OFFICE OF THE COUNTY EXECUTIVE

Milwaukee County

CHRIS ABELE • COUNTY EXECUTIVE

DATE: March 27, 2013

TO: Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Chris Abele, Milwaukee County Executive

SUBJECT: Appointment of Paul Fairchild to the Commission on Aging

Subject to the confirmation of your Honorable Body and pursuant to the provisions set forth in Milwaukee County General Ordinances Chapter 53.03 I am hereby appointing Paul Fairchild to the Milwaukee County Commission on Aging. Mr. Fairchild's term will end on April 1, 2016.

Your consideration of this appointment is appreciated.

Chris Abele
Milwaukee County Executive

CC: Supervisor Peggy Romo West, Chair, Health and Human Needs Committee
Kelly Bablitch, Chief of Staff, County Board of Supervisors
Stephanie Sue Stein, Director, Department on Aging
Jodi Mapp, Committee Clerk
Jennifer Collins, Research Analyst
Paul Fairchild

MILWAUKEE COUNTY COURTHOUSE, 901 NORTH 9TH STREET, ROOM 306, MILWAUKEE, WI 53233
TELEPHONE (414) 278-4211 FAX (414) 223-1375 COUNTY.MILWAUKEE.GOV/COUNTYEXECUTIVE

Paul R. Fairchild

1437 N. 50Th PlaceI Milwaukee, WI 53208 I prfairchild@mac.com
(M) 773-405-2292

President & Chief Executive Officer – Cream City Foundation, March 2012 to present
Cream City Foundation mobilizes philanthropic resources by harnessing the pride, passion, and commitment of lesbian, gay, bisexual, and transgender people and their allies to advance the human rights and respond to the human needs of LGBT people in Southeastern Wisconsin.

First Year Accomplishments Included:
- Led the board through changing the mission, vision, values, and developing a new strategic plan within the first 6 months
- Implemented the new strategic plan with a monitoring tool to track The Foundation's work for the next three years
- Increased The Foundation's annual grant making program by 99%
- Increased the visibility of The Foundation with more than 250 meetings including community organizations, foundations, corporations, individual donors, elected officials, the press, and program participants

Additionally served in a leadership role to begin merger negotiations with 4 organizations, began quarterly meetings with 9 corporations who are starting lesbian, gay, bisexual, and transgender employee resource groups, and introduced countless corporations and foundations to the intersection of LGBT equality and the human rights movement.

Chief Development Officer – Howard Brown Health Center, 2007-2010
Interim Chief Executive Officer – March – May 2010
Through implementation of the strategic plan, directed communications, resource development, and resale business for this Federally Qualified Health Center Look Alike. Howard Brown is the Midwest's largest provider of health care and human services to the gay, lesbian, bisexual, and transgender people of Chicago. Annual budget - $17,000,000.

Responsibilities included:
- Strategic Planning ▪Donor Communications ▪Community Relations ▪Staff Development ▪Volunteer recruitment and intake
- Member of the Executive Team ▪Board Development and Recruitment ▪In-kind donations and community resources
- Direct/supervise the following fund raising campaigns:
  - Board Gifts ▪Major Gifts ▪Individual Gifts ▪Staff Gifts
  - Corporate, Foundation, and Organizational Giving ▪Planned Giving
  - Government Grants and Contracts ▪Resale Stores ▪Special Events ▪Direct Mail

Accomplishments Included:
- Increased philanthropic giving by 45% in my first year, and maintained same level of giving through my 3 year tenure
- Increased resale revenue by 7% during this economic downturn
- Staff retention of 90%
- Created and implemented online communications and giving
- Created employee communications plan including quarterly staff newsletter

Vice President, Donor & Community Relations – Heartland Alliance for Human Needs & Human Rights, 2000 – 2007
Directed this complex organization's resource development department through implementation of the strategic plan. Managed a staff of 9, governing boards of 114, and auxiliary boards of more than 100, raise philanthropic income in excess of $6 million to support the work of this service-based human rights organization. Heartland Alliance provides housing, health care, human services and human rights protection for more than 100,000 poor, vulnerable and unprotected people annually.
Annual budget - $54,000,000.

Responsibilities included:
- Strategic Planning ▪Donor Communications ▪Community Relations ▪Staff Development ▪Volunteer recruitment and intake
- Member of the Executive Team ▪Supervise the Designs for Dignity Program

- Board Development and Recruitment:
  - 4 Governing Boards
    - Heartland Alliance for Human Needs & Human Rights ▪Heartland Housing Inc.
    - Heartland Health Outreach ▪Heartland Human Care Services
  - 4 Auxiliary Boards
    - Women's Board ▪West Suburban Board ▪Junior Board ▪Designs for Dignity
- Direct/supervise the following fund raising campaigns:
  - Board Gifts ▪Major Gifts ▪Individual Gifts ▪Staff Gifts ▪In-kind donations and community resources
  - Corporate Foundation and Organizational Giving ▪Planned Giving ▪Direct Mail
  - Special Events:
    - Kitchen Walk (Designs for Dignity Board) ▪The Celebration Ball (Women's Board)
    - Art Against AIDS (Junior Board) ▪Spirit Awards (Designs for Dignity Board)
    - Midwest Light of Human Rights Awards (Committee of Heartland's National Immigrant Justice Center)
    - A Celebration of Home (Home & Garden Tour, Committee of Heartland Housing)

Accomplishments included:

- Exceeded budgeted income by an average of 32% per year ▪Increased income by 36% per year
- In-kind donations increased by 40% ▪Maintained a fund raising cost of less than 18% average
- Added fourth auxiliary board, Designs for Dignity, bringing in more than 700 new donors
- Staff retention of 90% ▪Organizationally volunteers increased from 700 to more than 900
- Supervised the Communications Department through the re-branding of the organization and re-naming the organization's four subsidiary partners

Senior Director of Development – Heartland Alliance for Human Needs & Human Rights, December 2000 – February 2003

Responsibilities Included:

- Strategic planning Corporate Foundation and Organizational gifts ▪Direct Mail Campaign ▪Special Events
- Auxiliary and Board Development ▪Volunteer coordination including the Americorp*VISTA program
- Facilitate Capital Fund Raising Initiative ▪Community Resources ▪Create and maintain departmental budget
- Collaborate with department and program staff to assist them in reaching their fund raising goals

Accomplishments included:

- Creation and implementation of a Corporate Partnership Initiative securing more than $100,000 in new and increased corporate support
- Creation of a Junior Board, adding a third auxiliary to support the work of the organization and develop future volunteer leadership
- Revitalization of Heartland Alliance's two signature events, increasing the revenue by an average of 30% and an average cost of 31%
- Promoted to Vice President of Communications & Development within 2 years

Director of Development - Horizons Community Services – 1997-2000

Responsibilities included:

- Created and implemented annual fund raising plan
- Directed and supervised all fund raising efforts, marketing, information services and volunteer services
- Directed and managed $4 million capital campaign
- Media spokesperson
- Direct reports were; Grants Coordinator, Marketing & Public Affairs Coordinator/Special Events, Manager Information Services, Volunteer Coordinator

Accomplishments included:

- Increased major donor gifts by 28% ▪Increased donor count 26%
- Produced signature black tie event at 30% cost and increased gross income by 49%
- Secured advertising agency Leo Burnett *pro-bono* and launched a city-wide ad campaign, receiving national recognition for its creativity and its affirming messages about the community served
- Created and directed 25th Anniversary year of celebration

Image Consultant – Self Employed - 1990-1997
Developed and presented trainings and workshops about business etiquette, appropriate attire, and creating your own personal and professional image.

Management – Retail and Hospitality Industries – 1980-1990
Held a variety of positions from management of women's couture salon in Minneapolis to a bartender in the north woods of Michigan.

Administrator – Lexington House Corporation 1976-1980
Skilled health care facility caring for co-existing developmentally and physically disabled individuals of all ages, in a private facility as state institutions were first being dismantled by the State of Michigan.

Accomplishments included:

- Took the skilled health care facility from 382 violations of the Department of Public Health to no violation in the first year.
- Formed collaborations with the State Departments of Mental Health, Social Service, Public Health, Wayne County School District to coordinate care and education. The program became the model in the state for care of this population
- Recognized by the corporation with a 300% increase in salary within two years
- Retained by the corporation upon my resignation as a consultant

Education
Bachelor of Science, 1976 Mankato State University

- Mass Communications/Public Relations
- Sociology

OFFICE OF THE COUNTY EXECUTIVE

Milwaukee County

CHRIS ABELE • COUNTY EXECUTIVE

DATE: March 27, 2013

TO: Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Chris Abele, Milwaukee County Executive

SUBJECT: Appointment of Barbara Wyatt Sibley to the Commission on Aging

Subject to the confirmation of your Honorable Body and pursuant to the provisions set forth in Milwaukee County General Ordinances Chapter 53.03 I am hereby appointing Barbara Wyatt Sibley to the Milwaukee County Commission on Aging. Mrs. Wyatt Sibley's term will end on April 1, 2016.

Your consideration of this appointment is appreciated.

Chris Abele
Milwaukee County Executive

CC: Supervisor Peggy Romo West, Chair, Health and Human Needs Committee
Kelly Bablitch, Chief of Staff, County Board of Supervisors
Stephanie Sue Stein, Director, Department on Aging
Jodi Mapp, Committee Clerk
Jennifer Collins, Research Analyst
Barbara Wyatt Sibley

MILWAUKEE COUNTY COURTHOUSE, 901 NORTH 9TH STREET, ROOM 306, MILWAUKEE, WI 53233
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Barbara Wyatt Sibley

1840 N 1st Street, Milwaukee, Wisconsin 53212-3707
Home - 414-264-9888 **Home Fax**- 414-264-9781 **Cell** - 414-379-0997

WORK EXPERIENCE

Milwaukee Christian Center
Executive Director 2010 – 2012
A midsize nonprofit with an operating budget of $4.8 million dollars and a staff of approximately 75 FTE. The agency serves youth, young adults, families and seniors. Programs include senior recreation, nutrition and health services; youth afterschool and summer programming; neighborhood improvement that offers job readiness, affordable housing construction, owner occupied rehabs, handicap home accessibility and graffiti removal; emergency food pantry services and juvenile justice support to at risk youth.

State of Wisconsin - Department of Regulation and Licensing (DRL) – Madison, Wisconsin
Deputy Secretary 2006 - 2010
Was responsible for the day to day operations of the agency. The department licenses and regulates 132 different types of credentials in more than 58 professional fields. The agency issues approximately 27,500 new credentials each year and renews more than 350,000 credential holders each biennium. The agency also provides centralized administrative services to 64 boards, councils, and advisory committees. Organizational responsibility includes four divisions; Professional Credential Processing, Board Services, Enforcement, Management Services, and three offices; the Office of the Secretary, the Office of Legal Counsel, and the Office of Education and Examinations. Operating budget is approximately $13.8 million and agency staff of 125.

YWCA of Greater Milwaukee – Milwaukee, Wisconsin
President & CEO 2002 – 2005
Assumed leadership and management responsibility for the overall operation of the $44 million agency. This social service agency offered programs and services in a number of areas including Workforce Development, Girls Leadership, Older Adults, Transitional Housing, Adult Education and *W2 (Welfare to Work).*

Time Warner Cable – Milwaukee, Wisconsin
Area General Manager, Metro Region 2000 – 2002
Primary provider of cable telecommunication services in Southeastern Wisconsin. Led a team of 265 contributors who provided service to approximately 125,000 customers in city of Milwaukee. Managed installation, repair, plant maintenance, and payment/customer contact center functions.

Barbara J Wyatt – Consultant
Customer Service Consultant 1997 – 1999
Provided customer service expertise to major health care insurer. Acted as business unit representative in design and development of an $8.5 million customer contact center. Transition included legacy system, business processes, and performance management strategy for call center operations.

AT& T (Formerly SBC Communications) 1964 – 1997
Director Customer Services Operations (at the time of my retirement)
AT&T is the telecommunications provider for the Midwest region. Career included progressive leadership roles in customer services, human resources, network planning, installation and repair.

Barbara Wyatt Sibley

1840 N 1st Street, Milwaukee, Wisconsin 53212-3707
Home - 414-264-9888 **Home Fax**- 414-264-9781 **Cell** - 414-379-0997

EDUCATION

1988 **Duke University** – Durham, North Carolina
Certificate of Management Development

1985-89 **Milwaukee School Engineering** – Milwaukee, Wisconsin
Graduate Program - Engineering Management

1982 **Alverno College** – Milwaukee, Wisconsin
Bachelor of Arts - Business Management

BOARD MEMBERSHIPS

Current
Alverno College
Past
Community Care
Wisconsin Women = Prosperity
Willie D Davis Scholarship Fund
YWCA of Greater Milwaukee
Girl Scouts of Southeast Wisconsin
Alverno College Alumnae Association
New Concepts Self Development Center
Women's Fund
Shade Tree Family Resource Center
Inner City Arts Council

PROFESSIONAL AFFILIATION

Zonta Club of Milwaukee - Board of Directors, Co-Chair Program Committee

CHURCH ACTIVITIES

Milwaukee Interdenominational Sisterhood of Ministers Wives and Ministers Widows - Member
Mt Zion Missionary Baptist Church – Member
Mt Zion Ministers Wives – Chairperson
Mt Zion Mission Ministry - President Advisory Committee
Mt Zion Sunday School – Class Participant
Mt Zion Ushers – Senior Usher
Mt Zion Youth Ministry – Youth Leader
Wisconsin General Baptist State Convention – Member & Instructor Ministers Wives

COMMUNITY PARTICIPATION

National Black Marriage Day - Steering Committee Member

FAMILY INFORMATION

Married to Rev Louis E Sibley III, Senior Pastor of Mt Zion Missionary Baptist Church
Daughters, Kelly and Ingrid
Granddaughters Carine, Ilana and Hailey

The Impact of the Affordable Care Act on Milwaukee County's Behavioral Health Division

Prepared By:

Michael Bare
Research and Program Coordinator
Community Advocates Public Policy Institute

David Riemer
Senior Fellow
Community Advocates Public Policy Institute

November 28, 2012

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About the Community Advocates Public Policy Institute

Community Advocates established the Public Policy Institute to identify and carry out specific, evidence-based policy changes that will help reduce poverty and improve the quality of life for low-income individuals and families in Milwaukee and throughout Wisconsin.

