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Fiscal Analysis of Mental Health Redesign in Milwaukee County

About the Public Policy Forum

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

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Fiscal Analysis of Mental Health Redesign in Milwaukee County

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Davida Amenta, Researcher
Rob Henken, President

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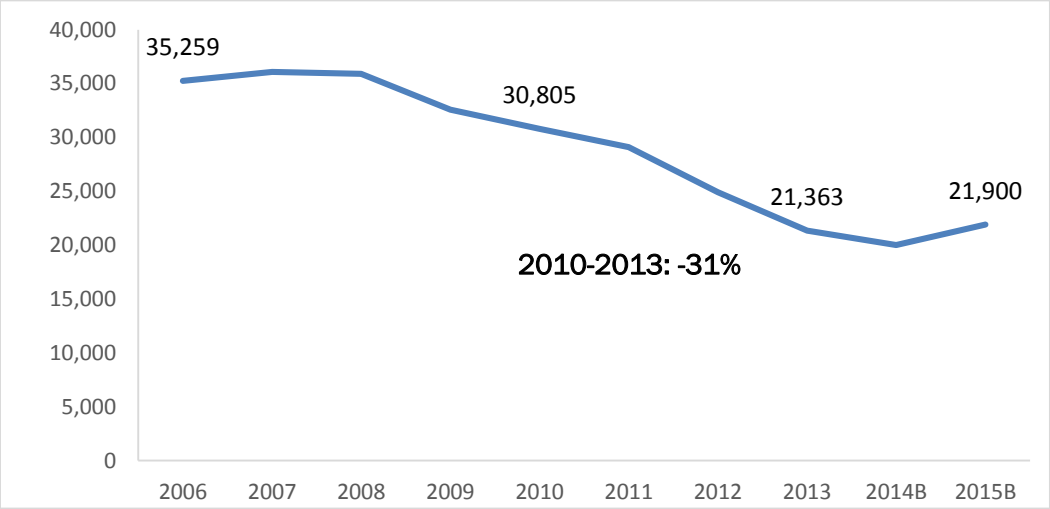
Executive Summary

The mental health care system in Milwaukee County has undergone dramatic change in recent years, as County and community leaders have sought to ease reliance on emergency and inpatient care while enhancing the range and scope of community-based mental health services. Between 2010 and 2013, adult inpatient capacity at the County's Mental Health Complex decreased by 31%, while admissions at its emergency room facility (referred to as the Psychiatric Crisis Service, or PCS) dropped by 15%. In addition, the County recently closed one of its 72-bed long-term care facilities and plans to complete the closure of its second facility by the end of 2015.

Adult inpatient capacity reduction (measured by patient bed days)



On the community side, an array of new treatment and recovery-oriented services has been added, including Comprehensive Community Services (CCS), a new Medicaid benefit that seeks to reduce inpatient admissions by strengthening early intervention and treatment programs; Community Recovery Services (CRS), which offers psychosocial services such as employment, housing, and peer support to eligible Medicaid clients; and a range of new community-based crisis services.

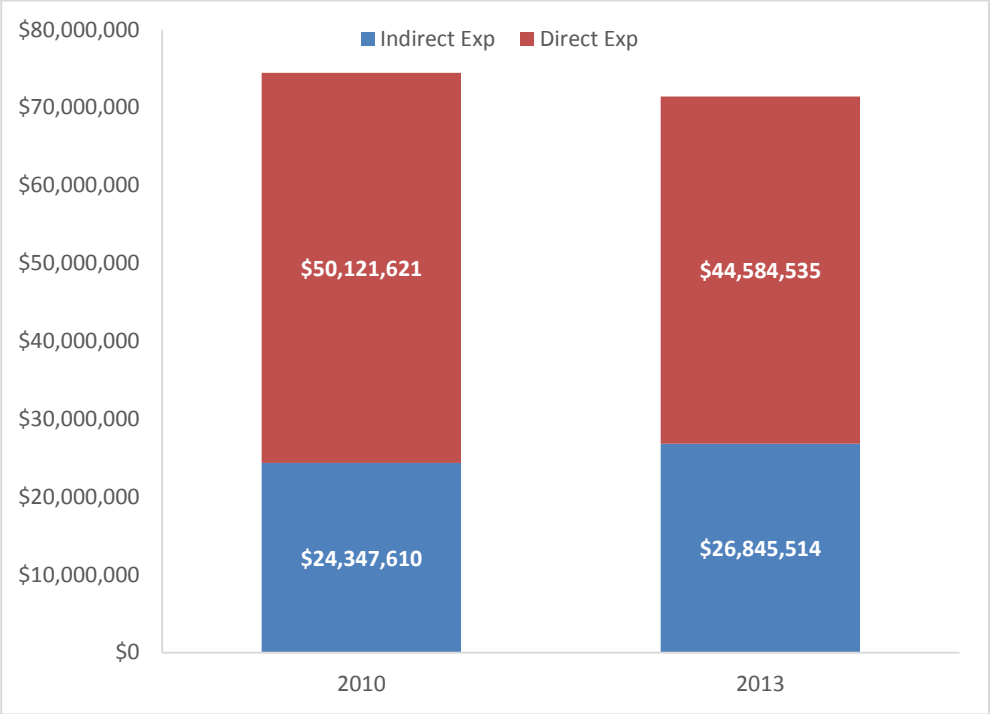
While it is relatively easy to describe these service changes, far less is known about the ***financial*** impacts of ongoing mental health redesign efforts. For example, how much is being saved on an annual basis from the vastly reduced inpatient/long-term care census? And, perhaps more important, can continued bed reductions at the Mental Health Complex generate the property tax levy savings that are likely to be required to achieve desired levels of community-based care?

In this report – commissioned by Milwaukee County and its Mental Health Redesign Task Force – the Public Policy Forum seeks to answer those questions. We do so first by assessing the fiscal impacts of the County's mental health redesign activities that have occurred to date, which we accomplish by "deconstructing" BHD's budget to isolate direct and indirect cost centers and appropriately distinguish between hospital and community-based expenditures. Then, we use that knowledge to consider how the implementation of a fully redesigned system of care will impact the Behavioral Health Division's (BHD) financial situation in the next two years.

The report begins by examining financial trends from the 2010-2013 timeframe, which was the period of time in which BHD initiated various mental health redesign strategies aimed at moving toward a community-based system of care. Our trend analysis revealed the following:

- While direct hospital-related expenditures at the Mental Health Complex decreased by $5.5 million (11%) – an amount that intuitively would appear to correlate with the decline in bed capacity – indirect costs unexpectedly increased by $2.5 million. To some degree, this was caused by factors beyond BHD's control, such as the central budget office's determination of BHD's legacy costs from retired employees, facility expenses, and charges from other departments.

Change in Mental Health Complex Expenditures, 2010-2013



- Overall staffing levels at the Mental Health Complex remained largely the same despite the reduced patient volume. We found this was largely attributed to increased staffing levels at PCS, which may have reflected a need to utilize clinical staff freed up from inpatient and long-term care downsizing to address previous understaffing at PCS.

- BHD was successful in enhancing patient revenues on a per-patient basis between 2010 and 2013, but the reduced patient census produced an overall net loss of about $3 million in patient revenue. Because that loss largely offset expenditure reductions, the County was unable to reduce its allocation of property tax levy to Mental Health Complex services.[1]

[1] In this analysis, when we refer to property tax levy we also include the County's annual Base Community Aids (BCA) allocation from the State of Wisconsin. Property tax levy and BCA are used interchangeably by the County to fill the gap between the amount spent to provide mental health services and the revenue that is recovered from patients and other sources.

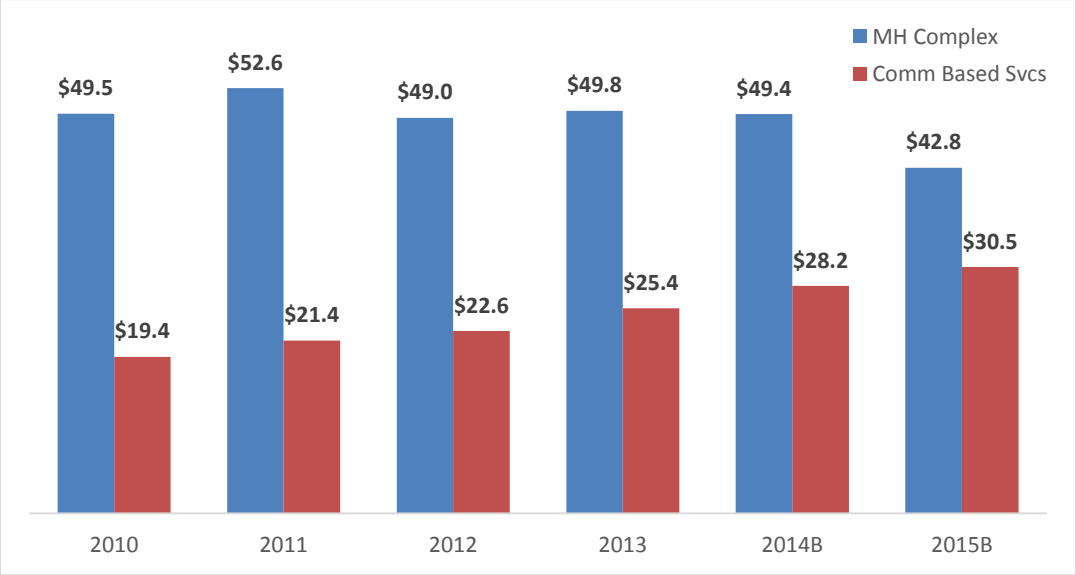
- BHD was able to increase its investment in community-based services during the 2010-2013 timeframe, with expenditures growing by $3.9 million (12%). However, BHD's community services as a whole became more dependent on property tax resources, which increased by $6 million. Because levy savings did not materialize from Mental Health Complex downsizing, those additional resources came from other parts of County government and/or general increases in the tax levy.

Overall, our trend analysis found that a key objective of mental health redesign – to use inpatient and long-term care downsizing as a means of freeing up property tax resources to invest in community-based services – had not been achieved as of the end of 2013.

We then turned to the 2014 and 2015 budgets to determine whether any of the trends observed for the previous four years had reversed, and whether additional savings associated with continued Mental Health Complex downsizing in those years were being generated for reinvestment in community-based services. The 2014 and 2015 budgets were characterized by even greater downsizing than had occurred the previous four years, including the closure of both long-term care facilities by the end of 2015; and by increased investment in community-based services.

We found that the financial benefits associated with these sharper declines in patient census had indeed become more pronounced. For example, property tax levy expenditures for Mental Health Complex service areas were budgeted to fall by about $7 million (14%) in 2015 when compared with 2013 actual amounts. However, the potential for greater savings still was limited by BHD's inability to substantially reduce indirect costs, which were projected to decline by only 4%; and by substantial budgeted reductions in patient revenue in conjunction with the reduced census. We also observed that increased staffing and expenditure levels at PCS continued to partially offset inpatient and long-term care savings.

Adult Mental Health Tax Levy Expenditures, 2010-2013 Actual and 2014-2015 Budget (millions)

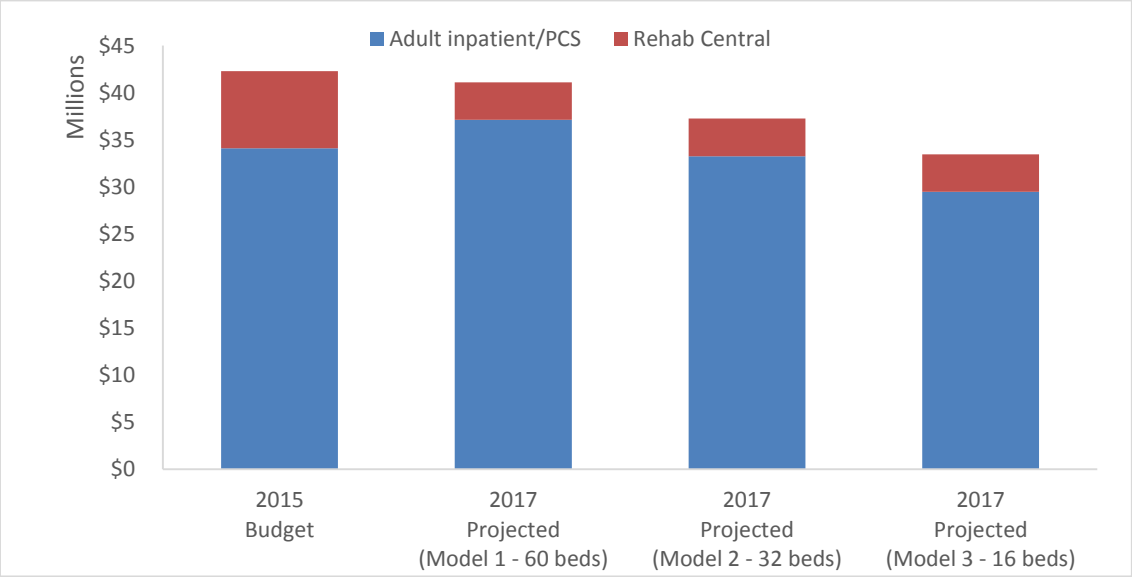


Finally, we used the information and insights gained from our trend analysis to conduct financial modeling that allowed us to estimate the financial impacts of 60-, 32-, and 16-bed adult inpatient scenarios. For each of our models, we took into account both the financial impacts associated with each bed capacity scenario, plus a calculation of the ongoing savings that would result from the closure of the Rehab Central long-term care facility in 2015.

Our modeling showed that BHD would need about $3 million of additional property tax levy in 2017 to support the two remaining Mental Health Complex functions (adult inpatient and PCS) than it budgeted for those functions in 2015. However, because $4.2 million in net savings would be derived from the closure of Rehab Central, there would be a total of about $1.2 million available for community reinvestment under that scenario in 2017. We also found that BHD could generate a $5 million property tax levy savings in 2017 (when compared to the 2015 budget) by downsizing from 60 to 32 adult inpatient beds, and an $8.8 million savings by downsizing to 16 adult inpatient beds. Again, both of those savings amounts include the positive fiscal impact associated with the closure of Rehab Central.

A key question is whether an investment of the projected savings from the 32- and 16-bed scenarios in community-based services would be sufficient to appropriately offset the increased need for such services in light of reduced inpatient bed capacity. We were unable to determine the answer to that question, but suggested that BHD should ascertain the types and scope of enhanced community-based services that might be implemented to make such a determination.

Projection of 2017 Mental Health Complex Tax Levy Spending Under Different Bed Scenarios



* While the Rehab Central long-term care facility will be closed in 2017, we still show a Rehab Central expenditure in 2017 in this figure. This is attributed to $4 million in needed BCA/levy expenditures to support Rehab Central clients in community settings and to pay remaining legacy costs.

Our modeling exercise not only revealed the amount of estimated savings that could be achieved through continued bed reductions, but also highlighted the fundamental constraints that will continue to impact BHD's financial future:

1. The Mental Health Complex's indirect costs are only loosely linked to its bed capacity, and this factor will continue to curtail overall savings that can be achieved with future downsizing initiatives.

2. Because key components of BHD's indirect cost structure are linked to its existing facility and its treatment as a regular department of Milwaukee County government, there is little it can do to reduce indirect costs without changes to those two circumstances.

3. While BHD can continue to generate sizable direct cost savings from additional reductions in adult inpatient bed capacity, the direct cost pressures associated with continued operation of PCS at its existing capacity will erode those savings and reduce the amounts available for community reinvestment.

The report concludes with five observations derived from our modeling and trend analysis:

- **Milwaukee County leaders should contemplate a new financial structure for the Mental Health Complex that sets it apart from the rest of Milwaukee County government.**

  As long as the Mental Health Complex continues to be subject to charges from other County departments and central service allocations from the central budget office, it is likely to receive only limited benefit from bed capacity and associated staffing reductions. An argument could be made – particularly in light of BHD's new governance structure that has it reporting to a new Mental Health Board – that the additional step of segregating BHD's finances from the rest of Milwaukee County government should occur, or that it should be placed under a separate mental health district or authority. Should this approach prove unworkable from an accounting, legal, or logistical perspective, then the County budget office and BHD at least should consider reforming internal budgeting and accounting practices to better isolate costs and revenues associated with BHD's various service areas.

- **Milwaukee County and State of Wisconsin leaders need to work jointly to address BHD's facility needs and questions.**

  Our analysis confirms what Milwaukee County leaders have known for quite some time: that facility costs at the existing facility are influenced most prominently not by the amount of square footage that BHD occupies for its hospital-related operations, but instead by its continued need to service and maintain the entire sprawling Mental Health Complex regardless of inpatient bed capacity, and by cost factors associated with its use of County facilities staff to do so. Furthermore, BHD officials have cited millions of dollars of needed repairs at the existing Complex, which have been deferred pending consideration of a possible new facility. It is unclear how those needs will be addressed given that recent state legislation places BHD operations spending under the purview of the Mental Health Board, but leaves capital and debt service costs under the purview of the County Board.

- **The future size, mission, and location of PCS will be central to any decision-making regarding adult inpatient bed capacity and a potential new facility.**

  An often overlooked issue in BHD's consideration of its optimal inpatient capacity and the possible construction of a new facility is the future size, scope, and operation of PCS. Our analysis shows that as long as PCS maintains its approximate current patient volume and staffing, then its costs are likely to continue to grow with inflation, thus partially offsetting any savings accrued from inpatient downsizing. In determining possible downsizing options and the size and location of a new facility, therefore, County and Mental Health Board leaders also should be considering how PCS will function in the future.

- **BHD should develop effective and transparent ways to measure the impacts of its community investments on inpatient and PCS demand and to track and project community-based service costs.**

  It will be tempting to view an opportunity to generate almost $9 million in annual savings from a 16-bed scenario as too promising to ignore, and to simply assume that by reinvesting those dollars in community-based services an appropriate balance of services can be created. We suggest, however, that the ability to safely downsize in such a substantial manner will be predicated on whether community-based investments truly decrease demand for inpatient care, and that a performance measurement system be developed to provide insight into that question before substantial additional downsizing occurs. Similarly, we recommend that BHD develop the financial data collection and reporting mechanisms that will be required to appropriately model future year community-based expenditures and revenues and guide decision-making on future investment options.

- **BHD needs more detailed analysis of its revenue structure and revenue opportunities to guide bed capacity decisions.**

  While BHD has made great progress in implementing a new electronic medical records system and improving its revenue collection practices, it would benefit from greater capacity to conduct sophisticated analysis of revenue trends and its patient mix. BHD also would benefit from additional expertise on Medicaid and Affordable Care Act issues and opportunities to help it appropriately gauge the impacts of major changes in its service design and delivery. Consequently, we suggest that BHD and the Mental Health Board consider options for developing the capacity to better monitor and analyze BHD's revenue performance, and to produce the types of revenue profiles and analyses that will be critical to determining the pros and cons of different bed capacity options.

Introduction

In October 2010, the Human Services Research Institute (HSRI) and Public Policy Forum published a report that detailed the need to redesign the adult mental health care delivery system in Milwaukee County. The report suggested a series of carefully-calibrated strategies to transition from a system that relied primarily on emergency and inpatient care to one that was predicated on services in community settings. The report stressed, however, that a safe and orderly reduction in bed capacity would require simultaneous investments in an appropriate and expanded mix of community-based services.

Since that time, Milwaukee County's Behavioral Health Division (BHD) has aggressively moved to implement several elements of the recommended redesigned system. Adult inpatient bed capacity has been substantially reduced; one of the County's two long-term care facilities has closed, with the second slated for closure by the end of 2015; and volume at the County's psychiatric emergency room has declined. At the same time, additional investments have been made to enhance community-based services.

The County's resolve to reduce its operations at the Mental Health Complex also created a need for detailed financial planning. Specifically, this initiative created an imperative for the County to accompany its downsizing initiatives with financial analysis that would reveal the budgetary impacts associated with a vastly reduced inpatient/long-term care census and the extent to which resulting savings could offset the cost of enhanced community-based alternatives.

A first step in this financial planning was taken in 2013, with the publication of a report by the Forum that assessed the fiscal challenges of Milwaukee County's Behavioral Health Division. The 2013 report sought to provide a baseline fiscal assessment that would be used to inform the mental health redesign process and ensure that programmatic recommendations were accompanied by a fundamental understanding of BHD's financial constraints.

In this report – commissioned again by Milwaukee County at the urging of leaders of its Mental Health Redesign Task Force – the Forum builds off its 2013 baseline analysis with a new and detailed fiscal examination. The primary purposes of this report are to 1) assess the fiscal impacts of the County's mental health redesign activities that have occurred to date; and 2) use that knowledge to consider how the full implementation of a redesigned system of care will impact BHD's financial situation and the finances of Milwaukee County as a whole.

An overriding research question at the root of this analysis is whether continued bed reductions at the Mental Health Complex will generate sufficient property tax levy savings to achieve desired spending levels on community-based services. To some extent, this is a "chicken and egg" problem. Enhanced community-based services are needed to reduce the Mental Health Complex census, but the savings derived from bed reductions are needed to provide additional community-based services.

Our starting point is an examination of actual BHD spending and revenue performance for the 2010-2013 timeframe in the areas of emergency, inpatient, long-term care, and community-based adult mental health services. We "de-construct" BHD's budget, peeling back multiple allocations of indirect costs to show the real impacts of the downsizing that occurred between 2010 and 2013. Both Mental Health Complex and community services budgets are reviewed from 2010 to 2013. After that task is accomplished, we present updated financial information from the 2014 budget and 2015 budgets. Finally, the analysis includes financial projections for 2017 under various adult

inpatient bed scenarios to estimate how much additional financial capacity actually would be derived from additional inpatient reductions to support enhanced investment in community-based services.

As we stated in the Introduction to our March 2013 report, the objective of our work is not to critique BHD's fiscal management, but instead to objectively analyze its financial challenges and opportunities. Our hope is to provide Milwaukee County budget officials and the new Milwaukee County Mental Health Board with an independent fiscal assessment and forecast with which to consider important programmatic changes moving forward.

Background

BHD provides and/or administers 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 responsibilities in this area are stipulated in Wisconsin's State statute 51.15, which assigns to counties the mandate of providing for "the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services."

BHD is housed at the Milwaukee County Mental Health Complex on Watertown Plank Road in Wauwatosa. At the Complex, Milwaukee County owns and runs an inpatient hospital consisting of four licensed units (one of which is for children and adolescents); two long-term care facilities (one for individuals with complex needs who require long-term treatment and one for individuals diagnosed with both developmental disability and serious behavioral health needs);[2] and a Psychiatric Crisis Service (PCS) that serves persons in need of emergency mental health treatment, a majority of whom are brought in by law enforcement on an Emergency Detention. PCS also encompasses a mental health outpatient Access Clinic and a Mobile Treatment Team.

In addition to being a direct provider of mental health services at the Complex, BHD contracts for a wide variety of community-based services, including targeted case management (TCM), community support programs (CSP), community residential services, outpatient treatment, substance abuse treatment and recovery support, crisis respite, and specialized services for children and adolescents.

The governance, administration, and funding of Milwaukee County's behavioral health services changed dramatically in April 2014 with the adoption of Wisconsin Act 203 by the Wisconsin Legislature and governor. The Act removes jurisdiction of those services from the Milwaukee County Board of Supervisors and instead places them under the control of a newly created Mental Health Board (MHB) comprised of 11 individuals with expertise or experience in various facets of mental health services and administration. Members were appointed in June 2014 and the Board held its initial meeting in July.

In addition to "oversee(ing) the provision of mental health programs and services in Milwaukee County," the MHB has administrative control over BHD's budget and personnel. That includes both the programs and services provided by the division at the Mental Health Complex and the services administered by its community services branch. While the MHB has the power to approve BHD's annual budget, the legislation stipulates that the property tax levy contained in the budget must be between $53 million and $65 million, unless a higher or lower amount is agreed to by the MHB, county executive, and county board. BHD's 2015 expenditure budget is $179.6 million, including $59.1 million in property tax levy. The budget funds 585 full-time equivalent employees (FTEs).

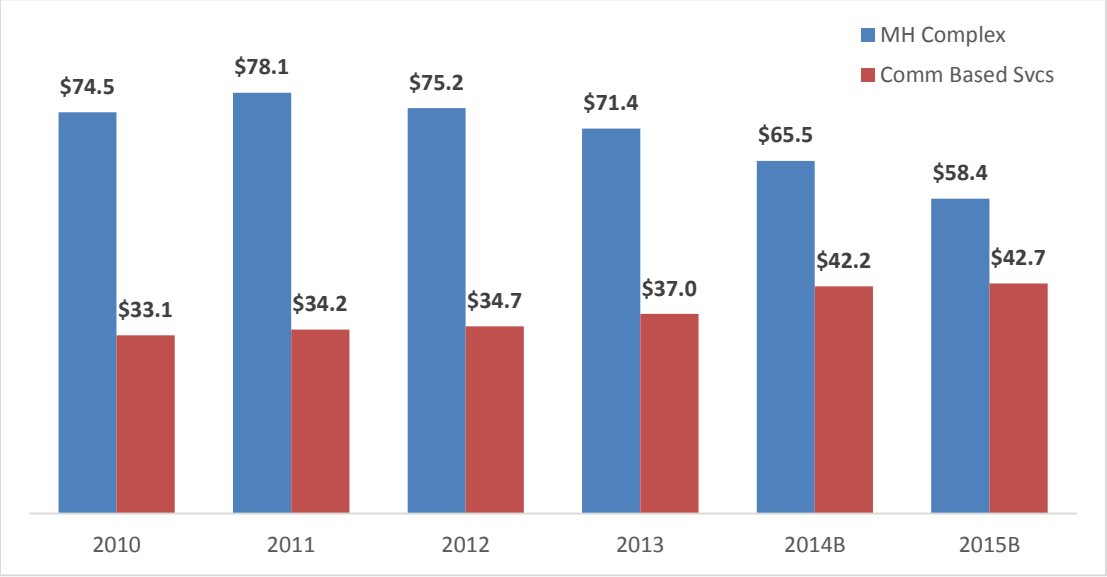
The focus of this report is the set of BHD programs and services that have been the subject of mental health redesign activities. Specifically, those are programs and services that pertain to adult mental health. Major programs that are excluded from this analysis are BHD's Wraparound Milwaukee program, its Family Intervention Support Services, its range of AODA services, and its Children's and Adolescent Inpatient Services (CAIS). In addition, the County's Emergency Medical

[2] One of the long-term care facilities, Hilltop, closed in January 2015 but it was in operation during much of the period of this analysis.

Services program has been housed in the BHD budget in recent years but is excluded from this analysis.

