the budget to fund a series of initiatives linked to community resource investment consistent with mental health redesign recommendations.

- The budget projected continued substantial challenges on the revenue side, with both direct revenue and state/federal revenue projected to decline by more than $3 million from 2011 actual amounts. Reductions in BCA and adult mental health community services funds from the state were partially responsible, as were efforts to adjust certain revenue accounts to

better reflect recent experience. On the positive side, BHD budgeted for a $250,000 increase in WIMCR revenue resulting from an effort to maximize that revenue source with the help of an outside consultant.

- BHD's personnel and fringe benefit costs both were budgeted to decline by more than $1 million from 2011 actual spending levels, despite the full-year impact of an initiative begun in 2011 to increase the salaries of psychiatrists and psychologists. One cause of the decline was an initiative to outsource the remainder of the TCM caseload. BHD also benefited from cost-saving changes to the county's employee health care package.

In **Table 6**, we drill down further into BHD's 2012 budget by breaking down budgeted expenditures in the four major mental health expenditure categories analyzed in the previous section of this report. The table compares 2012 budgeted expenditure levels with actual expenditure data from the previous three years and 2011 budgeted amounts.

Table 6: BHD 2012 Adopted Budget Expenditures in Four Key Service Areas

	2009	2010	2011	2011B	2012B
INPATIENT					
Acute Adult Inpatient	31,034,465	33,418,023	32,789,264	32,809,336	32,138,850
Child & Adolescent Inpatient	5,455,167	5,845,757	5,939,470	5,797,415	5,543,000
TOTAL	**36,489,632**	**39,263,779**	**38,728,733**	**38,606,751**	**37,681,850**
PSYCHIATRIC CRISIS SERVICES					
TOTAL	**16,656,843**	**16,870,442**	**18,962,747**	**17,178,229**	**18,099,822**
NURSING HOME					
Hilltop	15,200,977	15,349,238	16,691,928	14,253,348	14,518,649
Rehab Central	13,689,632	13,303,236	14,311,442	11,742,044	13,089,851
TOTAL	**28,890,609**	**28,652,474**	**31,003,370**	**25,995,392**	**27,608,500**
COMMUNITY SERVICES					
Day Treatment	2,175,128	1,904,575	2,182,728	2,325,711	2,298,886
CSP	9,407,231	9,854,590	10,178,138	10,085,680	9,886,580
TCM	4,826,990	4,349,195	4,132,733	4,589,382	3,646,050
SAIL	3,939,731	3,660,956	3,442,126	4,605,016	4,138,156
Community-based crisis services	520,644	1,100,935	739,530	812,635	2,692,635
Other community services	7,944,084	7,532,043	8,606,986	9,415,535	9,744,007
TOTAL	**28,813,808**	**28,402,295**	**29,282,242**	**31,833,959**	**32,406,313**
TOTAL BHD EXPS	**110,850,892**	**113,188,991**	**117,977,093**	**113,614,330**	**115,796,486**

Source: BHD BRASS fiscal reports

Attributing too much significance to one–year differences in expenditures in various cost centers at BHD is risky because such differences often can result from changes in methodology for allocating internal service charges among BHD's various centers, or other accounting changes. Nevertheless, examining the change between 2011 and 2012 expenditures in the context of some of the division's 2012 budget priorities reveals the following observations:

- Despite a realignment of inpatient operations that reduced adult acute inpatient capacity from 96 to 85 beds (11.5%), adult inpatient expenditures were budgeted to decrease by only about $600,000 (2%) from the previous year's actual and budgeted amounts. This likely resulted from a number of factors, including the need to accommodate inflationary increases in fixed costs, and the fact that newly realigned inpatient units – while producing a substantial decline in bed capacity – also incorporated the need for enhanced levels of treatment that precluded sharp reductions in staffing levels. It is important to note that BHD officials viewed the creation of new intensive treatment and women's treatment units as quality improvement initiatives, as opposed to cost-cutting strategies. Still, the 2012 budget shows that as BHD looks to the future, reductions in bed capacity may not necessarily produce substantial savings that can be reinvested in community-based services, at least to the extent that no units are fully closed.[9]

- While BHD was able to budget for an $800,000 reduction at PCS for 2012 when compared to 2011 actual spending, the 2012 budgeted amount was almost $1 million higher for PCS than the 2011 budgeted total, and substantially higher than actual spending in the two years before that. Thus, it appears the need to devote additional resources to PCS continued to be a fiscal challenge for the division.[10]

- Similarly, while budgeted nursing home expenditures in 2012 were substantially below actual expenditures in 2011, they were $1.6 million higher than 2011 budgeted amounts. This shows that when county and BHD officials formulated and adopted the 2012 budget (using the 2011 budget as their base), the need to devote additional resources to BHD's nursing home facilities also continued to be a major fiscal challenge.