The Public Policy Institute is intensely engaged in strategizing, researching, organizing, communicating, and developing policy and legislation in order to persuade policy makers to create public policies that directly help impoverished people lead better lives.

True to its name, the heart of the Community Advocates Public Policy Institute's work is advocacy. The Public Policy Institute is uniquely situated in a human services agency that serves more than 75,000 clients annually. This allows the Public Policy Institute to interact with clients and the staff who provide advocacy and supportive services.

The Public Policy Institute also joins with individuals and organizations at the local, state, and national levels to develop and implement a practical strategy to reduce poverty throughout Wisconsin. This approach includes constant monitoring and consideration of the policies and issues affecting health care, employment, housing, criminal justice and public safety, education, and prevention initiatives to ensure both the safety and success of the low-income communities in Milwaukee and throughout Wisconsin.

For more information on the Public Policy Institute, please visit: http://communityadvocates.net/ppi

I. Executive Summary

The Community Advocates Public Policy Institute has partnered with the Public Policy Forum 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 financial support from BHD and the Milwaukee County Department of Health and Human Services.

CA-PPI's role in the project was to understand, assess, and report on the impact of the ACA on BHD. This included educating BHD senior staff on the ACA. During several meetings, CA-PPI presented information and discussed a multitude of subjects related to the ACA's impact on BHD.

The ACA clearly has the potential to transform both BHD's financial outlook and the care that patients receive. Several ACA provisions are already in place and are already having an impact on BHD. For the most part, however, the effects of the ACA will occur in 2014 and future years because of timelines in the law, the opportunity provided to the State of Wisconsin to enact implementing legislation regarding Medicaid, and anticipated federal regulations, guidance, and approvals.

This report will discuss the ACA's expansion of health coverage options, its expansion of benefits, new care delivery models, and new funding opportunities. Each will be put in the context of BHD's services and patients.

Finally, this report will make recommendations on the future of BHD and how it can harness the ACA to increase Medicaid and insurance company revenue, reduce reliance on property taxes, and improve the care of the patients BHD serves. Because we do not yet know: (1) what Governor Walker, the Wisconsin Legislature, and other state policymakers will do regarding the potential expansion of Medicaid to individuals up to 133% of the federal poverty level; and (2) what the final regulations from the U.S. Department of Health and Human Services will look like with respect to the operation of Wisconsin's federally-facilitated exchanges and the details of the ACA's Essential Health Benefits package, it is not possible at this juncture to translate this report's recommendations into precise estimates with dollar figures. Even with this measure of uncertainty, however, we believe BHD can begin to take concrete steps—regarding both financing and services—to prepare for the implementation of the ACA.

II. Research Method, Limits of this Research, and Glossary of Terms

Research Method

The preparation of this report relied on interviews and conversations with Milwaukee County Behavioral Health Division staff, as well as a review of relevant literature. Full citations to sources can be found throughout this report.

Limits of this Research

This research was limited by the inability of BHD to provide data regarding eligibility and benefit characteristics—U.S. residency status, age, dependent children, custodial parent status, pregnancy, disability, family size, income, and insurance status—of the population it serves. The availability of this data would have allowed for a far more precise estimate of the impact of the ACA on BHD. With such information, for example, this report would have included a side-by-side that compares the population served, benefits provided, costs incurred, and the types and amounts of revenue received by BHD in 2011 without the ACA vs. the population that would have been served, the benefits that would have been provided, the costs that would have been incurred, and the types and amounts of revenues that would have been received by BHD in 2011 if the ACA were in effect. In the absence of such data, this report is limited to general conclusions and basic recommendations.

This research was also limited by the fact that we do not yet know: (1) what Governor Walker, the Wisconsin Legislature, and other state policymakers will do regarding the potential expansion of Medicaid to individuals up to 133% of the federal poverty level, and (2) what the final regulations from the U.S. Department of Health and Human Services will look like with respect to the operation of Wisconsin's federally-facilitated exchanges and the details of the ACA's Essential Health Benefits package. It is reasonable to assume, however, that the state's Medicaid program will *at least* be expanded to cover almost all legal residents (except those who are incarcerated) up to 100% of the federal poverty level, and may well be further expanded to cover all such persons up to 133% of the federal poverty level. It is also reasonable to assume that the decision to allow the federal government to operate the required exchanges in Wisconsin will have only a limited impact, at least in the near term, on the provision and financing of health care and, thus, only a limited impact on BHD. This report generally reflects these two assumptions.

Glossary of Acronyms

ACA – The Patient Protection and Affordable Care Act (Pub. L. No. 111-148)

BHD – Milwaukee County Behavioral Health Department

BHP – Basic Health Plan

CA-PPI – Community Advocates Public Policy Institute

DHHS – Milwaukee County Department of Health and Human Services

FPL – Federal Poverty Level

QHP – Qualified Health Plan

III. Background

The Community Advocates Public Policy Institute (CA-PPI) has partnered with the Public Policy Forum 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). The project was launched in April 2012 with financial support from BHD and the Milwaukee County Department of Health and Human Services (DHHS).

CA-PPI's role in the project was to understand, assess, and report on the impact of the ACA on BHD. This included educating BHD senior staff on the ACA. During several meetings, CA-PPI presented information and discussed a multitude of subjects related to the ACA's impact on BHD.

The ACA clearly has the potential to transform both BHD's financial outlook and the care that patients receive. Several ACA provisions are already in place and are already having an impact on BHD. For the most part, however, the effects of the ACA will occur in 2014 and future years because of timelines in the law for exchanges, the opportunity provided to the State of Wisconsin to Medicaid, and anticipated federal regulations, guidance, and approvals.

According to the Public Policy Forum's report titled "Assessing the Financial Outlook of Milwaukee County's Behavioral Health Division," "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)."[1]

The report explains further, "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."

This report will discuss the ACA's expansion of health insurance coverage options, expansion of benefits, new care delivery models, and new funding opportunities. Each will be put in the context of BHD's services and patients.

Finally, this report will make recommendations on the future of BHD and how it can harness the ACA.

[1] Henken, Rob. Allen, Vanessa. "Assessing the Financial Outlook of Milwaukee County's Behavioral Health Division." Public Policy Forum. October 2012.

IV. How Provisions of the ACA Will Affect BHD

1. Expanded Health Insurance Coverage

One of the ACA's main goals is to expand the number of people who are insured. The law achieves this goal through a combination of a tax on those who do not maintain "minimum essential coverage," an optional expansion of Medicaid for all persons up to 133% of the federal poverty level (FPL), a new Basic Health Plan (BHP) that states can create, premium subsidies for individuals between 133% and 400% of FPL who obtain private insurance coverage through health insurance exchanges, protections from insurance company discrimination, and other expansions of eligibility.

The chart below documents the patchwork effect of health coverage options available to low-income Wisconsinites after January 1, 2014. These options are available to both the uninsured and those who have health insurance coverage, depending primarily on their US residency status and income in relation to FPL. The chart does not present private insurance options other than those available through the exchanges, though it should be recognized that most Wisconsinites now receive and will continue to obtain their health insurance through employers (both private and public) outside of the exchanges. The chart also does not discuss Medicare, which is almost universally available to seniors 65 years of age and older.

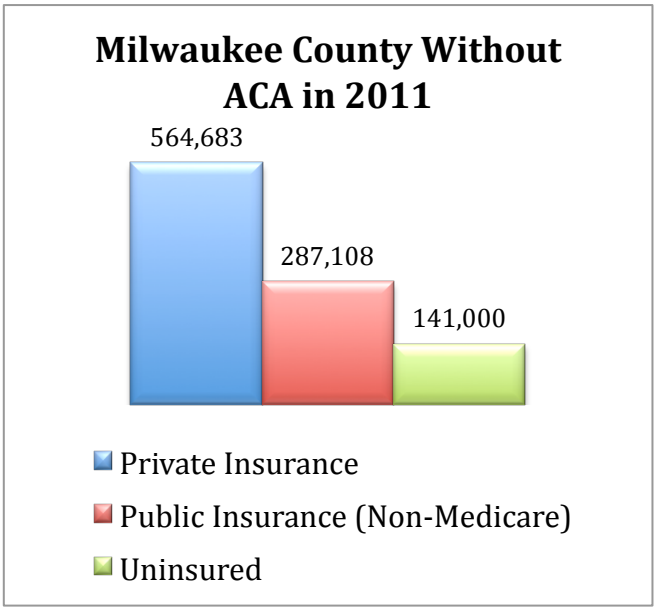
Low Income Health Coverage Options After January 1, 2014

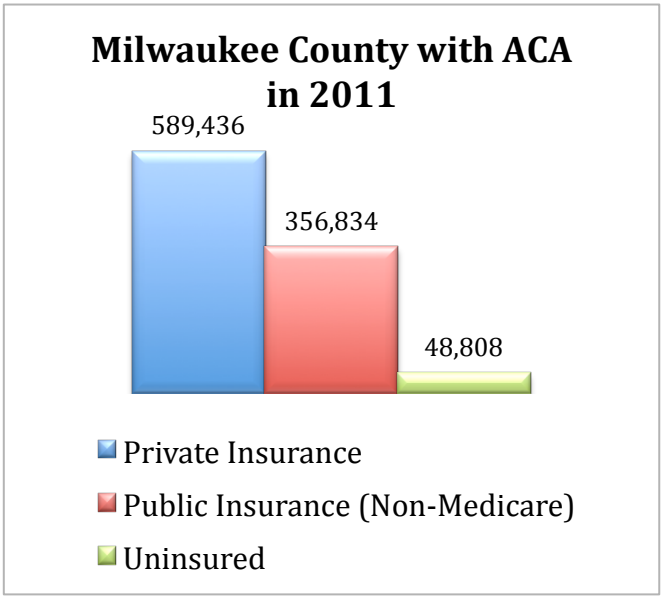
% of Federal Poverty Line	Minimum Coverage Requirement?º	Potentially Medicaid Expansion Population?	Basic Health Plan?	May Use Exchange?	Get Subsidy in Exchange?
0% to 100% - US and WI citizens	No	Yes, State Option	No	Yes	No
0% to 100% - Aliens who are lawfully present and paying taxes	No	No	No	Yes	Yes
100% to 133%	Yes*	Yes, State Option	No	Yes	Yes
134% to 200%	Yes*	No	State Option	If BHP exists No, otherwise Yes	If BHP exists No, otherwise Yes
201% to 400%	Yes*	No	No	Yes	Yes
Above 400%	Yes*	No	No	Yes	No

* Exemptions:
- Those who claim a religious exemption
- Individuals not lawfully present
- Individuals who are incarcerated
- Members of Indian tribes
- Individuals with gaps in coverage that are less than 3 months in duration
- Individuals with a monthly contribution that exceeds 8% of household income
- Individuals certified by HHS Secretary to be in a "hardship" (where no affordable plan is available)

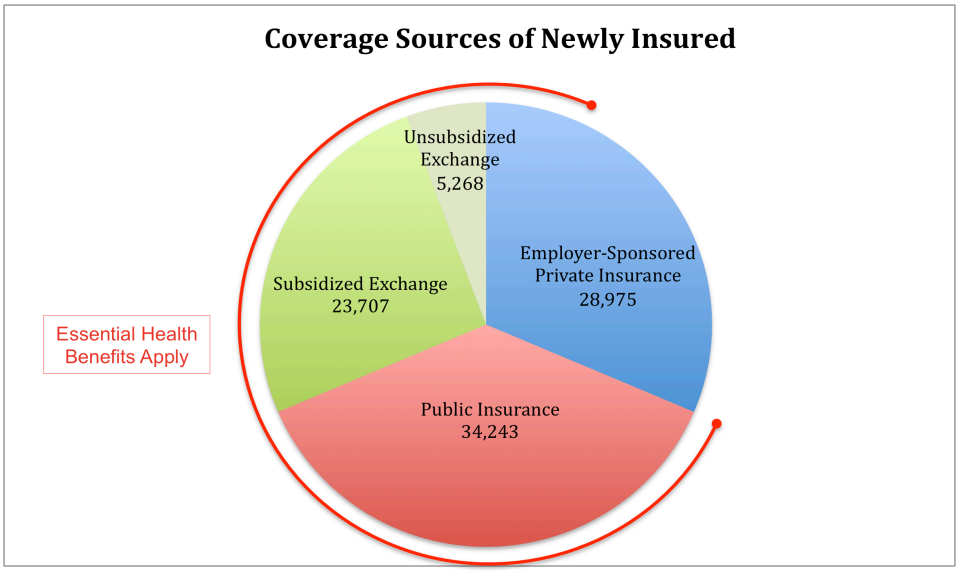
º The associated penalty applies to anyone who is non-exempt (see above) and above the tax-filing threshold (currently $9,750 individual, $19,500 couple filing jointly).

If the ACA were in effect in 2011, we estimate[2] that in Milwaukee County 69,726 more people would have had public insurance (other than Medicare), 24,753 more people would have had private insurance, and 92,192 fewer people would have been uninsured. The charts below compare the insurance status of County residents in 2011 without the ACA (status quo) with what their insurance status would be in 2011 if the ACA were in place.





The next chart provides additional estimates regarding those in Milwaukee County who would have become newly insured in 2011 if the ACA were in place. We estimate that 34,243 would move to public insurance (other than Medicare), 23,707 would move to subsidized coverage in the exchange, 5,268 would move to unsubsidized coverage in the exchange, and 28,975 would move to employer-sponsored private insurance.