As the redesign process has progressed, BHD has been successful in reducing the patient census at the Mental Health Complex. **Figure 1,** which compares total expenditures for inpatient, crisis, and long-term care services provided at the Mental Health Complex with community-based services over the past six years, suggests that the redesign has had substantial fiscal effect, at least in recent budgets. Whereas in 2010, BHD's expenditures on community-based services were only 44% of its expenditures on Mental Health Complex services, that ratio rose to 52% in 2013. In the 2015 budget, with Hilltop closed and Rehab Central projected to close by year end, the ratio of community-based to Mental Health Complex expenditures rises to 73%.

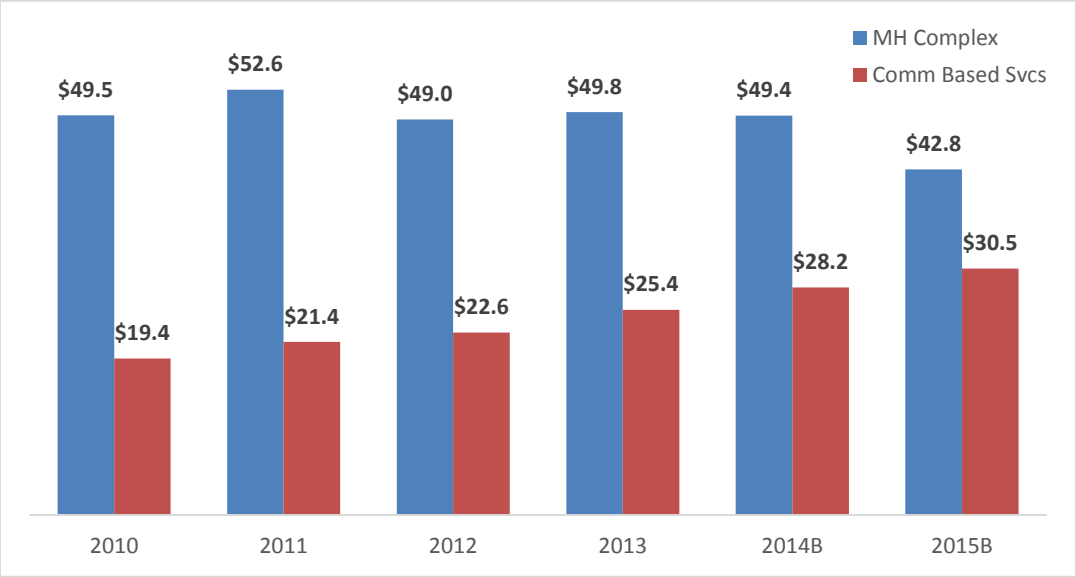
Figure 1: Adult Mental Health Expenditures, 2010-2013 Actual and 2014 and 2015 Budget (in millions)



Source: Data for this and all following tables were provided by BHD.

When we consider the expenditure of discretionary County resources (i.e. property tax levy and Base Community Aids), as opposed to total expenditures, a different picture emerges. In **Figure 2**, we see that despite a decline in Mental Health Complex patient censuses since 2010, the amount of levy/BCA required to support Mental Health Complex services remained stubbornly close to $50 million until the 2015 budget.

Figure 2: Adult Mental Health Property Tax Levy/BCA Expenditures, 2010-2013 Actual and 2014-2015 Budget (in millions)



Figures 1 and 2 raise several questions, including:

- Why have total expenses for Mental Health Complex services not declined more given the closure of long-term care facilities and overall declines in patient census?
- Why has the property tax levy required to support Mental Health Complex services declined by only 15% even though the patient census has decreased by a much larger margin?
- Are there actions BHD can take in the future to realize greater savings from Mental Health Complex downsizing that can support increased investment in community-based services?

This analysis attempts to answer these questions and provide a better understanding of BHD finances as the redesign process continues.

Inpatient, Long-term Care, and Emergency Services – Fiscal Trends

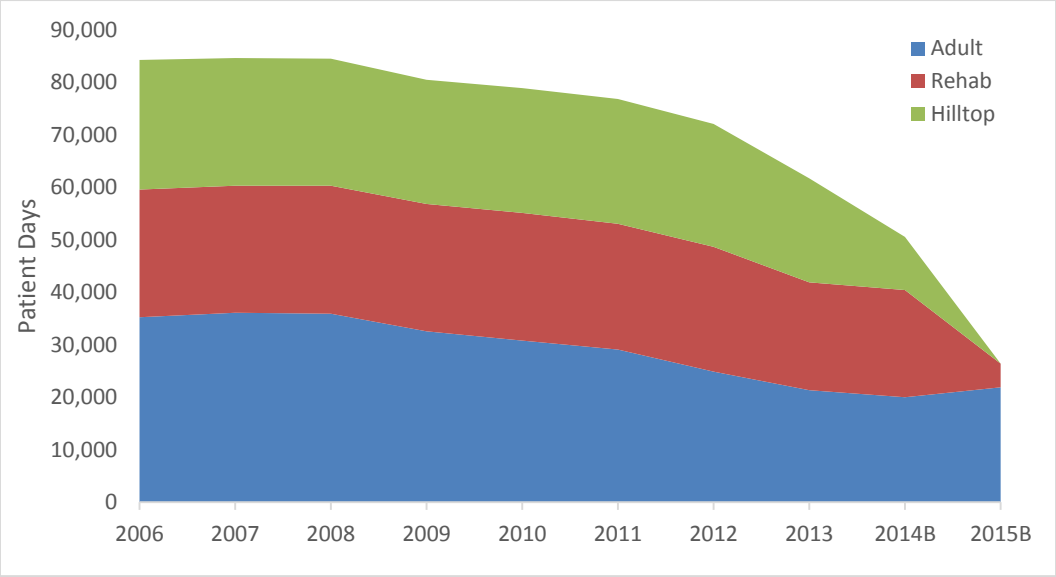
The starting point for our exploration of how downsizing has affected BHD's budget is an analysis of the budgetary changes between 2010 and 2013, the most recent year of actual budget data. (The 2014 and 2015 budgets are reviewed in a subsequent chapter and are incorporated into the projections of 2017 expenditure and levy.) Between 2010 and 2013, BHD substantially reduced its bed capacity at the Mental Health Complex. By teasing out the fiscal changes during that time period, we can begin to understand some of the dynamics of BHD's budget that may explain why greater savings have not been realized from those reductions.

Change in Mental Health Complex Patient Census by Service Area

Figure 3 illustrates how dramatically bed capacity at the Mental Health Complex has been transformed since 2006. With the projected closure of both Hilltop and Rehab Central by the end of 2015, the number of patient days – which is defined as the number of days a bed in any of the three inpatient areas is occupied – will have declined from more than 84,000 in 2006 to an estimated 26,413.

> BHD accomplished a substantial reduction in inpatient and long-term care bed capacity between 2010 and 2013 and plans to reduce Mental Health Complex bed capacity even more by the end of 2015, when both long-term care facilities are scheduled to be closed. At the same time, BHD has seen a decline in PCS admissions.

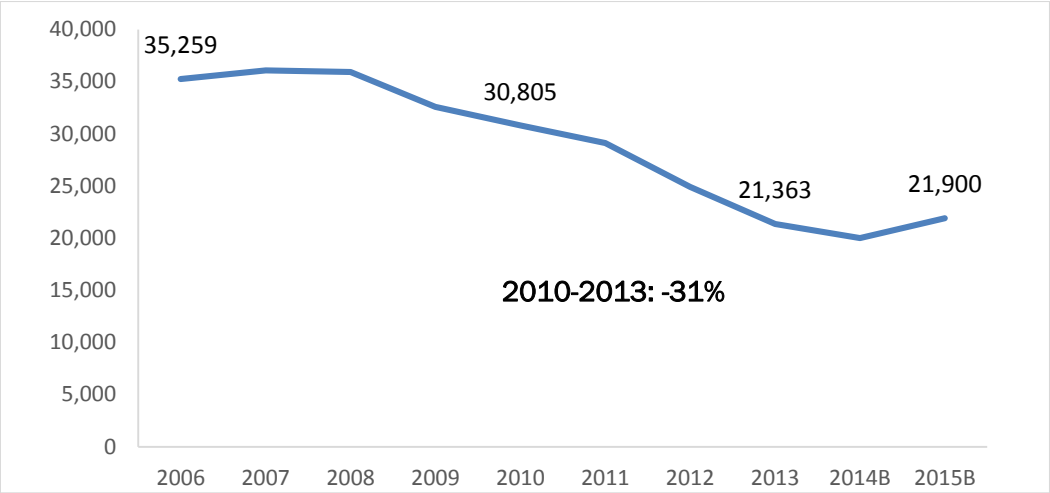
Figure 3: Change in Mental Health Complex Patient Days, 2006 through 2015



In **Figure 4**, we see that adult acute inpatient bed days declined by 31% from 2010 through 2013. This reflects a reduction in the number of licensed beds from 96 prior to 2010 (four 24-bed acute treatment units) to 66 in 2013 (one 24-bed women's treatment unit, one 18-bed intensive treatment unit, and one 24-bed acute treatment unit). The 2015 budget assumes a capacity of 60 inpatient beds.

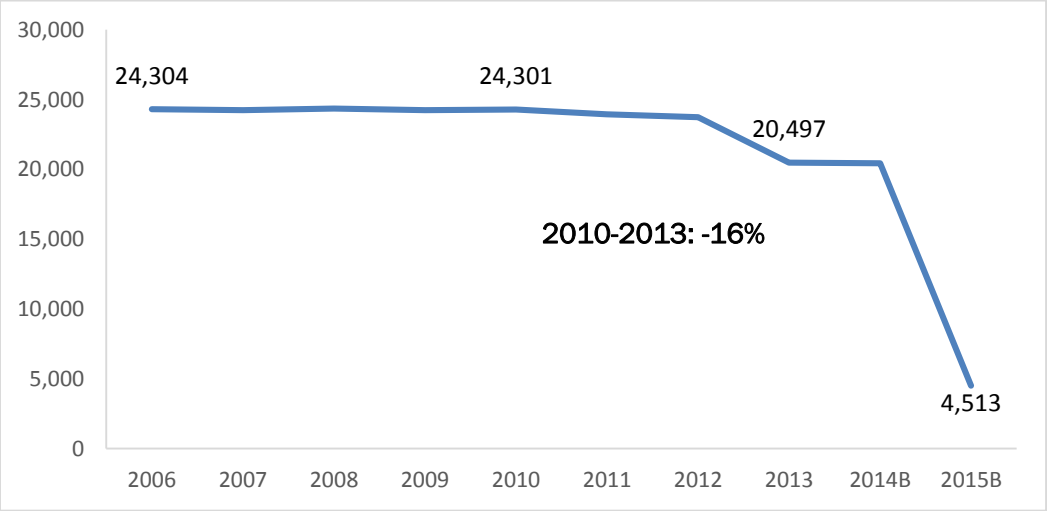
These inpatient bed reductions have been accomplished – in large measure – by a cooperative effort between BHD and private health systems to create agreements that stipulate conditions under which private hospitals with inpatient mental health capacity will accept transfers of patients from BHD. Those transfers generally have been limited to patients who have insurance coverage and who have relatively low levels of acuity. The confidence of private hospitals in being able to secure a safe and appropriate setting for a patient upon discharge from an inpatient unit also impacts their willingness to accept transfers from BHD.

Figure 4: Adult acute inpatient capacity reduction (measured by patient bed days)



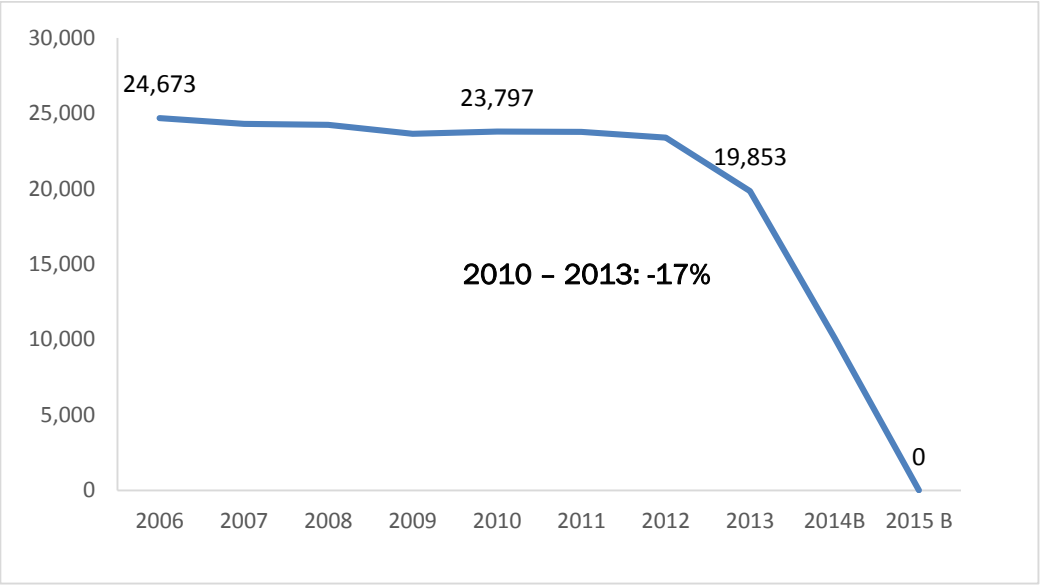
Rehabilitation Center–Central ("Rehab Central") is BHD's long-term care facility for individuals with complex physical, mental, and behavioral needs. Adjudicated patients, or patients referred by the court system due to criminal convictions, also are housed at Rehab Central. As shown in **Figure 5**, Rehab Central experienced a 16% reduction in patient days between 2010 and 2013, with most of that reduction occurring in 2013 as BHD moved several individuals into community placements in preparation for plans to close one of the facility's three 24-bed units by July 1, 2014 (an initiative that was successfully completed). BHD plans to continue the transfer of patients throughout 2015 with a goal of closing the facility completely by the end of the year.

Figure 5: Rehab Central capacity reduction (measured by patient bed days)



The Center for Independence and Development (also known as "Rehabilitation Center-Hilltop") provided a long-term care setting for individuals with co-occurring mental illness and intellectual disabilities. In April 2011, BHD notified the State of Wisconsin of its intention to begin a voluntary downsizing from 72 to 48 beds. That initiative is reflected in **Figure 6**, which shows a 17% reduction in patient bed days between 2010 and 2013. In February 2013, BHD announced plans to close the facility entirely, and that closure took place in January 2015.

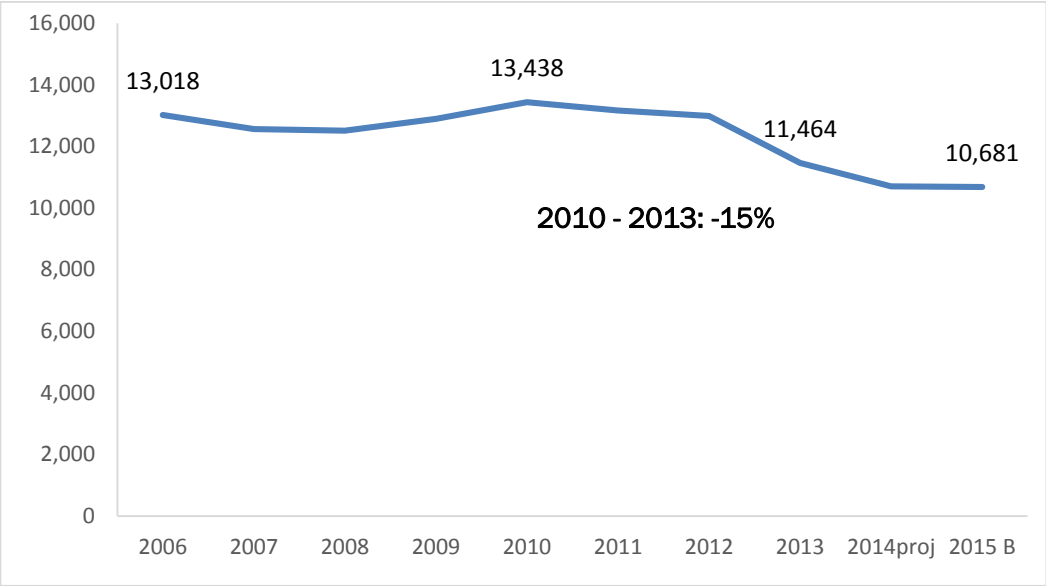
Figure 6: Hilltop capacity reduction (measured by patient bed days)



The other major hospital-related function performed by BHD at the Mental Health Complex is the operation of Milwaukee County's only psychiatric hospital emergency room, which serves both the general public and individuals brought in under "emergency detention (ED)" proceedings by law enforcement. Referred to as the Psychiatric Crisis Service (PCS), the emergency room operation provides 24/7 psychiatric emergency services including assessment, crisis intervention, and medications. PCS also maintains more than a dozen observation beds that are used for client observation for up to 48 hours as needed.

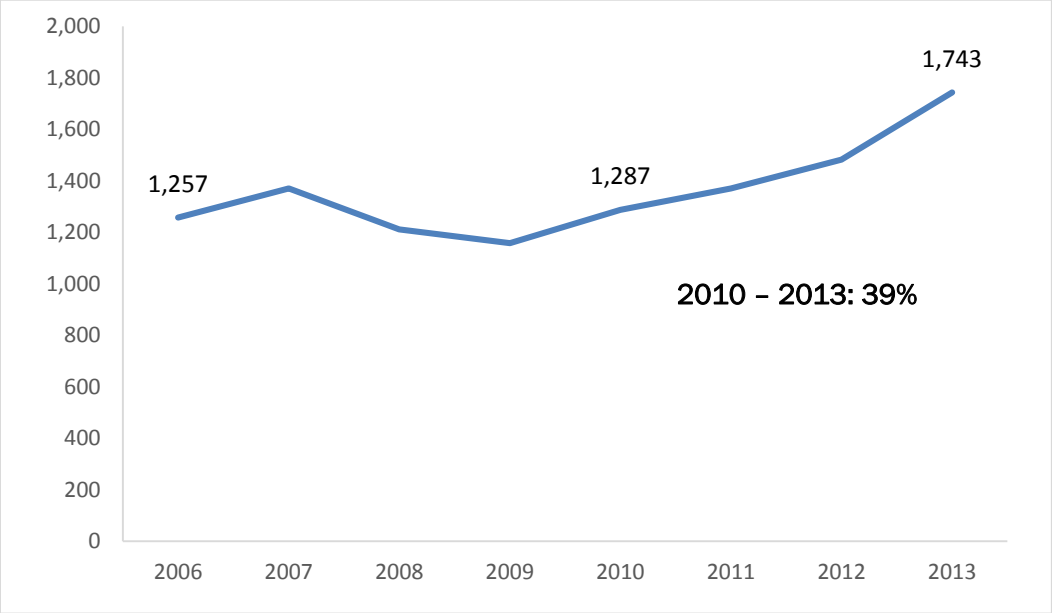
While PCS generally is not included in BHD's downsizing planning, BHD administrators have undertaken a number of initiatives in recent years to establish greater crisis capacity in the community and to diminish the use of PCS as the "front door" for the mental health system. As shown in **Figure 7**, PCS admissions declined by 15% from 2010 to 2013.

Figure 7: PCS admissions reduction



One of the central strategies used by BHD to reduce PCS admissions has been an expansion of its mobile treatment unit, which is designed to stabilize individuals experiencing mental health crisis in general hospital emergency rooms or other settings so as to potentially avoid a transfer or visit to PCS. In addition, BHD has made use of an increased number of crisis respite beds, which are beds purchased from community-based providers that similarly can be used to stabilize individuals and preclude a visit to PCS. **Figure 8** shows that nearly 1,800 patients were served by BHD crisis teams and crisis respite beds in 2013, an increase of 39% from 2010.

Figure 8: Increase in patients served by BHD crisis teams and community-based crisis respite beds



Expenditure Trends

Based on the decline in patient census in all four Mental Health Complex service areas from 2010 through 2013, we would expect to see sizable decreases in total BHD expenditures for those services. Somewhat surprisingly, as shown earlier in **Figure 1**, total expenditures in those service areas decreased by only 4%, from $74.5 million to $71.4 million.

To understand why expenditure decreases did not mirror the decline in patient census, we realigned BHD's Mental Health Complex expenditures into "direct" and "indirect" expenditure categories. (See box for further explanation of direct and indirect expenditures). As shown in **Figure 9**, between 2010 and 2013, direct expenditures decreased by about $5.5 million, or 11.5%, presumably as a result of reduced patient census. Indirect expenses, on the other hand, increased by about $2.5 million, or 9.3%.

While direct expenditures at the Mental Health Complex decreased during the past four years as would have been expected given the decline in the patient census, indirect costs unexpectedly increased. To some degree, this is attributable to factors that are beyond BHD's control, such as the central budget office's determination of BHD's legacy costs, facility expenses, and charges from other departments. BHD did realize savings in direct costs, but those are largely attributable to reductions in active fringe benefit expenses, and not to reductions in overall staffing levels. BHD also experienced savings in hospital support and drug expenses that are linked to reduced patient volumes.

A Note on Budget Methodology

Our analysis separates costs into direct and indirect categories. Direct costs are those that would be expected to change with patient census. Broadly speaking, indirect costs are overhead expenses that might be less sensitive to changes in the number of patients seen at BHD.

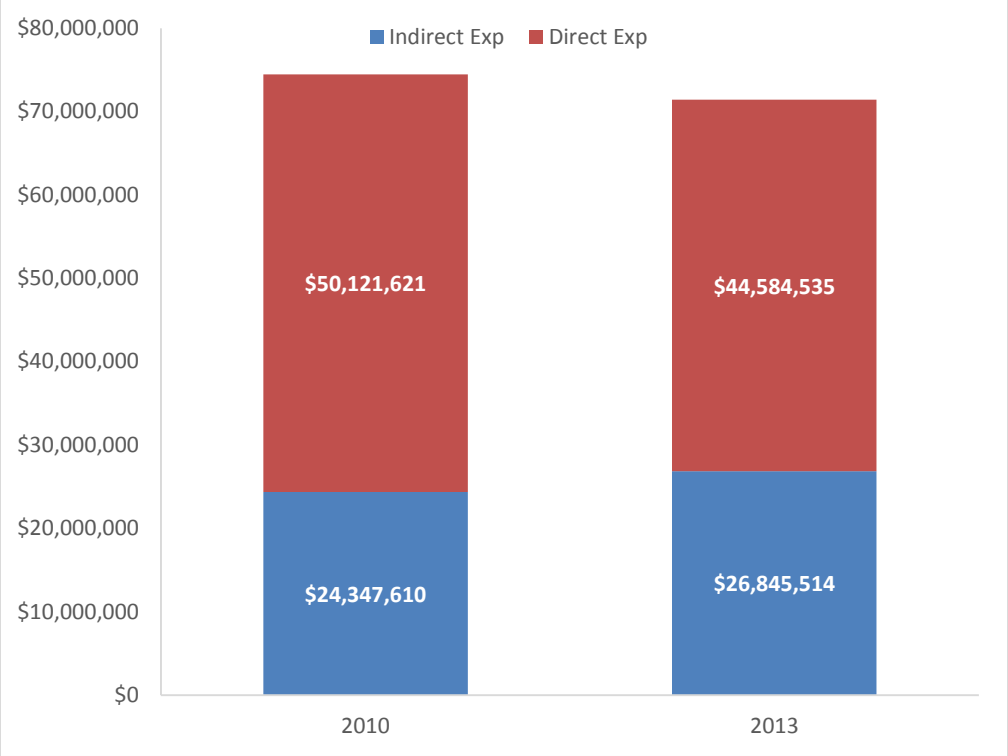
Direct expenses include the cost of doctors, nurses and other clinical personnel involved in direct patient care, as well as the cost of prescription drugs and other "commodities," and contractual services that directly support hospital operations. BHD organizes these costs into separate service areas for each facility: PCS, Adult Inpatient, Hilltop, and Rehab Central.

Our analysis makes a few adjustments to these direct budgets: 1) legacy expenses are removed and are instead considered as indirect costs; and 2) hospital support expenses (which BHD budgets within the indirect cost category of Operations), such as security, housekeeping, linen, dietary, storeroom, and support services administration, are added to direct costs. Additional adjustments are made to the PCS budget to remove expenditures related to the Access Clinic, Mobile Treatment Team, and community-based crisis service contracts and add those expenditures instead to the community-based services category. Observation beds in PCS are included in the analysis.

BHD budgets indirect costs in three basic services areas: Management, Operations, and Fiscal. These budget units include expenses relating to fiscal, human resources, information technology, facilities, and other overhead functions. They also include a variety of charges from other County departments (referred to as "crosscharges") that are applied to BHD's budget by the central budget office.

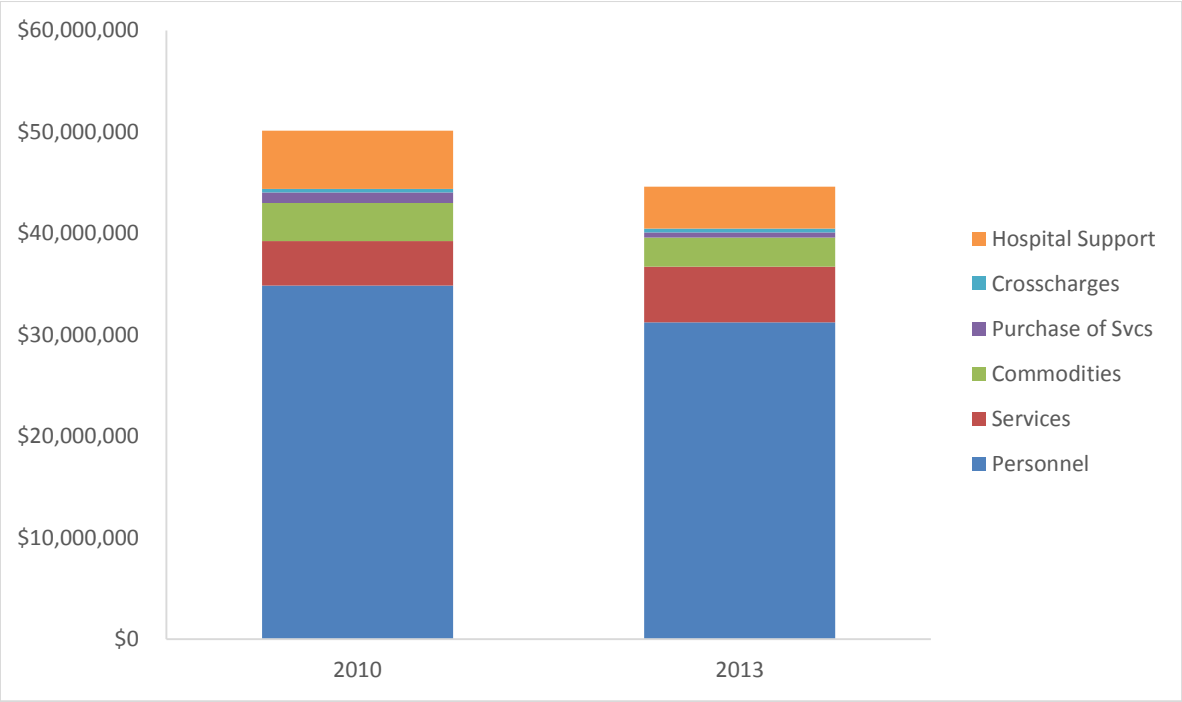
In addition to stripping out hospital support and adding it to the direct cost category, this analysis also reorganizes indirect costs into different categories that are more informative to the overall analysis: General Administration, Hospital Administration, and Facilities. **Appendix A** shows the "crosswalk" of budget units from the BHD budgeted area to the cost categories used throughout this analysis.