- In the end, the county's desire to jump-start mental health redesign by allocating an additional $3 million to community services (most of which shows up in the community-based crisis services line above) required an additional allocation of *property tax levy resources*, as shown in **Table 5**. Fiscal savings achieved by outsourcing TCM services, enhancing WIMCR revenues, reducing funding for BHD's information technology vendor (made possible by a new electronic medical records initiative), and implementing new cost-saving strategies for pharmacy and dietary services did not free up resources for community reinvestment, but instead were used to keep up with the demands of Mental Health Complex operations. This is similar to the budget paradigm faced by BHD in previous years.

An analysis of actual spending and revenues through the first six months of 2012 also reveals that several of the fiscal challenges that confronted BHD in 2009-2011 remain pressing today. The division's second quarter fiscal report projects a year-end deficit of $1.7 million. Of greatest concern are a projected $770,000 deficit in patient care revenue and a $1 million deficit in

[9] Another important variable in determining the financial savings that might be achieved via reductions in bed capacity is the acuity levels of the remaining patient population. For example, to the extent that reductions in inpatient capacity are achieved by transferring patients of relatively low acuity to private hospitals, thus leaving a patient population at the Mental Health Complex with proportionately greater acuity levels, corresponding reductions in staffing may not be possible.

[10] It should be recognized that efforts during the past three years to update BHD's cost allocation methodologies and to otherwise "clean up" accounting procedures may have impacted PCS expenditures and may modify the conclusion that service-related expenditure increases at PCS have been a major cost driver.

personnel expenditures despite a remarkable reduction in the average daily adult inpatient census from the 85 projected in the budget to 69. This would appear to indicate that a vastly reduced inpatient census has logically produced a decline in revenues, but has not been met with a corresponding decrease in inpatient expenditures.

In addition, despite BHD's commendable efforts to address longstanding areas of budgetary imbalance, it is notable that deficits again are forecast in overtime ($209,000), wages ($800,000) and "other revenues" ($368,000). Collectively, these projections may indicate that the division's efforts to fill gaps in areas that have created substantial mid-year deficits in previous years – while resulting in significant improvement – have not yet achieved complete success.

It is too early to comprehensively analyze BHD's 2012 revenue performance, but there are a couple of bright spots. One is a projected $377,000 surplus in WIMCR revenue, which reflects BHD's strategic approach to improving its cost reporting, and which may have even greater future potential given that several new strategies recommended by an outside consultant have yet to be implemented. Another is continued improvements cited by BHD fiscal officials in overall revenue collection strategies, which will be aided by full implementation of an electronic medical records (EMR) system and efforts to generate greater revenue from state-contracted HMOs and the Family Care program. The second quarter report likely does not fully capture the impact of those improvements, and BHD officials have expressed optimism that they will help the division reduce or eliminate the patient care revenue deficit by the end of the year.

Overall, from the perspective of BHD's mental health redesign planning, perhaps the most cautionary financial conclusion from BHD's 2012 budget and actual experience to date are that 1) a substantially reduced inpatient census at the Mental Health Complex has not freed up resources for reinvestment in community-based services; and 2) the continued existence of a structural deficit logically would make areas of structural imbalance the first target for any savings that eventually might be realized by downsizing Mental Health Complex operations.

Again, it is important to note that the creation of new specialized adult inpatient units and the reduction in census contained in the budget were not designed to produce budgetary savings, but instead responded to longstanding operational challenges that may have impacted the quality of inpatient care. It is apparent, however, that the reduction in inpatient revenues resulting from the lower census has exceeded BHD's ability to reduce costs, a reality that logically stems from the fact that the division still is staffing four distinct inpatient units (and thus has not been able to achieve substantial reductions in overhead), and that it has invested in higher staffing levels, compensation and other necessities required to improve care. In addition, the acuity levels of those being served at the Mental Health Complex likely has increased over time as the division has reached agreement with private health systems to care for patients of lower acuity.

Hence, an overriding takeaway is that without substantial changes in either the scope of operations or revenue performance, BHD likely will require an additional property tax levy allocation again in 2013 to address a remaining structural budget hole and accommodate inflationary increases in wages, benefits, commodities, and other fixed costs. If additional investments in community-based care also are desired, then an even more substantial property tax increase would be required.