[2] Estimates based on CA-PPI calculations derived from data in: Gruber, Jonathan, et al. "The Impact of the ACA on Wisconsin's Health Market." July 18, 2011. http://www.dhs.wisconsin.gov/aboutdhs/docs/WI-Final-Report-July-18-2011.pdf

We estimate[3] that, if the ACA were in effect in 2011, as many as 70,000 of the newly insured Milwaukee County residents would have obtained insurance coverage that included the Essential Health Benefits package, which will guarantee mental health and substance use disorder services.

a. Tax on Those Who Do Not Have Insurance Coverage

The ACA imposes an individual mandate, enforced via a tax, on individuals who do not have "minimum essential coverage" for health insurance. This insurance coverage mandate does not apply to individuals who: (1) are not lawfully present in the United States, (2) imprisoned, or (3) have a religious objection to health coverage. Otherwise, the ACA requires individuals—including a large segment of BHD's patients—to obtain and maintain health insurance. The mandate will thus substantially decrease the proportion of BHD's patients who are uninsured and unable to pay bills on their own and greatly increase the likelihood that BHD's patients will have health insurance and, thus, a reliable mechanism for paying the costs of their care.

b. Increased Coverage Through Expanded Medicaid Eligibility

i. General

Congress's original intent was to require states to expand Medicaid eligibility up to at least 133% of the Federal Poverty Level (FPL) for all U.S. residents. The Supreme Court, however, struck down the requirement that states must expand Medicaid eligibility up to 133% of FPL, making the expansion a choice for states.

In Wisconsin, Medicaid currently covers all children (BadgerCare+), pregnant women up to 300% of FPL (BadgerCare+), parents/caretakers of children under 19 up to 200% of FPL (BadgerCare+), and adults without dependent children up to 200% of FPL (BaderCare+ Core Plan).[4] The BadgerCare+ Core Plan's enrollment has been capped and suspended for the last couple of years.[5] The ACA requires, through a maintenance of effort provision, that the state keep its Medicaid eligibility through 2014 at the level it was at when the law was passed in 2010. For children, the state is required to keep its eligibility static through 2019.[6]

Should states expand their Medicaid programs to cover all who are eligible up to 133% of FPL, the cost of "newly eligible" enrollees will be paid for with generously enhanced federal reimbursement rates (FMAP) of 100% for 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter.[7] In addition, if Congress reauthorizes SCHIP, states will receive a 23% increase in the SCHIP FMAP for 2016 through 2019.[8] For Wisconsin, the SCHIP FMAP rate will rise from a mid-70% figure to a mid-90% figure. This means that states that expand their Medicaid programs up to 133% of FPL will not see a significant increase in state spending due to the very large increase in Medicaid eligibility and enrollment that the ACA permits. It is likely that Wisconsin may actually experience a *decrease* in its Medicaid costs associated with expanding eligibility up to 133% of FPL.

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[3] Estimates based on CA-PPI calculations derived from data in: Gruber, Jonathan, et al. "The Impact of the ACA on Wisconsin's Health Market." July 18, 2011. http://www.dhs.wisconsin.gov/aboutdhs/docs/WI-Final-Report-July-18-2011.pdf

[4] "U.S. Supreme Court Decision on the Federal Affordable Care Act." Wisconisn Legislative Council Information Memorandum. July 2012.

[5] "BadgerCare+ Core." Wisconsin Department of Health Services. http://www.dhs.wisconsin.gov/badgercareplus/core/index.htm

[6] Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[7] Id.

[8] Id.

Wisconsin's next biannual budget will set the state's Medicaid eligibility levels. As of the date of this report, it is unclear whether Governor Walker will seek an expansion of Medicaid eligibility. It is unclear whether the Wisconsin Legislature would approve an expansion. It is important to note that the BadgerCare+ and BadgerCare+ Core waivers expire at the end of 2013. It is also important to recognize that the U.S. Department of Health and Human Services has linked the enhanced federal reimbursement rates (mentioned above) to specific calendar years. Thus, if Wisconsin opts to delay the expansion of its Medicaid program until 2017, for example, it would not receive 100% reimbursement for 2017 and the following two years (with declines in FMAP to follow), but rather would immediately begin to experience the reduced reimbursement rate of 95% that is scheduled for calendar year 2017 (with further declines in FMAP to follow).

An expansion of Wisconsin's Medicaid programs would dramatically impact the care provided and revenue collected at BHD and should be monitored closely before the County completes its 2014 budget discussions. If the state decides not to expand Medicaid, some individuals would still gain insurance through the individual exchange where they would also be eligible for premium subsidies, some would continue with the level of coverage they had, and some would continue to be uninsured. The state government is likely to complete action on the Medicaid expansion question by July of 2014, thus allowing BHD, the Milwaukee County Department of Health and Human Services, the County Executive and the County Board to plan for the expansion—assuming it happens—before they make final decisions on the County's 2014 budget.

ii. Possibility of Future Modification of IMD Exclusion

BHD is an "institution for mental disease" (IMD), as defined by Section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)). An IMD is "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[9] IMDs are inpatient facilities that are excluded from federal Medicaid matching funds for patients ages 22 to 64. The federal government is generally prohibited from providing Medicaid funding for patients served by IMDs. This federal law was intended to ensure that states, either with their own funds or through a mixture of state and local funds, pay for the care of inpatient mental health services.[10]

The ACA stipulates, however, that under a "demonstration project," eligible states can receive federal Medicaid matching funds if they provide payment to privately owned and operated IMDs that have more than 16 beds. This allows for limited federal and state funding of mentally ill patients who are between ages 22 and 64, and whose care and treatment was previously excluded from Medicaid payments under the Social Security Act.[11]

The demonstration project will last three years. It designates $75 million in Medicaid funds, which must remain available through December 2015 and will only be distributed to eligible states while under the demonstration.[12] States' funding is dependent upon adequate data reporting as required by the U.S. Secretary of Health and Human Services. States must also explain how they will hold private institutions accountable for determining that patients have been adequately helped.[13]

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[9] "Compilation of Social Security Laws." Social Security Administration. http://www.ssa.gov/OP_Home/ssact/title19/1905.htm
[10] Id.
[11] "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf
[12] Id.
[13] Id.

Patient recipients must be enrolled Medicaid beneficiaries, be between the ages of 21 and 65, and require the care needed to treat an emergency psychological condition.[14]

It should also be emphasized that, at least for the purposes of the demonstration, the IMD waiver was made available only to privately owned and operated IMDs, and Wisconsin is not participating in the demonstration.

To become eligible, states completed a competitive application process and were then selected by the Secretary of Health and Human Services. The Secretary selected states in such a way so as to ensure an "appropriate national balance in the geographic distribution of such projects."[15] She selected 12 states to participate in the demonstration: Alabama, California, Connecticut, District of Columbia, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, and West Virginia.[16]

The outcome of the demonstration will be used to "assess whether this expansion of Medicaid coverage to include certain emergency services provided in non-government inpatient psychiatric hospitals improves access to, and quality of, medically necessary care, discharge planning by participating hospitals, and Medicaid costs and utilization." The Centers for Medicare & Medicaid Services (CMS), will be responsible for advising Congress on whether it should permanently amend or reverse the IMD Exclusion as laid out in the Social Security Act.[17]

Thus, the ACA has no immediate impact on BHD's IMD exclusion. This is, however, a legislative issue that should be monitored moving forward. If the experience of the 12 states that CMS chose to participate in this demonstration indicates that eliminating or modifying the general IMD exclusion will improve access or quality, lower costs, or both, BHD may wish to work with the State of Wisconsin and the state's congressional delegation to pursue an across-the-board change in federal policy regarding Medicaid reimbursement of IMDs. Such a policy change would have to address the issue of whether Medicaid reimbursement for IMDs would extend to both privately owned and operated IMDs and publicly owned and operated IMDs.

In the past, BHD has partnered with a private provider to work around the IMD exclusion. The County should explore this option again as it may be a viable option for increasing its Medicaid reimbursement revenue.

c. Possible Coverage Via a Basic Health Plan Option

The ACA's Basic Health Plan is an optional health coverage plan that allows states to offer a private insurance plan to consumers with incomes between 134% and 200% of the FPL, in lieu of offering these individuals coverage through either Medicaid or the individual exchange. The plan is paid for with federal funds that individuals would be entitled to through the individual exchange as premium subsidies (federal income tax credits). Specifically, states get to spend: "[T]he amount the Secretary [of the Department of Health and Human Services] determines is equal to [the sum of] 95 percent of the premium tax credits [available in the individual exchange] […], and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in

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[14] "Affordable Care Act Psychiatric Emergency Demonstration." Catalog of Federal Domestic Assistance. https://www.cfda.gov/?s=program&mode=form&tab=step1&id=719bc26f7f43f1b1cafe32592ff80a2e

[15] Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[16] "Medicaid Emergency Psychiatric Demonstration." Centers for Medicare and Medicaid Services. http://innovations.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/index.html

[17] "Medicaid Emergency Psychiatric Demonstration – Demonstration Design and Solicitation." Centers for Medicare and Medicaid Services. http://innovations.cms.gov/Files/x/MedicaidEmerPsy_solicitation.pdf

standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange…."[18]

It is unclear whether Wisconsin will establish a Basic Health Plan. If it does, it would be the only affordable health coverage option available to those between 134% and 200% of the FPL. Individuals who are eligible for the Basic Health Plan would be *in*eligible for both Medicaid and tax subsidies through the exchange.

If Wisconsin's policymakers begin to seriously explore the creation of a Basic Health Plan, BHD may wish to become actively involved to ensure that—compared to the alternatives of Medicaid or coverage through an exchange—the relatively low-income individuals who instead receive their health insurance through a Basic Health Plan experience no deterioration in access to, or the quality of, mental health or substance use disorder services. BHD may also wish to monitor the experience of other states that have adopted a Basic Health Plan if Wisconsin chooses not to, again for the purpose of assessing whether the exercise of this option makes access and quality better or worse with respect to mental health and substance use disorder services.

d. Coverage Through Health Insurance Exchanges

The ACA requires each state to have health insurance marketplaces—called exchanges—for the individual market (American Health Benefit Exchange) and the small group market (SHOP Exchange, for firms up to 100 full-time employees, unless Wisconsin chooses to limit this to firms of up to 50 full-time employees for the first two years). Exchanges will begin to function in late 2013, with exchange-facilitated insurance coverage beginning in 2014. Due to Governor Walker's decision to defer to the federal government on exchange establishment, the U.S. Department of Health and Human Services has no alternative but to establish a federally-facilitated exchange in Wisconsin.

The exchanges will act as a traffic cop for residents seeking health insurance, directing applicants to the right door for Medicaid, Medicare, the Basic Health Plan (if applicable), private insurance, etc. The exchanges are also a marketplace where applicants can "shop around" and compare "qualified health plans" (QHP). Beginning in 2014, as many as 1.5 million Wisconsinites may use the exchanges to access health coverage. Should the state elect to include large employers in the exchange after 2017, as many as 4.5 million Wisconsinites may use the exchanges.[19]

The law requires exchanges (regardless of who operates them) to:

- Consult during the design, implementation, and operational phases of the exchange with six types of stakeholders;
- Certify, re-certify, and de-certify qualified health plans;
- Designate navigators in compliance with the ACA; and
- Establish enrollment procedures (online portal, phone help line, and a path for agents and brokers).[20]

Generally, individuals with incomes between 100% and 400% of the FPL who are purchasing insurance through the individual exchange will be eligible for federal premium subsidies. These subsidies, which are delivered in the form of "refundable" federal income tax credits, will help lower-income participants in the exchange to pay more than 85% of the cost of their health insurance premiums. A calculator developed by the Kaiser Family Foundation, for example, found that a 19-year old

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[18] Sec. 1331. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[19] Estimates based on CA-PPI calculations derived from data in: Gruber, Jonathan, et al. "The Impact of the ACA on Wisconsin's Health Market." July 18, 2011. http://www.dhs.wisconsin.gov/aboutdhs/docs/WI-Final-Report-July-18-2011.pdf

[20] "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

adult at 134% of FPL would receive a subsidy of $2,919 per year to help buy an insurance plan costing $3,391 per year—in other words, this individual would receive an 86% subsidy for a plan with an actuarial value of 94% (which means the plan, on average, would pay for 94% of all health care costs).[21] The calculator estimates that a 64-year old adult at 134% of FPL would receive a $9,700 subsidy towards an insurance plan costing $10,172—in other words, a 95% subsidy for a plan that has a 94% actuarial value.[22] As incomes rise, the subsidy declines on a "sliding scale" formula, Subsidies of this magnitude will help a significant number of BHD's patients to afford health insurance.

It is possible that the federal government will require the exchanges to interface with local and county governments that provide health care. BHD should monitor and review any regulations related to federally-facilitated exchanges concerning the interaction between local/county governments and exchanges.[23] Even if federal regulations do not require, authorize, or even mention this interface, BHD should consider advocating for exchange policies that will benefit the individuals that BHD serves, particularly during the fluid federally-facilitated exchanges' establishment period, when it may be easier to obtain more favorable policies.

e. Protections from Insurance Company Discrimination

The ACA includes several provisions designed to protect consumers from insurance company discrimination and abuses.

Insurance companies already can no longer limit or deny coverage to children under 19 due to a pre-existing condition.[24] The same prohibition against restricting coverage due to pre-existing conditions will be true for adults beginning in 2014.[25] Before 2014, those adults can participate in the Pre-Existing Condition Insurance Plan.[26]

The law also ends lifetime and annual limits on coverage for all new health plans.[27] It ends the ability of insurance companies to withdraw one's coverage. And enrollees in health plans may now ask an insurer to reconsider its denial of coverage.[28]

Insurance companies must now publicly justify any unreasonable rate hikes. They may spend no more than 20% of premiums collected on administrative costs for individual and small group plans, and may spend no more than 15% of premiums collected on administrative costs in large group plans.[29]

The law also removes insurance company barriers to emergency services. Enrollees can seek emergency care at a hospital outside of the health plan's network. This may expand the population that seeks emergency services from BHD,[30] but it is not likely to significantly impact BHD.