Figure 9: Change in Inpatient, Long-Term Care, and PCS Total Expenditures, 2010-2013



In **Figures 10** and **11**, we compare the different categories of direct and indirect expenditures for 2010 and 2013. This detailed breakdown provides additional insight into why the substantial reduction in patient capacity at BHD did not produce an even larger reduction in expenditures.

Figure 10: Breakdown of Direct Expenditure Categories, 2010 and 2013



With regard to direct expenditures, personnel costs – which are the largest category of direct expenditure – declined by about $3.6 million. Personnel costs include direct compensation such as salary, overtime, premium and other types of pay, as well as health care and pension expenses for active employees, social security, and assorted other benefits. Interestingly, as shown in **Table 1**, the expenditure decrease is not linked as much to a decline in the number of full-time equivalent employees (FTEs) – which decreased by about seven positions during the period – as to reductions in fringe benefit costs for active employees, which resulted from health care savings experienced countywide. Other direct expenditure categories that decreased included commodities (primarily drug costs) and hospital support services.

Table 1: Actual FTEs, 2010 and 2013[3]

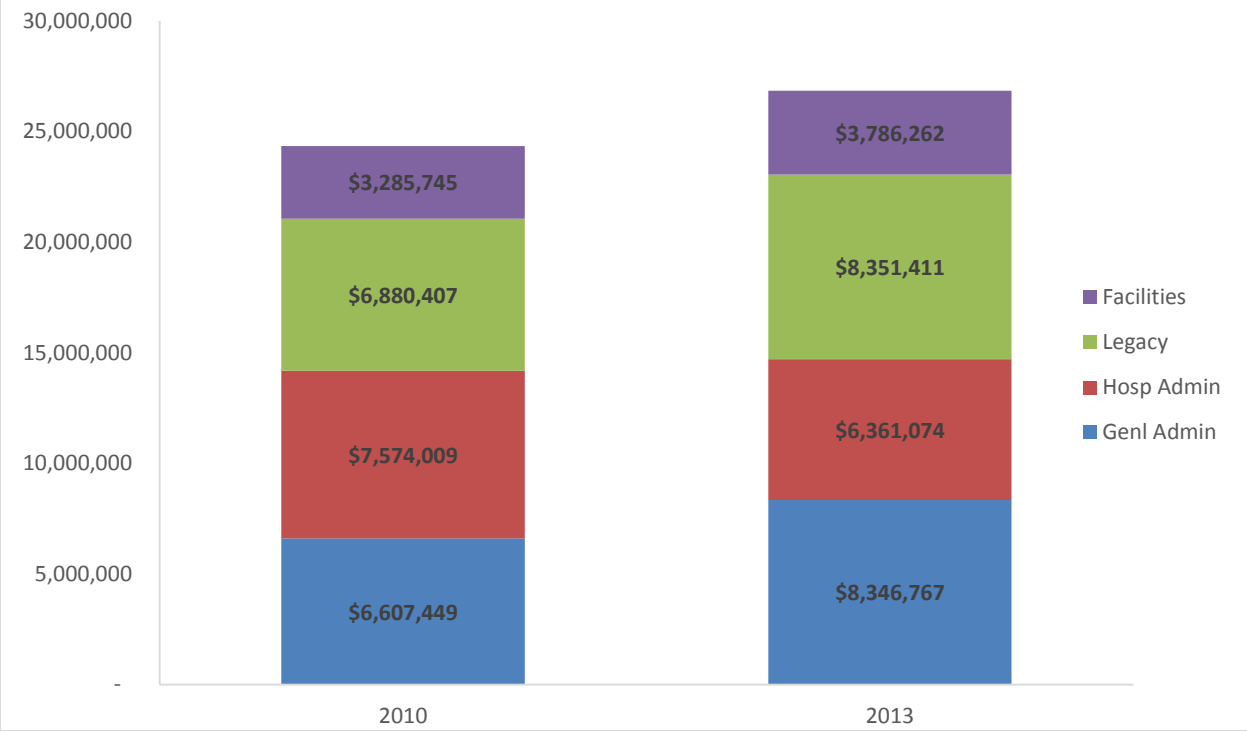
	2010	2013
Adult Inpatient	190.09	171.60
Rehab Central	82.32	89.84
Hilltop	97.60	86.96
PCS	58.87	73.65
Total	**428.88**	**422.05**

The savings in direct costs between 2010 and 2013 would have been considerably larger if not for an increase of about 15 FTEs in PCS over this period. It is unclear why PCS saw an increase in staffing during a period when admissions declined. One explanation may be linked to data limitations. BHD managers often shift personnel between service areas, and some psychologists and psychiatrists are shared between PCS and other Mental Health Complex services. This dynamic may not be accurately portrayed in BHD's assignment of personnel and costs for budgetary purposes, making it difficult to reliably compare FTEs between service areas. Another explanation may be that staffing levels in 2010 were deemed insufficient, and BHD used the opportunity of adult inpatient and long-term care downsizing to transfer staff from those areas to fill perceived gaps at PCS.

It is also important to note that BHD administrators report the number of patients who require "one-to-one" supervision has increased, limiting their ability to reduce staffing. The physical layout of inpatient wards also presents challenges to reducing staffing. With the reduction in census, more patients can be accommodated in single rooms, so staff is still required to supervise the same amount of space.

[3] Actual FTEs reflect actual expenditures for salaries and overtime (divided by 1.5) and do not necessarily correspond to budgeted FTE. Also, the FTEs for PCS in **Table 1** reflect only the ER and Observation unit.

Figure 11: Breakdown of Indirect Expenditure Categories, 2010 and 2013



With regard to indirect expenditures, we see that hospital administration costs declined while General Administration, Legacy, and Facilities experienced substantial cost increases. The following provides additional details on those three cost categories.

- General administration expenditures charged to Mental Health Complex areas increased by $1.7 million from 2010 to 2013. About two thirds of this cost category is related to BHD administrative staff such as managers, accountants, human resources personnel, and clerical personnel. That portion of general administration overhead actually declined by about $400,000 (1.6%). BHD' ability to reduce expenses in this area even further may have been limited given that the division's administrative needs do not necessarily decline at the same pace as its patient capacity (e.g. a budget still needs to be monitored and produced every year regardless of whether the patient census has declined). In addition, BHD faced substantial pressure during this period to undertake corrective actions and other responses to federal and state audits, which required it to develop new quality control and tracking measures.

  About 31% of the general administration category is comprised of County crosscharges, which reflect charges from other County departments over which BHD has little control, and which increased by about $2 million during the time period.[4] Those charges include direct charges from departments like the Corporation Counsel for representation of persons in commitment proceedings. The largest single crosscharge is for the Central Services Allocation ($1.3 million in

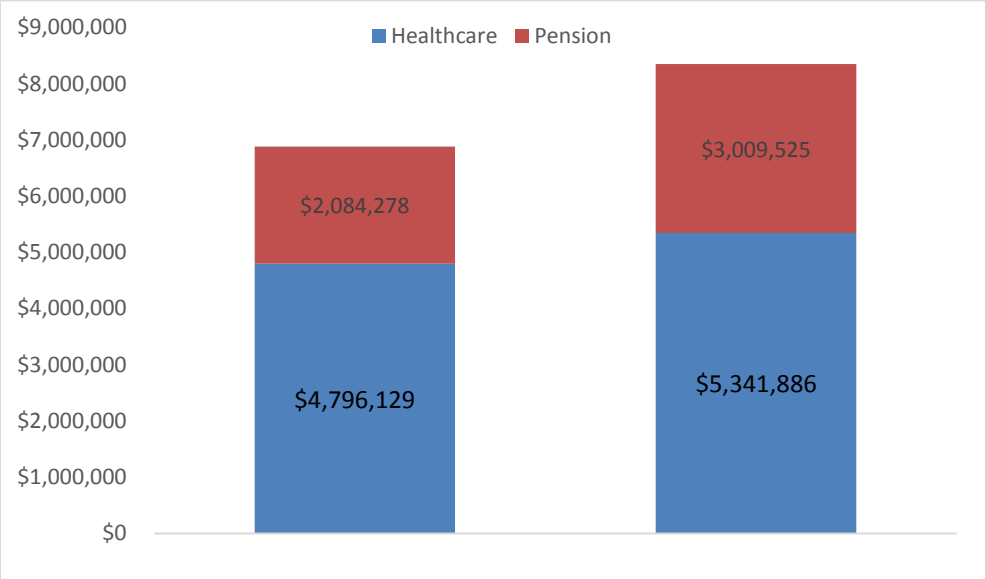
[4] As will be discussed later in this report, while crosscharge amounts are determined by the central budget office, BHD does have some control over how they affect the Mental Health Complex because it elects how to allocate such costs among each of its own service areas.

2013). This charge helps to ensure that users of centralized County services in areas like Audit, Central Accounting, Human Resources, and Payroll pay for the costs of those services.

- **Legacy costs** are one of the primary components of indirect costs. In 2013, they accounted for almost one third of indirect costs, and they increased by $1.5 million between 2010 and 2013. Legacy costs reflect BHD's share of overall County pension and retiree health care costs, which is determined by a formula developed by the central budget office that is largely based on the division's share of the County workforce. Legacy expenses are impacted by general health care inflation in southeast Wisconsin and the performance of the County's pension fund investments.

  It is also worth noting that most of BHD's legacy costs are allocated to the Mental Health Complex service areas, as those areas employ the greatest number of personnel in the division by a wide margin. **Figure 12** shows the change in legacy costs for the four Mental Health Complex service areas during the period.

Figure 12: Mental Health Complex Legacy Costs, 2010 and 2013[5]



- **Facilities** expenditures charged to Mental Health Complex areas increased by about $500,000 between 2010 and 2013. Because of the physical design of the Complex, reductions in bed capacity do not always translate into a reduced footprint of usable space. For example, rooms that were previously occupied by two patients are now generally used as single rooms. In some cases, units that are no longer in use for patient care have been repurposed as office or storage space. Another important factor in facilities expenses is that BHD was under a state-imposed statement of deficiency regarding its facilities and was required to make additional investment in a variety of facility improvements. About 20% of the division's facilities expenses are crosscharges from the Facilities Maintenance division and other County departments that pay for skilled trades labor.

[5] Legacy expenses shown in **Figure 11** reflect direct expenditure areas only. This figure does not include legacy expense tied to employees in indirect cost centers that are allocated to direct service areas (for example, legacy related to fiscal and general administrative staff) or legacy related to hospital support staff.

The sprawling nature of the Mental Health Complex over 25 acres of land and the aging condition of its basic infrastructure have been cited as fiscal and operational problems for years. As long as BHD programs are located at the Mental Heath Complex, costs associated with maintaining the Complex will represent a significant source of indirect spending that will be difficult to control or reduce in conjunction with service levels.

Revenue Trends

Our examination of Mental Health Complex expenditure levels during the 2010-2013 timeframe provides only partial information about the financial impacts of downsizing initiatives. Equally important is what happened on the revenue side of the ledger, given that a lower patient census would be expected to reduce the amount of reimbursement revenues collected by BHD.

> While BHD was successful in enhancing patient revenues on a per-patient basis between 2010 and 2013, the reduced patient census at the Mental Health Complex produced an overall net loss of patient revenue of about $3 million. That loss – combined with a decrease of about $450,000 in other revenue – tracked closely to expenditure reductions. As a result, the County was unable to reduce its allocation of tax levy/BCA to Mental Health Complex services. Thus, a key objective of mental health redesign – to use inpatient and long-term care downsizing as a means of freeing up resources to invest in community-based services – had not been achieved as of the end of 2013.

Net Patient Revenue

The predominant type of revenue collected by BHD for its inpatient services is "Net Patient Revenue" (NPR). This revenue category consists of revenue collected from the federal Medicaid and Medicare programs, as well as private insurance reimbursement, reimbursement collected directly from patients, and other forms of third party reimbursement. As shown in **Table 2**, BHD collected $20.3 million in NPR in 2013, which was about $3 million (13%) less than it collected in 2010, when it was serving considerably more patients.[6] (A smaller revenue source – referred to as "Other Revenues" – consists primarily of grants. Because it only comprised 2% of total Mental Health Complex revenues of $71.4 million in 2013, that category is not considered in detail here.)

Table 2: Mental Health Complex Patient Revenue, 2010 and 2013

	2010	2013	% Change 2010-2013
Net Patient Revenue	$22,984,207	$20,030,204	-13%
Other Revenue	$2,003,971	$1,558,703	-22%

Figures 13 and **14** break down the different types of NPR in 2010 and 2013. The majority of BHD clients are enrolled in Medicaid (T-19), which generally covers low-income individuals with limited assets, or Medicare (T-18), which generally covers individuals age 65 and over.

BHD's revenue "pie" distinguishes between two types of Medicaid reimbursement: "Straight T-19" and "T-19 HMO." In Wisconsin, nearly two thirds of all Medicaid enrollees are enrolled in plans managed by Health Maintenance Organizations, or HMOs. "T-19 HMO" revenue is related to services

[6] This includes revenue from the Wisconsin Medicaid Cost Reporting (WIMCR) program, which provides reimbursement to counties for patient services that they are unable to claim from Medicaid themselves because of state Medicaid policies.

provided to those Medicaid managed care recipients. "Straight T-19" revenue is received directly from the state Medicaid program to reimburse BHD for care to those patients who are not enrolled in managed care.

Figure 13: Net Patient Revenue by Payer Source, 2010

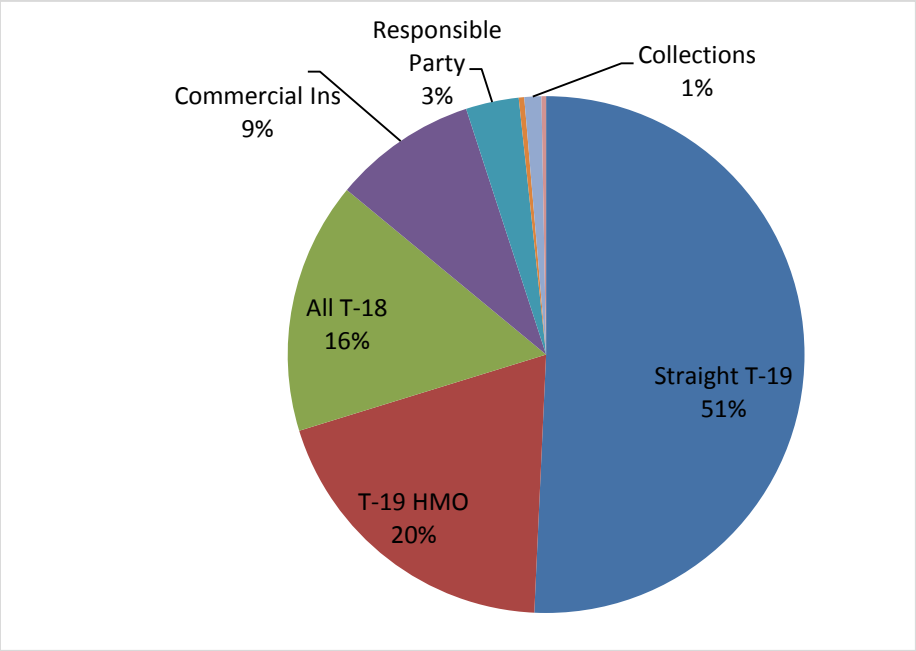
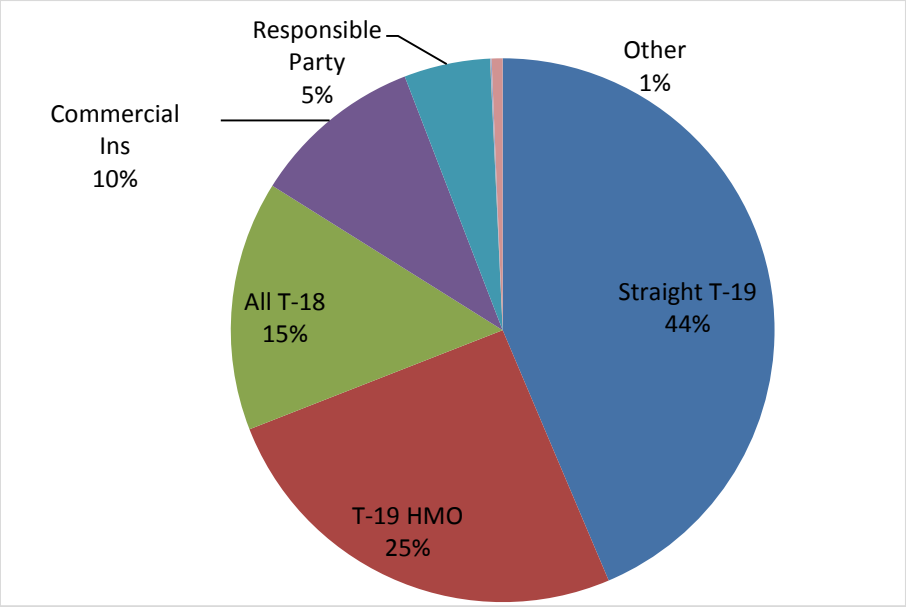


Figure 14: Net Patient Revenue by Payer Source, 2013[7]



[7] **Figures 13** and **14** depict cash receipts during each year, which may not correspond to dates of service. Also, while most of the revenues shown above are related to care provided at the Mental Health Complex, also included are smaller amounts related to outpatient, case management, and other community-based services. The data in **Figures 13** and **14** do not include WIMCR payments.

Most straight T-19 Medicaid reimbursement received for BHD inpatient services is based on a per diem rate that is negotiated with the state annually and that takes into account both direct and indirect expenses. The Medicaid per diem rate covers some, but not all, BHD costs. Medicaid also reimburses for professional services fees, which are fees charged for procedures or specific treatments.

Taken together, Medicaid and Medicare represent 85% of BHD patient revenue. Consequently, it is important to note some of the limitations associated with these revenue sources, such as:

- Reimbursement for professional services under straight T-19 is much lower than the per diem rate relative to costs covered.
- BHD does not receive a per diem reimbursement for inpatient services provided to individuals between the ages of 18 and 64 who are on straight T-19 because the Mental Health Complex is classified by the Federal government as an "Institute of Mental Disease" (IMD).[8] Federal law excludes IMDs from receiving reimbursement for those patients through straight T-19.
- Medicaid HMOs pay per diem rates for their clients between the ages of 18 and 64 who arrive at the Complex via an emergency detention. The HMOs will not reimburse BHD for care related to voluntary inpatient admissions for such clients.
- Medicare coverage has a lifetime limit on inpatient days which can limit reimbursement.
- BHD's management of issues such as eligibility determination, claiming, tracking, and collecting revenues can affect the amount of revenue that is collected.

It is also important to note that in 2013, 12.5% of patients in acute adult inpatient units had no insurance, and the entire cost of providing their care was assumed by BHD. Going forward, the percentage of uninsured patients – as well as the percentages of patients enrolled in Medicaid HMOs and straight T-19 – likely will change as a result of implementation of the Affordable Care Act.

Figures 13 and **14** show that there has been noticeable growth in BHD's T-19 HMO revenue, and a corresponding decline in revenue from patients with Straight T-19. As a percentage of NPR, T-19 HMO revenue has grown from 20% in 2010 to 25% in 2013. This shift is good news for BHD given the reimbursement limitations associated with straight T-19. The figures also indicate that the percentage of NPR collected from commercial insurance did not decline during the period (and actually increased slightly), which also is good news in light of concerns that the Complex's "payer mix" would be negatively impacted by its efforts to transfer more patients with commercial insurance to private hospitals for care.

Overall, while total NPR declined between 2010 and 2013 (due to the declining patient census), **Table 3** shows that on a per patient (or patient day) basis, reimbursement rates increased between 2010 and 2013 for most service areas.[9] BHD has made it a priority in recent years to maximize NPR, most notably through the implementation of electronic medical records and new claims processing procedures. In addition, BHD has emphasized enrolling as many uninsured patients as possible in Medicaid, and steering those patients to Medicaid managed care, which is not affected

[8]An IMD is any institution with more than 16 beds that is primarily engaged in mental health care.
[9] Net Patient Revenue/patient day is calculated by dividing total net patient revenue (including WIMCR) by patient days for Adult Inpatient, Rehab Central and Hilltop. The calculation for PCS divides Net Patient Revenue by ER admissions.

by the IMD exclusion. Rehab Central is the one area where revenues per patient day have declined. This is due to a reduction in Medicaid rates during this period.

Table 3: NPR per Patient Day in Four Mental Health Complex Service Areas

	2010	2013	% Change
Adult Inpatient	$319.02	$375.83	18%
PCS	$335.63	$374.79	12%
Central	$133.61	$122.35	-8%
Hilltop	$226.91	$261.77	15%

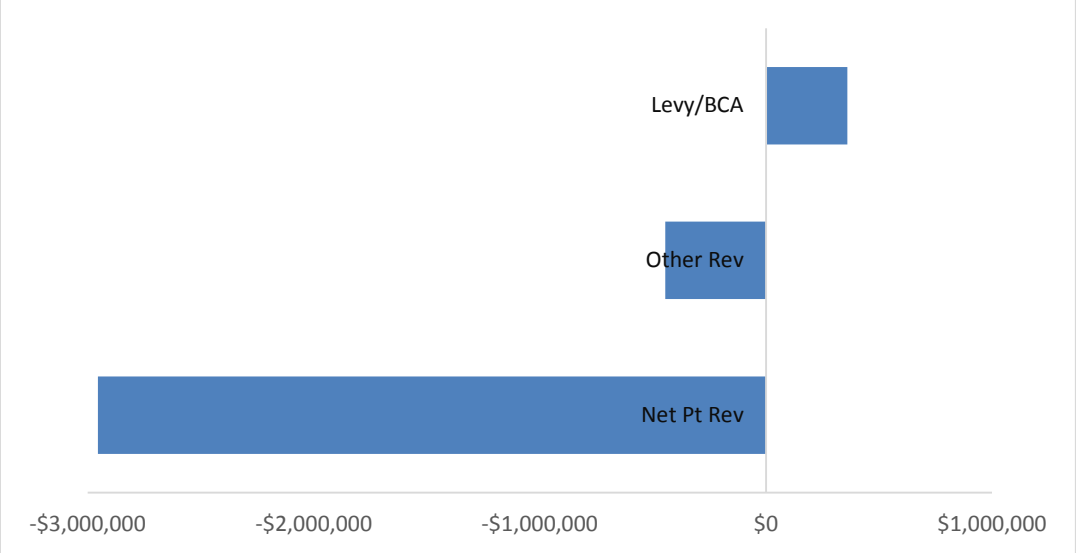
Levy/BCA

As discussed in the introduction to this report, evaluating the fiscal impacts of mental health redesign activities requires looking at both total expenses and local discretionary funds. In addition to property tax levy, in this analysis we include the County's annual Base Community Aids (BCA) allocation from the State of Wisconsin as a source of discretionary revenue. Property tax levy and BCA are used interchangeably by the County to fill the gap between the amount spent to provide mental health services and the revenue that is recovered from patients and other sources.

BCA is a source of general social services funding provided by the State of Wisconsin that can be used at the County's discretion to support a variety of social services, including mental health, substance abuse treatment, disabilities, and delinquency services. In 2015, the County projects that its state BCA allocation will be about $32 million; about $22 million of that amount will be earmarked to BHD, with the remainder allocated to the Department of Health and Human Services (DHHS).

The Forum's March 2013 report found that as BHD had begun to initiate downsizing activities, patient revenues were decreasing faster than expenses, requiring a larger subsidy of property tax levy and BCA. **Figure 15** incorporates actual revenue figures for 2013 and shows that situation has been alleviated somewhat but still remains true. Revenues still are decreasing in line with patient census, but the overall increases in BHD's reimbursement rates (as shown in **Table 3**) have helped limit revenue losses. In 2013, BHD dedicated slightly more levy/BCA (about $360,000) to Mental Health Complex services than it had in 2010.

Figure 15: Change in Major Mental Health Complex Revenue Sources, 2010-2013



Trend Analysis Conclusion

Our analysis of fiscal trends at the Mental Health Complex from 2010 through 2013 indicates that substantial reductions in the patient census in all four service areas yielded only a 5% reduction in overall expenditures and necessitated a slight *increase* in the amount of levy/BCA dedicated to Mental Health Complex activities. We cite several explanations for these findings.

One explanation is that total FTEs at the Mental Health Complex have stayed relatively constant. Expenditure savings in direct costs between 2010 and 2013 instead are attributable to fringe benefit reductions and savings in services and commodities. As noted above, there may be several causes for the relatively constant staffing levels at the Complex despite reduced patient volumes.

Trends in indirect costs also contribute to BHD's challenge in reducing overall expenditures. Many of the indirect charges included in BHD's budget – such as legacy costs and general County overhead – are beyond the control of BHD. It is important to note that from a countywide budgetary perspective, there is logic in the manner in which many of these charges are allocated to BHD. These costs make up part of BHD's Medicaid reimbursement rate and are added to other reimbursement claims to state and federal programs. By including a share of the County's overall overhead costs in BHD's claims to external payer sources, the County can legitimately boost reimbursement for BHD services.

Where logic may be lacking, however, is the expectation that as BHD downsizes it can also absorb a growing load of indirect costs. This analysis has shown that BHD has been able both to reduce direct expenditures (to some extent) and to increase revenues on a per patient basis. While both of those trends have generated levy savings, increases in indirect costs have eaten away at those savings. As a result, property tax levy was not freed up for reinvestment in community services, and the community-based investments that were made were derived from countywide sources.

We did a parallel analysis for each of the service areas individually, which found differing trends with regard to expenditures, revenues, and use of levy/BCA. Detailed descriptions of fiscal trends and

indicators by service area are contained in **Appendix B**. **Figure 16** summarizes the 2010-2013 changes in levy/BCA by service area.