BHD 2013 BUDGET REQUEST

Analyzing the challenges faced by BHD in preparing its 2013 requested budget crystallizes the division's overriding fiscal challenges. As has been the norm for Milwaukee County during the past decade, at the beginning of the county's 2013 budget process in April 2012, departments were instructed by the central budget office to develop budgets that would require no additional property tax levy from their 2012 budgeted amount. Furthermore, they were instructed to do so while absorbing centrally allocated increases in wages and benefits (both for active employees and to account for BHD's share of countywide legacy costs).

Consequently, as BHD officials and fiscal staff set out to develop their 2013 budget request, they immediately were confronted not only with leftover problems discussed above from 2012 and prior years, but they also were required to address a $4.6 million net increase in wage and benefit increases required to support 2012 staffing levels. **Table 7** shows how the four major service areas analyzed in this report fared in response to those challenges by comparing expenditure levels in the 2013 requested budget with those of previous years.

Table 7: BHD 2013 Requested Budget in Four Key Service Areas

	2009	2010	2011	2012B	2013R
INPATIENT					
Acute Adult Inpatient	31,034,465	33,418,023	32,789,264	32,138,850	30,789,044
Child & Adolescent Inpatient	5,455,167	5,845,757	5,939,470	5,543,000	5,906,910
TOTAL	**36,489,632**	**39,263,779**	**38,728,733**	**37,681,850**	**36,695,954**
PSYCHIATRIC CRISIS SERVICES					
TOTAL	**16,656,843**	**16,870,442**	**18,962,747**	**18,099,822**	**19,219,364**
NURSING HOME					
Hilltop	15,200,977	15,349,238	16,691,928	14,518,649	13,689,945
Rehab Central	13,689,632	13,303,236	14,311,442	13,089,851	13,345,141
TOTAL	**28,890,609**	**28,652,474**	**31,003,370**	**27,608,500**	**27,035,086**
COMMUNITY SERVICES					
Day Treatment	2,175,128	1,904,575	2,182,728	2,298,886	2,556,485
CSP	9,407,231	9,854,590	10,178,138	9,886,584	9,698,895
TCM	4,826,990	4,349,195	4,132,733	3,739,931	3,499,852
SAIL	3,939,731	3,660,956	3,442,126	4,138,156	4,247,423
Community-based crisis services	520,644	1,100,935	739,530	2,692,635	2,617,921
Other community services	7,944,084	7,532,043	8,606,986	9,650,122	9,687,950
TOTAL	**28,813,808**	**28,402,295**	**29,282,242**	**32,406,313**	**32,308,526**
TOTAL BHD EXPS	**110,850,892**	**113,188,991**	**117,977,093**	**115,796,486**	**115,258,930**

Source: BHD BRASS fiscal reports

This snapshot analysis reveals the following:

- After a substantial increase in spending on community services in the 2012 budget, the 2013 request essentially maintains community services expenditures at the 2012 level. The table above shows a slight decrease, but that is in part attributable to reduced expenditures from outsourcing the Downtown CSP caseload.

- BHD was able to reduce expenditures from 2012 budgeted levels on acute inpatient and nursing homes. This largely resulted from two downsizing initiatives that are discussed in greater detail below.

- The trend of increased expenditures on PCS continues in the 2013 budget request, with an increase of $1.2 million over the 2012 budgeted amount. This may be attributed, in part, to efforts to transform the former Crisis Walk-in Clinic at the Complex to a Mental Health Access Center, which provides a broader array of services.

A deeper examination reveals the following major fiscal strategies employed by BHD and DHHS officials in their 2013 budget request that help explain these observations.

- In addition to the fiscal challenges posed by wage and benefit increases for BHD's workforce, the division was required to accommodate more than $500,000 in additional Mental Health Complex costs linked to increased dietary, security, maintenance and utility costs and decreased space rental revenues. In addition, the requested budget includes $1.3 million related to the completion of the EMR project.

- BHD officials continued their effort to "clean up" various expenditure and revenue accounts to better reflect actual experience and reduce the structural deficit going forward. While those steps exacerbated the division's overall budgetary challenge in 2013, they reflect a commendable effort that has occurred over the past several years to eliminate budget holes caused by inaccurate or outdated budgeting and accounting. Some expenditure adjustments were included in the Mental Health Complex cost increases cited above, while a major revenue reduction was a $300,000 adjustment linked to an earlier revenue maximization initiative.

