2016 Milwaukee County Behavioral Health Division Budget Request Follow-Up

July 8, 2015

Hello Mental Health Board Members:

The following questions were received on July 5th from Mary Neubauer, Milwaukee Mental Health Task Force Co-chair & Member of the Milwaukee County Mental Health Board. These questions are a follow-up to the responses sent out on June 29th.

We are sending responses to these questions to Ms. Neubauer and the Mental Health Task Force, as well as to all members of the Mental Health Board. We hope this information is helpful as we move forward in the recommendations and support of the proposed 2016 budget for the Milwaukee County Behavioral Health Division.

1. Question one requested a **breakout** of budget data for each of three major program areas: Adult Community Services, Wraparound, and Community Crisis Services. We were asking that staff provide funds budgeted for Adult Community Services for 2015 and for 2016 respectively, funds budgeted for Wraparound for 2015 and 2016, and funds budgeted for Community Crisis Services for 2015 and for 2015. The attachment 1 document provided in response to this question only has the BHD **combined** budget – it does not provide the requested breakout for Adult Community Services, Wraparound, and Community Crisis Services so I am again requesting this – hoping the wording of the question this time is clear.

Please see "Attachment 1 – Updated". This includes 2016 budget for BHD, Hospital, Community Services Branch, and "Community Crisis Services".

2. Question # 2 addressed staff positions being added and eliminated – thank you for the listing. Regarding the positions being added, please specify which BHD department they are being added to: Adult Crisis Services, Inpatient, CARS, Wraparound, etc.

Staff Changes 2016 Budget versus 2015 Budget

Title #	Description	Change	Comments
4505	Program Evaluator	1.0	Community Services
45135	Adm Coord BH	1.0	Community Services
50772	BH Staff Psychiatrist	0.5	Acute Adult Inpatient
52115	Med Staff Coordinator	1.0	Psychiatry Admin
57761	Integrated Service Coor	4.0	3.0 WRAP, 1.0 Community Services
59025	BH Emer Serv Clinician	3.0	Adult Crisis Mobile Team
80039	Deputy AdministratorOutpatient	1.0	Reclass from "Exdir2-Assthospadm2-Mhc"
80043	Exdir2-Assthospadm2-Mhc	(1.0)	Reclass to "Deputy Administrator Outpatient"
80101	Chief Officer Clinical	1.0	Reclass from "Exdir2-Assoc Dir Clin Compl"
80108	Exdir2-Assoc Dir Clin Compl	(1.0)	Reclass to "Chief Officer Compliance"
80103	Chief Quality Officer	1.0	Created 2015 (not included in 2015 budget)

Can you please clarify what is the status of the position Director of Crisis Services – is this funded as a separate position in the 2016 budget. Since Sue Gadacz left, Amy Lorenz has had two very big jobs – Director of Crisis Services and Deputy, Community Access to Recovery Services.

2016 Milwaukee County Behavioral Health Division Budget Request Follow-Up

Transitions in several leadership roles have provided the opportunity to redesign positions and responsibilities throughout the Behavioral Health Division. This is a common and healthy practice in organizations.

At this time, Amy's primary role is Deputy, Community Access to Recovery Services, and responsibility for community based crisis services is continuing with Amy in this new role. Amy has transitioned some responsibilities and duties to other members of the crisis management team, and day to day leadership for crisis services has been well managed during this transition.

The redesign of roles and responsibilities for the future state is still under development. One of the next steps in this plan will be to transition oversight of PCS and the Observation Unit to Jennifer Bergersen in her role as the Chief Clinical Officer. Further discussions are also underway related to the transition and leadership of some crisis services projected to reside in the North side center in the future.

There is a new position created: Deputy Administrator Outpatient. Given that the Access Clinic use is expected to dramatically decline as more people have insurance coverage, the BHD responsibility for outpatient services is also significantly reduced. What are the responsibilities of this position?

The “Deputy Administrator Outpatient” is the official title of the Deputy, Community Access to Recovery Services Division mentioned above. The position was reclassified from the previous title of “Exdir2-Assthospadm2-Mhc”.

3. Joint Commission Accreditation. What is the estimated cost to move forward with Joint Commission Accreditation activities in 2016, both county staff and any external resources? What is the target date for achieving this accreditation?