Figure 16: Change in levy/BCA expenditures in Mental Health Complex service areas, 2010-2013

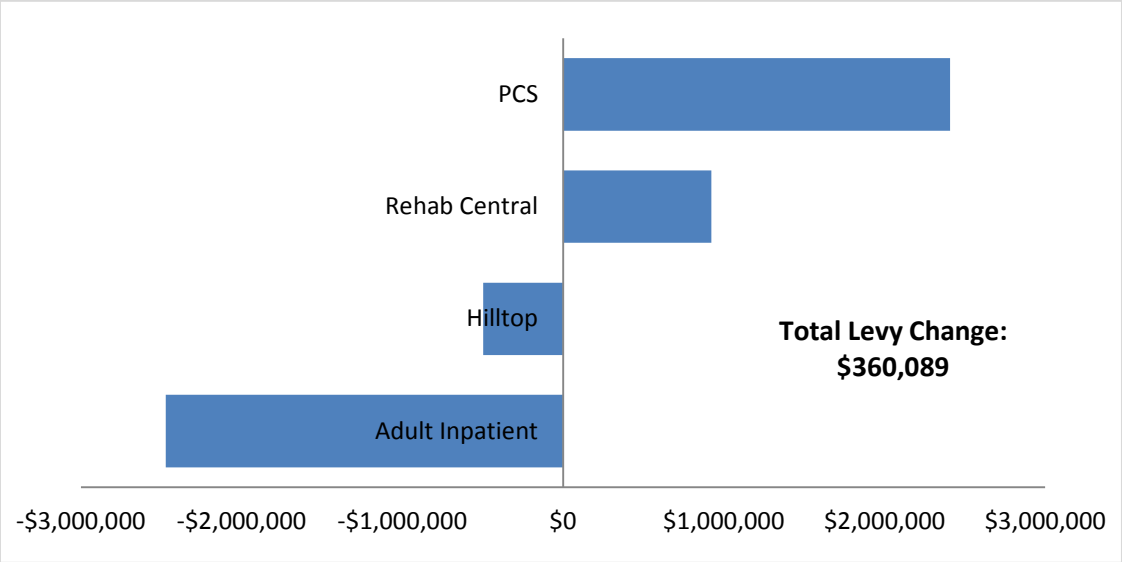


Figure 16 suggests that if costs had been maintained at PCS, or even increased at a rate which corresponded to revenues, overall levy savings at the Mental Health Complex would have been much greater. While there may be very good clinical reasons for increased expenditures at PCS, from a fiscal perspective it appears that some of the savings from downsizing are being redirected to PCS rather than to community-based services.

Community-Based Services – Fiscal Trends

A primary goal of the County's mental health redesign is to increase the availability of community-based services. This objective recognizes the advantages of community-based care from a clinical perspective, as well as the fact that any efforts to downsize hospital-related functions *must* be carefully calibrated with enhanced services in the community to allow for a safe and orderly reduction in bed capacity.

> Examination of financial trend data indicates that BHD was able to increase its investment in community-based services during the 2010-2013 timeframe, with expenditures growing by $3.9 million, or 12%. We also find that because many of the services on the community side are provided by outside vendors, indirect and overhead costs were not a significant factor in the growth in expenditures. Our analysis also shows that BHD's community services as a whole became more dependent on property tax levy/BCA during the period. The levy/BCA allocation increased in total by $6 million, with about $2 million of that amount needed to make up for losses in other types of revenue.

In this section, we examine expenditure and revenue trends for the wide array of County-funded community-based mental health services. For the purposes of this report, the term "community-based service" refers to any mental health program funded by the County other than emergency, inpatient, or long-term care provided at the County's Mental Health Complex. The County contracts for most community-based services with nonprofit social services agencies, but it does provide some types of those services itself.

This analysis, like the previous analysis of Mental Health Complex fiscal trends, focuses on actual expenditures and revenues for the 2010 to 2013 timeframe.

Description of Community-Based Programs

BHD funds a broad array of community-based services ranging from case management to outpatient psychiatric care to community-based crisis respite. The "front door" to many of the County's community mental health services is Service Access to Independent Living (SAIL), a County-funded and County-staffed unit that conducts needs assessments and refers clients to appropriate services.

The following provides a brief description of the major community-based mental health services that are funded and/or provided by BHD. In describing those services, we place them into four categories: treatment, recovery, crisis, and residential.

Treatment Services

- **Outpatient services** are clinic-based services, such as medication management and one-on-one or group therapy. The County contracts with two providers for outpatient services: the Medical College of Wisconsin and Outreach Community Health Centers. In addition, the County runs a drop-in Access Clinic at the Mental Health Complex that is staffed by County personnel. The County Access Clinic is not strictly comparable to the other two outpatient settings in that it provides assessment and referral services, in addition to outpatient treatment. The Access Clinic has been described as an Urgent Care setting for individuals with ongoing mental health

concerns. It serves uninsured indigent individuals, while clients with some form of insurance (including Medicaid) are referred to the contracted outpatient providers.

- **Day Treatment**, also known as partial hospitalization, provides clients a regular daily array of therapeutic services in both group and individual settings. Clients attend treatment for a minimum of five hours each day, over a term of weeks or months. Day Treatment is provided exclusively by County personnel at the Mental Health Complex. We classify it as a community-based service because it could be provided at other community locations and does not require support from a hospital or long-term care setting.

- **Targeted Case Management (TCM)** provides case management to individuals with severe and persistent mental illness. This form of case management does not directly involve licensed clinicians; instead, it offers support and monitoring, and it helps coordinate resources available in the community such as housing, medical, and social services. Medication management can be a major component of TCM as well. In 2010, the County operated its own TCM programming and also outsourced some TCM services to community agencies, but it began outsourcing all TCM services in 2013. Currently, the County uses nine TCM providers.

- **Community Support Program (CSP)** offers more comprehensive case management than TCM that also involves intense clinical treatment. The County staffed two CSPs in 2013 and contracted for additional CSP services with six community providers. The 2015 budget eliminates the remaining County CSPs and contracts for all CSP services.

Recovery Services

- **Community Recovery Services (CRS)** is a mental health benefit created in the 2009-11 state budget that offers psychosocial services such as employment, housing, and peer support to eligible Medicaid clients. CRS focuses on assessment, development of an individualized plan of care, and supporting the consumer in their plan of care. Individuals can participate in CRS and other programs such as CSP or TCM at the same time, maximizing their opportunity for recovery and independence. The program began at the start of 2014 with a capacity of 63 clients and was expected to grow to 140 by the end of the year.

- **Comprehensive Community Services (CCS)** is a new Medicaid benefit that, according to the State, seeks to reduce inpatient admissions by strengthening the array of county resources in early intervention and treatment. CCS also is viewed as a “step down” benefit for individuals with mental health needs who are transitioning away from a CSP but require more service intensity than outpatient care. BHD believes this program will address the wide “clinical gap” between CSP and TCM by offering clients access to a flexible array of individualized services that will help them meet their recovery potential. CCS funds a wide array of services, including medication management, psychotherapy, employment training, and life skills training. In its initial implementation, CCS expenses will be fully funded by the federal and state governments. BHD began its CCS program in August 2014, with an anticipated enrollment of 92 clients through December.

- **Community Linkages and Stabilization Program (CLASP)** supports recovery and independence through post-hospitalization extended support and treatment, making use of Certified Peer Specialists who are overseen by a clinical coordinator. In 2013, BHD served 248 individuals in CLASP.

Crisis Services

- **Crisis Resource Center (CRC)** is a 24-hour walk-in resource facility that offers short-term stabilization to people experiencing a psychiatric crisis. BHD contracts for the operation of two such centers in the community. The centers provide clients with a comprehensive crisis stabilization plan and links to community-based resources. They also provide a range of services themselves, including nursing, psychotherapy, group therapy, and peer support.

- The **Mobile Treatment Team (MTT)** responds to behavioral health crises in the community, with the goal of reducing PCS admissions, in particular those involving law enforcement. BHD's MTT is comprised of nurses, emergency service clinicians, and a psychologist, all of whom are County employees. In a review of 2011 data, BHD found that the MTT was able to significantly reduce the need for Emergency Detentions. For example, of 102 referrals from law enforcement, 88% of those EDs were dropped and clients were able to find a voluntary alternative to an ED.[10] According to BHD data, the MTT responded 1,413 times in 2013, an increase of 52% from 2010 levels.

- **Crisis stabilization homes (crisis respite beds**) are provided by contract agencies and serve adults who need additional stabilization following inpatient treatment or observation. Stabilization beds also are used to serve individuals awaiting a residential placement who could benefit from a short-term stay to provide structure and support before the intended placement. These beds also can be used to provide temporary support for individuals who are in crisis and who need respite from their present living environment.

Residential Services

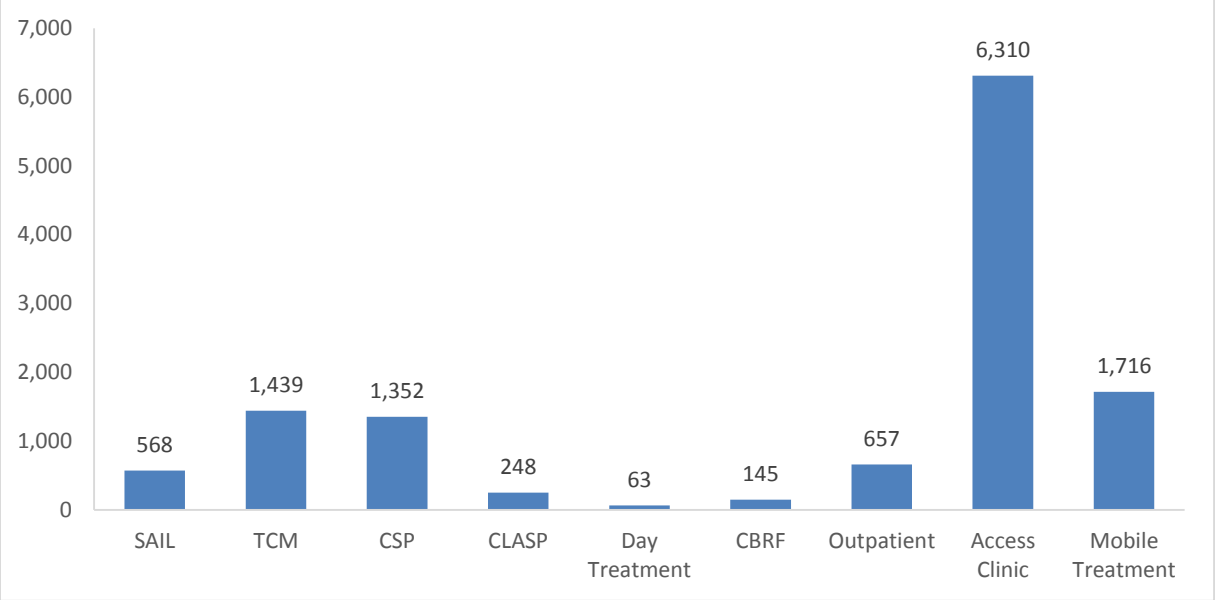
- **Community-Based Residential Facilities (CBRF)** are contracted residential units (typically eight beds) that provide a structured group residential setting for clients with substantial clinical needs. Clients are supervised 24 hours each day, with staff and other members of the client's support network helping in the transition to more independent living. Services include individual counseling, support groups, medication education and monitoring, financial management, and crisis prevention.

- **Adult Family Homes** are four- to six-bed residential units that offer less intensive supervision and support than CBRFs. They are often used by clients transitioning out of a long-term care setting. BHD does not contract for adult family home services, but instead refers clients to such homes from a State directory and reimburses the homes as utilized on a fee-for-service basis. Reimbursement does not involve levy/BCA or other revenue sources discussed in this report, but instead typically involves Community Options Program (COP) funding, which is a form of Medicaid funding available to elderly people and people with long-term disabilities. Because of the specialized use of these residential services, their unique funding arrangement, and BHD's limited and sporadic use of these homes, they are not part of the analysis in this section.

Figure 17 summarizes the number of clients served by BHD community-based treatment and recovery programs in 2013.

[10] Informational Report by DHHS Director Hector Colon dated October 10, 2013.

Figure 17: Number of clients served in major community-based programs, 2013



Note: These are not exclusive categories, in other words the same patient may have been served by two or more programs.

It is important to note that the County's Department of Health and Human Services has a Housing Division that works closely with BHD to provide various forms of housing to individuals who receive services from BHD or who have recently been discharged from the Mental Health Complex. Those include **Pathways to Permanent Housing**, a 27-bed transitional housing program serving individuals who require a lower level of residential care than that provided by a CBRF; **supported apartments** that transition clients to independent living; and various **supportive housing** units that provide independent living in conjunction with on-site case management and peer support.

Because these programs are not included in BHD's budget and are not under the purview of the Mental Health Board, we do not consider them in detail in this report. However, enhancing capacity in these housing programs likely will be critical to achieving broader redesign goals of downsizing inpatient and long-term care services.

Expenditure Trends

Table 4 breaks down the division's expenditures in 2013 by the major program components described above, and also distinguishes between expenditures on County-operated versus contracted community-based services. It should be noted that CRS and CCS are not included in this table, as both programs began enrolling clients in 2014.

Table 4: Community services expenditures, 2013

	Community Provider	County Programs	Total
TCM	$3,623,237	$169,571	$3,792,808
CSP	$3,737,749	$6,114,160	$9,851,909
CLASP	$404,714		$404,714
Outpatient	$2,829,423		$2,829,423
Crisis Services	$2,279,435		$2,279,435
Day Treatment	$0	$2,567,655	$2,567,655
Other	$576,945		$576,945
SAIL – Contracted Services	$1,442,219	$2,248,975	$3,691,194
PCS – Crisis Services, MTT, Access Clinic	$2,484,073	$3,783,978	$6,268,051
CBRF - Vendor Pymts	$4,647,385		$4,647,385
Total	**$22,025,179**	**$14,884,339**	**$36,909,518**

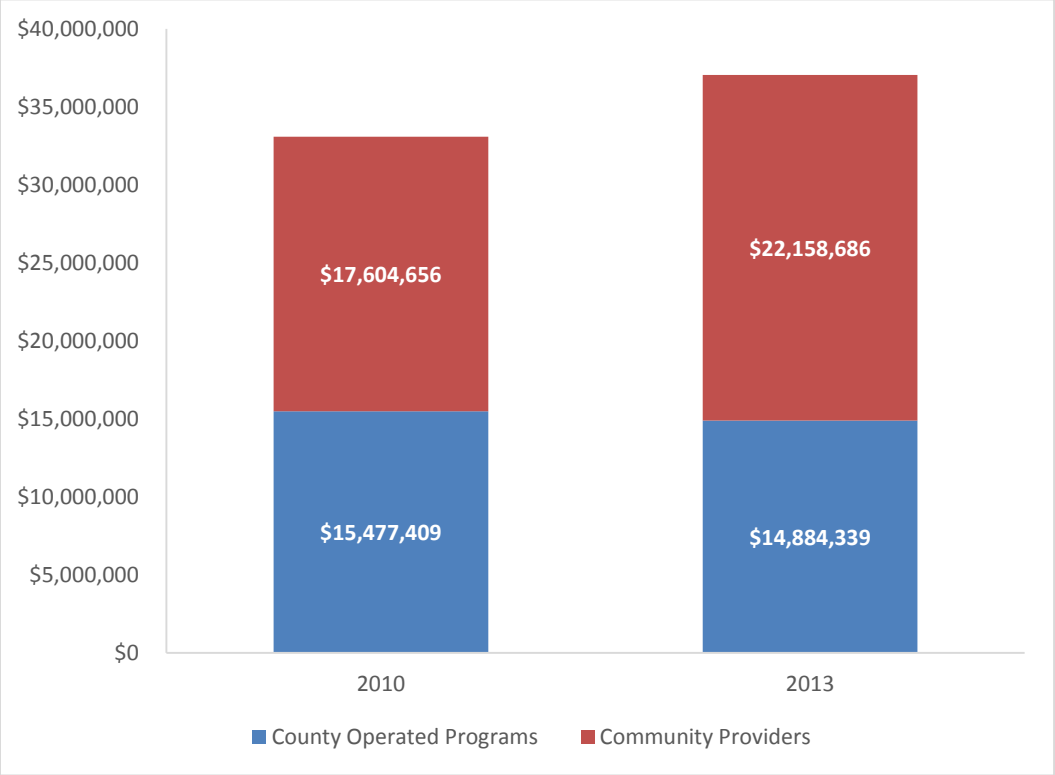
Source: Total purchase of service costs taken from data sent by BHD's budget staff; program costs provided by BHD's Community Services and Reinvestment Division. Due to differences in data sources, expenditures for community-provided services do not add up exactly to the total shown in ***Figure 20****.*

It is important to note that the costs reflected in BHD's budget for contracts with community providers are indicative only of the net expense to the provider. In other words, because the providers submit their own claims to Medicaid and other sources of insurance, BHD's contract cost does not reflect the full cost of services, but only the net cost (or levy/BCA contribution) after Medicaid and insurance reimbursement is taken into account. In addition, in some cases, providers serve more individuals than specified in their contract with the County, and those additional expenditures are not accounted for here.[11]

Notwithstanding that important caveat, **Figure 18** shows that from 2010 to 2013, BHD's budget for mental health community services increased by $3.9 million, with expenses totaling $37 million in 2013. **Figure 18** also shows that expenditures on programs administered by County staff declined during this period, which is largely attributed to the phasing out of County-provided TCM.

[11] Reimbursement for that care, however, is part of the WIMCR claim submitted by the County to Medicaid on an annual basis.

Figure 18: Mental health community-based services expenditures, 2010-2013[12]



Indirect costs, which proved to be a major factor in cost trends of inpatient service areas, are far less significant for community-based services. That is because those costs are applied only to County-operated programs, which made up only one third of total community-based services expenditures in 2013. As a result, indirect costs comprise only about 14% of BHD's community services budget.

Revenue Trends

While the primary source of revenue support for inpatient services is patient revenue, community-based services are financed through a wider variety of revenue sources. In fact, net patient revenue made up less than one tenth of BHD's total community-based services revenue in 2013 and was related solely to CSP and Day Treatment. It is important to recognize, however, that Medicaid and other insurance reimbursement for contracted services do play a larger role in financing community-based services than is reflected in BHD's budget; as discussed above, those forms of reimbursement typically are collected by the vendors and are not shown in BHD's budget.

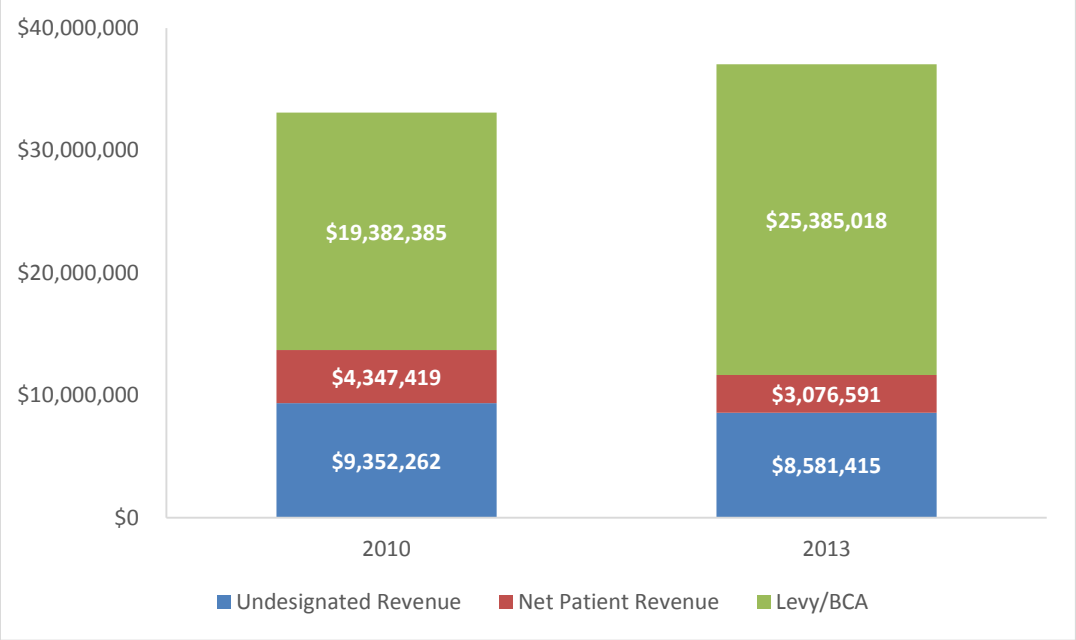
Significantly, undesignated revenues make up about one quarter of revenues in the community-based services budget. Those include State grants such as the Mental Health Block grant and IMD regular relocation revenue, both of which are general sources of State funding for mental health

[12] Expenditures for Community Providers includes all of CBS Administration (6402) and provider payments budgeted in SAIL and in the PCS Budget. County-Operated Programs include County-run CSP, TCM, SAIL, Day Treatment, and estimated expenditures in PCS for the Mobile Treatment Team and Access Clinic.

services that are not tied to specific services or clients. Because undesignated revenues are not connected to a specific expense, BHD has some discretion in how they are budgeted.

Between 2010 and 2013, the proportion of BCA/levy dedicated to community-based services increased, as shown in **Figure 19**. This was caused, in part, by the outsourcing of TCM, which reduced patient revenue. IMD relocation revenue also dropped by $622,000 between 2010 and 2013.

Figure 19: Mental health community-based services revenues, 2010-2013[13]



A key question that cannot be answered by fiscal analysis, but instead must involve evaluation of specific services and service populations, is how much of the increase in new levy/BCA investment funded additional capacity to serve people who had previously been unable to access care, as opposed to enhanced services for individuals already receiving support from BHD. That question is important because a redesigned system of care that relies less heavily on inpatient and emergency services should provide better access to community-based services for individuals who have not already become part of the BHD "system" through hospitalization.

[13] Community-based services total expenditures includes $3.7 million in 2010 and $3.8 million in 2013 related to MTT and Access Clinic. This analysis assumes that these expenditures are entirely funded with levy.

2014 and 2015 Budgets

This section briefly reviews the 2014 and 2015 BHD budgets in the context of the trends described in the previous sections. Analysis of these budgets – which show continued progress in the redesign of the mental health system – also sets the stage for the financial modeling conducted in the next section of this report.

> In BHD's 2014 and 2015 budgets, we see more clearly the effect of recent sharp declines in patient census, as expenditures for Mental Health Complex service areas fall by about $13 million (18%) by 2015 when compared with 2013 actual amounts. We also see a $7 million (14%) decline in the amount of levy/BCA dedicated to the Mental Health Complex. However, reductions in levy/BCA expenditures at the Mental Health Complex still do not come close to the 75% reduction in bed capacity that has occurred since 2010. This demonstrates the financial challenges that policymakers will face in attempting to finance a fully redesigned system, assuming that BHD continues to be a provider of inpatient and emergency services.

It is important to note our analysis is somewhat limited in these sections because *budgeted* amounts can differ substantially from *actual* budgets, particularly with regard to patient expenditures and revenues. Budgeted amounts in those areas represent a "best guess" based on anticipated bed capacity and trends in revenue collections. The *actual* expenditures, posted after the year-end close, reflect changes in patient volume or payer mix, policy changes that are enacted during the budget year, and changes in Medicaid reimbursement that may not have been anticipated in the budget. In addition, certain indirect costs – including legacy – are not finalized until late in the budget year and can differ substantially from budgeted projections.

2014 Budget – Overview

BHD's 2014 budget significantly accelerated inpatient and long-term care downsizing initiatives while also piloting new community-based treatment models and introducing new recovery and rehabilitation benefit programs. The following is a summary of major new or expanded redesign initiatives contained in the 2014 budget:

- Adult Hospital Programs
  - Adult Acute Inpatient – A total of 57 acute adult inpatient beds were anticipated (one 21-bed women's treatment unit, one 15-bed intensive treatment unit, and one 21-bed acute treatment unit).[14]
  - Rehab Central – The number of licensed beds were reduced from 72 to 48 (and from three to two units) by July 1, 2014. To accommodate this reduction, $793,000 was invested in community-based services intended to directly serve those discharged from the facility, including 20 additional CSP slots and additional group home and adult family home beds.

[14] The County's 2014 adopted budget narrative describes the 57-bed alignment noted above, but the budget contained sufficient funding for BHD to accommodate 66 beds if deemed necessary.

- Hilltop – Full closure of Hilltop was projected to occur by November 1 and actually occurred early in 2015. Net savings of $759,000 were budgeted for the phased closure, with the full financial impact being recognized in 2015.

- PCS – No major changes.

- **Community-Based Services.** Overall, the 2014 budget cited $4.9 million in new and enhanced community investments, including:

  - An additional $417,000 for existing CSP programs to pilot Assertive Community Treatment (ACT) and Integrated Dual Disorder Treatment (IDDT) models.

  - Funding for a peer-run drop-in center evening and weekend operation.

  - $275,000 for CRS implementation.

  - In the PCS budget, $365,000 was added to increase Mobile Treatment Team staffing and to expand its capacity to 24 hours per day.

  - CCS was projected to begin enrolling participants in July. No County funding was allocated, as the State has agreed to reimburse the County for both the federal and non-federal shares of Medicaid-allowable costs.

While final 2014 fiscal results are not yet available, BHD's most recent projection is for a property tax levy surplus of $9.0 million for the year. Mental Health Complex services tracked closely to budgeted property tax levy amounts. On the community-based services side (which includes AODA and other service not considered in this analysis), expenses were substantially lower than budgeted at $94 million, compared with a budget of $102 million. Revenues also were lower, but to a much lesser extent, generating a levy savings of $4.9 million.

According to fiscal staff, some of the surplus is attributed to changes in billing practices. By bringing billing closer to dates of service, BHD was able to increase collections on a one-time basis for Wraparound and crisis services. BHD also has been able to increase rates of collection for adult inpatient services, which will have an ongoing positive effect.

An additional positive note is that BHD's new status under Wisconsin Act 203 allows it to retain any 2014 surplus in a reserve for use in future years. In prior years, this surplus would have gone to the County General Fund.

2015 Budget – Overview

BHD's 2015 requested budget was the first to be considered by the new Mental Health Board, and the first that was subject to Wisconsin statutory provisions capping the property tax levy amount at $65 million unless agreed to by the Mental Health Board, County Executive, and County Board. The following summarizes major redesign initiatives.

Mental Health Complex Programs

- Adult Acute Inpatient – The budget assumes a total of 60 adult inpatient beds. Higher acuity levels of patients at the Mental Health Complex necessitated an increase of 19 FTEs to implement a new nursing staffing model.