- BHD's BCA allocation for 2013 was decreased by $1.8 million to account for the state's decision to "intercept" $2.7 million of BCA related to its takeover of Income Maintenance programs, as opposed to charging the county that amount in property tax levy. Because the move was tax levy neutral in DHHS' overall budget, BHD's requested budget includes an additional $1.4 million in property tax levy, which helps offset the BCA reduction but still leaves the division $400,000 short.

- BHD included two major revenue increases in its requested budget to help bridge the budget gaps cited above: a $2.4 million increase in WIMCR revenue (offset by a $192,000 consultant fee) attributed to cost report improvements suggested by its consultant; and a $1.1 million increase in patient care revenue from Family Care CMOs to support nursing home clients who are eligible to be enrolled in the program. Both initiatives are laudatory from a

financial perspective, but it should be noted that the amounts of additional anticipated revenues from each are speculative.

- BHD also included two major Mental Health Complex downsizing initiatives to reduce expenditures: elimination of one unit (24 beds) from the Rehabilitation Center-Hilltop long-term care facility, which is expected to produce $195,000 in savings in 2013 and eliminate 30 FTEs (annual savings will be substantially higher in 2014 and beyond, as the unit would not be closed until July 1); and elimination of one 24-bed acute inpatient unit (effective April 1, 2013), producing a savings of $875,000 and eliminating 32.5 FTEs.

- The requested budget includes an initiative to outsource the division's Downtown CSP program, for a net savings of nearly $400,000. This may represent one of the last substantive outsourcing opportunities for BHD short of outsourcing direct Mental Health Complex clinical services (the division also operates one remaining CSP on Milwaukee's south side).

Overall, it is telling and quite familiar that despite accumulating $1.4 million in savings from downsizing initiatives and $3.3 million in additional revenue from two new revenue maximization initiatives, BHD found itself with next to nothing to invest in mental health redesign-generated community resource recommendations (an investment of $50,000 was included in the requested budget for this purpose). As in previous years, BHD's fixed costs in the areas of personnel and physical plant required substantial additional resources, so savings generated from outsourcing, revenue maximization and – unique to 2013 – a substantial downsizing of inpatient and nursing home units were steered toward those areas. Anything left over was used to plug structural gaps observed in previous years.

From a financial perspective, operating in this fashion is both necessary and appropriate, and BHD officials should be credited for developing cost-cutting and revenue-generating strategies to plug holes and accommodate fixed cost increases without additional property tax levy support. From a programmatic perspective, however, the goal of using Mental Health Complex downsizing savings to enhance community-based care has remained highly challenging.

LOOKING TOWARD THE FUTURE

The overriding purpose of this analysis was to analyze BHD's overall financial condition, as defined primarily by its need for increasing amounts of Milwaukee County property tax levy that exceeds expected annual growth in the levy. Only after conducting that analysis can we consider the primary question posed by the adult mental health redesign initiative, which is whether a gradual downsizing of Mental Health Complex operations might not only allow BHD to achieve fiscal stability, but also produce sufficient savings to sustain a meaningful expansion of community-based services.

Based on the data provided by BHD, it appears that recent actions to downsize inpatient capacity; outsource housekeeping, dietary and case management services; and maximize patient care and cost reporting revenue have allowed BHD to substantially reduce longstanding structural holes in its budget (at least on paper – some revenue projections still are uncertain). If indeed that is the case, then the question moving forward is whether additional expenditure reduction and revenue maximization strategies are available that might allow BHD to offset its annual increases in personnel and fixed overhead costs with only inflationary increases in its share of the county's locally allocated resources. We analyze that question below from the separate perspectives of both the expenditure and revenue sides of the budget ledger.

Expenditures

BHD's ability to control annual expenditure increases at the Mental Health Complex may hinge on the following:

1) **Taming cost pressures at PCS**. As discussed earlier, it is logical and intuitive that PCS costs would have grown substantially during the past three years because of efforts to enhance staffing levels/compensation and shore up the physical plant following increased scrutiny of Mental Health Complex operations. It also is logical that PCS costs would have increased more dramatically than acute inpatient and nursing home costs because offsetting savings related to the dietary and housekeeping initiatives would not have been as substantial. Still, we see that after a 13.8% increase in actual PCS expenditures from 2009 to 2011, BHD has been required to budget $1 million (or in excess of 5%) increases over the previous year's budgeted amounts in both 2012 and in its 2013 budget request. It is important to note that those increases are not being driven by increases in PCS visits or admissions, which have been relatively stable over the past four years.

   BHD fiscal officials believe the sizable increase from 2009 to 2011 not only was caused by beefed up staffing, security, etc., but also may have resulted from the way certain expenditures on Mental Health Complex improvements were categorized. This reflects an overriding problem observed during the course of this analysis that it is very difficult to pinpoint cost pressures and their potential causes at BHD because budgeting and accounting procedures often change from year to year.