The direct cost in fees for Joint Commission Accreditation is approximately $45,000 per three year accreditation cycle ($7,225 per year x 3 = ~$22,000 for accreditation and a one-time per three years survey cost of ~$23,000). Of note, Joint Commission Accreditation also meets the "Deemed Status" compliance requirements for Centers for Medicare and Medicaid System (CMS) and thus does "double-duty" in a cost/preparation value sense. The cost of county staff accreditation activities cannot be easily or simply separated from our day-to-day costs. This is a result of these improvement activities being part of the larger organizational evolution to be a high performing healthcare delivery system. As we have previously noted: "...accreditation reflects a commitment to a set of organizational and performance standards that support quality and safety of care and organizational practices...[and thereby]...the use of these standards assists the organization in evaluating, measuring, and improving performance." In non-fee related external resources, we estimate approximately $25,000 for additional consultation and mock survey activities in 2016. While these external resources are more discrete and easier to cost, they also are pivotal to the larger institutional imperative to ensure safe, high quality systems of care. The target date for achieving accreditation at this moment is unknown as three (3) variables have yet to be determined: First, the outcome of the 2015 Mock Survey will narrow the possible timeline; second, the outcome of the Request For Proposal for Acute Services will further narrow the possible timeline; and third, feedback and direction is anticipated following the next Quality Sub-Committee of the Mental Health Board and any additional guidance from the board itself.

Of note, the Milwaukee County Mental Health Bylaws Article II state: "...the board will assure the quality, safety and effectiveness of acute inpatient services in compliance with Joint Commission Standards]."

4. Adult Crisis Services – follow-up questions

- Adult Day Treatment – how many unduplicated clients have been served to date in 2015?

  38 individuals have been served in Adult Day Treatment between 1/1/2015 and 6/30/2015.

- Psychiatric Crisis Services Admissions – the budget (page 4) refers to "admissions" at Psychiatric Crisis Services – the answer addresses admissions at the Obs, Acute Adult or CAIS. How many PCS admissions have occurred to date in 2015? Are there additional people who come to PCS for assistance and are not counted in the admissions numbers – for example if law enforcement brings someone and they are not "admitted" to be served at PCS and instead sent to jail – are they included in the count?

  PCS has had 5,444 admissions through July 5, 2015. This number includes people who come to PCS for assistance and are later sent to a different location after a psychiatric assessment. 1.8% of the 5,444 were sent to jail.

- Of the number of adult crisis mobiles completed, how many are completed in person? What are the number of mobiles completed for children and adolescents?

  100% of crisis mobiles are completed in-person. 903 mobiles have been completed for children and adolescents by Wraparound's Mobile Urgent Treatment Team through June 2015.

- We raised a question regarding funding for access clinic services since the budget shows a dramatic reduction in the number yet there is a strong probability that the number of uninsured will rise. Please provide more specifics about the contingency plan – how much funding is allocated to this service and how does this compare with funding for 2015? How will there be sufficient flexibility in funds if the budgeted needs are too low?

  In 2015, Access Clinic had a budget of $1,632,054. The 2016 requested budget includes $1,257,644 funding for Access Clinic. This reduction of $374,410 is primarily related to an anticipated decrease in medication spending of $589,177. Increases include funding at Access Clinic South, increased cross charges, and adjustments to various accounts. This budgeted amount will be able to meet the demand for services even with potential individuals being disenrolled in 2016 and needing to seek services at the Access Clinics.

- As noted in the questions, Expenditures for Adult Crisis Service increase by 2.3 million while the number of people served drops very significantly. The answer refers to several factors that contribute to this increase. Please provide a breakout with the dollar figures. How much for salary increase, how much for legacy costs, etc. What were BHD's allocated legacy costs in 2015 and what are they for 2016?

Crisis Services 2015-2016 Expenditure Variance Summary

Item	2016-2015 Variance ($million)
Internal Cross Charge	$2.2
Personnel Costs	$1.5
Pharmacy Savings	($0.4)
Increase for access south	$0.2
Transfer of Crisis Contracts to Community	($1.2)

Total	$2.3

2015-2016 BHD Legacy Costs

	2015 Budget	2016 Requested Budget	Variance
Legacy Healthcare	$8,474,419	$7,569,812	$(904,607)
Legacy Pension	$7,225,794	$6,539,696	$(686,098)
Total	$15,700,213	$14,109,508	$(1,590,705)

5. Inpatient Services

- Regarding the increase in revenue due in part to increased collection, when did BHD change policies to more aggressively attempt to collect revenue from patients? This is a policy area that merits further discussion outside of budget process, as we continue to hear that about the harmful impact this is taking on patients, the majority of whom are very low income without ability to pay and most were hospitalized involuntarily.

  There has not been a change in the patient collection process. A more structured and discipline approach to accounting and recognizing revenue has been developed which takes into account current cash receipts, payor mix, and historical write off trends has been developed.

The response to question 5 refers to the "Mental Health Board Scorecard". Who is creating this scorecard and what is the current status? This should reflect input from board members – when and how will that be solicited?

BHD is currently developing a high-level overarching scorecard to be presented at regular intervals to the Mental Health Board. Scorecards for division leaders are also being developed. These scorecards will be brought to the Quality Committee in September and the Mental Health Board in October for approval.