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[21] See "Health Reform Subsidy Calculator," Kaiser Family Foundation. http://healthreform.kff.org/subsidycalculator.aspx
[22] *Id.*
[23] State Senator Kathleen Vine out (D-Alma) introduced legislation (Wisconsin Senate Bill 273) that would have required the exchanges to include a strong prisoner transition process and coordinate between the exchange, Medicaid and other governmental health institutions including county-run substance use disorder and mental health facilities.
[24] "Children's Pre-Existing Conditions." http://www.healthcare.gov/law/features/rights/childrens-pre-existing-conditions/index.html
[25] Popper, Richard. "Covering More Uninsured Americans Who Have Pre-Existing Conditions." Health Care Blog. http://www.healthcare.gov/blog/2011/02/pcip-enrollment.html
[26] "Preexisting Condition Insurance Plan." Department of Health and Human Services. http://www.healthcare.gov/law/features/choices/pre-existing-condition-insurance-plan/index.html
[27] "Lifetime & Annual Limits." Department of Health and Human Services. http://www.healthcare.gov/law/features/costs/limits/index.html
[28] "Patients' Bill of Rights." Department of Health and Human Services. http://www.healthcare.gov/law/features/rights/bill-of-rights/index.html
[29] "Value for Your Premium Dollar." Department of Health and Human Services. http://www.healthcare.gov/law/features/costs/value-for-premium/index.html

BHD should be aware of these new protections so that it can help ensure that those who are now able to get insurance coverage are indeed covered and do not face arbitrary cut-offs of benefits.

f. Other Expanded Eligibility Provisions

i. CLASS Act

The ACA included a long-term care program called the Community Living Assistance Services and Supports Act (CLASS Act). It was intended to be a voluntary long-term care insurance program that serves adults with multiple functional limitations, or cognitive impairments who have: (1) paid monthly premiums for at least five years, and (2) been employed during three of those five years.[31]

The Obama Administration indefinitely suspended the CLASS Act in October of 2011, citing concerns about its sustainability. The ACA required that the Secretary of Health and Human Services formulate a plan to ensure that the program would be financially solvent for at least 75 years, a stipulation Secretary Sebelius and HHS were unable to guarantee after extensive review.[32]

Though not implemented, the CLASS Act has not been officially repealed. In February of 2012, the House of Representatives voted to do so; the Senate has yet to take similar action.[33]

Should this provision of the ACA be revisited, it may have an impact on the long-term care patients at BHD. However, it is unlikely this law will ever be implemented.

ii. Young Adult Coverage

The ACA allows parents to keep their dependent children on their health plans until age 26. This provision will allow more of BHD's young patients to be insured and afford treatment. BHD should be aware of this new provision of the law and ensure that those young adult patients who are now able to get insurance coverage through their parents are indeed covered.

2. Expanded Benefits

The ACA also expands health insurance benefits in several ways. It establishes a new "Essential Health Benefits Package" that applies to Medicaid, the Basic Health Plan, and plans sold in the individual and small group markets (whether such plans are offered inside or outside of the exchanges). The ACA also requires Medicaid, Medicare, and private insurance plans to pay the full cost of certain prevention and wellness services that BHD provides. Though not discussed in this report, BHD should also be aware of and weigh in on any potential changes to federal mental health parity requirements.

a. Essential Health Benefits Package

The ACA requires Medicaid, the Basic Health Plan, and plans sold in the individual and small group markets (whether inside and outside of the exchanges) to provide coverage for "essential health

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[30] "Doctor Choice and ER Access." Department of Health and Human Services. http://www.healthcare.gov/law/features/rights/doctor-choice/index.html

[31] Sec. 8001. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[32] Khan, Human. "Obama Drops Long-Term Health Program." ABC News. 14 October, 2011. http://abcnews.go.com/blogs/politics/2011/10/obama-administration-drops-long-term-health-care-program

[33] Abrams, Jim. "House Votes to Repeal CLASS Act, Part of 2010 Health Care Law." Huffington Post. 1 Febraury, 2012. http://www.huffingtonpost.com/2012/02/01/class-act-repeal_n_1248430.html

benefits."[34] The "essential health benefits" requirements do not apply to large group plans, unless after 2017 the state elects to make its Small Business Health Options Program (SHOP) exchange available to larger employers with 100 or more employees and such firms utilize the SHOP exchange to provide coverage.

The Affordable Care Act defines essential health benefits to "include at least the following general categories and the items and services covered within the categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care."

The law explicitly includes "mental health and substance use disorder services, including behavioral health treatment"[35] in the list of essential health benefits. This is especially important to BHD and the patients it serves who are enrolled in Medicaid and individual and small group health plans. BHD stands to potentially receive new revenue for the services it provides to Medicaid enrollees and persons covered by individual and small group plans.

Neither the ACA itself, nor the federal regulations and guidelines that the U.S. Department of Health and Human Services has issued thus far, fully explain what types of "mental health and substance use disorder services" are included within that category of service. The Department will soon promulgate regulations that provide further insight, but even those regulations may leave some questions unanswered.

However, one important step that the Department has taken to clarify the meaning of "mental health and substance use disorder services" has been the Department's assertion that, at least for insurance plans sold through the exchanges, these (and other) benefits will have the meaning that they have in each state's "benchmark" plan. The Department has also established a process for determining what each state's "benchmark" plan happens to be.

Like all other states, Wisconsin will soon be required to choose a "benchmark" plan for the essential health benefits package. According to a summary of the intended approach of the U.S. Department of Health and Human Services: "[S]tates would have the flexibility to select a benchmark plan that reflects the scope of services offered by a 'typical employer plan.' This approach would give states the flexibility to select a plan that would best meet the needs of their citizens. States would choose one of the following benchmark health insurance plans:

- One of the three largest small group plans in the state by enrollment;
- One of the three largest state employee health plans by enrollment;
- One of the three largest federal employee health plan options by enrollment; or
- The largest HMO plan offered in the state's commercial market by enrollment.

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[34] Sec. 1302. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[35] Sec. 1302. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

"If states choose not to select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the state."[36]

It is not clear whether Wisconsin will make this choice. It is not even clear whether the Wisconsin Office of the Commissioner of Insurance or Wisconsin Department of Health Services have done research on the choices. Federal regulations have yet to be released, but an earlier "bulletin" indicated the deadline for the benchmark decision would be the end of September of 2012. That deadline (if it was indeed a deadline) has now passed. The state has indicated it is awaiting further regulations from the federal government before making any decision. Whether Wisconsin will select a "benchmark" plan even after the promulgation of federal regulations remains to be seen.

This is a policy that BHD should closely monitor and work hard to influence. It relates directly to which of BHD's health services will in fact be covered by those enrolled in Medicaid, a Basic Health Plan, and individual and small group health insurance plans. It thus bears directly on which services BHD can bill for. BHD should actively work with the state—and, if the state takes a pass, with the federal government—to establish a "benchmark" plan for Wisconsin that broadly defines covered benefits for mental health and substance use disorder services to include case management, family psychological education, chronic illness management, recovery, etc.

b. Prevention and Wellness Coverage

The ACA establishes access for adults enrolled in Medicaid to receive preventive services with no out-of-pocket costs. For any preventive services to be free to the patient, the United States Prevention Services Task Force (USPSTF) must assign it a grade of "A" or "B."

The ACA also establishes prevention and wellness benefits for Medicare beneficiaries. It establishes coverage of annual "wellness visits" for Medicare beneficiaries. This section of the ACA also makes several references to the USPSTF recommendations, specifically regarding which services should be offered as part of prevention and wellness visits.[37] The law removes all out-of-pocket costs for Medicare beneficiaries, thus guaranteeing first dollar coverage, for all prevention and wellness services with "A" or "B" ratings from the USPSTF.[38] Finally, the law gives the Secretary of HHS the authority to modify or eliminate coverage of preventive and wellness services that are not consistent with the recommendations of the USPSTF.[39]

Any preventive health services that BHD provides to Medicaid enrollees, Medicare beneficiaries, and those enrolled in new private insurance plans may now be free to BHD's patients as a result of the ACA. BHD should be aware of which preventive health services it will not be receiving payment for directly from the patient, and which preventive health services will instead be paid for by Medicaid, Medicare, or private insurance.

3. Care Delivery

The ACA offers several ways that BHD (and the County as a whole) could transform the way it delivers health care. These include potentially becoming a "navigator" that assists patients in finding

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[36] "Essential Health Benefits." Department of Health and Human Services. http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html

[37] Sec. 4103. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[38] Sec. 4104. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[39] Sec. 4105. Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

health coverage, and establishing a Medicaid Health Home or Medicare Accountable Care Organization that coordinates care.

a. Health Navigators

The exchanges established by the ACA are required to fund and award grants to "navigators" that will educate the public on the exchanges, distribute "fair and impartial information," facilitate enrollment, and provide referrals to those with complaints and questions about health plans. These navigators "may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers."[40] Navigators will have the ability to screen and refer patients to the proper door for health coverage. Since BHD performs a function similar to this for its patients, BHD may be able to formalize the program as a "navigator" and apply for approval—and funding—of its "navigator" function.

While the ACA does not formally list government agencies such as BHD as entities that might become navigators, the law does not preclude a government agency such as BHD from performing the navigator role. This is a determination that will have to be made once an exchange authority is established in Wisconsin. BHD should monitor the policies developed for federally-facilitated exchanges, to ensure (at the very least) that the option of having BHD serve as a navigator is not prohibited or discouraged.

b. Medicaid Health Home Option

The ACA establishes the Medicaid health home model, which is a care delivery option for Medicaid providers. Recipients of health home services must have at least two chronic conditions, or one chronic condition with a risk of a second chronic condition, or one serious and persistent mental health condition. "Chronic condition" is a term defined by the Secretary, but includes by law: mental health conditions, substance use disorders, asthma, diabetes, heart disease, and being overweight as evidenced by having a Body Mass Index (BMI) over 25. States began implementing health homes on January 1, 2011. The federal government will pay 90% of the costs of the care during the first eight fiscal years that the state's plan is in effect.[41]

BHD should be in dialogue with the Wisconsin Department of Health Services about this care delivery model as it may be a viable option for some of BHD's services. Specifically, BHD should explore creating a behavioral health home model. A prime candidate is its state-certified Community Support Program (CSP), which provides intense case management services, nursing and psychiatric services to thousands of people in Milwaukee County at several locations every year. Several states have already implemented Medicaid behavioral health homes.[42]

c. Accountable Care Organization Option

An Accountable Care Organization (ACO) is a Medicare coordinated care delivery model. According to the Department of Health and Human Services, "ACOs create incentives for health care

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[40] Sec. 1311. Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[41] "Health Homes." Centers for Medicare and Medicaid Services. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html

[42] For one example, see Missouri: "Health Care Home." Missouri Department of Mental Health. http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm

providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary."[43]

According to rules proposed by the federal government, "[A]n ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients they serve with Original Medicare (that is, those who are not in a Medicare Advantage private plan). The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries. The ACO would be a patient-centered organization where the patient and providers are true partners in care decisions."

According to Ron Manderscheid, an expert on behavioral health delivery and Executive Director of the National Association of County Behavioral Health and Developmental Disability Directors, "Last year, CMS issued final regulations governing Accountable Care Organizations (ACOs) under Medicare. These final regulations recognize hospitals, primary care practices, federally qualified health centers (FQHCs), and rural health centers as qualified entities to form ACOs. They do not, however, recognize behavioral healthcare provider organizations as qualified entities." Thus, Manderscheid recommends that behavioral health providers think creatively about how to form or be a part of an ACO.[44]

Several Wisconsin providers have already become ACOs. It is not within the scope of this analysis to determine how BHD could qualify to be an ACO or whether it should. BHD should, however, conduct an analysis to determine whether it may be able to improve its service to patients, increase funding opportunities, or both, if it becomes an ACO alone or in partnership with an outside ACO.

4. Funding Opportunities

The ACA includes billions of dollars for infrastructure investment, workforce development, health care improvement, and research. BHD should examine the opportunities and apply for funding it may qualify for.

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[43] "Accountable Care Organizations: Improving Care Coordination for People with Medicare." http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html

[44] Mandersheid, Ron. "Are you Prepared to Lead ACOs from the Rear." Behavioral Health Care. 11 October, 2012. http://www.behavioral.net/blogs/ron-manderscheid/are-you-prepared-lead-acos-rear

V. Recommendations

The ACA is an extremely complex law with wide-ranging impacts on Milwaukee County. Its implementation offers an opportunity to reevaluate Milwaukee County's continuum of mental health and substance use disorder services, and identify policy changes that could improve its services, increase revenues, and potentially lower property taxes. Following are three major sets of recommendations that, if followed, will assist Milwaukee County in making optimal use of the ACA to achieve these service, revenue, and tax goals.

1. Gather Relevant Data

BHD will need to gather relevant data on the *number of insured* County residents after implementation of the ACA, and the *services* that insurance will make available to them. It is imperative that the County quickly gathers the data and dollars associated with these two variables.

The increase in the *number of insured* County residents will occur primarily because of: (1) the likely expansion of Medicaid coverage beginning January 1, 2014, to a much larger number of adults without dependent children who have incomes up to 133% of FPL, and (2) the provision to persons between 133% and 400% of FPL of sliding-scale premium subsidies if they use the ACA's exchanges to buy qualified health plans.

The impact on the scope of *services* that will be covered by insurance will occur because Medicaid enrollees, those participating in a state Basic Health Plan (if one is created), and all individuals who obtain insurance in the individual and small group markets, will have coverage that includes the ten benefits included in Essential Health Benefits package.

BHD and Milwaukee County need to generate current and reliable data on the potential impact of the ACA that will assist BHD leadership and County policymakers in formulating future decisions. Such data should include the following information about BHD's current patients:

1. U.S. residency status;
2. Age;
3. Dependent children (number and ages);
4. Custodial parent status;
5. Pregnancy status;
6. Disability status (potential qualification for Medicaid or Medicare coverage);
7. Family size and income (thus, percent of the Federal Poverty Level);
8. Insurance status (uninsured, Medicaid, Medicare, private insurance, or other coverage); and
9. The extent to which each patient's insurance covers mental health and substance use disorder treatment.

County policymakers, including those in BHD, the Department of Health and Human Services, the County Executive, and the County Board, will be unable to respond in an informed manner to the ACA's impact on the County unless they have a projection of which of BHD's current patients will:

1. Continue to have health insurance (and if so, what type);
2. Gain insurance coverage once the ACA becomes law, and, if so, which type of coverage;
3. Remain uninsured, despite the ACA;
4. Obtain coverage (whether newly insured or already insured) that includes the Essential Health Benefits package that provides insurance-financed coverage of their mental health and substance use disorder treatment; and

5. Have no insurance-financed coverage (whether newly insured, already insured, or uninsured) of their mental health and substance use disorder treatment, either because the ACA's Essential Health Benefits package does not cover the particular form of treatment they need or simply because the ACA does not apply to such individuals at all.