   Regardless of the extent to which significant increases in PCS expenditures can be attributed to accounting issues, an important question is whether PCS operations have stabilized to the

point that substantial enhancements of clinical staff should not be necessary in the foreseeable future. If that is the case, and if recent sizeable investments in community-based crisis services significantly reduce the demand for such services at the Mental Health Complex, then there may even be potential to reduce PCS expenditures in future years. During the past year, BHD has opened a second community-based crisis resource center, created an enhanced Mental Health Access Clinic, and established a new Community Linkages and Stabilization Program, each of which holds promise to reduce activity levels at PCS. BHD officials may wish to further analyze the potential for expenditure reduction strategies to correspond with lower activity levels and factor that potential into budget and mental health redesign planning.

2) **Realizing substantial relief from inpatient and Hilltop unit closures**. Perhaps the most important near-term fiscal question for BHD is whether the ongoing annual savings in staffing and overhead produced by the closure of one acute inpatient unit and one unit at Hilltop in 2013 (assuming those requests are adopted in the budget) will allow those major cost centers to stop being the biggest annual drain on BHD's overall budget. Because the two proposed unit closures will not occur until mid-year, some additional savings also should materialize in 2014 that may be available to help fund community enhancements. The larger question, however, is whether after these steps are taken, will Mental Health Complex operations be "right-sized" to the extent that annual increases in fixed costs going forward can be covered by increases in patient care or other non-property tax revenues.

   Unfortunately, our analysis of the cost savings projected by BHD from its unit closures reveals that is unlikely to be the case. **Table 8** reproduces figures from a BHD work document used to develop the 2013 budget request that show initial projected cost savings that would result from the closure of one of the four adult acute inpatient units as of April 1, 2013. This information shows that BHD initially projected an annual expenditure savings of $2.5 million and an annual property tax levy savings of $1 million out of total expenditure amounts of $30.3 million and $23.8 million respectively. The lower property tax levy savings is caused by the estimated loss of $1.5 million of patient care revenue associated with the reduced census.[11]

[11] The savings amount of $875,224 cited in the requested budget differs from the amount shown in the table because of changes that occurred when this and other initiatives were plugged into the county's budgeting system (BRASS). We use the budget figures shown in the table because this was the information that could be readily provided to us by BHD. We are confident that even if we had access to and used the BRASS numbers, our overall findings would have been the same. Also, we focus on the closure of an adult inpatient unit in this analysis, but the findings generally are the same for the closure of a Hilltop unit.

Table 8: Projected Annualized Savings from Closing One Acute Treatment Unit

	2013 Baseline	2013 Request w/1 Closure	9-Month Savings
Personal Services	18,235,808	16,284,336	1,951,472
Services	545,291	443,049	102,242
Commodities	1,687,691	1,371,249	316,442
Other charges	1,040,505	1,040,410	95
Capital outlay	30,000	24,375	5,625
Crosscharges	11,331,451	11,168,882	162,569
Total Expenditures	**32,870,746**	**30,332,301**	**2,538,445**
Direct revenue	7,990,558	6,492,328	(1,498,230)
State and federal revenue	-	-	-
Total Revenues	7,990,558	6,492,328	(1,498,230)
Property Tax Levy	**24,880,188**	**23,839,973**	**1,040,215**

Source: Work document provided BHD fiscal staff

The paramount question is why BHD is able to realize only a 4% savings in property tax levy when it is reducing its bed capacity by 27% (24 of 88 beds). That BHD would not be able to reduce its levy by a percentage that is directly proportional to the reduction in beds makes intuitive sense given that substantial overhead and infrastructure needs remain for the three units, and that it is impossible to reduce costs for items like heating, maintenance and housekeeping on a proportional basis. Still, reason would dictate that savings of greater than $1 million out of a $24 million property tax levy allocation should be achievable with the closure of one of four adult inpatient units for nine months of the year.

Deeper analysis reveals that the cause for this discrepancy is the internal and external crosscharges that are allocated to the acute adult inpatient budget. While **Table 8** shows substantial savings in personnel costs and commodities that are along the lines of what might be expected from the closure of one unit, BHD estimates only a $163,000 (1.4%) savings from its $11.3 million crosscharge allocation. This finding obviously suggests the need for a deeper understanding of the nature of BHD's internal and external crosscharges and the methodology for allocating those costs, which we will attempt to convey briefly here.