- Rehab Central – Two units at Rehab Central will close in 2015: one by July 1 and the second by November 1. An expenditure reduction of $1.5 million related to closure is offset by a loss of revenue of $1.7 million (the full impact of savings from the closure will be recognized in 2016). Also, to accommodate the closure, $2.3 million is invested in services needed to serve eight high-acuity Rehab Central clients in the community or at State institutions.

- Hilltop – With the closure of Hilltop in 2014, the 2015 budget includes only clean-up expenses and revenues.

- PCS – A new nursing model for PCS adds 11 FTEs (while also eliminating 4.7 FTEs of overtime).

- Overhead –More than 20 FTEs are abolished from indirect organizations during the course of the year. In addition, the budget reflects more than $1 million in savings from reduced dietary, security, housekeeping, maintenance, and utilities savings linked to downsizing.

- Community-Based Services

  - The two remaining County-provided CSPs are outsourced in the 2015 budget.

  - CRS is not expanded beyond the 140 participants anticipated in 2014. The service array is enhanced via the addition of two eight-bed CBRFs to house CRS participants. This produces an increased property tax levy cost of $315,000.

  - The 2015 budget reflects full implementation of CCS, serving 245 clients. The budget indicates that some TCM and CSP clients will be transferred to the CCS benefit if clinically appropriate. No additional tax levy is budgeted given the State's ongoing commitment to cover all Medicaid-reimbursable costs with federal and state revenues.

2014 and 2015 Budgets in Context of 2010-2013 Fiscal Trends

The 2014 and 2015 budgets both show accelerating progress toward the goal of redirecting resources from inpatient to community-based services. Indeed, as shown in **Figure 20**, expenditures on community-based services jump by almost $6 million (15%) between 2013 actual spending levels and 2015 budgeted amounts, while Mental Health Complex expenditures fall by nearly $13 million (18%). **Figure 21** focuses on levy/BCA and shows a similar pattern.

Figure 20: Total adult mental health expenditures, 2013 actual through 2015 budgeted (in millions)

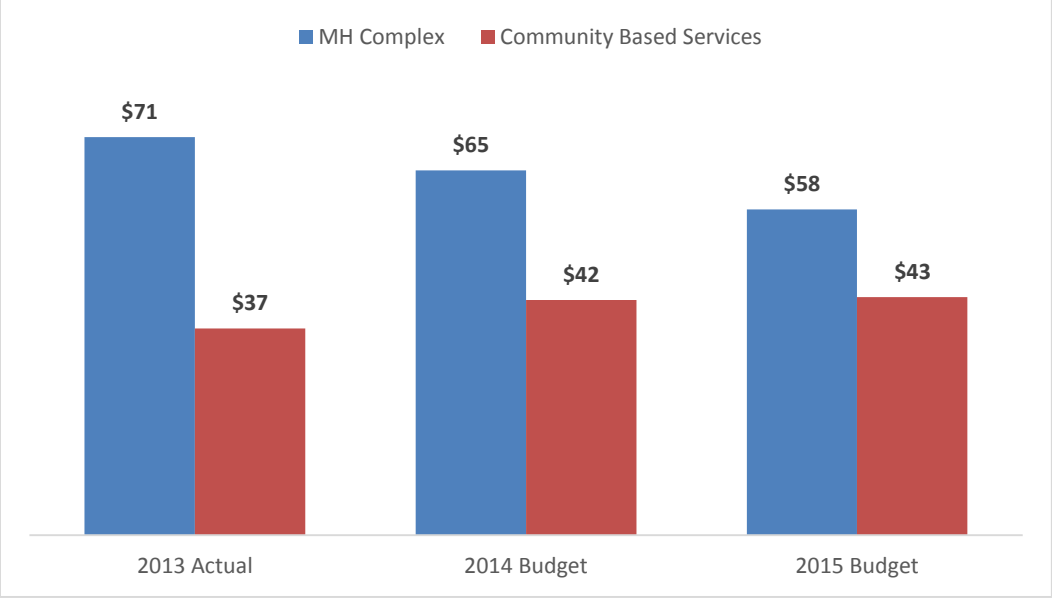
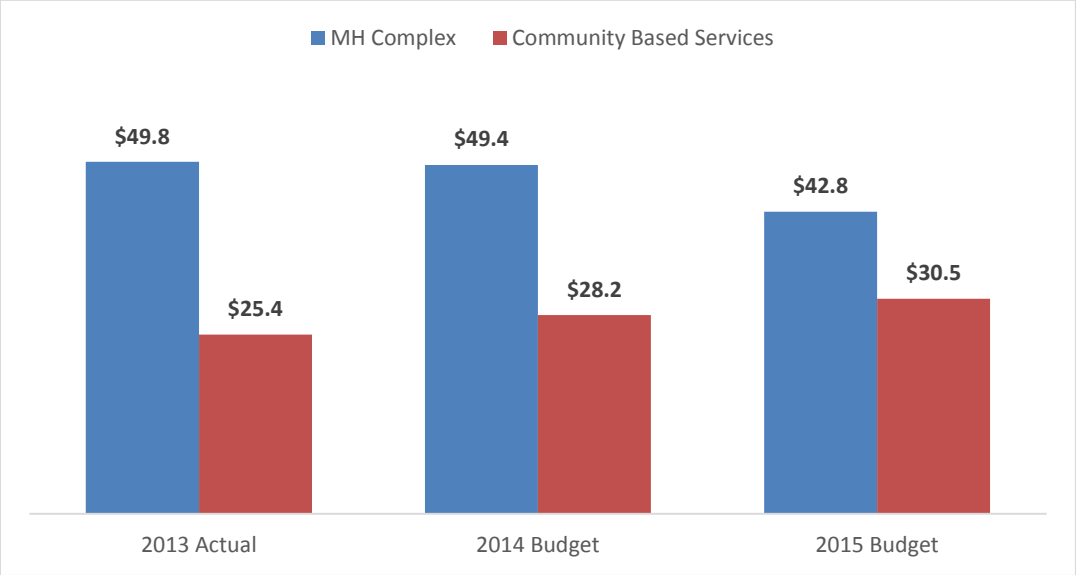


Figure 21: Mental health BCA/property tax levy expenditures, 2013 actual through 2015 budgeted (in millions)



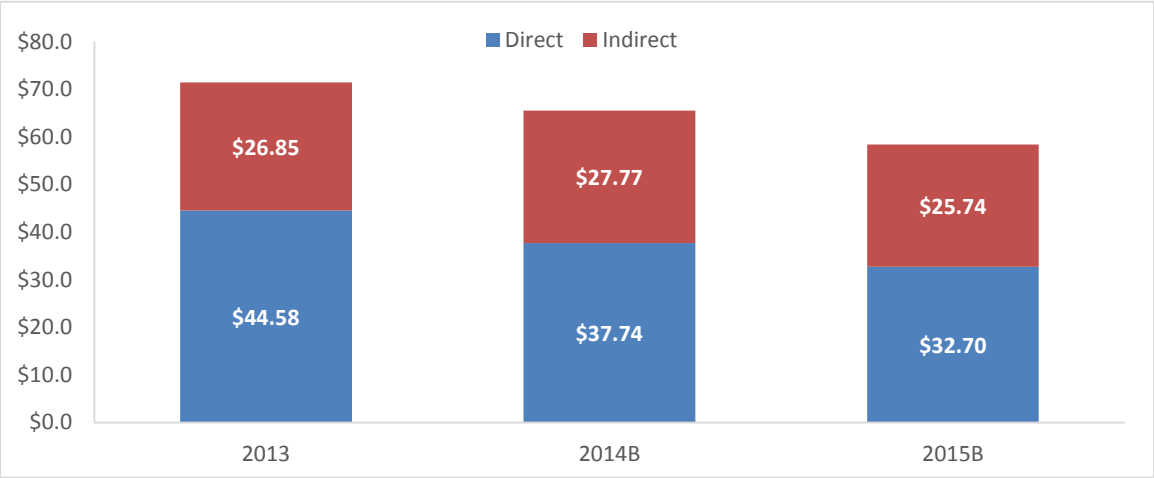
A couple of important caveats are in order regarding these findings, however. First, comparisons between prior year actual expenditure amounts and current or future year budgeted amounts are not always accurate given the volatility of BHD's budget, as noted at the beginning of this section.

In addition, increased expenditures on community-based services do not necessarily reflect an expansion of such services to serve new clients or to enhance the array of available services available to the broad spectrum of existing clients. Instead, those increases may reflect increases in the rates paid to contracted service providers, or the shift of dollars to serve specific individuals in the community who previously were housed at the Mental Health Complex. For example, as noted

above, BHD's 2015 budget contains an additional $2.3 million in community-based services specifically to serve eight former Rehab Central clients in the community. While accomplishing that goal for these eight individuals is consistent with the principles of redesign, the $2.3 million should not be viewed as an enhancement of general community-based mental health services.

With regard to Mental Health Complex expenditures, **Figure 22** shows that direct expenditures continue to fall substantially as Hilltop and Rehab Central are closed. Yet, remarkably, indirect expenditures decline by only 4% despite the vastly reduced census.

Figure 22: Mental Health Complex expenditures, 2013 actual through 2015 budgeted (in millions)



As explained earlier, a significant component of BHD's indirect costs is crosscharges from other County departments. It can be difficult to analyze annual fluctuations in County crosscharges because expenses can shift between cost categories. For example, in the 2015 budget, the Information Management Services Division transferred software contracts from BHD's budget (where they were shown as a direct cost) to its own budget, and then increased its crosscharge to BHD. If we deduct the $900,000 relating to software expenses from total County crosscharges, there is still an increase of about $450,000 in County crosscharges between 2013 and 2015. BHD's charges from Risk Management and the Cost Allocation Plan both increased substantially, although some other charges declined. The portion of indirect costs attributable to BHD's own overhead declined during this time period by a more substantial $2.5 million, or 10%.

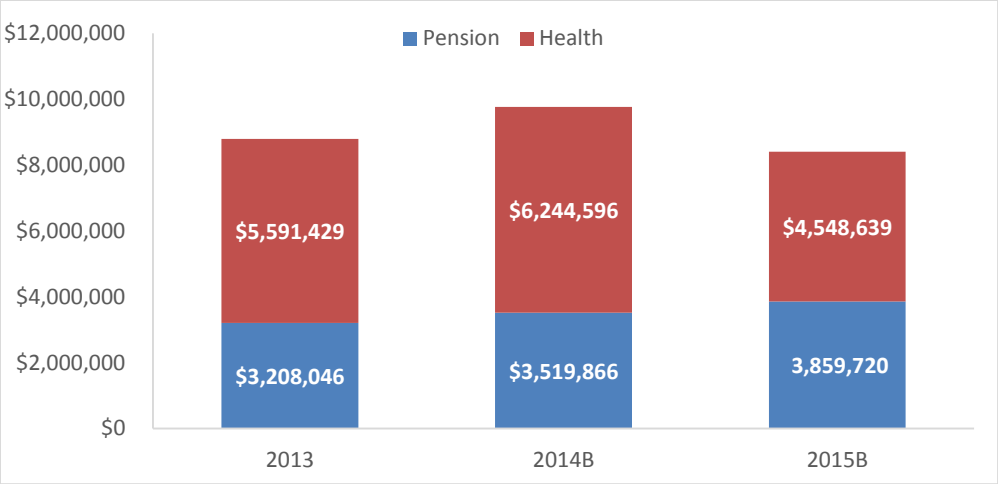
Drilling down further into direct costs, we see in **Table 5** that FTEs decreased by about 27% between 2013 and the 2015 budget. The bulk of those reductions are attributed to the downsizing and eventual closures of Hilltop and Rehab Central. Staffing of adult inpatient units and PCS has increased over the past two budgets.

Table 5: Mental Health Complex FTEs, 2013-2015

	2013 Actual	2014 B	2015 B
Adult Inpatient	171.60	168.64	175.18
Rehab Central	89.84	82.34	51.26
Hilltop	86.96	43.47	0.00
PCS	73.65	75.52	82.21
Total	**422.05**	**369.98**	**308.65**

Finally, with regard to the legacy component of indirect expenditures at the Mental Health Complex, **Figure 23** shows that those expenditures have declined only slightly since 2013, dropping by 4.5% despite the sharp reduction in FTEs. One reason for the consistency of legacy expenses is that the central budget office allocates legacy costs to departments based on a three-year average. Consequently, BHD's projected allocations in 2014 and 2015 lag the declines in FTEs.

Figure 23: Mental Health Complex legacy expenditures, 2013 actual through 2015 budgeted



Financial Modeling: Projection of BHD'S 2017 Financial Status

In this section, we report on the results of a financial model that projects BHD's budgetary outlook in 2017 based on three different adult inpatient bed capacity scenarios. We selected 2017 – only two years from now – based on input from BHD officials, who see that as the year in which key community-based enhancements will have fully taken hold and in which BHD might be able to move to a different and potentially much smaller inpatient model.

Some of the variables in our 2017 funding model were relatively easy to determine, such as anticipated salary and fringe benefit increases, which are based on assumptions in the County's five-year projections for County government as a whole. Other variables are more subjective, such as staffing levels for various inpatient bed scenarios and allocation of indirect costs among service areas. For both of those variables, we relied on BHD fiscal and clinical staff to supply us with information to plug into our model. In fact, all major modeling assumptions – if not developed by BHD staff – at least were reviewed by BHD.

Overall, the projections in this section should be recognized as only a general indicator of change over the next two to three years. Its value is as a starting point for consideration of the fiscal impacts associated with different system redesign scenarios, and for deliberation over how fiscal impacts should influence eventual decision-making.

The primary objective of our modeling is first to determine how much local property tax levy may be needed in 2017 to support Mental Health Complex operations under different bed capacity scenarios, and then to compare that amount with 2015 budgeted levy/BCA to determine whether "savings" would be available for reinvestment in community-based services. These are critical questions given both the property tax limitations contained in Wisconsin Act 203, and the fact that additional property tax levy savings achieved through Mental Health Complex downsizing are likely to continue to be required to enhance investment in the community.

To calculate 2017 property tax levy/BCA amounts, we needed to project Mental Health Complex expenditures, and then "net out" projected revenue. Assumptions regarding inpatient staffing levels are a primary component of our expenditure projections. As noted above, because of our lack of clinical knowledge regarding the staffing required to maintain appropriate levels of patient care, we turned to BHD to supply those assumptions. Other important assumptions are that admissions and FTEs at PCS do not change regardless of inpatient bed capacity, and that BHD remains in its current facilities at the Mental Health Complex in Wauwatosa.

Upon determining the projected amounts of property tax levy/BCA required for each bed capacity scenario in 2017 for the two remaining Mental Health Complex service areas (adult inpatient and PCS), we then compare those amounts with 2015 budgeted levy/BCA allocations for the two service areas to come up with a net fiscal impact. However, to estimate the total amount of levy/BCA "savings" available for reinvestment, we also need to take into account the impacts associated with the closure of Rehab Central, which is scheduled to occur at the end of 2015.

BHD's 2015 budget includes $8.2 million of levy/BCA to support the operation of Rehab Central until it closes at year end. After the facility closes, some of that levy/BCA will be needed to directly support Rehab Central clients in community settings. While it is impossible to predict that cost, in consultation with BHD we roughly estimate it to be $3.6 million. When we combine that cost with $400,000 in legacy charges to Rehab Central that will not be fully phased out until 2018, we arrive

at a total estimated levy/BCA savings of $4.2 million in 2017. Consequently, $4.2 million of net Rehab Central "savings" are taken into account in each of our inpatient bed capacity models.

It is important to recognize that while our modeling shows that $4.2 million theoretically will be freed up in future budgets from the closure of Rehab Central, there are several other factors – including the need to reallocate certain Rehab Central costs to other areas of BHD's budget – that also must be taken into account by decision-makers when they determine the amount of resources available for community reinvestment in the 2016 budget.

The Three Models

The financial modeling exercise conducted in this section explores fiscal impacts associated with 60-, 32-, and 16-bed adult inpatient capacity scenarios in 2017. These three scenarios were selected after consultation with BHD officials.

For each of the scenarios, it is assumed that BHD operates the beds at the existing Mental Health Complex in Wauwatosa and that it does so alongside a Psychiatric Crisis Service (PCS) that continues to see the same volume of patients. Each of the scenarios also assumes the closure of the Rehab Central long-term care facility by the end of 2015 (as currently anticipated), leaving adult inpatient and PCS as the only two Mental Health Complex functions serving adults.

The 60-bed scenario represents the "status quo" and is seen as the maximum number of inpatient beds that BHD will continue to operate going forward. Conversely, the 16-bed scenario is seen as the minimum number of beds that BHD would operate without getting out of the inpatient business entirely. The 32-bed scenario is seen as a possible middle ground, though 40- and 48-bed scenarios also could have been explored for that purpose.

The following summarizes each model in terms of beds, FTE requirements, and levy/BCA savings (when compared to the 2015 budget).

Model 1	Model 2	Model 3
60 beds	32 beds	16 beds
385 FTEs	312 FTEs	249 FTEs
$1.2 million savings	$5.0 million savings	$8.8 million savings

Model #1: 60 Acute Adult Inpatient Beds

Model 1 assumes that BHD's adult inpatient bed capacity stays at its current capacity of 60 beds. This is essentially the "status quo" scenario.

Model 1 shows only $1.2 million in net savings for Mental Health Complex services in the 2017 budget, despite the full closure of Rehab Central. This reflects BHD's inability to substantially reduce facilities and internal overhead costs, and its need to accommodate inflationary increases in employee compensation, commodities, and other hospital-related costs. This model shows that if BHD's current bed capacity stays the same, annual cost increases associated with operating those beds and PCS will eliminate the net savings accrued from the closure of Rehab Central within a few years.

Staffing Projection

Direct FTEs, or workers directly involved in patient care in the four adult inpatient areas, have declined since 2010 largely because of reductions in the number of beds and patient days. **Table 6** shows the trend in direct FTEs among the four Mental Health Complex service areas and our projection of direct FTEs in 2017 under a 60-bed scenario. The 267 FTES is a reduction of about 53 positions, or 16%, from the 2015 budget. This reduction is almost entirely attributable to the anticipated closure of Rehab Central by the end of 2015, as well as a slight reduction in hospital support personnel.

Table 6: Model 1 Direct Staffing FTEs

	2010 Actual	2013 Actual	2015 Budget	2017 Projected
Adult Inpatient	190.09	171.60	175.18	175.18
Rehab Central	82.32	89.84	51.26	-
Hilltop	97.60	86.96	0.00	-
PCS	58.87	73.65	82.21	82.21
Hospital Support	19.22	17.37	11.12	9.80
Total Direct	**448.10**	**439.78**	**319.77**	**267.19**

As we have seen in our previous analysis, indirect staffing does not decline at the same rate as direct staffing. In **Table 7**, we show recent trends and a 2017 projection for staffing for indirect cost areas of the Mental Health Complex budget under the 60-bed scenario (e.g. administration, human resources). As with direct FTEs, this staffing projection also was provided directly by BHD. It should be noted that for this calculation, we first had to determine indirect staffing levels for all of BHD, and then project the allocation of indirect staff to the Mental Health Complex functions. Both totals are shown in the table.

Table 7: Model 1 Indirect Staffing FTEs

	2010 Actual	2013 Actual	2015 Budget	2017 Projected
General Admin	52.9	57.3	43.4	40.7
Hospital Admin	66.0	60.1	70.6	62.0
Facilities	19.4	18.1	16.0	14.9
Total	**138.2**	**135.5**	**129.9**	**117.6**
Total Allocated to MH Complex	**100.9**	**94.9**	**92.6**	**78.8**

Expenditure Projection

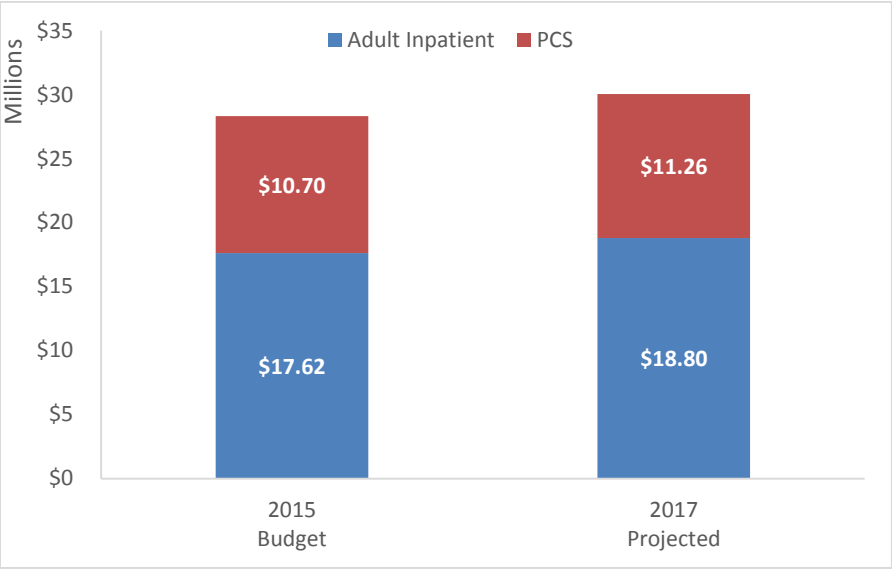
Using the staffing projections outlined above – as well as assumptions contained in the County's five-year modeling regarding countywide salary and fringe benefit cost increases over the next two years – we can estimate 2017 personnel-related expenditures. We also project expenditures for other parts of the Mental Health Complex budget, including contracted services, commodities (e.g. food and prescription drugs), and crosscharges from other County departments. In general, these budgetary accounts are assumed to increase 2.5% between 2015 and 2017.

These projections allow us to calculate an overall estimate of Mental Health Complex expenditures for 2017. As in our budget and trend analyses in previous sections, we break down our estimates by both direct and indirect costs, using the same allocation methodology we employed earlier.[15]

Figure 24 shows that direct expenditures to support the two remaining Mental Health Complex service areas (adult inpatient and PCS) would grow by about $1.7 million (6.1%), from $28.3 million in 2015 to $30.1 million. This increase relates primarily to rising salary and fringe benefit costs, as well as inflationary increases in services, commodities, crosscharges, etc. As noted above, staffing levels for these two service areas would remain largely the same.

[15] See page 13 for a description of our budget methodology. Essentially, this methodology is designed to appropriately segregate Mental Health Complex costs from community-based service costs and distinguish costs that are directly related to hospital-based services from other categories of overhead costs.

Figure 24: Model 1 Projection of Direct Expenditures[16]



In Table 8, we show our projection of total indirect expenditures for the Mental Health Complex, again broken down between adult inpatient and PCS. We also distinguish between traditional indirect costs – which include the Mental Health Complex's share of general BHD management and administration, general County overhead charges, hospital administration, and facilities – and legacy costs charged to the Mental Health Complex functions. Here, we see an increase of about $2.6 million, or 13.1%.

Table 8: Model 1 Projection of Indirect Expenditures

	2015 Budget	2017 Projected	Percent Change
Adult Inpatient			
Indirect Orgs	$9,634,061	$11,028,534	
Legacy	$3,372,550	$3,717,635	
Total Indirect	$13,006,611	$14,746,169	13.4%
PCS			
Indirect Orgs	$4,679,697	$5,332,534	
Legacy	$1,925,382	$2,110,876	
Total Indirect	$6,605,079	$7,443,410	12.7%
Total Mental Health Complex	**$19,611,690**	**$22,189,579**	**13.1%**

[16] 2015 direct expenditures in Figure 24 are lower than the total amount shown in Figure 22 in the previous section because they do not include 2015 expenditures for Rehab Central.

A few notes are in order regarding the development of these indirect cost projections:

- Facilities expenses increase (from $6.3 million in the 2015 budget to $6.5 million in our projection) even though the number of FTEs associated with facilities is projected to decline by one FTE. This is because salaries are a relatively small proportion of the total facility expense. Crosscharges for DAS – Facilities Maintenance are projected to increase by 2.5%, as are utilities and other building-related services. Essentially, the model suggests that as long as BHD remains in its current facility, this source of indirect cost will not change substantially.

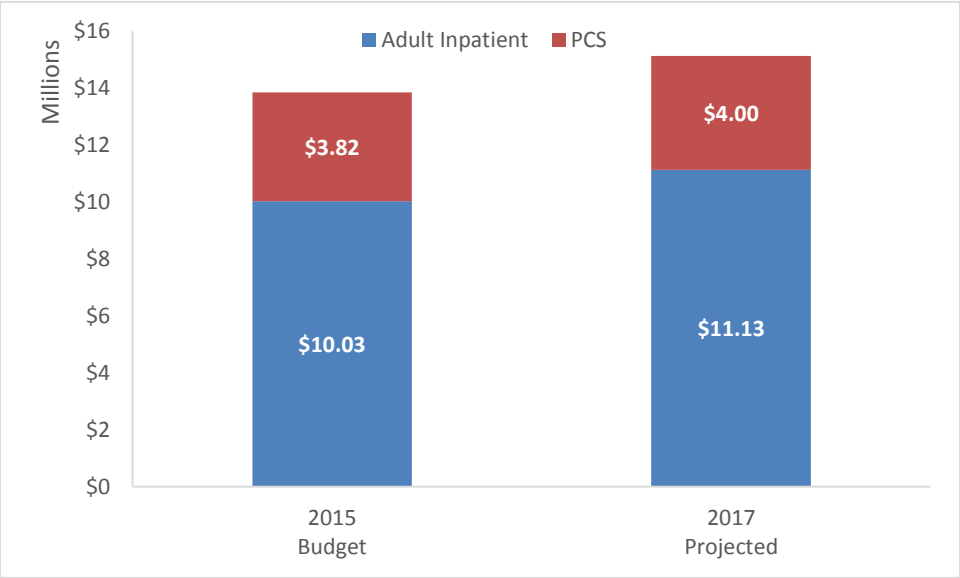
- In order to project indirect costs for adult inpatient and PCS in 2017, we estimated total costs for certain indirect cost categories within BHD's budget, and then made assumptions regarding how those costs would be allocated across all of BHD's direct service areas. Our methodology for doing so was reviewed by BHD fiscal staff. While total indirect costs for BHD are not projected to change significantly by 2017, our model assumes that the percentage allocated to adult inpatient and PCS each will increase (in part because the closure of Rehab Central and Hilltop leaves fewer service areas), resulting in an increase in indirect costs to both areas. It is important to recognize that these projections do rest on somewhat speculative assumptions. If actual indirect cost allocations differ substantially from our assumptions, then our overall fiscal projections would be materially impacted.