With such data, it will be possible to: make more informed decisions about the future role of BHD in helping the residents of Milwaukee County obtain mental health and substance use disorder services, understand the new and changing flows in revenues that will be available to pay for both non-BHD and BHD services, and make plausible estimates about the need to use property tax dollars to pay for certain Milwaukee County residents to obtain certain types of mental health and substance use disorder services. Such data will also greatly increase the prospect that the policymakers and stakeholders who are involved in discussions about the future of BHD will be able to make evidence-based decisions about whether BHD should continue operating as it is, reduce/downsize services, or move services entirely to community-based or private providers.

Without such data, much of the future of the County's mental health and substance use disorder treatment redesign effort will be largely guesswork.

2. General Recommendations for BHD

Regardless of the longer-term decisions that must be made about BHD's future role, BHD and the County will wish to make prudent shorter-term decisions about the impact of the ACA. To improve the quality of such shorter-term decisions, BHD and the County should take immediate action to better understand the complexities of the ACA and shape the law's implementation in Wisconsin to meet the needs of BHD, County government, and Milwaukee County taxpayers.

Following are seven specific steps that the County should take:

a. Full-Time ACA Coordinator

Several health care providers of BHD's size in Wisconsin have added a full-time position to examine the law and prepare for its impacts. The County should consider assigning a staff person the full-time responsibility of: (1) analyzing how the law will impact BHD (and the rest of the County), (2) following legislative and regulatory developments (including those related to quality measures at inpatient psychiatric facilities,[45] and many others), and (3) developing and implementing plans to manage any changes that impact BHD in ways that allow BHD to improve County residents' access to mental health and substance use disorder treatment, improve the quality of care that BHD itself delivers, and increase the per-patient revenue that BHD is able to obtain from Medicaid, Medicare, and private insurance. While many of the ACA's changes do not take full effect until 2014, the County should begin preparing now and through 2013.

b. Carefully Consider New Programs and Growing Current Programs

County policymakers should carefully consider any new programs and growing any current programs. Policymakers and the new full-time ACA coordinator should vet any changes or additions to ensure that they fit the context of the ACA and its changes to BHD's service role.

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[45] "CMS Proposals to Improve Quality of Care During Hospital Inpatient Stays." Centers for Medicare and Medicaid Services. http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4346

c. Advocate for the Medicaid Expansion and Health Homes

Milwaukee County should actively advocate for an expansion of Wisconsin's Medicaid program up to 133% of the FPL. BHD could potentially increase its patient care revenue by millions of dollars every year, and this population would be able to seek affordable treatment.

BHD should be in dialogue with the Wisconsin Department of Health Services about the possibility of establishing Medicaid Health Homes for some of its services. This care delivery model may be a viable option for some of BHD's services, including its CSP locations.

d. Coping with the IMD Exclusion

The ACA has no immediate impact on BHD's IMD exclusion, though future legislation may result from a demonstration project included in the ACA. This is a legislative issue that BHD should monitor moving forward. If the experience of the 12 states that CMS chose to participate in the ACA's IMD demonstration project indicates that eliminating or modifying the general IMD exclusion will improve access or quality, lower costs, or both, BHD may wish to work with the State of Wisconsin and the state's congressional delegation to pursue an across-the-board change in federal policy regarding Medicaid reimbursement of IMDs.

The County should also explore the prospect of partnering with a private provider in order to avoid the IMD exclusion.

e. Monitor Exchange Implementation and Become A Navigator

It is possible that the federal government would require the exchanges to interface with local and county governments that provide health care. BHD should monitor and review any federal regulations related to Wisconsin's federally-facilitated exchanges for these developments. Even if federal regulations do not require, authorize, or even mention this interface, BHD should consider advocating for exchange policies that will benefit the individuals that BHD serves, particularly during the fluid period at the beginning of Wisconsin's exchange experience when it may be easier to obtain more favorable policies.

Milwaukee County should also carefully consider applying to be a navigator when the regulations are available from the federally-facilitated exchange authority, and if an analysis shows it would be in BHD's interest. We suspect that becoming a navigator would help increase BHD's revenues and the level of care that patients receive. Accordingly, BHD should monitor the policies developed for federally-facilitated exchanges, to ensure (at the very least) that the option of having BHD serve as a navigator is not prohibited or discouraged. As a part of the planning to become a navigator, BHD should examine and update its screening processes at each patient entry point so that the processes line up with eligibility standards and patient protections established by the ACA.

f. Be Aware of and Responsive to Changes to Covered Benefits

BHD should monitor any changes to federal mental health parity requirements. It is unclear as of the date of this report how the federal mental health parity law interacts with the ACA.

BHD should monitor any developments related to the essential health benefits package, because it relates directly to which of its health services will be covered by those enrolled in Medicaid, a Basic Health Plan, and individual and small group health insurance plans, and it relates directly to which services it can bill for.

Many of the preventive health services that BHD provides to Medicaid enrollees, Medicare beneficiaries, and those enrolled in new private insurance plans may now be free to BHD's patients as a

result of the ACA. BHD should be aware of which services it will not be receiving revenue for directly from the patient.

g. Explore Enhancing BHD's Revenue Using the ACA

BHD should examine the possibility of paying out-of-pocket costs that patients cannot afford if doing so would on balance yield greater patient revenues.

Finally, BHD should persistently examine new funding opportunities created by the ACA for potential revenue and new programs.

3. Determine BHD's Future Target Population and Core Services

In light of the ACA and good data, County policymakers should reevaluate two policy decisions: BHD's target care population, and its role in mental health and substance use disorder services.

a. Clarify BHD's Target Care Population

The County must decide how best to target its limited resources to two groups:

- Those individuals who (despite their coverage under ACA) Milwaukee's non-BHD providers can never be expected to provide adequate treatment for their mental illnesses and substance use disorders; and
- Those individuals who will have no ACA-based insurance coverage at all for mental health or substance use disorder treatment.

There is a case to be made that *anyone* who has health coverage (whether Medicaid, private policies, self-insured employers, or Medicare) for mental health and substance use disorders, and needs mental health or substance use disorder treatment, should be covered by their insurers with no involvement from BHD. We know, however, that *some* within this group—certainly in the short term, and possibly in the long run—will not obtain timely and adequate treatment through their insurers' arrangements with private (i.e., non-BHD) providers, for most or even any of the mental health or substance use disorder treatment they need.

BHD therefore should take the following steps with respect to Milwaukee County residents who have health insurance that covers mental health and substance use disorder treatment:

- Define in advance which groups of insured individuals are in fact likely to obtain excellent-to-adequate insurance-financed treatment for their mental health illnesses or substance use disorder through their insurers' chosen providers, encourage and expect those individuals to use such non-BHD providers, but be prepared to serve those individuals on the condition that BHD is reimbursed 100% for its costs; and
- Define in advance the group of individuals who, though insured, are *not* likely to obtain excellent-to-adequate insurance-financed coverage for their mental illnesses or substance use disorders through their insurers' chosen providers, and:
    - To the extent their insurers and providers *could* change the way they diagnose and treat mental health or substance use disorders so as in the future to provide them with excellent-to-adequate treatment, pressure the insurers and providers to improve their processes so that BHD need not be involved; but

- To the extent such insurers and providers continue to provide inadequate treatment, be prepared to serve those individuals on the condition that BHD is reimbursed 100% for its costs.

BHD's primary target patient population, however, should be those who will face significant barriers to getting insurance and affordable care. This population includes:

- Those transitioning out of incarceration and who, to the extent the State of Wisconsin fails to establish a robust system to immediately enroll them in Medicaid or private insurance upon release, are uninsured and, thus, have no insurance-based coverage—at least temporarily—for treatment of any mental illnesses or substance use disorders;
- Those who are not lawfully present in the United States, but nonetheless must be given emergency services; and
- Other low-income individuals who are uninsured because they are ineligible for Medicaid, do not qualify for subsidies in the exchanges, or for other reasons.

These populations will be unlikely to be able to access mental health and substance use disorder services elsewhere. BHD must be prepared to estimate in advance the numbers in each group, and be prepared to serve them. BHD should simultaneously seek to reduce their numbers, e.g., by working with the Wisconsin Department of Corrections and the state's exchanges (administered by the federal government for the foreseeable future) to increase the probability that those transitioning out of incarceration are enrolled in Medicaid or exchange-facilitated subsidized coverage immediately upon their release. BHD and the County will need to acknowledge, and deal with the reality, that many people in Milwaukee County could fall into gaps in the emerging health insurance system, and that among this group a portion will need mental health and substance use disorder treatment and yet have no insurance mechanism whatsoever to pay the bill. With private providers unlikely to step up and fill the gap, BHD must be prepared to play this role.

b. Clarify BHD's Service Role

County policymakers must also determine the *types* of mental health and substance use disorder services that BHD should provide, and how to provide the highest-quality services at the lowest feasible cost, with respect to all three groups: (1) the overwhelming majority of Milwaukee County residents who will have health insurance *and* insurance-financed coverage for mental health and substance use disorder treatment once the ACA takes effect in 2014, (2) the smaller group of residents who will have insurance but *no* insurance-financed coverage of mental health and substance use disorder treatment,[46] and (3) the residual group of uninsured residents.

An argument can be made that the ACA might eliminate the need for BHD to provide services to almost everyone. Michael Hogan, Ph.D., who is the Commissioner of the New York State Office of Mental Health, has made the argument: "If the new federal law equalizing coverage for mental conditions with that for medical-surgical care works as hoped, there may no longer be a need for a public system to handle mental health in the long run."[47]

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[46] Typically because their insurance coverage is not via Medicaid, the individual or small group market, or Medicare—all of which require coverage of mental health and substance use disorder treatment—but through larger employers who offer bare-bone insurance benefits that exclude mental health and substance use disorder treatment. It must be remembered that Wisconsin and federal parity requirements only apply to these larger employers *if* they offer mental health and substance use disorder treatment in the first place. Under both state and federal law, however, larger employers are free *not* to offer such coverage. While many do so, some do not.

[47] Hogan, Michael. "Will We Need a Separate Mental Health System in the Future?" Mental Health news. Vol. 14 No. 4. Fall 2012. http://www.mhnews.org/back_issues/MHN-Fall2012.pdf

Currently, Chapters 46 and 51 of the Wisconsin Statutes clearly mandate a role for Milwaukee County in behavioral health services, but those laws were written at a time when:

- Many Wisconsinites lacked health insurance;
- Health insurance often did not cover mental health and substance use disorder services;
- The insurance-based provision of these services (if and when it occurred) was often not on a parity basis; and
- The ACA did not exist.

In short, much of the context for Chapters 46 and 51 has dramatically altered. Given the nature of that alteration, it is improbable that BHD's role should remain the same. BHD leadership and County policymakers should undertake a thoughtful examination of whether and how BHD's role should change.

The prior section of this report discussed whether, in light of the ACA, it is now appropriate for BHD to modify its target population, i.e., change *who* it serves. In light of the ACA, it is now equally appropriate for BHD to modify the *types* of mental health and substance use disorder services it provides, i.e., change *how* it serves.

i. Insured Persons with Mental Health and Substance Use Disorder Coverage

The starting point is to determine, for the first of the three groups discussed above—that is, for those who will have insurance that includes coverage for mental health and substance use disorder treatment—how BHD should interact with this group's insurance plans and the plans' mental health and substance use disorder treatment providers. BHD has four choices:

- **Be an Advocate:** Help such individuals to gain timely access and quality services from their insurance-financed providers of mental health and substance use disorder treatment, but not be a provider itself;
- **Be an Insurance-Financed Provider:** Contract with the individuals' insurers to be *the* approved provider, or be *among* the set of approved providers, that deliver mental health and substance use disorder treatment, per agreements that cover BHD's full costs;
- **Be a Fallback Provider:** If advocacy does not produce adequate results and even though the individuals' insurers have not entered into contracts with BHD, nonetheless be a "fallback" provider that does what insurance-financed providers have failed to do by delivering needed, timely, high-quality mental health and substance use disorder treatment… and then try to obtain payments from the insurers that cover BHD's full costs, but recognize that insurers will often either refuse to pay or pay less than full cost, requiring County taxpayers to make up the difference; or
- **Cover Uncovered Services:** To the extent that insured individuals in this group do not have insurance-financed coverage for specific *levels* of needed mental health or substance use disorder treatment—particularly inpatient services or long-term care services—then BHD has little alternative but to step in and be available to provide these uncovered services.

With respect to this final role, BHD should still seek to capture payments from individuals' insurers on the ground that the insurers will save money in the long run (for acute care and covered mental health and substance use disorder services) if they pay BHD for its provision of uncovered mental health and substance use disorder services. BHD should also seek to capture out-of-pocket payment from the individuals who receive these uncovered services to the extent they have an ability to pay. Setting up

efficient programs for maximizing "voluntary" collections from insurers, and billing individuals fairly on a sliding scale, will be important.

Ultimately, however, for many of the individuals who receive such uncovered services, BHD will be unable to obtain either voluntary payments from insurers or out-of-pocket payments from the individuals in question that equal BHD's cost of service. Thus, the only way for BHD to provide uncovered services will be to obtain a subsidy, either from state funds (as is currently the case for TANF-eligible individuals receiving SUD services) or the County's property tax levy.

To minimize this subsidy, Milwaukee County should work aggressively to: (1) pressure the U.S. Department of Health and Human Services to formulate an expansive definition of the Essential Health Benefits package's definition of required mental health and substance use disorder services that covers inpatient, outpatient, and long-term care services to the fullest extent possible; (2) pressure state Medicaid administrators and elected leaders to adopt the same expansive definition; and (3) pressure the federal administrators of Wisconsin's health insurance exchanges to adopt the same expansive definition for Qualified Health Plans. At the same time, BHD and the County need to assume that (at least for several years, and perhaps indefinitely) federal and state policies are likely to exclude coverage for some of the most important—and most costly—mental health and substance use disorder treatment services that Milwaukee residents need and BHD has historically provided. Thus, the challenge is to simultaneously push for federal and state policies that reduce the number, scope, and cost of uncovered services, while simultaneously preparing to deliver and finance those services in an appropriate manner.

ii. Insured Persons without Mental Health and Substance Use Disorder Coverage and Uninsured Persons

For this pair of groups, BHD's role is clearer, but more costly. If the individual's insurance does not cover mental health and substance use disorder treatment at all, or if the individual is uninsured, then BHD will need to be available to provide all levels of mental health and substance use disorder services.