BHD's 2012 budget includes a total of $43.5 million in crosscharges. Of that amount, about $6.2 million reflects BHD's charges for services provided by other county government departments (e.g. information technology support, central payroll and accounting, legal services, architectural and engineering services, laundry services, sewer/water) or its share of certain general county government costs that are budgeted centrally (e.g. worker's compensation, insurance services, computer mainframe charges). The remaining $37 million consists of BHD's internal overhead/administrative costs that are allocated to each major subunit of the division proportional to that unit's share of BHD's overall budget.[12] Those costs are delineated by administrative/overhead cost center in **Table 9**.

[12] About 20% of this $37 million consists of "legacy" costs that will remain an obligation of Milwaukee County regardless of whether the personnel costs associated with the internal services are reduced or even eliminated.

Table 9: BHD Administrative/Overhead Cost Centers

Cost Center	2012 Allocation
Central Admin	4,800,995
Psychiatry Admin	851,806
Psychology Admin	363,993
Nursing Admin	2,061,109
Organizational Dev	1,274,137
Personnel and Payroll	826,479
Quality Mgmt	614,646
Education	974,057
Security	687,479
Legal Services	442,993
Support Services Admin	70,775
Dietary	3,383,789
Storeroom	363,525
Pharmacy	97,659
Clerical Pool	801,182
Facilities Maintenance Admin	2,809,744
Facilities Maintenance Psych Hosp	3,507,418
Housekeeping	2,368,655
Linen	536,242
Facility Maintenance Day Hosp	440,000
Fiscal Admin	1,375,133
Fiscal Services	883,689
Accounts Receivable	1,459,634
Admissions	961,127
Mgmt Information	2,007,558
Medical Records	1,500,106
Staffing Office	611,167

Understanding the nature of these charges and their prominence in BHD's adult acute inpatient budget makes it easier to understand why the savings produced by the closure of more than a quarter of BHD's adult inpatient beds are relatively meager. For example, support functions like accounts receivable, fiscal services and overall administration logically cannot be cut at the same ratio as inpatient beds (e.g. if there are six accountants serving all of BHD, it may not be possible to cut even one of those positions just because an inpatient unit is closing). In addition, costs for maintaining and operating the physical plant – like heating, water/sewer, groundskeeping, minor maintenance, security – would not diminish significantly as long as Mental Health Complex operations remain at their current location. Similarly, any reductions in the county's central service costs that accrue from the reduction in positions associated with one unit either are nonexistent or very small, and BHD's share of such savings is even smaller.

Consequently, it appears that from a fiscal perspective, the closure of a single acute adult inpatient unit and a single unit at Hilltop (which produces an even smaller estimated annualized savings of $239,000) should be viewed similar to the outsourcing of dietary and housekeeping services at BHD. These are steps that address BHD's immediate budget

challenges and, in the process, decrease baseline operations spending. That puts the division in a better position to combat inflationary fixed cost pressures in the future, but it appears that the small decrease in baseline spending only makes a small dent in the overall structural problem, and that it certainly does not free up substantial resources for community investment.

This analysis also raises several important questions and potential action steps for the future, including the following:

- Has BHD conducted a thorough examination of the cost centers that comprise the $37 million in internal crosscharges to determine whether the impending closure of both an inpatient and Hilltop unit could produce more sizeable savings?

- If the closure of two units would not produce substantial savings in internal overhead and administration, then how much additional downsizing would that take? Should BHD be establishing a plan to engage in additional downsizing that might correspond with its ability to realize significant savings in administration and overhead?

- Would a new, smaller facility substantially reduce physical plant-related costs, or would many of those costs remain in a new county-owned facility because they are tied to the county's larger cost allocation methodology? If many of those costs would remain, might it be best for the county to focus on further consolidating operations at the existing Complex, as opposed to pursuing a new county-owned facility?

The answer to those questions are imperative in determining BHD's fiscal future. If it turns out that closing additional units above those proposed in 2013 (if even possible from a patient care perspective) would produce only incremental cost savings because of BHD's overhead realities, then county leaders face a difficult dilemma. They either must recognize that providing inpatient, long-term care and emergency mental health services to a largely indigent population is a money-loser and budget for that reality, or they will have to consider getting out of the hospital and long-term care business entirely.

It also is difficult, after reviewing BHD's administrative/overhead costs, to avoid asking whether BHD would be better off contracting for the inpatient and long-term care beds it deems necessary with one or more of the private hospital systems, which presumably would have the ability to operate with a far less expensive administrative/overhead burden. That would particularly be the case for a private system that already has a robust administrative/overhead infrastructure and that could fold BHD's operations into that infrastructure for a reasonable additional cost. Of course, a critical question is whether a qualified private sector provider that has the clinical capacity to appropriately care for BHD's most acute patients exists, and whether that provider (or providers) would be willing to contract with BHD for those services under reasonable terms.