- Indirect costs include County crosscharges that are allocated to BHD by the County Comptroller's office and the Department of Administrative Services. These costs were described in detail in previous sections of this report. The model assumes that County crosscharges in their entirety will increase by 2.5%, but that because of decreasing FTEs at BHD, the overall allocation of County crosscharges to BHD will offset that increase.

Revenue Projection

In order to calculate the total property tax levy/BCA required to support Mental Health Complex operations in 2017, we also need to take into account the amount of revenue that will be generated from those operations. BHD provided revenue projections for adult inpatient for 2017, which take into account recent changes in Medicaid reimbursement rates and assumptions regarding patient acuity and insurance coverage. For PCS, we assume a revenue increase of 5%. As shown in **Figure 25**, total revenues for the two service areas are projected to increase by about $1.3 million, or 9.3%.

Figure 25 - Model 1 Projection of Mental Health Complex Revenues



Projection of 2017 Property Tax Levy/BCA and Savings Available for Reinvestment

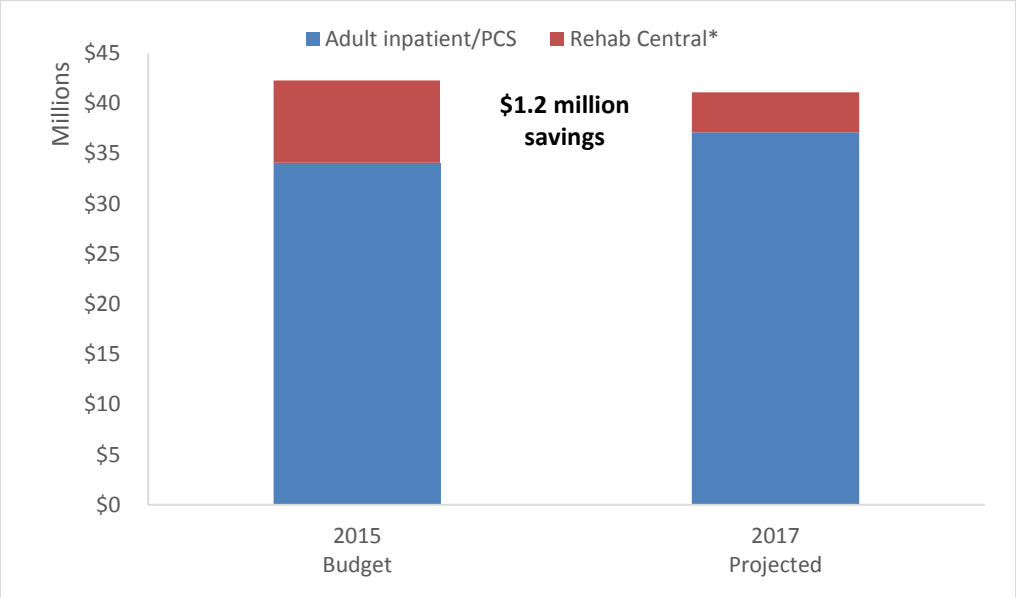
To determine levy/BCA impacts in the two Mental Health Complex service areas in 2017, we subtract projected revenues from projected expenses and compare those totals to 2015 budgeted amounts. Table 9 shows that BHD would need about $3 million of additional tax levy/BCA in 2017 to support remaining Mental Health Complex operations, although staffing levels for those operations essentially are unchanged.

Table 9: Model 1 Projection of Mental Health Complex Levy/BCA

	2015 Budget	2017 Projected	Percent Change
Adult Inpatient			
Direct Expense	$17,621,326	$18,795,149	6.7%
Indirect Expense	$13,006,611	$14,746,169	13.4%
Total Expense	$30,627,937	$33,541,318	9.5%
Revenue	$10,029,584	$11,133,670	11.0%
Levy/BCA	$20,598,353	$22,407,648	8.8%
PCS			
Direct Expense	$10,704,871	$11,262,154	5.2%
Indirect Expense	$6,605,079	$7,443,410	12.7%
Total Expense	$17,309,950	$18,705,564	8.1%
Revenue	$3,822,627	$4,002,661	4.7%
Levy/BCA	$13,487,323	$14,702,903	9.0%
Total Mental Health Complex	**$34,085,676**	**$37,110,551**	**8.9%**

The projected $3 million increase in levy/BCA requirements for remaining Mental Health Complex operations does not take into account the $4.2 million in net levy/BCA savings related to the closure of Rehab Central. Consequently, as shown in **Figure 26**, when we factor in those savings, our modeling suggests ***that about $1.2 million in levy "savings" would be available to BHD in 2017 for reinvestment in community-based services*** under our Model 1 scenario of 60 adult inpatient beds.

Figure 26: Model 1 Projection of Net Mental Health Complex Levy/BCA Savings



* While Rehab Central will be closed in 2017, we still show a Rehab Central expenditure in this figure. This is attributed to $4 million in needed BCA/levy expenditures to support Rehab Central clients in community settings and to pay remaining legacy costs.

Summary of Model 1

Given the trends described earlier in this report, it is not surprising that Model 1 shows only $1.2 million in net savings for Mental Health Complex services in the 2017 budget, despite the full closure of Rehab Central. Model 1 maintains existing adult inpatient bed capacity and assumes that PCS activity and staffing remains the same, which requires a projected $3 million increase in the amount of BCA/levy required to operate the two service areas in 2017. This reflects the fiscal pressure exerted on BHD by its inability to substantially reduce facilities costs and other forms of internal indirect costs, and its need to accommodate assumed inflationary increases in employee compensation, commodities, etc. Hence, the $4.2 million in net savings associated with the final stage of the Rehab Central closure are largely offset n 2017 by the projected increased cost of maintaining the adult inpatient and PCS service areas at existing capacity.

Model #2 – 32 Acute Adult Inpatient Beds

Model 2 explores the fiscal impacts of a scenario in which BHD's acute adult inpatient beds are reduced from 60 to 32. As with Model 1, Model 2 assumes that PCS utilization and staffing remain at 2015 levels.

Staffing Projection

Tables 10 and **11** show FTE projections for direct and indirect cost areas. These projections were developed by BHD based on their estimate of staffing needs for a 32-bed facility. The number of beds declines by 47% as compared to Model 1, but BHD projects more modest decreases in direct and indirect staffing. We see a decrease of 57 FTEs (22%) in direct cost areas and a decrease of 14 FTEs (18%) in indirect cost areas.

Model 2 yields $5 million in net savings when the closure of Rehab Central is taken into account. A key consideration is whether the potential availability of $5 million to reinvest in community-based services would be sufficient to offset the impacts of a 28-bed reduction in the county's overall system of care.

Savings related to the reduction of 28 adult inpatient beds total only $1.6 million. The relatively insignificant nature of the inpatient savings stems from several factors, including BHD's assumption that hospital staffing only could be reduced by 21%, an inability to produce substantial savings in indirect cost areas, and a projected decline in annual patient revenues of more than $5 million.

Table 10: Model 2 Direct Staffing FTEs

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)
Adult Inpatient	175.20	175.20	119.10
Rehab Central	51.30	-	-
Hilltop	0.00	-	-
PCS	82.20	82.20	82.20
Hospital Support	11.10	9.80	8.50
Total Direct	**319.80**	**267.20**	**209.80**

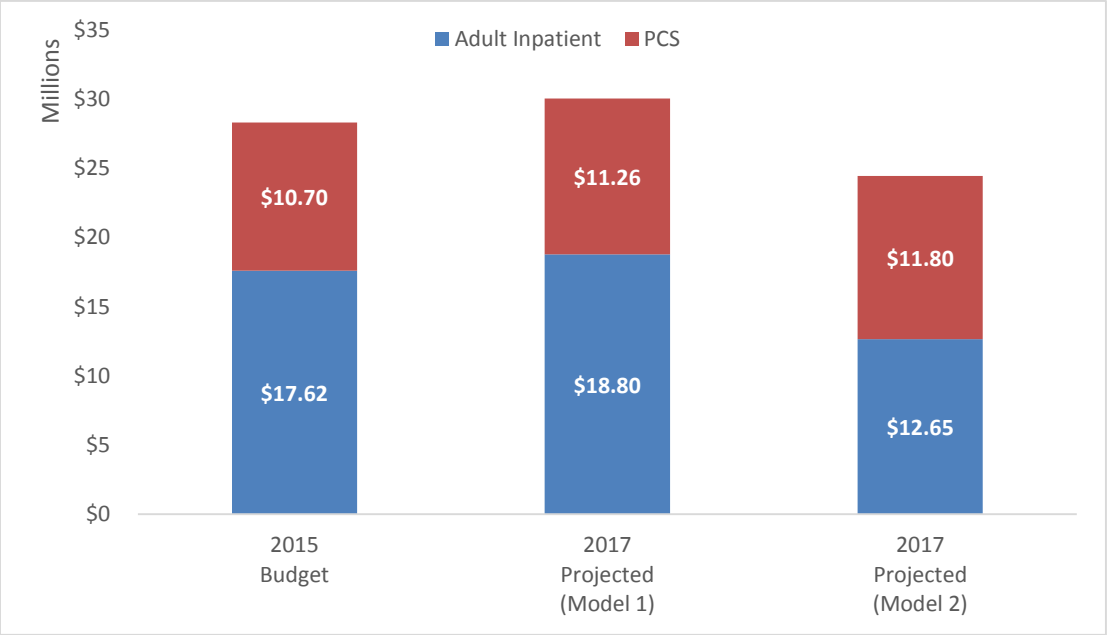
Table 11: Model 2 Indirect Staffing FTEs

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)
Facilities	16.0	14.9	13.4
Hosp Admin	70.6	62.0	50.6
Genl Admin	43.4	40.7	38.3
Total Indirect	**129.9**	**117.6**	**102.3**
Total Allocated to MH Complex	**92.6**	**78.8**	**64.4**

Expenditure Projection

Using these staffing projections and the assumptions described in Model 1 regarding salaries and benefits, contractual services, commodities, and other direct and indirect costs associated with Mental Health Complex operations, we can calculate projected direct and indirect expenditures under the 32-bed scenario. **Figure 27** shows that direct expenditures would be reduced by $3.9 million from 2015 expenditure levels.

Figure 27: Model 2 Projection of Direct Expenditures



Indirect expenses under this model decline by only $866,000 in comparison with 2015, as shown in **Table 12**. The fact that indirect expenditures decrease by such a small amount when compared to the 2015 budget – despite the reduction of 28 beds – again shows the difficulty BHD will face in achieving substantial savings from downsizing because of its inability to reduce indirect staffing and costs.

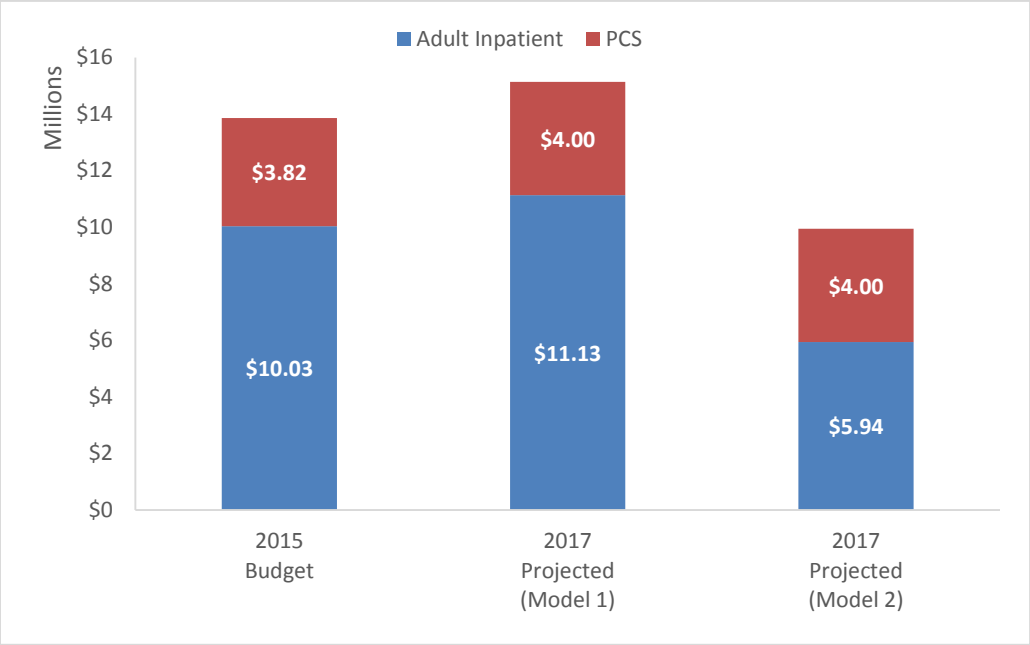
Table 12: Model 2 Projection of Indirect Expenditures

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)
Adult Inpatient			
Indirect Orgs	$9,634,061	$11,028,534	$9,181,110
Legacy	$3,372,550	$3,717,635	$3,122,890
Total Indirect	$13,006,611	$14,746,169	$12,304,000
PCS			
Indirect Orgs	$4,679,697	$5,332,534	$4,330,559
Legacy	$1,925,382	$2,110,876	$2,110,876
Total Indirect	$6,605,079	$7,443,410	$6,441,435
Total Mental Health Complex	**$19,611,690**	**$22,189,579**	**$18,745,435**

Revenue Projection

Our revenue projection for a 32-bed adult inpatient facility again was developed by BHD staff, taking into account projected Medicaid reimbursement rates and assumptions regarding patient acuity and insurance coverage. For PCS, we again assume a revenue increase of 5%. As shown in **Figure 28**, total revenues for the two service areas are projected to decrease by $3.9 million when compared to the 2015 budget and $5 million when compared to the 2017 60-bed scenario.

Figure 28: Model 2 Projection of Mental Health Complex Revenues



Projection of 2017 Property Tax Levy/BCA and Savings Available for Reinvestment

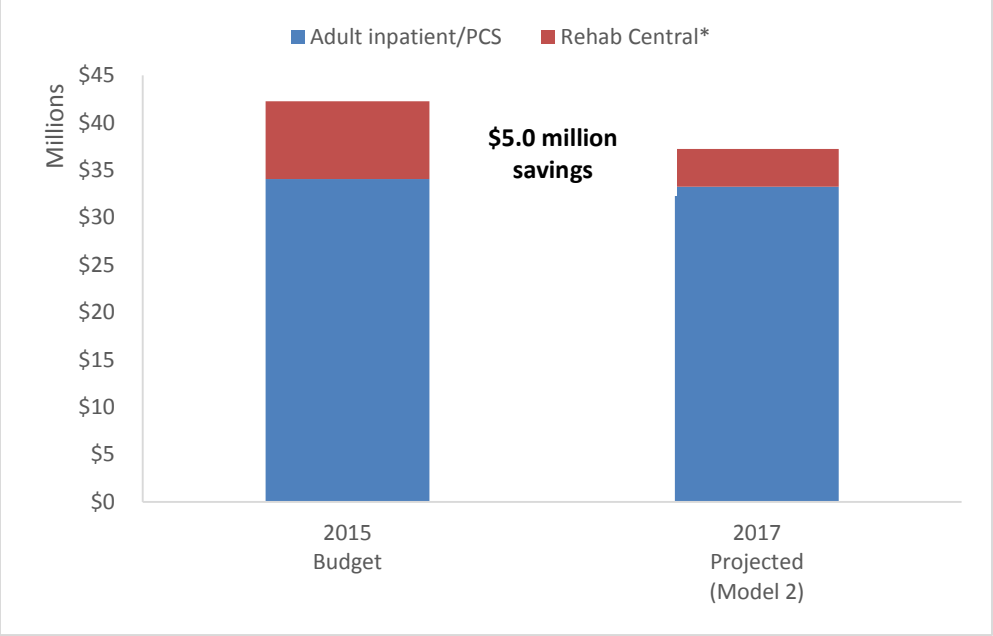
In **Table 13**, we combine our expenditure and revenue projections to develop an estimate of total property tax levy/BCA required to support the Mental Health Complex for the 32-bed adult inpatient scenario. We find that for the two remaining service areas combined, there is a $3.9 million levy/BCA savings when compared to Model 1, and an $828,000 levy/BCA savings when compared to the 2015 budget.

Table 13: Model 2 Projection of Mental Health Complex Levy/BCA

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)
Adult Inpatient			
Direct Expense	$17,621,326	$18,795,149	$12,653,047
Indirect Expense	$13,006,611	$14,746,169	$12,304,000
Total Expense	$30,627,937	$33,541,318	$24,957,048
Revenue	$10,029,584	$11,133,670	$5,937,957
Levy/BCA	$20,598,353	$22,407,648	$19,019,090
PCS			
Direct Expense	$10,704,871	$11,262,154	$11,800,047
Indirect Expense	$6,605,079	$7,443,410	$6,441,435
Total Expense	$17,309,950	$18,705,564	$18,241,482
Revenue	$3,822,627	$4,002,661	$4,002,661
Levy/BCA	$13,487,323	$14,702,903	$14,238,821
Total Mental Health Complex	**$34,085,676**	**$37,110,551**	**$33,257,911**

The projected $828,000 savings in levy/BCA requirements for remaining Mental Health Complex operations does not take into account the net estimated levy/BCA savings of $4.2 million in the 2017 budget from the closure of Rehab Central. As shown in **Figure 29**, when we factor in those savings, our modeling suggests ***that about $5 million in levy "savings" would be available to BHD in 2017 for reinvestment in community-based services*** under our Model 2 scenario of 32 adult inpatient beds.

Figure 29: Model 2 Projection of Net Mental Health Complex Levy/BCA Savings



* While Rehab Central will be closed in 2017, we still show a Rehab Central expenditure in this figure. This is attributed to $4 million in needed BCA/levy expenditures to support Rehab Central clients in community settings and to pay remaining legacy costs.

Summary of Model 2 Fiscal Impact

Looking only at the adult inpatient service area, our modeling indicates that a reduction of beds from 60 to 32 would produce a savings of only $1.6 million in levy/BCA expenditures when compared to budgeted expenditures in 2015. Given that PCS would require an additional expenditure of $750,000, this means that BHD would save less than $1 million in levy/BCA in 2017 from its combined operation of adult inpatient and PCS services if it were to reduce its capacity to 32 beds.

When we factor the closure of Rehab Central into our analysis, we arrive at an overall projection of $5 million in net savings. A key consideration for policymakers is whether the potential availability of $5 million to reinvest in community-based services is sufficient to offset the growth in community-based services that would be needed to accommodate the elimination of 28 inpatient beds in the county's overall system of care.

The relatively modest nature of the levy/BCA savings that would be generated from a 47% reduction adult inpatient bed capacity stems from several factors. First, a key component of our estimate is the direct and indirect staffing that would be required for a 32-bed facility, which according to BHD could be reduced substantially (by about 21% when compared to our Model 1 staffing estimate), but not by a percentage that is equivalent to the reduction in bed capacity. In addition, we see that important indirect cost areas would not see substantial reductions, and that annual patient revenues would decline substantially, reducing expenditure savings.

Model #3 – 16 Acute Adult Inpatient Beds

This scenario explores the fiscal impacts of a scenario in which BHD's acute adult inpatient beds are reduced from 60 to 16. Again, we assume that PCS remains at status quo (i.e. utilization and staffing at PCS remain at 2015 levels).

Staffing Projection

Tables 14 and 15 show FTE projections for direct and indirect cost areas under the 16-bed model. These projections again were developed by BHD based on their estimate of staffing needs for a 16-bed facility. Here, we see a decline of an additional 56.5 direct FTEs (27%) from Model 2, and a reduction of about seven indirect FTEs (7%). The relatively small reduction in indirect FTEs reflects the fact that a certain level of administrative staffing is required to support PCS operations irrespective of the Mental Health Complex's bed capacity.

Model 3 would produce a net savings of $8.8 million for community reinvestment when compared to the 2015 budget. Whether this amount is sufficient to offset the impacts of a 44-bed reduction in adult inpatient capacity would hinge on factors such as the willingness of private health systems to enhance their inpatient bed capacity and the effectiveness of community-based services in decreasing demand for inpatient care. Meanwhile, the cost per bed under this scenario is almost $1 million on an annual basis. Hence, if BHD wishes to pursue this alternative, then it would appear to make sense to explore whether there are other providers that could operate a 16-bed facility less expensively, or whether BHD could reduce its costs at a different location or under a different administrative structure.

Table 14: Model 3 Direct Staffing FTEs

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)	2017 Projected (Model 3)
Adult Inpatient	175.20	175.20	119.10	63.90
Rehab Central	51.30	-	-	-
Hilltop	0.00	-	-	-
PCS	82.20	82.20	82.20	82.20
Hospital Support	11.10	9.80	8.50	7.20
Total Direct	**319.80**	**267.20**	**209.80**	**153.30**

Table 15: Model 3 Indirect Staffing FTEs

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)	2017 Projected (Model 3)
Facilities	16.0	14.9	13.4	13.4
Hosp Admin	70.6	62.0	50.6	44.8
Genl Admin	43.4	40.7	38.3	37.4
Total Indirect	**129.9**	**117.6**	**102.3**	**95.5**
Total Allocated to MH Complex	**92.6**	**78.8**	**64.4**	**57.3**

Expenditure Projection

Using these staffing projections and the assumptions used in earlier models regarding salaries and benefits and other costs, we can calculate projected direct and indirect expenditures under the 16-bed scenario. **Figure 30** shows that direct expenditures would be reduced by $9.7 million, and **Table 16** shows that indirect expenses would decline by $3.1.million, when compared to 2015 budgeted amounts.

Figure 30: Model 3 Projection of Direct Expenditures

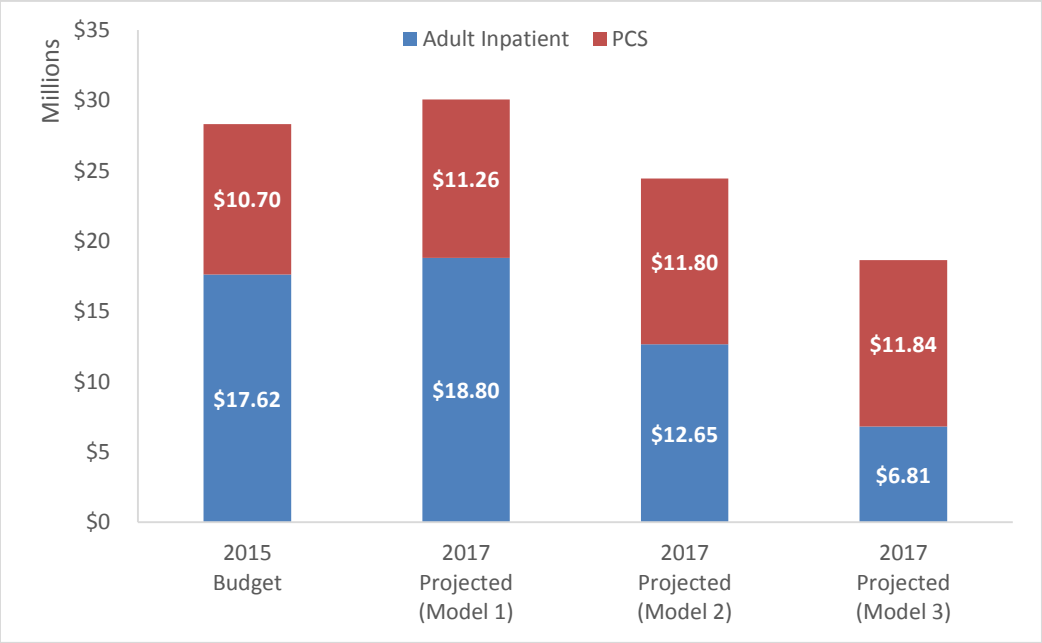


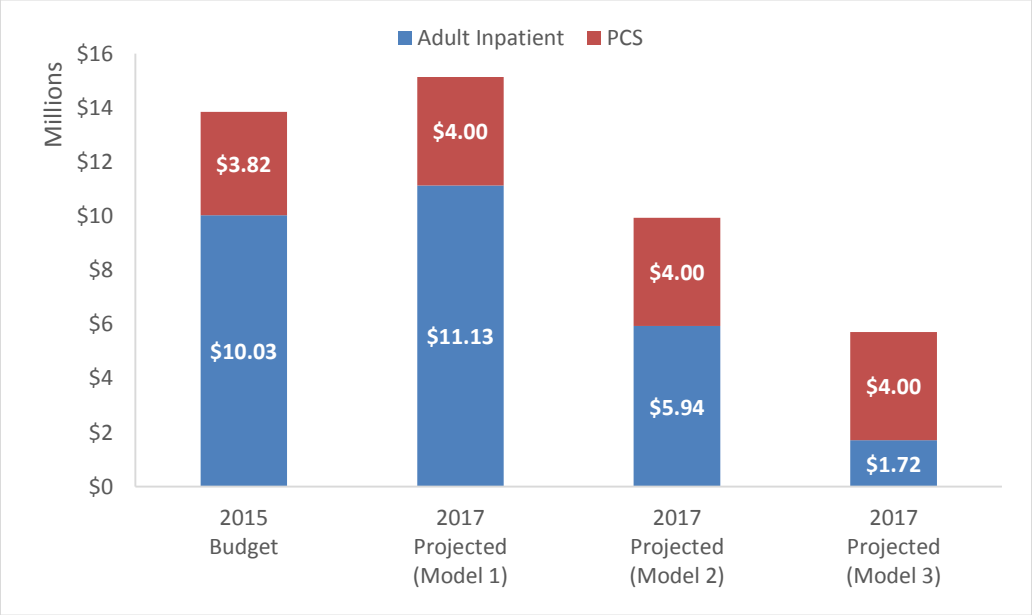
Table 16: Model 3 Projection of Indirect Expenditures

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)	2017 Projected (Model 3)
Adult Inpatient				
Indirect Orgs	$9,634,061	$11,028,534	$9,181,110	$8,034,368
Legacy	$3,372,550	$3,717,635	$3,122,890	$2,563,788
Total Indirect	$13,006,611	$14,746,169	$12,304,000	$10,571,155
PCS				
Indirect Orgs	$4,679,697	$5,332,534	$4,330,559	$3,847,711
Legacy	$1,925,382	$2,110,876	$2,110,876	$2,110,876
Total Indirect	$6,605,079	$7,443,410	$6,441,435	$5,958,587
Total Mental Health Complex	**$19,611,690**	**$22,189,579**	**$18,745,435**	**$16,529,742**

Revenue Projection

Our revenue projection for a 16-bed adult inpatient facility again was developed by BHD staff, while we again assume a revenue increase of 5% for PCS. As shown in **Figure 31**, total revenues for the two service areas are projected to decrease by about $8.2 million in comparison with the 2015 budget. The substantial (82%) decrease in adult inpatient revenues – which are projected to total only $1.7 million in 2017 for a 16-bed facility – stems from BHD's analysis of its current patient mix and its assumption that a 16-bed publicly administered facility would need to be largely reserved for patients with no insurance coverage. This, of course, is an important assumption that will significantly impact decision-making on the viability of a 16-bed facility.[17]

Figure 31 - Model 3 Projection of Mental Health Complex Revenues



Projection of 2017 Property Tax Levy/BCA and Savings Available for Reinvestment

In **Table 17**, we combine our expenditure and revenue projections to develop an estimate of total property tax levy/BCA required to support the Mental Health Complex for the 16-bed adult inpatient scenario. We find that for the two remaining service areas combined, there is a $4.6 million savings when compared to the 2015 budget. This represents a savings of 13% from a 73% reduction in adult inpatient bed capacity.