As noted above, BHD should still seek to capture payments from individuals' insurers, on the ground that the insurers will save money in the long run (for acute care and covered mental health) if they pay BHD for its provision of uncovered mental health and substance use disorder services. BHD should also seek to capture out-of-pocket payments from the individuals who receive these uncovered services, to the extent they have an ability to pay. Again, as noted above, setting up efficient programs for maximizing "voluntary" collections from insurers, and billing individuals fairly on a sliding scale, will be important.

Ultimately, however, BHD will be unable to obtain either voluntary payment from insurers or out-of-pocket payments from the individuals in question that equal BHD's cost of service. Thus, the only way for BHD to provide appropriate mental health and substance use disorder services (outpatient, inpatient, and long-term care) to this group will be to obtain a subsidy, either from state funds or the County's property tax levy.

c. Repositioning BHD

The enactment of the ACA, its validation by the U.S. Supreme Court, and the ramifications of the results of the 2012 elections, requires BHD to chart a new course.

The first step is to get good data—ACA-relevant data that will explain *who* has insurance, and what *type* of mental health and substance use disorder treatment their insurance will pay for. Without such data, BHD and Milwaukee County are sailing on the ocean in a storm without a compass.

The second step is to use good data to make clear decisions. The ACA will change who BHD serves. The ACA will change what services BHD provides. The law will reduce the number of people in

Milwaukee county who need to rely on BHD for mental health and substance use disorder treatment, and it will alter the financing mechanisms available to pay both non-BHD providers and BHD for certain kinds of treatment.

Helping Milwaukee County residents who do have insurance-financed coverage for mental health and substance use disorder treatment to find the best available providers, even if those providers have no connection with BHD itself, is potentially an important role for BHD to play in the new environment.

But the ACA's structure means that BHD will continue to directly serve many people in Milwaukee County. The extent and magnitude of such services, however, should be planned for in a strategic manner. Some who have insurance-financed coverage for mental health and substance use disorder treatment, many who lack such coverage (because of either limitations in their insurance or, simply, lack of any health insurance), and those that state mandates require BHD to be responsible, will continue to turn to BHD for mental health and substance use disorder treatment.

BHD must develop a clear and coherent plan for: (1) *how* to serve as an advisor and advocate for people in Milwaukee County who need mental health and substance use disorder services, even if BHD itself does not provide them; (2) *who* BHD itself will continue to serve in the future; (3) what *types* or *levels* of service BHD will provide; (4) *how* the cost of services that insurance does not pick up will be financed; and (5) what *part* of that non-insurance financing must fall on the County property tax. BHD and County policymakers will then have to explain, implement, and correct this plan on an ongoing basis.

VI. Conclusion

The ACA will greatly transform the scope and nature of health insurance coverage and health care delivery in Milwaukee County, and it will greatly expand the number of County residents who have health insurance coverage.

The law will also change the benefits received by those with Medicaid, Medicare, and individual and small group plans when the Essential Health Benefits package is fully implemented, and new consumer and patient protections are put in place. In particular, it will substantially increase the number whose insurance covers mental health and substance use disorder treatment.

The law has the potential to transform how some care is delivered, especially in Medicaid and Medicare settings.

All of these changes will significantly alter the way in which County residents seek and receive mental health and substance use disorder treatment, and the way that treatment is paid for.

In particular, these changes will have a major impact on both the scope of insurance-financed services provided by BHD, and the revenue it collects. In the short term, BHD should continue to systematically gather data and analyze the exact impacts so that it is ready to respond to each provision of the law. In the longer term, BHD and County policymakers need to engage in a fundamental examination of: (1) the populations BHD should serve in the future, and (2) what services BHD should provide, so that the overall system of providing the residents of Milwaukee County with mental health and substance use disorder treatment services becomes more integrated with the overall health care residents receive, produces better outcomes, and imposes a lower burden on the local property tax.

The ACA is not a panacea that will automatically bring about all of these good results, but it is a powerful tool whose potential should be fully explored and utilized.

VII. Contact Information

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To: Peggy Romo West, Chair, and Committee Members
Milwaukee County Board Health and Human Needs Committee

From: Robert Pietrykowski, Chair
Milwaukee County Aging and Disability Resource (ADRC) Governing Board

Date: March 13, 2013

Re: Overview of Authorization, Roles, and Responsibilities for Milwaukee County ADRC Governing Board
(For Information Only)

Please see the attached overview, as a means of introduction to the Milwaukee County ADRC Governing Board. We would be happy to meet with the Committee in the future to answer questions or to provide additional information.

The Milwaukee County Aging & Disability Resource Center (ADRC) Governing Board

Overview

The formation and maintenance of a Governing Board is mandated in the ADRC contract with the State of Wisconsin Department of Health Services (DHS) so that, "Consumers have a voice in governance and there is local guidance and oversight over the performance of the Aging and Disability Resource Centers."

The composition of the Board is intended to reflect the ethnic and economic diversity of Milwaukee County. At least one-fourth of the members are older people or people with physical or developmental disabilities or their family members, guardians, or other advocates reflective of the ADRC's target population. In Milwaukee County, our Board is comprised of seventeen people (see attached roster), approved by the County Board. The Board meets every other month. Some of the key duties of the Governing Board, as stated in the contract:

- Develop a budget, monitor expenditures for and oversee the operations of the ADRC. (Note that in the case of Milwaukee County, when a county operates the ADRC, its operations are subject to the county's ordinances and budget; therefore our role is limited to overseeing operations)
- Monitor and ensure the quality of services provided by the ADRC and participate in ADRC and Department quality assurance activities.
- Represent the interests of all target groups served by the Aging and Disability Resource Centers.
- Review ADRC customer complaints and appeals to determine if there is a need to change the ADRC's policies and procedures or otherwise improve performance.
- Analyze and recommend system changes to address the needs of older people and people with physical or developmental disabilities for long-term care and related services.

This last duty has several requirements, including gathering public data annually on the adequacy of long-term care services in the County and identifying gaps in services

as well as potential new community resources and sources of funding for services. In addition, the Board is directed to review grievances and appeals for the long term care system in the area, to determine if a need exists for system changes.

It should be noted that Milwaukee County also has Resource Oversight Committees for both the Aging Resource Center and the Disability Resource Centers. Our roles overlap somewhat in terms of monitoring the performance of the Resource Centers. In addition, although people whose primary diagnosis is mental illness are not specifically covered in the ADRC mission statement, our Board is also interested in keeping abreast with changes in the mental health system because many ADRC consumers are also mental health consumers. We also discuss issues that may overlap with the Commission on Aging and with CCSB. Both Stephanie Sue Stein and Geri Lyday regularly attend our meetings to keep us updated on overlapping issues.

Since our Board became fully operational in February, 2011, we have put more emphasis on the last duty mentioned, analyzing and recommending system changes, in order to determine consumer needs and gaps in services. In 2011, DHS required us to hold a public hearing to obtain consumer input re: long term care services available in Milwaukee County. We took this responsibility very seriously, and enlisted the help of the Managed Care Organizations serving County residents to notify consumers about a series of four public hearings held in different venues throughout the County. Unfortunately, the Managed Care Organizations did not help to promote the hearings in any meaningful way, and we experienced poor turnouts across the board. What we did hear from consumers and caregivers in attendance is about the importance of improving transportation services available to older people and people with disabilities, along with affordable housing options. Consumers and their caregivers at every venue consistently referenced these two areas as key gaps in the system.

In an effort to better educate ourselves on some of the **transportation** issues mentioned at the public hearings, we heard from staff from Milwaukee County's Transit Plus and New Freedom Programs. We also invited DHS's statewide vendor for Non-Emergency Medical Assistance, LogistiCare, to a meeting, and expressed several concerns about expanding the program to Milwaukee County. We have consequently sent another letter to DHS outlining areas of improvement needed now that a new vendor will be selected. We copied the County Board and our State legislative delegation as well.

In January of 2012 we held a special meeting with executives from the Managed Care Organizations to learn more about their organizations, service trends, fiscal challenges, and to hear their suggestions for improving the **Family Care, PACE, and Family Care Partnership programs**. A representative of the **IRIS** program attended our February 2012 Board meeting and responded to the same set of questions. We also invited advocates to present information to the Board on their services,

including representatives from the State Bureau on Aging and Long Term Care Ombudsman Program, Disability Rights Wisconsin, and Legal Action Wisconsin.

We expressed concerns about the **enrollment cap on Family Care** at both the federal and state levels, and received a response from federal Health and Human Services Secretary Kathleen Sebelius who ultimately rejected the request to place a cap on enrollments.

In 2013, the Board has decided to focus on the following issues:

- Improving/monitoring the Non-Emergency Medical Transportation (NEMT) program
- Discussions with Family Care providers re: the impact of the policy placing geographic restrictions on transportation and whether consumers have faced service access issues as a result
- Efforts to ensure regional cooperation in all publicly-funded transportation programs, so that consumers have access to providers and services in neighboring counties

In addition, the Board plans to follow the County budget process in terms of the Transit System budget and how its programs serving older adults and disabled adults may be affected by funding changes.

We look forward to working with the County Board and the Health and Human Needs Committee on ensuring that the needs of older people and people with disabilities are recognized and addressed.

By Supervisor Romo West

File No. 13-363

A RESOLUTION

establishing guidelines surrounding Milwaukee County's efforts to transition the Behavioral Health Division's long-term care facilities to a community-based model of care

WHEREAS, the Milwaukee County Department of Health and Human Services Behavioral Health Division (BHD) operates two licensed nursing home facilities that provide long-term, non-acute care to patients who have complex medical, rehabilitative, psychosocial needs and developmental disabilities; and

WHEREAS, Rehabilitation Center-Central is a 70-bed, Title XIX certified, skilled-care licensed nursing home and the newly renamed Center for Independence and Development (formerly Hilltop) is a Title XIX certified facility for persons with developmental disabilities with 72-beds—though policy adopted in the 2013 Adopted Budget calls for a reduction of 24 beds by July 1, 2013; and

WHEREAS, in February 2013, the County Executive announced his intention to shift patients in BHD's long-term care units from BHD to integrated, community settings within the next three years in his State of the County address; and

WHEREAS, this action follows previous recommendations, and planning efforts, including 2011 Adopted Budget amendment 1A011, which stated the following:

> *The Behavioral Health Division will work with the Disabilities Services Division (DSD) to develop a plan to downsize the 72-bed Rehabilitation Center-Hilltop Title XIX certified facility for Persons with Developmental Disabilities. The Department of Health and Human Services-Disabilities Services Division will provide options counseling to current Hilltop clients, exploring, where appropriate, placements in the community. The Director, Department of Health and Human Services shall provide quarterly informational reports to the Committee on Health and Human Needs regarding the progress of this initiative.*

; and

WHEREAS, in March 2013, the Director, Department on Health and Human Services and BHD Administrator presented an informational report on the long-term care unit closure to the County Board's Committee of the Whole (File No. 13-199); and

WHEREAS, it is imperative that careful planning precedes the closure of units, and that the focus of such planning should be on ensuring the well-being of the residents and not on how quickly the facilities can be downsized; now, therefore;

BE IT RESOLVED, that the Milwaukee County Board of Supervisors hereby endorses the following guidelines for shifting persons from BHD's long-term care facilities to integrated, community settings:

1. Prior to the full closure of long-term care units operated by Milwaukee County, a more robust continuum of community services will be developed, including: housing, specialized behavioral health services, and crisis services

2. Given the reliance on the Family Care program, prior to successfully relocating individuals to community-based settings, the Department of Health and Human Services and BHD will work with the managed care organizations in Milwaukee County to ensure the development of resources and capacity to meet the specialized needs of the individuals relocating to the community

3. Careful planning, including individual planning with residents, guardians and families will precede the relocation of all long-term care residents

4. Any housing consumers may be relocated to shall be licensed, provide blended case management on site, on-site peer support, and best practice programming (examples of which may include: music therapy, financial literacy, and exposure to community enrichment activities/volunteer opportunities)

5. As part of the planning process, the department will organize local community meetings focusing on educating the community on the relocation of consumers, answering questions, and addressing concerns from community members and stakeholders

6. Workshops will be organized for community-based long-term care providers who may be interested in accepting new clients from the facilities to ensure planning for adequate supports and quality of life programming are established

7. BHD will work with the Department of Human Resources to hold employee workgroups to discuss the downsizing process, and the options available to employees who may be at a risk of layoff due to the closures

; and

BE IT FURTHER RESOLVED, that the Director, Department of Health and Human Services is authorized and directed to submit a report detailing the fiscal

analysis of this initiative to the County Board by the September 2013 Meeting Cycle so that the Board may review the report's findings prior to 2014 budget deliberations; and

BE IT FURTHER RESOLVED, the aforementioned report shall include a full analysis of the planned use of funding to support the relocation effort of individuals who are and are not eligible for Family Care, and the funding necessary to sustain and enhance the full continuum of needed community-based services.

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 4/3/13

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: A resolution establishing guidelines surrounding Milwaukee County's efforts to transition the Behavioral Health Division's long-term care facilities to a community-based model of care.

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☒ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

This resolution seeks to establish guidelines for the transition of the individuals who currently reside in the county's long-term care facilities to settings in the community. Implementation of the policies outlined in the resolution, which mostly include enhanced planning and the organization of some meetings, may require additional staff time, but otherwise have no direct fiscal impact.

Department/Prepared By Jennifer Collins, County Board Research Analyst

Authorized Signature Jennifer Collins

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

Did CBDP Review?[2] ☐ Yes ☐ No ☒ Not Required

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

[2] Community Business Development Partners' review is required on all professional service and public work construction contracts.