3) **Controlling annual increases in personnel costs**. Even with the closure of two units and the proposed outsourcing of the Downtown CSP caseload, BHD will continue to have the second largest workforce of any organizational unit in county government. Consequently, the division remains highly susceptible to having Milwaukee County's overall personnel costs drive its financial future.

   One of the relatively surprising findings of this analysis is that county "legacy" and other fringe benefit costs not only were *not* a driver of increased property tax allocations for BHD from 2009 through 2012, but that the division actually benefited financially from countywide health care changes, thus freeing up resources for other initiatives. It appears that may change in 2013, however, as BHD was required to absorb more than $3 million in increased pension and retiree health care costs in its 2013 requested budget.

   As the Public Policy Forum has explained in several Milwaukee County fiscal analyses in recent years, county legacy costs (and any increases in those costs) are not budgeted centrally, but instead are allocated to departments based on their proportion of the county's active workforce. Consequently, labor-intensive departments like BHD suffer most from overall increases in the cost of health care or the size of the county's unfunded pension liability, and they also are penalized when substantial workforce reductions occur in other parts of county government.

   BHD's downsizing and outsourcing initiatives – as well as changes implemented by the county to reduce the employer share of health care and pension costs – have benefited it financially in recent years because of this methodology, but its capacity to avail itself of personnel reduction strategies may be somewhat exhausted after 2013, unless it continues with Mental Health Complex downsizing. Consequently, if county fiscal officials continue their current methodology for allocating legacy costs – and those costs continue to substantially outrun inflation – then any funding prioritization they may wish to give to mental health-related community investments likely would need to take a backseat to efforts to keep up with rising personnel costs.

   At the very least, our analysis suggests it is inappropriate to treat BHD's Mental Health Complex operations like other county departments by allocating increasing shares of legacy costs to the division, while insisting that it comply with flat or reduced property tax levy directives. In addition to failing to recognize the unique inflation-related cost pressures faced by BHD (such as rising pharmaceutical costs), this policy fails to recognize its unique workforce demands. In a hospital setting, it is impossible to maintain vacancies in key medical and nursing positions, and it is unrealistic to expect BHD to compete with private health systems for medical personnel within an antiquated compensation structure that is predicated on the salary structure of the rest of county government, as opposed to the regional health care industry. The willingness of policymakers and fiscal officials to recognize that BHD's Mental Health Complex operations merit different budgetary treatment may be particularly important given that BHD's outsourcing and revenue maximization strategies soon may be exhausted.

Revenues

Similarly, there are a handful of key imperatives on the revenue side that will determine BHD's fiscal future.

1) **Preparing realistic short-term and multi-year revenue projections.** BHD has been plagued for more than a decade by an inability to reliably estimate major patient care revenue streams on an annual basis, thus placing the division in great danger of running mid-year budget deficits and precluding its ability to engage in thoughtful long-range fiscal planning. In many respects, the fault for this predicament does not lie with BHD, but with its reliance on state and federal reimbursement rates that can shift significantly from year to year, and that often are not even established until after BHD has adopted its annual budget or is well into its fiscal year.

   Nevertheless, BHD could improve its fiscal plight by 1) better documenting and explaining the complexity of its major revenue projections to the central budget office and elected officials so they have a better understanding of the need to manage the division's financial risk; 2) modeling annual and multi-year revenue scenarios and incorporating those scenarios into annual and multi-year programmatic decision-making; and 3) refraining from plugging uncertain revenue estimates into annual budgets, which only serves to exacerbate its revenue uncertainty.

   To their credit (as discussed above), BHD officials have made a concerted effort in recent years to fill known revenue gaps and enhance the reliability of revenue collections and projections with the EMR implementation and the use of cost reporting consultants. New risk also has been created in recent years, however, from inserting uncertain revenue projections associated with those strategies and other revenue maximization initiatives into annual budget requests.

   For a variety of reasons – including the transition to EMR and the intense workload of BHD's small fiscal staff – we were not able to secure the data needed to dig deeply into BHD's revenue picture for this analysis. We would recommend that going forward, the division do that digging itself and paint a clear picture of each of its major revenue streams and revenue initiatives. That should include analysis of potential threats and opportunities regarding its patient mix – which has changed significantly in recent years because of efforts to transfer growing numbers of patients to private health systems – and both short-term and multi-year forecasts. That information should be provided at least annually for key decision-makers in DAS, the county executive's office and the county board.