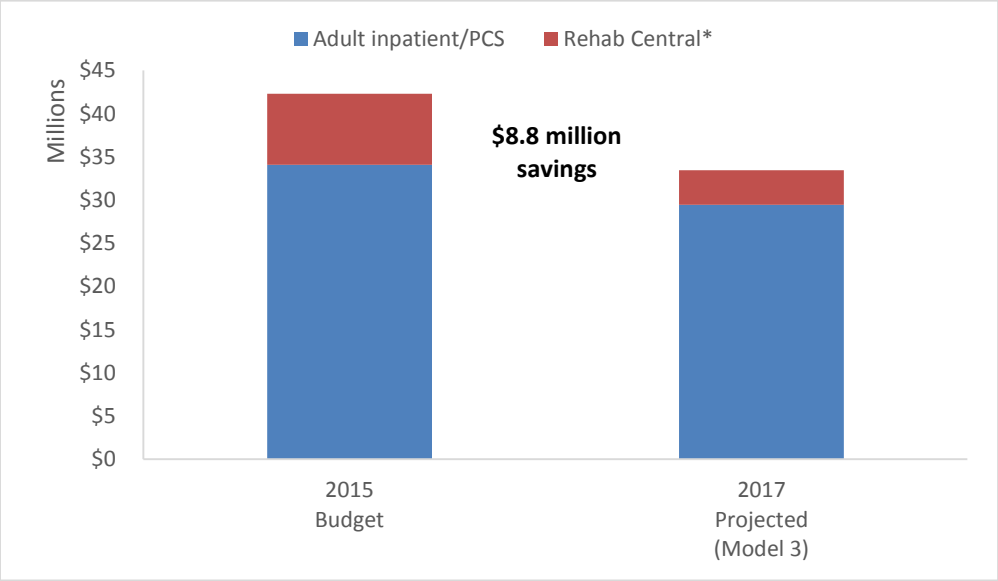
[17] The so-called "IMD exclusion" that prevents BHD from receiving Medicaid reimbursement for inpatient services provided to certain Medicaid-eligible individuals between the ages of 21 and 64 likely would be lifted under this model, as it only applies to facilities with more than 16 beds. However, because it is assumed that the facility largely would serve uninsured individuals, BHD would not benefit significantly from this circumstance.

Table 17: Model 3 Projection of Mental Health Complex Levy/BCA

	2015 Budget	2017 Projected (Model 1)	2017 Projected (Model 2)	2017 Projected (Model 3)
Adult Inpatient				
Direct Expense	$17,621,326	$18,795,149	$12,653,047	$6,809,298
Indirect Expense	$13,006,611	$14,746,169	$12,304,000	$10,571,155
Total Expense	$30,627,937	$33,541,318	$24,957,048	$17,380,453
Revenue	$10,029,584	$11,133,670	$5,937,957	$1,717,233
Levy	$20,598,353	$22,407,648	$19,019,090	$15,663,220
PCS				
Direct Expense	$10,704,871	$11,262,154	$11,800,047	$11,837,940
Indirect Expense	$6,605,079	$7,443,410	$6,441,435	$5,958,587
Total Expense	$17,309,950	$18,705,564	$18,241,482	$17,796,527
Revenue	$3,822,627	$4,002,661	$4,002,661	$4,002,661
Levy	$13,487,323	$14,702,903	$14,238,821	$13,793,866
Total Mental Health Complex	**$34,085,676**	**$37,110,551**	**$33,257,911**	**$29,457,086**

The projected $4.6 million savings in levy/BCA requirements for remaining Mental Health Complex operations does not take into account the net estimated levy/BCA savings of $4.2 million in the 2017 budget from the closure of Rehab Central. As shown in **Figure 32**, when we factor in that savings, our modeling suggests ***that about $8.8 million in levy "savings" would be available to BHD in 2017 for reinvestment in community-based services*** under our Model 3 scenario of 16 adult inpatient beds.

Figure 32: Model 3 Projection of Net Mental Health Complex Levy/BCA Savings



* While Rehab Central will be closed in 2017, we still show a Rehab Central expenditure in this figure. This is attributed to $4 million in needed BCA/levy expenditures to support Rehab Central clients in community settings and to pay remaining legacy costs.

Summary of Model 3 Fiscal Impact

Our modeling indicates that a reduction of adult inpatient beds from 60 to 16 – combined with the impacts of PCS' cost to continue existing levels of service and the closure of Rehab Central – would produce a net savings of $8.8 million for community reinvestment when compared to the 2015 budget. Whether this amount is sufficient to justify a bed reduction of that magnitude is difficult to determine.

We are not in a position to comment on the efficacy of such a scenario from the standpoint of countywide inpatient bed capacity, as that analysis would hinge on factors such as the willingness of private health systems to enhance their inpatient bed capacity and the effectiveness of community-based services in decreasing demand for inpatient care. Similarly, because we are unable to determine whether the County would be able to reinvest most or all of the $8.8 million in community-based mental health services (as opposed to using some of these savings for other countywide needs), and precisely how it would do so, we cannot speculate on the programmatic and clinical impacts that would be associated with such a decision.

From a financial standpoint, while Model 3 at first glance seems like an attractive option, it is important to recognize that the levy/BCA cost under this option is almost $1 million per bed on an annual basis, as shown in **Figure 33**.

Figure 33: Levy/BCA Cost per Adult Inpatient Bed Under Different Bed Capacity Scenarios

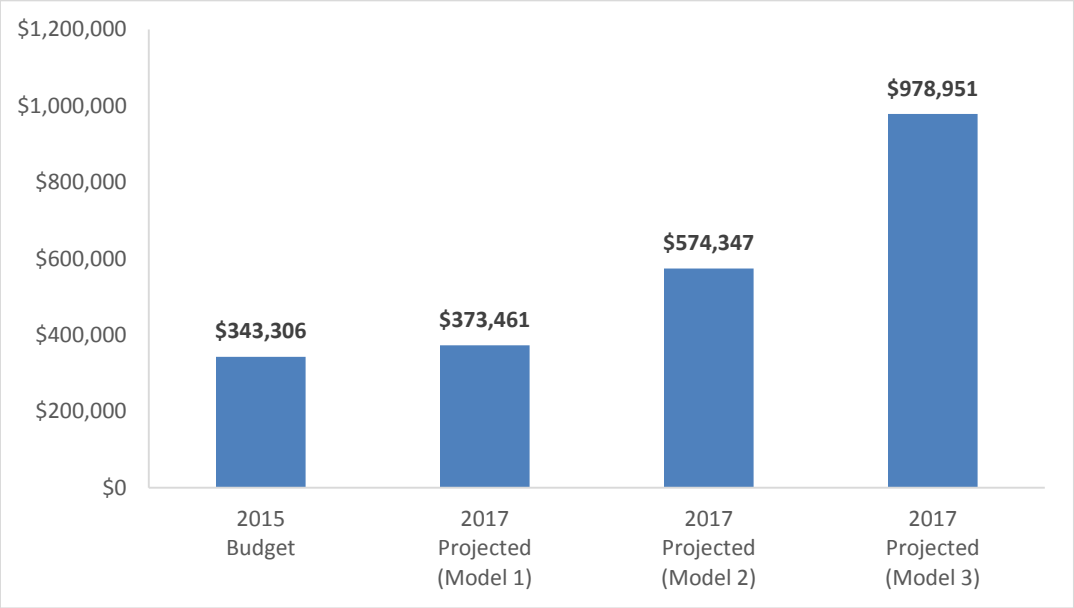


Figure 33 brings up an important set of questions for BHD, the Mental Health Board, and other providers of inpatient mental health services in Milwaukee County. For example, if there is a determination that BHD can and should reduce its inpatient bed capacity, then it would appear to make sense to explore whether there are other providers that could make available 32 beds at less than $575,000 per bed in local subsidy, or operate a 16-bed facility for less than $975,000 per

bed.[18] On the other hand, these numbers could lead some to argue that if BHD plans to retain an adult inpatient facility, then economies of scale might dictate that it pursue a larger facility that can spread indirect costs across a larger number of revenue-producing beds and hold down per-bed costs.

An additional set of questions revolves around the current Mental Health Complex facility, and whether the approximately $6.5 million in annual facility costs could be dramatically reduced at a different location. If that is the case, then the reduced bed capacity scenarios may produce greater financial benefits. It is also important to note, however, that capital expenditures have not been considered in our analysis, and that the fiscal impacts associated with building a new facility, demolishing the existing facility and selling the land on which it is located, and repairing and improving the existing facility if BHD should remain there would need to be thoroughly explored under any of our models.

Again, we cannot answer these questions. Our modeling suggests, however, that if the County is interested in exploring a scenario in which it operates only a small number of adult inpatient beds for highly acute and uninsured patients, then those beds may turn out to be very expensive to operate on a per-bed basis. Consequently, if that is the path it takes, then it may wish to consider a different governance and administrative structure for doing so.

[18] It should be noted that if BHD contracts with a private provider for inpatient services, then certain indirect costs (e.g. legacy costs and central service allotments) that are currently allocated to adult inpatient would be reallocated to PCS and other County departments, thus increasing expenditures in those areas.

Conclusion

This report was designed to provide Milwaukee County and its Mental Health Board with a detailed analysis of Mental Health Complex finances that would 1) shed light on the true fiscal impacts of recent and potential future bed reductions; and 2) provide insight into the resources that might be available as a result of such reductions for reinvestment in community-based services. Annual County budget documents have provided limited perspective on those questions by showing property tax levy trend information for the different BHD functional areas. Our analysis provides a far more complete and accurate picture by disaggregating direct and indirect cost centers and more accurately distinguishing between hospital-based elements of BHD's budget and those that are community-based.

We began by examining financial trends from the 2010-2013 timeframe, which was the period of time in which BHD initiated various mental health redesign strategies aimed at moving toward a community-based system of care. During this period, patient bed days at the Mental Health Complex declined from 79,000 in 2010 to 62,000 in 2013. Our trend analysis revealed the following:

- While direct hospital-related expenditures at the Mental Health Complex decreased by $5.5 million (11%) – an amount that intuitively would appear to correlate with the decline in bed capacity – indirect costs unexpectedly increased by $2.5 million. To some degree, the increase in indirect costs was attributable to factors beyond BHD's control, such as the central budget office's determination of BHD's legacy costs, facility expenses, and charges from other departments. With regard to direct expenditures, we found that the decrease was linked largely to reduced fringe benefit costs associated with countywide health care and pension savings. Overall staffing levels remained largely the same despite the reduced patient volume, in part because of increased staffing levels at PCS.

- BHD was successful in enhancing patient revenues on a per-patient basis between 2010 and 2013, but the reduced patient census produced an overall net loss of about $3 million in patient revenue. Because that loss largely offset expenditure reductions, the County was unable to reduce its allocation of property tax levy/BCA to Mental Health Complex services.

- BHD was able to increase its investment in community-based services during the 2010-2013 timeframe, with expenditures growing by $3.9 million (12%). However, our analysis also showed that BHD's community services as a whole became more dependent on property tax levy/BCA, which increased by $6 million. Because levy/BCA savings did not materialize from Mental Health Complex downsizing, those additional resources came from other parts of county government and/or general increases in the tax levy.

Overall, our trend analysis found that a key objective of mental health redesign – to use inpatient and long-term care downsizing as a means of freeing up property tax resources to invest in community-based services – had not been achieved as of the end of 2013.

We then turned to the 2014 and 2015 budgets to determine whether any of the trends observed for the previous four years had reversed, and whether additional savings associated with continued Mental Health Complex downsizing in those years were being generated for reinvestment in community-based services. The 2014 and 2015 budgets were characterized by even greater downsizing than had occurred the previous four years, as Hilltop was projected to close by the end of 2014 and Rehab Central by the end of 2015.

We found that the financial benefits associated with these sharper declines in patient census had indeed become more pronounced. For example, levy/BCA expenditures for Mental Health Complex service areas were budgeted to fall by about $7 million (14%) when compared with 2013 actual amounts. However, these levy savings still were restrained by BHD's inability to substantially reduce indirect costs, which were projected to decline by only 4%; and by substantial budgeted reductions in patient revenue in conjunction with the reduced census. We also observed that increased staffing and expenditure levels at PCS continued to partially offset inpatient and long-term care savings.

Finally, when we conducted financial modeling to estimate the financial impacts of three adult inpatient bed scenarios, we again observed the following dynamics first revealed by our trend analysis:

- The Mental Health Complex's indirect costs are only loosely linked to its bed capacity, and this factor will continue to curtail overall savings amounts that can be achieved with future downsizing initiatives.

- Because key components of BHD's indirect cost structure are linked to its existing facility and its treatment as a regular department of Milwaukee County government, there is little it can do to reduce indirect costs without changes to those two circumstances.

- While BHD can continue to generate sizable direct cost savings from additional reductions in adult inpatient bed capacity, the direct cost pressures associated with continued operation of PCS at its existing capacity will erode those savings and reduce the amounts available for community reinvestment.

Despite these obstacles, our modeling showed that BHD could generate a $5 million levy/BCA savings in 2017 (when compared to the 2015 budget) by downsizing to 32 adult inpatient beds, and an $8.8 million savings by downsizing to 16 adult inpatient beds, when cost savings from the closure of Rehab Central also are included. Should BHD and Mental Health Board leaders wish to pursue either of those alternatives, an important next step would be to determine the types and scope of enhanced community-based services that might be implemented with those savings amounts. Such an exercise would allow those with programmatic and clinical expertise to determine whether such enhancements would be sufficient to appropriately mitigate the impacts of reduced inpatient bed capacity, and to create the robust set of community-based services envisioned as part of the mental health redesign planning process.

From a narrower fiscal lens, the findings of our modeling and trend analysis lead us to the following concluding observations:

- **Milwaukee County leaders should contemplate a new financial structure for the Mental Health Complex that sets it apart from the rest of Milwaukee County government.**

  As long as the Mental Health Complex continues to be subject to crosscharges from other County departments and central service allocations and legacy charges from the central budget office, it is likely to receive only limited benefit from bed capacity and associated staffing reductions. This problem is partially attributed to the fact that these allocations and charges do not directly reflect the changes that are occurring at the Complex, though it also is attributed to the complicated manner in which BHD must allocate such centralized charges across its various functions.

An argument could be made that in light of BHD's new governance structure created by Wisconsin Act 203, additional steps should be taken to segregate its finances from the rest of Milwaukee County government, or to remove it entirely from the auspices of Milwaukee County and place it under a separate mental health district or authority. This approach could be pursued for all of BHD, or solely for the Mental Health Complex, with other functions remaining under the County's health and human services department.

Under such an approach, BHD could purchase administrative, legal, facilities, and other overhead services from the County or outside entities, and be billed for such services based on their actual cost. Similarly, legacy costs could be allocated based on actual BHD retirees, as opposed to a general allocation based on the size of its active workforce.

It is unclear whether these steps would produce savings for BHD or its Mental Health Complex functions, and it is likely that they would produce negative fiscal impacts for the rest of county government. However, forming a new financial structure for the Mental Health Complex that segregates its actual cost of doing business at least would ensure that decision-making regarding bed capacity is not skewed by an indirect cost structure that has limited linkage with actual activity.

Should this approach prove unworkable from an accounting, legal, or logistical perspective, then the Milwaukee County budget office and BHD at least should consider reforming internal budgeting and accounting practices to better isolate costs and revenues associated with BHD's various service areas. The new Mental Health Board needs accurate, service-level fiscal data to gauge bed capacity and community investment options going forward. Unfortunately, the current fiscal framework does not lend itself to that type of information gathering and sharing.

- **Milwaukee County and State of Wisconsin leaders need to work jointly to address BHD's facility needs and questions.**

Our analysis confirms what Milwaukee County leaders have known for quite some time: that facility costs at the existing facility are influenced most prominently not by the amount of square footage that BHD occupies for its hospital-related operations, but instead by the continued need to service and maintain the entire sprawling Mental Health Complex, and by cost factors associated with its use of County facilities staff to do so.

We are unable to determine whether the more than $6 million charged annually to the Mental Health Complex service areas for facilities costs is a reasonable amount and how that might compare to similar costs at a different facility. That question should be analyzed as part of the County's ongoing space planning activities and/or by BHD staff. What is crystal clear, however, is that the facilities savings that ostensibly should be available from a substantial reduction in bed capacity will not materialize at the existing Mental Health Complex location.

An equally important question emerges regarding the future capital needs of the Mental Health Complex and how those will be treated under the budget framework created by Wisconsin Act 203. BHD officials have cited millions of dollars of needed repairs at the existing Complex, which have been deferred pending consideration of a possible new facility. If BHD stays put, then those needs will need to be addressed, but it is unclear how that would occur.

Capital and debt service costs are not included in BHD's budget and are not subject to the fiscal parameters created by Wisconsin Act 203. Furthermore, the Mental Health Board does not have any direct bonding authority. Consequently, any major capital repairs or improvements at the Mental Health Complex that involve County bonding would need to be approved by the County Board, and would need to compete with other daunting capital needs faced by the County. The same holds true for any capital investment in a new facility that would involve County bonding.

This paradigm poses several questions, including the following:

- What if County Board leaders disagree with BHD or the Mental Health Board in terms of a facility plan, or if the County is otherwise unable or unwilling to dedicate bond proceeds for capital repairs or a new facility?

- Would BHD have the capacity to "cash finance" its capital needs, either through its regular operating budget or reserves, and how would that play into other budget considerations and the tax levy restrictions contained in Act 203?

- Would a facility lease be a better option than owning a building in light of these questions?

- Are there other ways to finance capital repairs or a new facility outside of the use of County borrowing (e.g. state or private sector financing that would be repaid by BHD as part of its operating budget)?

- Might the cost of constructing a new facility be accommodated in any financial arrangement involving the sale of the existing property?

Given that these questions are linked to state legislation as well as County concerns, it would be logical for policymakers from both governments to be engaged in identifying answers.

- **The future size, mission, and location of PCS will be central to any decision-making regarding adult inpatient bed capacity and a potential new facility.**

An often overlooked issue in BHD's consideration of its optimal inpatient capacity and the possible construction of a new facility is the future size, scope, and operation of PCS. Our analysis has shown that as long as PCS maintains its approximate current patient volume and staffing, then its costs are likely to continue to grow with inflation, thus partially offsetting any savings accrued from inpatient downsizing. In addition, it will continue to demand substantial physical space, administrative overhead, and other indirect components that comprise a significant portion of the Mental Health Complex's financial and physical structure.

In determining possible downsizing options and the size and location of a new facility, therefore, County and Mental Health Board leaders also should be considering how PCS will function in the future. While county government is statutorily mandated to ensure the provision of emergency mental health services in Milwaukee County, it is not required to provide those services itself, nor to provide them at one location or as part of a larger inpatient facility. It is possible, for example, that the County could consider the development of multiple smaller mental health emergency/crisis services within the community, or that it could contract with a private provider to provide those services at new or existing facilities. A consideration that would relate to either

of those options is whether 18 observation beds currently housed at PCS would need to be retained at the site of inpatient units.

Conversely, if a determination is made that the existing PCS service model should be continued, then that needs to be factored into the fiscal analysis of various inpatient bed capacity scenarios. It is possible, for example, that a decision to maintain PCS in its current form will steer policymakers toward consideration of a larger inpatient bed capacity scenario given that certain direct and indirect costs associated with additional beds could be shared and spread across a larger emergency room facility.

- **BHD should develop effective and transparent ways to measure the impacts of its community investments on inpatient and PCS demand and to track and project community-based service costs.**

  In an analysis of mental health inpatient bed capacity released by the Forum and Human Services Research Institute in September 2014,[19] we recommended that BHD should "identify performance metrics to evaluate whether the (community-based) services that individuals are receiving are having a desired impact on hospitalizations and other recovery-oriented outcomes." We reiterate that recommendation here in light of the findings of our fiscal modeling.

  It will be tempting, for example, to view an opportunity to generate almost $9 million in annual savings from a reduction to 16 beds as too promising to ignore, and to simply assume that by reinvesting those dollars in community-based services an appropriate balance of services can be created. We would caution, however, that the ability to safely downsize in such a substantial manner will be predicated on whether community-based investments truly decrease demand for inpatient care, and that a performance measurement system must be developed to provide insight into that question before such downsizing can occur.

  We would make a similar point on the fiscal side of the community-based services equation. The expansion of CCS and CRS and the implementation of other community-based service enhancements still are in their early stages. Yet, BHD still does not possess (at least to our knowledge) the financial data collection and reporting mechanisms that will be needed to appropriately model future year community-based expenditures and revenues and guide decision-making on future investment options. Developing such mechanisms should be an immediate priority for BHD staff.

- **BHD needs more detailed analysis of its revenue structure and revenue opportunities to guide bed capacity decisions.**

  While BHD has made great progress in implementing a new electronic medical records system and improving its revenue collection practices, we observe that it would benefit from greater capacity to analyze and respond to revenue trends on a timely basis, and to develop the type of sophisticated revenue profiles and projections that should be a central part of decision-making on bed capacity options. BHD also would benefit from additional expertise on Medicaid and

[19] This report can be accessed at http://publicpolicyforum.org/sites/default/files/MilwaukeeInpatientCapacity.pdf.

Affordable Care Act issues and opportunities to help it appropriately gauge the impacts of major changes in its service design and delivery.

As shown in our modeling, the mix of insured and uninsured patients under different bed capacity scenarios – as well as the types of insurance coverage these patients possess and anticipated reimbursement rates – will have a huge financial impact and must be carefully examined during upcoming discussions about the future size and location of the Mental Health Complex. While our modeling used recent revenue trends to broadly estimate projected revenues under the various scenarios, the fact that BHD only recently converted to an electronic medical records system precluded our ability to access the types of information that would have allowed for more sophisticated analysis. Furthermore, we were unable to ascertain where future opportunities might exist to grow revenue streams under different capacity scenarios.

Consequently, we would suggest that BHD and the Mental Health Board consider options for developing the capacity to better monitor and analyze BHD's revenue performance, and to produce the types of revenue profiles and analyses that will be critical to determining the pros and cons of different bed capacity options. While outside consulting expertise may be required for such a task, it is also possible that this type of expertise could be built within BHD, or that it exists within organizations affiliated with current Mental Health Board members and could be secured on an in-kind basis.

Appendix A – Crosswalk from BHD Indirect areas to PPF Analysis Indirect Categories

			Functional Indirect Cost Categories			
			General Admin	Hospital Admin	Hospital Support	Facilities
6312	CENTRAL ADMINISTRATION	MANAGEMENT	6312	0		
6313	CLINICAL COMPLIANCE	MANAGEMENT		6313		
6323	PSYCHIATRY ADMINISTRATION	MANAGEMENT		6323		
6324	PSYCHOLOGY ADMINISTRATION	MANAGEMENT		6324		
6325	NURSING ADMINISTRATION	MANAGEMENT		6325		
6326	SOCIAL SERVICES ADMINISTRATION	MANAGEMENT		6326		
6328	PROFESSIONAL EDUC-PSYCHCHIATRY	MANAGEMENT		6328		
6332	ORGANIZATIONAL DEV ADMIN	MANAGEMENT	6332			
6333	PERSONNAL AND PAYROLL	MANAGEMENT	6333			
6334	QUALITY MANAGEMENT	MANAGEMENT		6334		
6336	EDUCATION	MANAGEMENT		6336		
6503	SECURITY	OPERATIONS			6503	
6504	LEGAL SERVICES	OPERATIONS	6504			
6512	SUPPORT SERV ADMIN	OPERATIONS			6512	
6513	DIETARY	OPERATIONS			6513	
6514	STOREROOM	OPERATIONS			6514	
6515	PHARMACY	OPERATIONS			6515	
6516	CLERICAL POOL	OPERATIONS	6516			
6532	FACILITIES MAIN ADMIN	OPERATIONS				6532
6533	FACLT MAINT-MAIN BLD	OPERATIONS				6533
6535	HOUSEKEEPING	OPERATIONS			6535	
6536	LINEN	OPERATIONS			6536	
6537	FACILITY MAINT--DAY HOSP	OPERATIONS				6537
6552	FISCAL ADMIN	FISCAL	6552			
6553	FISCAL SERVICES	FISCAL	6553			
6554	ACCOUNTS RECEIVABLE	FISCAL	6554			
6555	ADMISSIONS	FISCAL		6555		
6556	MANAGEMENT INFORMATION	FISCAL	6556			
6557	MEDICAL RECORDS	FISCAL		6557		
6558	STAFFING OFFICE	FISCAL		6558		

Appendix B – Fiscal Trends by Service Area

To provide further insight into the fiscal performance of Milwaukee County's Mental Health Complex during the 2010-2013 timeframe, we examined the four service areas independently.

In the first set of figures below, we show percentage changes in total expenditures, direct expenditures, and indirect expenditures for each of the service areas, and also compare those to the percentage change in patient census. It is notable that while each of the service areas experienced a decline in patient activity, direct expenditures declined for only three of the four service areas; at PCS, they increased by 7%. It is also notable that indirect expenditures increased for each of the four service areas despite the decrease in patient census.