Milwaukee County
Inter-Office
MEMORANDUM

Date: March 28, 2013

To: Supervisor Peggy Romo West, Chair, Committee on Health and Human Needs

From: Maria Ledger, Director, Department of Family Care

Subject: Potential Impact of the Governor's Recommended Budget on the Department of Family Care

I respectfully request that the attached informational report be scheduled for review by the Committee on Health and Human Needs at its meeting on April 17, 2013.

The Family Care program integrates home and community-based services, institutional care services (i.e., nursing homes), Medicaid personal care, home health, and other services that were previously funded separately. The Milwaukee County Department of Family Care (MCDFC) Managed Care Organization (MCO) currently serves more than 7,945 members.

The Governor's proposed budget includes as a performance measure the following: "Triple number of individuals self-directing services in the IRIS program." IRIS (Include, Respect, I Self-Direct) is a Wisconsin program where participants self-direct their publicly funded, community-based, long-term care supports and services.

Expecting new enrollments to triple only for one program will impact not only the Department of Family Care but also the State Medicaid budget. The State Department of Health Services has noted on several occasions that Family Care is more cost effective than either IRIS or the Legacy Waiver programs.

The Department of Family Care recognizes that while remaining cost effective, we must also provide high quality services for members. We know that we are succeeding, because our members themselves report high levels of satisfaction with the care and services they receive. In 2012:

- 93% of members surveyed are happy with the quality of the services they receive
- 91% of members surveyed would recommend the MCDFC MCO to a friend
- 95% and 91% of members surveyed receive help from their Care Manager (CM) and RN when they need it
- 95% and 94% of members surveyed report their CM and RN listen to their concerns

If you have any questions, please call me at 287-7610.

Maria Ledger

Maria Ledger, Director
Milwaukee County Department of Family Care

cc: County Executive Chris Abele
Chairwoman Marina Dimitrijevic, Milwaukee County Board of Supervisors
Amber Moreen, Chief of Staff, Office of the County Executive
Raisa Koltun, Director of Legislative Affairs, Office of the County Executive
Jodi Mapp, Committee Clerk, Milwaukee County Board of Supervisors
Kim Hodson, Chief Financial Officer, MCDFC

County of Milwaukee

INTEROFFICE COMMUNICATION

DATE: March 29, 2013

TO: Sup. Peggy Romo West, Chair, Committee on Health and Human Needs

FROM: Stephanie Sue Stein, Director, Department on Aging

RE: Informational report regarding potential impact of the 2013-2015 State Budget on the Milwaukee County Department on Aging

I respectfully request that the attached informational report be scheduled for review by the Committee on Health and Human Needs at its meeting on April 17, 2013.

The proposed 2013-15 state budget submitted by Governor Scott Walker fails to include certain "hold harmless" provisions and will have a negative impact on aging programs if adopted as presented.

The State of Wisconsin allocates federal Older Americans Act (OAA) funds and adds some state General Purpose Revenue (GPR) to help meet the needs of older people. Programs serving Milwaukee County seniors include home-delivered and congregate meals, family caregiver support, and such supportive services as transportation, benefit specialist/legal services, and minority senior centers among others.

According to new census data, Milwaukee County's percentage of the state's low-income elderly population has seen a modest decline relative to the rest of the state. Wisconsin Department of Health Services estimates that Milwaukee County Department on Aging (MCDA) will lose approximately $114,000 annually due to the changing demographics. As a result of that change, and because the 2013-2015 state budget lacks "hold harmless" provisions to maintain current service levels, some aging programs will be effected.

The statewide Aging Network is advocating for "hold harmless" provisions in support of aging programs be added to the 2013-2015 state budget.

If you have any questions, please call me at 2-6876.

Stephanie Sue Stein, Director
Milwaukee County Department on Aging

cc: County Executive Chris Abele
Supervisor Marina Dimitrijevic

cc: Jennifer Collins
Antoinette Thomas-Bailey
Jonette Arms
Thomas Condella
Mary Proctor Brown
John Janowski
Gary Portenier
Pat Rogers

COUNTY OF MILWAUKEE
INTER-OFFICE COMMUNICATION

DATE: March 25, 2013

TO: Supervisor Marina Dimitrijevic, Chairwoman, Milwaukee County Board of Supervisors

FROM: Héctor Colón, Director, Department of Health and Human Services
(Prepared by B. Thomas Wanta, Administrator/ Chief Intake Officer – DCSD)

SUBJECT: **Report from the Director, Department of Health and Human Services, requesting authorization to increase the 2013 purchase of services contract with the Running Rebels Community Organization in the amount of $100,000 from $1,525,944 to $1,625,944**

Issue

Section 46.09 of the Milwaukee County Code of General Ordinances requires County Board approval for the purchase of human services from nongovernmental vendors. No contract or contract adjustment shall take effect until approved by resolution of the County Board. Per section 46.09, the Director, Department of Health and Human Services (DHHS), is requesting authorization to increase the Delinquency and Court Services Division's (DCSD) 2013 purchase of services (POS) contract with Running Rebels Community Organization.

Background

In December 2012, DHHS recommended, and the Milwaukee County Board of Supervisors approved, a 2013 POS with Running Rebels Community Organization (RRCO), in the amount of $1,525,944. This contract provides targeted monitoring services for up to 109 youth per day and is primarily funded by revenue from the State Department of Corrections - Youth Aids.

Discussion

The Delinquency and Court Services Division (DCSD) has identified targeted monitoring services as a key component of the recently established (9-1-13) Milwaukee County Accountability Program (MCAP), which is designed as a local, community-oriented, safe, and cost-effective alternative to incarcerating youth at the State-run Lincoln Hills facility.

The Running Rebels Community Organization provides targeted monitoring services to youth in MCAP while in detention, during home passes, and when youth are placed back home in the community (in the form of school visits, home visits, calling schedule, and curfew checks). The level of monitoring varies according to the program phase.

MCAP has run at full capacity (12 youth) in secure detention since inception. The Targeted Monitoring Program is also operating at full capacity.

In order to successfully serve the volume of youth recommended by the judicial system for the MCAP program and the Running Rebels Targeted Monitoring in 2013, DCSD is seeking to increase the Running Rebels contract. It is the intent of DCSD to amend the 2013 Purchase of services contract with the Running Rebels Community Organization in two increments of $50,000 to allow DCSD to monitor the expansion of service without immediately committing the full $100,000. This would allow for flexibility if utilization trends change.

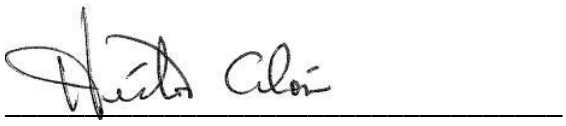
Recommendation

It is recommended that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to increase the purchase of services contract with the Running Rebels Community Organization (RRCO), in an amount of $100,000 to $1,625,944. The contract amendment would be effective for the period of January 1, 2013 through December 31, 2013.

Fiscal Effect

The necessary funding is included in the 2013 DCSD purchase of services budget, therefore, there is no tax levy effect. A fiscal note form is attached.

Respectfully,



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Kelly Bablitch, County Board
Don Tyler, Director, DAS
Craig Kammholtz, Fiscal & Budget Administrator, DAS
CJ Pahl, Assistant Fiscal & Budget Administrator, DAS
Antionette Thomas-Bailey, Fiscal & Management Analyst, DAS
Jennifer Collins, Analyst, County Board Staff
Jodi Mapp, Committee Clerk, County Board Staff

File No.
(Journal,)

(ITEM) Report from the Director, Department of Health and Human Services, requesting authorization to increase the 2013 purchase of services contract with the Running Rebels Community Organization in the amount of $100,000 from $1,525,944 to $1,625,944 by recommending adoption of the following:

A RESOLUTION

WHEREAS, per section 46.09 of the Milwaukee County Code of General Ordinances, the Director, Department of Health and Human Services (DHHS), is requesting authorization to increase the Delinquency and Court Services Division's (DCSD) 2013 purchase of services (POS) contract with the Running Rebels Community Organization (RRCO); and

WHEREAS, the Milwaukee County Board of Supervisors adopted Resolution File No. 13-21 authorizing a 2013 purchase of services contract for RRCO to provide target monitoring services as well as other services in the amount of $1,525,944; and

WHEREAS, DCSD has identified targeted monitoring services as a key component of the recently established Milwaukee County Accountability Program (MCAP), which is designed as a local, community-oriented, safe, and cost-effective alternative to incarcerating youth at the State-run Lincoln Hills facility; and

WHEREAS, DCSD requires flexibility to timely serve the volume of youth that the judicial system deems appropriate for the MCAP program in 2013; and

WHEREAS, DCSD's 2013 Adopted Budget contains sufficient funding to support this contract increase; now, therefore,

BE IT RESOLVED, that the Milwaukee County Board of Supervisors hereby authorizes and directs the Director, DHHS, or his designee, to execute a contract amendment in the amount of $50,000 for targeted monitoring services with the Running Rebels Community Organization for the period of January 1, 2013 through December 31, 2013:

Running Rebels 2013 Base Contract	$1,525,944
Targeted Monitoring Program Amendment #1	$50,000
CONTRACT TOTAL	$1,575,944

BE IT FURTHER RESOLVED, that the Director, DHHS, or his designee, is hereby authorized and directed by the Milwaukee County Board of Supervisors to execute a second amendment to the 2013 purchase of services contract with the Running Rebels Community Organization that would provide an additional $50,000 for a not-to-exceed total contract amount of

$1,625,944 if DCSD determines that a second amendment is necessary to accommodate the volume of youth identified for targeted monitoring services:

Running Rebels 2013 Adjusted Contract	$1,575,944
Targeted Monitoring Program Amendment #2	$50,000
CONTRACT TOTAL	$1,625,944

MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 3/25/13

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Report from the Director, Department of Health and Human Services, requesting authorization to increase the 2013 purchase of service contract with the Running Rebels Community Organization in the amount of $100,000 from $1,525,944 to $1,625,944

FISCAL EFFECT:

☒ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☐ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☐ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	0	0
	Revenue	0	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A. The Director of the Department of Health and Human Services (DHHS) is requesting authorization to increase a contract with the Running Rebels Community Organization by $100,000 for the period of January 1, 2013 through December 31, 2013.

The contract is administered by the Delinquency and Court Services Division (DCSD) and the amendment would accommodate additional youth recommended by the judicial system for the Milwaukee County Accountability Program (MCAP) and the Running Rebels Targeted Monitoring in 2013.

B. The contract would increase by a total of $100,000 from $1,525,944 to a not-to-exceed amount of $1,625,944. The $100,000 increase would be divided into two amendments of $50,000. The second amendment would only be issued by DCSD if it determines additional funding is necessary to keep pace with the service volume.

C. There is no tax levy impact associated with approval of this request in 2013 as funds sufficient to cover associated expenditures are included in DCSD's purchase of service contract line. DCSD's 2013 Budget includes $8,276,359 in account 8123 – purchase of service contracts. To date, $7,038,625 in purchase of service contracts has been executed.

D. No assumptions are made.

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Clare O'Brien, Fiscal & Management Analyst

Authorized Signature

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

Did CDPB Staff Review? ☐ Yes ☐ No ☒ Not Required

COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: March 25, 2013

TO: Supervisor Marina Dimitrijevic, Chairwoman – Milwaukee County Board

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Paula Lucey, Administrator, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, requesting authorization to increase a purchase of services contract with Community Advocates involving the prevention of prescription drug misuse and abuse in Milwaukee County as well as to provide protective payee program activities at the Behavioral Health Division**

Issue

Section 46.09 of the Milwaukee County Code of General Ordinances requires County Board approval for the purchase of human services from nongovernmental vendors. No contract or contract adjustment shall take effect until approved by resolution of the County Board. Per Section 46.09, the Director of the Department of Health and Human Services (DHHS) is requesting authorization to increase the purchase of services contract with Community Advocates for activities related to the prevention of drug misuse and abuse as well as for protective payee services for clients in the Behavioral Health Division (BHD).

Discussion

Prevention Grant

In January 2013, BHD received a $92,649 grant from the State Department of Health Services (DHS) issued under the Wisconsin Strategic Prevention Framework Partnerships for Success II (SPF PFS II). The grant's purpose is to provide a comprehensive, evidence-based, prevention approach to reduce the non-medical or unauthorized use of prescription drugs by focusing on two goals: 1) Reduce the non-medical/unauthorized availability of and access to prescription drugs among 12-25 year olds within sub-grantee geographic areas and 2) Establish a statewide systemic surveillance system to identify prescription drug misuse and abuse. These goals will be addressed through the implementation of evidence-based strategies at the local level.

These funds are available as a result of a three-year federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA) received by the State DHS-Division of Mental Health and Substance Abuse Services. Funds are being directed to the nine highest need counties throughout the state. Sadly, Milwaukee County ranked first exhibiting the greatest need for preventative interventions due to misuse and abuse of prescription drugs.

Community Advocates administers and staffs the work of the Milwaukee Coalition of Substance Abuse Prevention (MCSAP). This 40-member coalition is comprised of Milwaukee County citizens, substance abuse service professionals, and individuals who are familiar with the consequences of alcohol and other drug abuse.

Given the experience of Community Advocates administering the MCSAP work and with prevention programming, BHD is proposing to partner with them on this grant. The scope of work entails the annual collection of data related to the National Outcome Measurement System/Government Performance and Results Act (NOMS/GPRA). In addition, we are required to report the number of evidence-based programs, policies and practices implemented, and the number of people reached by the prevention strategies used.

Protective Payee Program

BHD is also seeking to retroactively contract with Community Advocates for protective payee program services. BHD sponsors a protective payee program for clients that require assistance with financial management services to ensure that they have adequate resources throughout the entire month and the ability to learn money management skills. In the March cycle, the County Board approved File No. 13-204 which established a payee services contract with the Milwaukee Mental Health Associates (MMHA) from May to December 2013 in an amount of $9,462.

However, coverage for January to April was inadvertently missed in the December 2012 cycle and should have been included in BHD's package of 2013 contracts. The services in the protective payee program were delivered by Community Advocates from January – April 2013. Approval of this contract would retroactively provide funding for payee services by $4,731 from January to April. In May, the responsibility for protective payee program will transfer from Community Advocates to MMHA for the remainder of the year.

Fiscal Effect

Prevention Grant

The SAMHSA grant supports 100% of the cost of the prevention activities. Therefore, there is no tax levy effect. A fiscal note form is attached.