2) **Continuing efforts to improve its revenue collection acumen**. We are impressed with the manner in which BHD has focused in recent years on improving and enhancing its billing processes and procedures, as well as with its ability to secure resources to invest in EMR and cost reporting consultants. This reflects a conclusion – which is supported by our analysis – that enhancing patient care revenues is one of the most important long-term strategies BHD can pursue from a financial perspective, given the dim prospects for additional general

support from the State of Wisconsin, and the desire to use any increases in property tax levy for enhancement of community-based services.

While there is no question that EMR and other strategies currently being pursued by BHD fiscal staff have potential to produce several million dollars of increased revenue annually, it will be important for the division to attempt to quantify the difference such improvements may make. As explained above, our capacity to do so for this analysis was limited by lack of data.

Let us assume, however, that even after accounting for the increases in WIMCR and EMR-generated revenue that are contained in the 2013 requested budgeted, there is potential to further increase patient care revenue by 10-15% per year, or about another $4-5 million annually. That, of course, would be a significant infusion of additional revenue for BHD, but in light of its remaining structural problems and the division's fixed cost pressures, it still is questionable whether it would be enough to obviate the need for increased property tax revenue and allow for increased investments in community-based services.

Another important revenue collection initiative involves the division's efforts to extract greater levels of reimbursement from Family Care CMOs for eligible individuals housed at Hilltop. Again, this initiative makes sense from numerous perspectives. If it is viewed by BHD as a key piece of its long-term fiscal puzzle, however, then it should be accompanied by realistic estimates of its revenue enhancement potential, as well as transparent information for DAS and policymakers regarding key barriers and how those might be overcome. A key issue for BHD, for example, will be its ability to work with guardians of those housed at Hilltop to convince them that enrollment in Family Care and a community-based approach to care for their loved ones is appropriate. BHD may wish to lay out that challenge for fiscal officials and policymakers to promote a better understanding of the revenue potential associated with its Family Care strategy, as well as the potential impact on long-term downsizing plans.

3) **Responding to the ACA and changes in Medicaid**. As discussed in the Introduction, a secondary purpose of this analysis – in addition to providing a baseline assessment of BHD's fiscal condition to assist mental health redesign deliberations – is to inform consideration about potential opportunities related to implementation of the Affordable Care Act. We find that ACA has considerable potential to benefit BHD by reducing its volume of uninsured patients. At the same time, however, potential major changes in Medicaid reimbursement rates that may result from federal and state budget challenges pose a considerable potential threat.

With regard to the ACA, our analysis shows that roughly 23% of all admissions to inpatient and PCS in 2011 (a total of 3,842 admissions) lacked an insurance source. Given that BHD's total billable costs in 2011 for inpatient and PCS services were about $60 million, if ACA implementation substantially reduced that number, then several million dollars of additional revenue could materialize.

To illustrate that point, let's assume that ACA implementation cut the number of uninsured admissions to inpatient and PCS in half, or by roughly 1,900 admissions. It is not possible to discern BHD's potential cost recovery for the additional covered admissions because we do not know the level of insurance coverage that would be provided. We do know, however, that in 2011, BHD's reimbursement rates for adult inpatient, CAIS and PCS services were 23%, 56%, and 24% respectively. Those rates do not reflect reimbursement rates for covered patients because they include the uninsured population, so we would need to bump them up a bit. If we do so by assuming that BHD could have received reimbursement for 40% of its billable costs for an additional 1,900 individuals in 2011, at an average billable cost of $3,698 per admission (this is the actual 2011 average for these three service categories combined), then we can estimate that BHD hypothetically could have collected an additional $2.8 million in reimbursement revenue under our assumed scenario.

In addition to providing coverage to significant numbers of additional patients, ACA also could positively impact BHD's revenue streams by eliminating or modifying the IMD exclusion; expanding Medicaid coverage to additional behavioral health-related services; or enhancing Medicaid reimbursement rates for certain services. Conversely, if federal and state budget challenges necessitate further limitations on Medicaid coverage for certain services (such as TCM, which almost became a non-reimbursable service several years ago), or a reduction in current reimbursement rates, then any gains realized by reducing the uninsured population could be negated.

It is too early to tell how ACA implementation will impact these questions, or whether the law will be implemented in its current form at all. Our analysis does give a sense of the financial stakes that may be involved, however, and the need for BHD to be closely monitoring these issues and incorporating various scenarios into its fiscal and redesign planning.