Figure B1: Percentage change in census and total expenditures for Mental Health Complex Service areas, 2010-2013

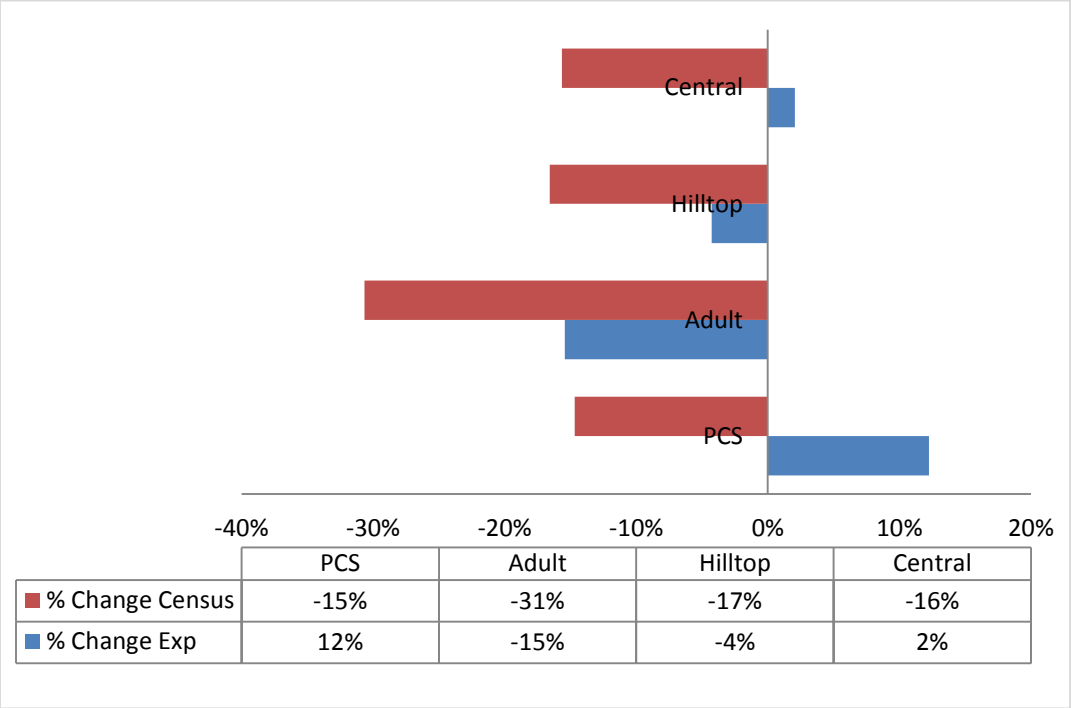


Figure B2: Percentage change in census and direct expenditures for Mental Health Complex Service areas, 2010-2013

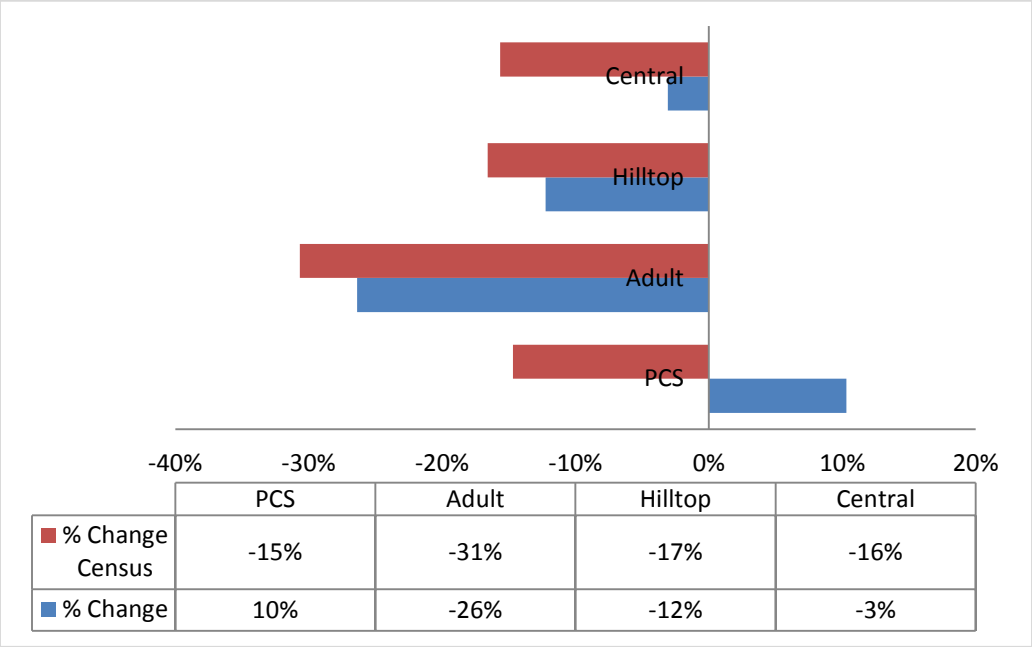
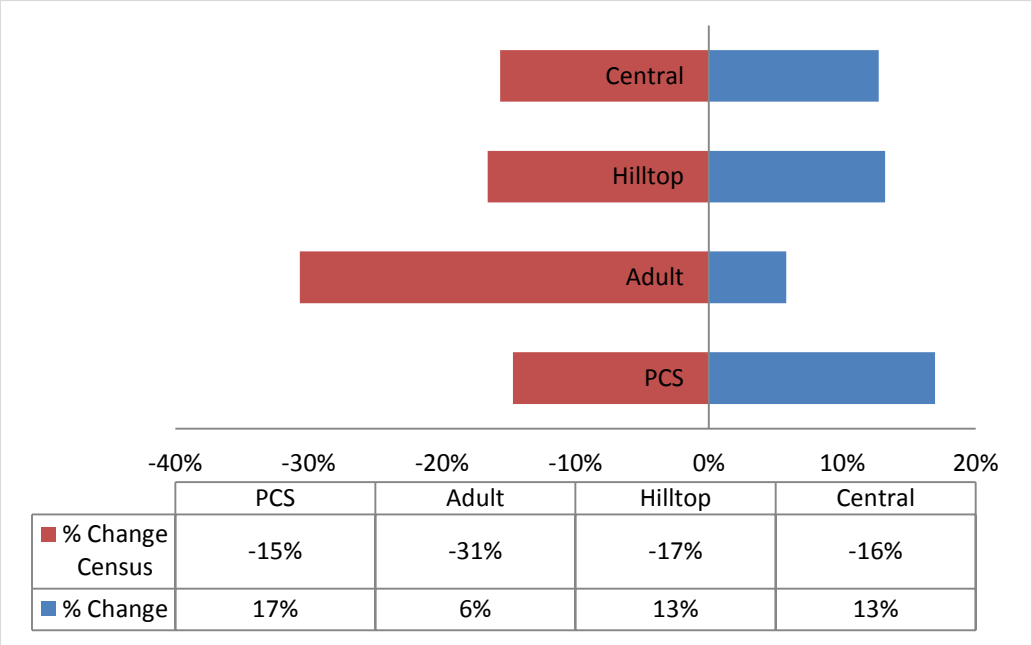


Figure B3: Percentage change in census and indirect expenditures for Mental Health Complex Service areas, 2010-2013



Adult Inpatient

Adult inpatient had the largest decline in patient census of the four areas. We see in **Table B1** that direct expenditures declined by 26%, which tracked pretty closely to the decline in patient census, although indirect expenditures grew by 6%. The number of FTEs[20] allocated to adult inpatient decreased by 18, from 190 to 172. Other areas of savings included commodities accounts (primarily drug expenses), which decreased by $1.3 million, and hospital support, which fell by almost $600,000.

Table B1: General Financial Data, Adult Inpatient

	2010	2013	% Change
Patient Days	30,805	21,363	-31%
Direct FTE	190	172	-10%
Total Expense	$32,549,926	$28,278,567	-15%
Direct Expense	$21,183,365	$16,251,914	-26%
Indirect Expense	$11,366,561	$12,026,653	6%
Net Pt Revenue	($9,827,383)	($8,028,890)	-18%
BCA/Levy	($22,721,695)	($20,249,677)	-14%

On the revenue side, as shown in **Table B2**, NPR per patient day increased from $319 to $376, thus softening the impact of the decline in patient census. In fact, shrinking costs exceeded the decline in net patient revenue, allowing for levy/BCA savings of $3.4 million in this service area.

Table B2: Financial Indicators, Adult Inpatient

	2010	2013
Expense/Patient Day	$1,056.64	$1,323.72
NPR/Patient Day	($319.02)	($375.83)
Recovery Rate	30%	28%

Rehab Central

Table B3 shows that although census declined at Rehab Central, total operating expenses increased slightly. This was caused, at least in part, by an increase in the number of FTEs during the study period from 82 to 90. Rehab Central did experience reduced costs for drugs and hospital support, but increasing indirect costs overrode those savings.

[20] FTEs were determined by dividing the average budgeted salary into actual salary and overtime expenses for the year. Actual expenses take into account labor transfers, vacancies and overtime and are a better indicator of labor costs than budgeted salary amounts.

Table B3: General Financial Data, Rehab Central

	2010	2013	% Change
Patient Days	24,301	20,497	-16%
Direct FTE	82	90	9%
Total Expense	$13,297,803	$13,570,590	2%
Direct Expense	$8,985,333	$8,709,330	-3%
Indirect Expense	$4,312,470	$4,861,260	13%
Net Pt Revenue	($3,246,863)	($2,507,776)	-23%
BCA/Levy	($9,399,738)	($10,321,873)	13%

On the revenue side, we see in **Table B3** and **Table B4** that total NPR declined by 23%, while on a per patient basis it also declined by 9%. As a result, levy/BCA increased by 13% to compensate for the slight increase in total expenses and a reduction in NPR. The reduction in revenue is also quite noticeable in terms of the recovery rate, or the percentage of expense offset by NPR. This declined from 24% to 18% between 2010 and 2013.

Table B4: Financial Indicators, Rehab Central

	2010	2013
Expense/Patient Day	$547.21	$662.08
NPR/Patient Day	($133.61)	($122.35)
Recovery Rate	24%	18%

Hilltop

While the patient census at Hilltop declined by roughly the same amount as that of Rehab Central during the 2010-2013 timeframe, BHD reduced actual FTEs at Hilltop, generating a decrease in direct expenditures, as shown in **Table B5**. Hospital support expenditures also decreased by almost $500,000. Even with an increase in indirect expenditures, total expenditures at Hilltop declined by 4%.

Table B5: General Financial Data, Hilltop

	2010	2013	% Change
Change in Census	23,797	19,853	-17%
Direct FTE	98	87	-11%
Total Expense	$15,414,912	$14,757,769	-4%
Direct Expense	$10,585,414	$9,289,878	-12%
Indirect Expense	$4,829,498	$5,467,891	13%
Net Pt Revenue	($5,399,802)	($5,196,950)	-4%
BCA/Levy	($9,469,790)	($8,972,607)	-5%

Net patient revenue on a per patient basis also increased by 15% at Hilltop, as shown in **Table B6**, from $227 in 2010 to $262 in 2013. The combination of a decrease in total expenditures and an increase in per capita revenues generated a 5% savings in levy/BCA.

Table B6: Financial Indicators, Hilltop

	2010	2013
Expense/Pt Day	$647.77	$743.35
NPR/Pt Day	($226.91)	($261.77)
Recovery Rate	35%	35%

PCS[21]

Although admissions dropped during the study period, FTEs at PCS increased by 15 positions, from 59 to 74. As shown in **Table B7**, this led to a 10% increase in direct expenditures, coupled with the overall increasing trend in indirect costs.

Table B7: General Financial Data, Crisis Services

	2010	2013	% Change
ER Admissions	13,438	11,464	-15%
ER/Obs only	59	74	31%
Total Expense	$13,206,590	$14,823,123	12%
Direct Expense	$9,367,509	$10,333,414	10%
Indirect Expense	$3,839,081	$4,489,709	17%
Net Pt Revenue	($4,510,159)	($4,296,588)	-5%
BCA/Levy	($7,885,963)	($10,270,986)	30%

Net patient revenue also declined by 5% at, PCS during the period. Consequently, levy/BCA invested in PCS grew by 30%, offsetting the savings experienced in other areas.

Table B8: Financial Indicators, Crisis Services

	2010	2013
Expense/Pt Day	982.78	1,293.01
NPR/Pt Day	($335.63)	($374.79)
Recovery Rate	34%	29%

[21] For purposes of this analysis, between 23% and 27% of total PCS expense was determined to be properly categorized as community-based services, rather than inpatient services. These include purchase of service contracts that are budgeted in PCS and expenses relating to the Mobile Treatment Team and Outpatient Clinic. BHD reported that these services are entirely funded with levy.

MILWAUKEE COUNTY MENTAL HEALTH BOARD FINANCE COMMITTEE

PUBLIC FINANCING OVERVIEW

PROCESS

What authority does the Milwaukee County Mental Health Board (MCMHB) have over its Budget under Act 203?

MCMHB'S GENERAL MANDATE

MCMHB shall:

- **Oversee the provision of mental health programs and services in Milwaukee County;**
- **Budget and allocate monies for those programs and services;**
- **Attempt to achieve cost savings.**

MCMHB'S SPECIFIC MANDATE

- MCMHB shall *propose* a budget to the CEX that shall include the total amount of:
  - mental health budget (patient revenues, and all other sources, such as grants, private contributions, gifts, bequests, etc.);
  - community aids amount;
  - tax levy amount.
- MCMHB may not *propose* a tax levy amount that is less than $53,000,000 or more than $65,000,000.

CEX NOT REQUIRED TO FOLLOW MCMHB TAX LEVY AMOUNT RECOMMENDATION

CEX in proposed budget *may* include a *different* tax levy amount than that proposed by the MCMHB.

BUT

But not a tax levy amount less or more than the $53,000,000/$65,000,000 floor/ceiling.

UNLESS

- MCMHB transfers jurisdiction over a County function, service, or program to itself related to mental health or highly integrated with mental health services, not under its jurisdiction by statute (so not under org unit 6300 or 8700) by an affirmative vote of majority of MCMHB and Milwaukee County Board.

Or

- Majority of the MCMHB and Milwaukee County Board approve, and CEX agrees, that the tax levy amount may be less than $53,000,000 or more than $65,000,000 for a fiscal year.

IF SO

- If the MCMHB so transfers such a function, service, or program, the tax levy amount for mental health is increased by amount equal to amount from tax levy expended by county on that function, service, or program in fiscal year preceding fiscal year in which transferred.
- $65 million ceiling may be exceeded by this amount in any year that MCMHB has jurisdiction over transferred function, service, program.

COUNTY BOARD'S ROLE RE MENTAL HEALTH BUDGET

County Board shall *incorporate* into mental health budget:

- **Tax levy amount proposed by CEX (after CEX takes into consideration tax levy amount proposed by MCMHB*);***
- **Amount of community aids allocation;**
- **All other amounts proposed by MCMHB that are *not* tax levy funds *or* community aids funds (i.e, patient revenues, and other sources, such as grants, private contributions, gifts, and bequests).**

COMMUNITY AIDS ALLOCATION

Amount from county's community aids allocation is the amount received by Milwaukee County Board under s. 46.40 that maintains or increases the expenditures for mental health functions, programs, and services paid from county's community aids allocation in previous fiscal year to extent of the availability of community aids funds from the state.

BUILDING RESERVE FUND

Capital Reserve

- MCMHB shall ensure the maintenance, as a segregated cash reserve, of an annual charge of 2% of the original cost of new construction or purchase or of the appraised value of buildings of existing mental health hospital structures and equipment.
- If the hospital or any of its equipment is replaced, any net cost of replacement in excess of the original cost is subject to an annual charge of 2%.
- MCMHB may require appropriation from reserve sums for the enlargement, modernization, or replacement of a mental health "infirmary" and its equipment.

OPERATIONAL RESERVE FUND

Milwaukee County Treasurer must hold any funds budgeted for mental health functions, programs, services, not encumbered/expended by end of fiscal year, in reserve fund.

- **Reserve funds may be used at any time to cover mental health budget deficits.**
- **Reserve funds exceeding $10 million may be used at any time for any Milwaukee County mental health function, program, service.**
- **Reserves may not be all cash and could consist of account receivables.**

MENTAL HEALTH BOARD CAPITAL FUNDING

- How much does the County budget for mental health projects?
  - 2015 Capital Outlay: $603,750
  - 2015 Capital Improvement Budget : $90 million
- Who can request Capital Fund?
  - Any Milwaukee County department may request capital funding through a fund transfer. Requests for projects made through a fund transfer must identify a source of funds to pay for the project, such as a surplus in another project.

Q&A

Question: What is the MCMHB's role, if any, with determining a policy on reserves?

Answer: MCMHB should implement a process (including prioritization on use of funds) for BHD Administration to submit requests to use operational reserve funds in excess of $10 million, i.e, BHD Administration follows MCMHB protocol and approval for those expenditures.

Q&A

Question:

How should the Mental Health Board respond to major unexpected brick and mortar expenses given limited reserves?

Answer:

The Building Reserve Fund could be tapped as well as any funding exceeding $10 million in the Operational Reserve Fund (via a to-be-established procedure by MCMHB for such a disbursement).

Request capital funding from the Milwaukee County Board.

Q&A

Question:

- How would any new building for the hospital be financed?

Answer:

- MCMHB does not have direct bonding authority - cannot issue debt.
- The MCMHB could pay for capital projects from operating revenues or available reserves.
- The County Board could authorize bonding for mental health projects.
- CEX/Administration could lobby for legislation for MCMHB to issue bonds. (But no guaranteed future source from which to repay bonds other than annual operating levy).

COUNTY OF MILWAUKEE
Inter-Office Communication

DATE: April 6, 2015

TO: Pete Carlson, Chairperson, Milwaukee County Mental Health Board Finance Committee

FROM: Héctor Colón, Director, Department of Health and Human Services
Approved by Patricia Schroeder, Administrator, Behavioral Health Division

SUBJECT: Informational Report Regarding Impact of the 2015-2017 Governor's Budget

Issue

In early February, Gov. Scott Walker released his 2015-2017 State of Wisconsin Budget (submitted to the Wisconsin Legislature as Assembly Bill 21 & Senate Bill 21). Fiscal and program staff for the Behavioral Health Division (BHD) have reviewed the budget and identified potential risks and initiatives that could conceivably impact programs and services.

At this time, this initial assessment is based on staff interpretation of AB21, the Legislative Fiscal Bureau (LFB) Budget Summary, the "Budget and Brief" document and State Department of Health Services' summary of the budget. For many of these initiatives, additional information is needed in order to ascertain the full impact to BHD.

Discussion

Proposed Budget Impact on BHD's Programs and Services

The following are initiatives identified as potential impact and/or risk items for BHD:

Emergency Detentions (pg. 59 Governor's Budget and Brief/pg. 1732 of AB21) – Effective July 1, 2016, the budget bill provides for the same process for determining an emergency detention (ED) in Milwaukee County as is currently in place for the rest of the state. Presently, in Milwaukee County, a law enforcement officer signs a statement of emergency detention and transports the individual to BHD's Psychiatric Crisis Services (PCS) or medical emergency room (depending on the need for medical clearance of said patient), where the patient is given a psychiatric evaluation as to their disposition. If the patient is admitted, then the treatment director decides whether to supplement the current Emergency Detention with a Treatment Director's Supplement (TDS). By placing the TDS, the probable cause hearing is scheduled for 72 hours from the time of detention (not counting holidays/weekends).

Under the process followed by the rest of the state, unless a hearing is held, an individual cannot be detained by law enforcement or the facility for more than 72 hours after the individual is taken into custody.

The bill further requires that a psychiatrist, psychologist, or mental health professional perform the crisis assessment and agree to the detention.

The budget also allocates one-time funding of $1.5 million in 2015-2016 for this effort to be distributed by DHS as grants to counties. LFB's report indicates that the bill does not create specific requirements for the allocation of the funds or their use.

This funding is woefully insufficient to cover costs statewide and won't even come close to supporting the additional costs of conducting crisis assessments in Milwaukee County alone. BHD's Director of Crisis Services believes that the Crisis Mobile Team (CMT) would have to expand significantly to effectively implement the new process. The extent of this expansion will depend on whether this requirement will be that of a face-to-face assessment compared to a phone assessment (which is now done in most counties).

BHD estimates the cost of additional personnel, travel, space and other support between $2 and $2.5 million. This cost is a very rough estimate and assumes the face-to-face requirement. If the new process reflects a phone assessment and only a face-to-face assessment as needed, the cost would be less. Under this option, BHD could utilize physicians from PCS to complete the phone assessments but then dispatch CMT if needed.

According to BHD's Crisis Services Director, not all counties complete the assessment as described in the bill. Many counties give approval for payment of the involuntary treatment and not all counties complete a face-to-face crisis assessment. Even though the bill as drafted asserts to only impact Milwaukee County, it will actually effect other counties, especially if counties are no longer able to do these assessments by phone. Additionally, many counties in the state do not utilize psychiatrists, psychologists or mental health professionals as defined by Ch. 51 for completion of crisis assessments. This requirement would be a significant change and could potentially create additional costs in other counties.

Changes to Badger Care for Childless Adults (pg. 62 Budget and Brief) – Based on statewide enrollment projections, Badger Care for Childless Adults is expected to increase to 155,200, or 400 percent, by 2016-2017 compared to a starting point of 28,800 in 2011-2012. It also contributes to over half of the department's cost to continue for general purpose revenue funding, or $383 million.

In order to contain costs, the budget lays out a number of eligibility changes. The bill indicates that DHS will seek a waiver to "reform" coverage for childless adults by requesting the following changes: 1) monthly premiums will be imposed 2) higher premiums for those engaging in risky behaviors 3) requirement for a health risk assessment 4) eligibility limit of four years and 5) mandatory drug testing.

The eligibility changes contained in AB21 could potentially reverse the positive effects BHD has experienced with the elimination of the childless adult waitlist and expansion of Badger Care to this population. Since Medicaid expansion took effect last April, BHD has experienced a significant decline in those visiting the Access Clinic. As a result, the Access Clinic, which provides mental health services for uninsured Milwaukee County residents, experienced a 44 percent decrease in the number of individuals seeking care and services in 2014 compared to 2013.

The CARS Director believes the eligibility changes to the Badger Care program for this population will impact both BHD's success in implementing the plan submitted to the State for the Comprehensive Community Services (CCS) program and extending Targeted Case Management (TCM) to the AODA population. Individuals enrolled in CCS who lose their Badger Care eligibility will subsequently lose eligibility for CCS and other Medicaid programs. These changes will also have an impact on the ability of clients to obtain and/or maintain housing benefits that require ongoing case management services.

Undoubtedly, BHD would face greater financial exposure by continuing to provide services to this population. If these eligibility changes are approved, BHD may need to re-evaluate whether to offer services to only those who are Medicaid eligible in order to remain within its statutory imposed levy limit of $65 million.

Disproportionate Share Hospital (DSH) Payments (item #23 in DHS Summary of Governor's Recommendations) – These payments are provided to hospitals, including BHD, which care for indigent patients. The total payments budgeted statewide is $35.9 million in SFY2016 and go down slightly to $35.8 million in SFY2017. The State budgeted $36.7 million statewide in SFY2015 so the allocation for SFY2016 reflects a reduction of $800,000. BHD received a total of nearly $1.2 million in DSH revenue in 2014. Based on the statewide cut, BHD may realize a reduction in DSH revenue for 2015.

State Mental Health Allocation (Item #32 in DHS Summary of Governor's Recommendations & pg. 20 of Budget and Brief) - Effective January 1, 2016, the budget consolidates mental health funding of $24.3 million for distribution statewide to counties. This provision expands the statutory purpose of community aids funding to include mental health funding which would reflect Mental Health Treatment Services, Community Support Programs/Psychosocial Services and the Community Options Program. The intent is to create efficiencies in the "distribution of funding to counties." There is very little known about what this actually means. The LFB summary indicates that the change would still provide for the same allocation to individual counties. Yet, more information is needed as to how this change will be implemented.

IMD and community placement funding (pg. 31 of AB21) – The bill eliminates State payments for relocating individuals from an IMD or ICFMR. "Under current law, if a skilled nursing facility or an intermediate care facility is found to meet the classification of an institution for mental diseases, DHS must pay for care in the community or in that institution for mental diseases for individuals meeting certain criteria. Current law also requires DHS to pay for relocations of certain individuals who have mental illness to the community. The bill eliminates both of these requirements."

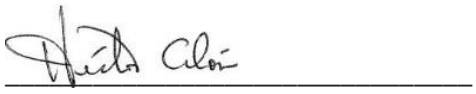
The language removes the requirement for DHS to pay for care in the community or in an IMD. There is concern that this could potentially pertain to $5.9 million in IMD Relocation funding that CARS currently receives to fund its Community Based Residential Facilities (CBRFs). Further clarification is needed on this language.

Residential Substance Abuse Services – This provision provides an additional $8 million of funding over the biennium for residential-based substance abuse treatment services. Currently, Medical Assistance revenue is only available for hospital inpatient and outpatient services but not for services provided in a residential setting. This is one area that could provide an opportunity for additional revenue to BHD CARS.

Recommendation

This report is informational and no action is required.

Respectfully Submitted:



Héctor Colón, Director
Department of Health and Human Services

cc: County Executive Chris Abele
Raisa Koltun, County Executive's Office
Josh Fudge, Director, Office of Performance, Strategy & Budget
Matt Fortman, Fiscal & Management Analyst, DAS

Introduction to New Pay Ranges

March 2015

Today's Situation

- Existing grades are not tied to local market factors/rates
- Existing grades do not match with current market starting rates, averages or maximums for positons
- Wide variations in the number and difference between steps
- Equity concerns
  - Similar positions across the County not consistently assigned to grades
- Concept of steps no longer utilized by other employers
  - Limit manager flexibility
  - Costly to maintain

The Move to Market Appropriate Pay Ranges: Why Change…

- Market appropriate pay range structure developed to include *Minimum, Midpoint,* and *Maximum* for each pay range
- *Minimum* reflects market appropriate starting rate for the position
- *Midpoint* reflects the average pay for the same position in the identified market
- *Maximum* reflects the highest rate that this position could be paid; anyone at or above the maximum would be frozen (red-circled)

Benefits of the Change to New Pay Ranges

- Employees with no experience in the position would have a market appropriate starting rate
- Managers have greater flexibility in offers, equity adjustments, and overall pay administration
- Market appropriate starting rates and pay ranges positively effect recruitment and retention efforts
  - The County's biggest turnover group is employees *with less than three years* of service.

Process

- Independent third-party surveys were used to determine new pay range assignments
- Based on survey data positions were assigned to market appropriate pay ranges
- Data reviewed and range assignment approved by department leaders
- Cost analyzed to move employees to new pay range minimum
- Equity reviewed for all like positions across the County
  - i.e. Marketing Manager, Administrative Assistant, etc.

Results/Costs

- Change from 156 grades that contain varied number of steps to a single set of 84 pay ranges with a common structure
- Cost to minimum analyzed
  - All Classified positions = $146,770 (annualized, does not include fringe)
    - The majority of the above expense is associated with the following position:
      - Registered Nurses – Approximately $75,000
      - Certified Nursing Assistants – Approximately $19,500

Next Steps

- Finalize and conduct education/communication plan around new ranges for managers
- Increase employee starting rates to new minimums effective April 12th, 2015
- Work with departments on any follow-up equity review as necessary
- Begin process to assess how best to manage employee compensation through the new pay ranges and prepare for 2016 Budget cycle