Protective Payee Program

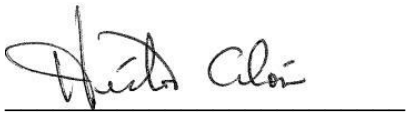
Total funds of $4,731 for this program will be allocated from the overall purchases of service funds in the 2013 Budget. A fiscal note form is attached.

Recommendation

It is recommended that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to increase the purchase of services contract with Community Advocates by $92,649 from May 1, 2013 through December 31, 2013. It is also recommended to increase the protective payee portion of the contract by $4,731 from January 1 to April 30, 2013. These

actions would increase the existing contract with Community Advocates by a total of $97,380 from $1,350,000 to $1,447,380.

Respectfully Submitted,



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Kelly Bablitch, County Board
Don Tyler, Director, DAS
Craig Kammholtz, Fiscal & Budget Administrator, DAS
CJ Pahl, Assistant Fiscal & Budget Administrator, DAS
Antionette Thomas-Bailey, Fiscal & Management Analyst, DAS
Jennifer Collins, Analyst, County Board Staff
Jodi Mapp, Committee Clerk, County Board Staff

File No.
(Journal,)

(ITEM *) Report from the Director, Department of Health and Human Services, requesting authorization to increase a purchase of services contract with Community Advocates involving the prevention of prescription drug misuse and abuse in Milwaukee County as well as to provide protective payee program activities at the Behavioral Health Division by recommending adoption of the following:

A RESOLUTION

WHEREAS, per Section 46.09 of the Milwaukee County Code of General Ordinances, the Director of the Department of Health and Human Services (DHHS) is requesting authorization to increase the existing purchase of services contract between Community Advocates and the Behavioral Health Division for the purpose of administering a drug misuse and abuse prevention grant as well as the Protective Payee Program; and

WHEREAS, in January 2013, BHD received a $92,649 grant from the State Department of Health Services (DHS) to provide a comprehensive, evidence-based, prevention approach to reduce the non-medical or unauthorized use of prescription drugs; and

WHEREAS, these funds are available as a result of a three-year federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA); and

WHEREAS, funds have been directed to the nine highest need counties throughout the state and Milwaukee County ranked first exhibiting the greatest need for preventative interventions due to misuse and abuse of prescription drugs; and

WHEREAS, Community Advocates administers and staffs the work of the Milwaukee Coalition of Substance Abuse Prevention (MCSAP), a 40-member coalition comprised of Milwaukee County citizens, substance abuse service professionals, and individuals who are familiar with the consequences of alcohol and other drug abuse; and

WHEREAS, working in partnership with Community Advocates, BHD will be required to collect and report all of the National Outcome Measurement System/Government Performance and Results Act (NOMS/GPRA) data on an annual basis through the online data collection system; and

WHEREAS, in addition to the prevention grant, Community Advocates would also administer activities related to the Protective Payee Program which assists some Social Security and/or Supplemental Security Income (SSI) recipients who require assistance in the management of these resources; and

WHEREAS, the Social Security Administration (SSA) authorizes the appointment of an individual or organization to receive Social Security and/or SSI benefits on behalf of an individual who cannot manage his or her money; and

WHEREAS, Community Advocates has an existing 2013 contract to provide AODA prevention and Crisis Resource Center services and experience with the Protective Payee Program; and

WHEREAS, total expenditures included in this request are $92,649 for the drug misuse and abuse prevention initiative as well as $4,731 for the Protective Payee Program for a total of $97,389 which would increase the contract from $1,350,000 to $1,447,380; and

WHEREAS, there is no tax levy impact associated with approval of this request because associated expenditures are included in the 2013 BHD Budget; now, therefore,

BE IT RESOLVED, that the Director of the Department of Health and Human Services, or his designee, is authorized to increase the existing purchase of services contract between Community Advocates and the Behavioral Health Division by $92,649 from May 1, 2013 to December 31, 2013 for the purpose of administering the activities of the prevention grant; and

BE IT FURTHER RESOLVED, that the Director of the Department of Health and Human Services, or his designee, is authorized to retroactively increase the existing purchase of services contract between Community Advocates and the Behavioral Health Division by $4,731 for the purpose of administering the Protective Payee Program for the period of January 1, 2013 through April 30, 2013.

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MILWAUKEE COUNTY FISCAL NOTE FORM

DATE: 3/25/13

Original Fiscal Note ☒

Substitute Fiscal Note ☐

SUBJECT: Report from the Director, Department of Health and Human Services, requesting authorization to increase a purchase of services contract with Community Advocates involving the prevention of prescription drug misuse and abuse in Milwaukee County as well as to provide protective payee program activities at the Behavioral Health Division

FISCAL EFFECT:

☐ No Direct County Fiscal Impact

☐ Existing Staff Time Required

☒ Increase Operating Expenditures
(If checked, check one of two boxes below)

☐ Absorbed Within Agency's Budget

☐ Not Absorbed Within Agency's Budget

☐ Decrease Operating Expenditures

☒ Increase Operating Revenues

☐ Decrease Operating Revenues

☐ Increase Capital Expenditures

☐ Decrease Capital Expenditures

☐ Increase Capital Revenues

☐ Decrease Capital Revenues

☐ Use of contingent funds

Indicate below the dollar change from budget for any submission that is projected to result in increased/decreased expenditures or revenues in the current year.

	Expenditure or Revenue Category	Current Year	Subsequent Year
Operating Budget	Expenditure	92,649	0
	Revenue	92,649	0
	Net Cost	0	0
Capital Improvement Budget	Expenditure		
	Revenue		
	Net Cost		

DESCRIPTION OF FISCAL EFFECT

In the space below, you must provide the following information. Attach additional pages if necessary.

A. Briefly describe the nature of the action that is being requested or proposed, and the new or changed conditions that would occur if the request or proposal were adopted.
B. State the direct costs, savings or anticipated revenues associated with the requested or proposed action in the current budget year and how those were calculated. [1] If annualized or subsequent year fiscal impacts are substantially different from current year impacts, then those shall be stated as well. In addition, cite any one-time costs associated with the action, the source of any new or additional revenues (e.g. State, Federal, user fee or private donation), the use of contingent funds, and/or the use of budgeted appropriations due to surpluses or change in purpose required to fund the requested action.
C. Discuss the budgetary impacts associated with the proposed action in the current year. A statement that sufficient funds are budgeted should be justified with information regarding the amount of budgeted appropriations in the relevant account and whether that amount is sufficient to offset the cost of the requested action. If relevant, discussion of budgetary impacts in subsequent years also shall be discussed. Subsequent year fiscal impacts shall be noted for the entire period in which the requested or proposed action would be implemented when it is reasonable to do so (i.e. a five-year lease agreement shall specify the costs/savings for each of the five years in question). Otherwise, impacts associated with the existing and subsequent budget years should be cited.
D. Describe any assumptions or interpretations that were utilized to provide the information on this form.

A. The Director of the Department of Health and Human Services (DHHS) is requesting authorization to increase a contract with Community Advocates by $92,649 to administer a drug misuse and abuse prevention grant. In addition, the contract would increase by $4,731 for services related to the Protective Payee Program.
.
B. The department's contract with Community Advocates would increase by a total of $97,380 from $1,350,000 to $1,447,380.

C. There is no tax levy impact associated with the approval of this request in 2013. All costs associated with the prevention initiative are 100 percent funded by a federal grant from the Substance Abuse and Mental Health Services Administration (SAMHSA). A fund transfer will be submitted in 2013 to increase expenditures and offsetting revenues by $92,649.

The $4,731 in costs associated with the Protective Payee Program are covered in the purchase of services contract line within the 2013 Community Services Bureau (CSB) Budget.

D. No assumptions are made.

[1] If it is assumed that there is no fiscal impact associated with the requested action, then an explanatory statement that justifies that conclusion shall be provided. If precise impacts cannot be calculated, then an estimate or range should be provided.

Department/Prepared By Clare O'Brien, Fiscal & Management Analyst

Authorized Signature

Did DAS-Fiscal Staff Review? ☐ Yes ☒ No

Did CDPB Staff Review? ☐ Yes ☐ No ☒ Not Required

COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: March 25, 2013

TO: Supervisor Peggy Romo-West, Chairwoman – Health & Human Needs Committee

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Clare O'Brien, DHHS Fiscal & Management Analyst

SUBJECT: **From the Director, Department of Health & Human Services, submitting an informational report regarding the potential impact of the 2013-2015 State Budget on the Milwaukee County Department of Health and Human Services (Informational only unless otherwise directed by the Committee)**

Issue

The report reflects a request from the Health and Human Needs Committee Chairwoman for a written summary detailing the impact of the Governor's 2013-2015 Budget on the Department of Health and Human Services (DHHS).

Background

Based on staff review of the 2013-2015 Governor's Budget and analysis provided by the State of Wisconsin's Legislative Fiscal Bureau, the following identifies the major State budgetary changes affecting DHHS:

Behavioral Health Division

Mental Health Initiatives
A major new investment included in the Governor's Budget is $29 million for Mental Health programs. Within this mental health package, there are two initiatives that would allow BHD to augment its current services within its Community Services Branch (CSB): Comprehensive Community Services (CCS) and Peer Run Respite Centers.

Two other proposals contained in this mental health package are already being provided through BHD's Wraparound Program. The budget allocates $3.8 million in General Purpose Revenue (GPR) funding for Coordinated Service Teams (CST), a program that would manage services for children who are involved in two or more systems of care, as well as $500,000 in GPR for the expansion of In-Home Counseling for children. The CST funding will not affect Milwaukee County as it applies only to counties that don't offer children's mental health services with a wraparound philosophy. In addition, In-Home Counseling services are currently paid for through Wraparound's managed care system.

Comprehensive Community Services (CCS) -Total Investment: $10.2 million: This component would expand intensive, targeted community-based care for persons with mental health or substance abuse disorder beginning July 1, 2014. The budget would increase funding and

position authority to expand the CCS program statewide. Under this initiative, counties would organize into consortia with Milwaukee County being proposed as its own consortium. Of the $10 million in available GPR, $6 million is already earmarked for the 26 current participating counties if they regionalize service delivery. BHD plans to request a significant portion of the remaining $4 million.

In determining the impact to clients currently receiving services through BHD's Community Services Bureau, staff reviewed the number of clients served in 2011. Of the 10,248 total served, CSB determined that approximately 5,000 met the criteria for CCS. However, given that CCS is a voluntary program, the full 5,000 may not select CCS as a service option. Assuming that most clients will choose to participate, however, the new program is likely to exceed its capacity.

According to the LFB analysis of the Governor's Budget, the CCS funding is based on 3,200 individuals receiving services annually statewide. Both Milwaukee and Dane Counties do not offer CCS currently and the number of participants in these counties alone could easily exceed the 3,200 estimate. While the state indicated it will seek additional Medicaid revenue, this may still prove insufficient and potentially expose counties to paying the local share.

Peer-Run Respite Centers – Total Investment $1.3 million: This initiative involves the establishment of three regional Peer-Run Respite Centers to improve outcomes of individuals in crisis or individuals having difficulty coping with mental illness through services such as peer supports, 24/7 hotlines, wellness activities, respite, and hospital diversion. The budget includes funding for one position starting July 1, 2014 and $1.3 million in GPR beginning in SY2015. The State plans to issue a Request for Proposals (RFP) to allocate the funds.

Similar to the CCS initiative, the funding budgeted for the Peer-Run Respite Centers may be insufficient to meet the statewide need. Staff estimates that it could cost up to approximately $1.2 million to establish one center compared to the $400,000 budgeted for each of the three centers. The $1.2 million reflects costs to secure a building for eight beds, obtain the appropriate licensure, train staff on safety codes, and hire staff for a 24/7 operation.

Given the potential fiscal issues, DHHS will continue to monitor the CCS and Peer-Run Respite initiatives and gather further information.

Health Care Reimbursement

Included in the State Budget are a number of eligibility and potential reimbursement changes that may significantly impact BHD. It is premature, however, to accurately quantify the changes until the department is able to conduct a more careful analysis and more details are provided by the State.

One area that holds some revenue potential for BHD is the expansion of the Badger Care Plus Core Plan for childless adults (non-elderly adults without dependent children). The Budget assumes an additional 82,500 childless adults will enroll by January 1, 2014 and increase to

nearly 100,000 (including current Core plan members) by January 2015. Currently, there is a waiting list of about 146,000 individuals for Core Plan coverage.

The Core Plan covers only basic primary and preventive care so it would not cover BHD's inpatient or community services. However, it does cover emergency department services delivered through BHD's Psychiatric Crisis Services (PCS). Currently, if an individual receives services from PCS and has no ability to pay, this cost is written off as charity. BHD must analyze its patient data and income information in order to ascertain the fiscal impact. Complicating the analysis is that some parents who are currently covered may lose their Badger Care coverage as a result of eligibility changes in the Budget.

An area that may have a more negative impact to BHD's reimbursement involves the methodology by which Medicaid reimbursement is calculated for PCS. Currently, the rate is determined based on a per diem and the new method reflects reimbursement based on a patient's diagnosis. This is expected to reduce BHD's Medicaid reimbursement for PCS services by approximately $600,000.

Department of Health and Human Services

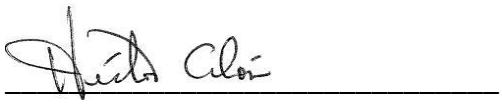
Youth Aids

No cuts are expected in youth aids revenue though the budget includes an increase to the daily rates charged to counties for youth placed in State juvenile corrections facilities. The daily rates increase to $297 (from $289) as of July 1, 2014 and $304 as of July 1, 2015. The increased rates would reduce any 2013 and 2014 Youth Aids surplus achieved as a result of a lower average daily population (ADP). Over the most recent 18 months, the average actual ADP (157.9) was 7.2 lower than the 2013 DHHS Budget (165.1).

Over the last few years, DHHS has experienced surpluses in Youth Aids due to these lower ADPs. Based upon the proposed rate increase, the projected 2013 surplus could be reduced by approximately $300,000 and the 2014 surplus could be reduced by approximately $500,000.

Recommendation

This report is informational only and no action is required.



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