Community Access to Recovery Services
Please provide the following

- Unduplicated client count for 2015 Actual for each of the community programs requested.

2015 YTD Unduplicated Client Counts	
CLASP	109
CSP	1,167
TCM	1,470
CRS	61
CCS	109

- Data was not provided for Crisis Resource Centers. Please provide this and breakout by north side and south side (2014 actual, 2015 actual to date, and proj for 2015 and 2016)

Crisis Resource Center Admissions

	2014	2015 YTD (6/30/2015)	2015 (Proj)	2016 (Proj)
CRC North (opened 8/20/2014)	154	271	542	540
CRC South	319	203	406	400

- Please review and correct the CCS numbers in the table. The table lists enrollment of 92 in 2014. This is more than the number currently enrolled and must be an error – and is not consistent with other numbers in this document. In addition, these numbers are very low and not in alignment with the numbers for Milwaukee County projected by DHS in their February 2014 report to the Joint Committee on Finance. DHS …"conservatively estimates that Milwaukee CCS enrollment will increase to 800 in CY 16 and 1,100 in CY 17. This program is an entitlement and requires that individuals who are eligible and desire the CCS benefit must be served. How many of those served are transitions from existing programs such as CSP vs new enrollments?

CCS Client Counts by Year

Year	2014	2015 (Proj)	2016 Proj)
CCS	24	245	560

Please see updated CCS figures listed above. Of the 109 individuals enrolled in CCS by Milwaukee County so far, 62 were new consumers, 46 were TCM or CSP consumers, and 1 was a CBRF consumer.

Projections reported in February 2014 were estimates created prior to experience implementing this complex benefit. Knowledge has been gained since implementation that more accurately projects how quickly providers can expand to accept new clients for enrollments to occur.

- Attachment 1 does not provide the breakout by program area that was requested – please provide this. We need to be able to compare the budgets for community services for 2014, 2015, and 2016, for inpatient services, for adult crisis services, etc.

Please see "Attachment 1 – Updated". This includes 2016 budget for BHD, Hospital, Community Services Branch, and "Community Crisis Services".

- I am very concerned about the further cuts to Wiser Choice and AODA services of $1.1 million, especially after the major loss of federal grant funding for Wiser Choice last year. We are asking again, how many people will be impacted by this further cut? The budget projects that a cut of $1.1 million means only 200 fewer people will be served – won't a cut of this magnitude impact many more people?

In 2015, we are projecting to underspend in the Wiser Choice network by $1million.

- I requested a copy of the detailed plan for CCS implementation – please advise as to how I can obtain this.

BHD's CCS implementation plan will be shared with the Mental Health Board when finalized. Please see page 4 of the administrative update presented at the July 25, 2015 Mental Health Board meeting for an overview of this plan.

- A follow up question regarding the End Homelessness initiative. The budget allocates $750,000 from BHD and the response indicates that this will serve only 75 people. That is a very high cost ($10,000 per person). I am requesting more detail as to the services that the $750,000 is funding.

  Up front costs are necessary for this initiative as the funds cover staff salary and case management regardless of the number served. Since this is a new initiative for Milwaukee County, it is hard to predict how many will be served in year one. 75 is a conservative estimate. By the end of year three, 300 will be served.

STAFF CHANGES AND IMPACT ON BUDGET

- A number of new positions are listed. Please indicate which departments/Program Areas (Community Services, Crisis, Inpatient, etc.) each position will report to.

  Please see response to Question #2 above.

- A number of positions are eliminated, primarily staff from the long term care units. What is the overall total of the salary and benefit costs for the positions eliminated? Given that a commitment was made to invest savings from the downsizing into expanded community mental health services, how much money is being saved by downsizing long term care – and how much in additional funding is being invested to expand community services and add **new** capacity?

  For 2016 there is a net decrease of (72) FTE's with ($4.6M) of salary and current benefit cost savings.

  Downsizing long term care – the 2016 budget includes a net savings (reduced expenditures net of lost revenue) of $4.5M over 2015 budget for the final closure of Central Rehab. This excludes internal cross charges of overhead which needed to be reallocated to other departments. The 2016 CARSD budget includes an additional $13.7M and $5.7M in expenditures and tax levy respectively when compared to the 2015 budget for that division. As stated in previous budget presentations to both the Mental Health Board and the Mental Health Finance Committee there are significant investments to create capacity, improve and expand community services in 2016. A few of these initiatives includes the creation of a North side clinic, continued expansion of CCS, the creation of two 5-bed CBRFs and two additional CBRFs.

MEDICAID BILLING QUESTIONS

I am again expressing concerns about the impact of the changes in Medicaid billing on the viability of our providers. In the past the County had long delays in billing Medicaid which resulted in agencies not getting paid. That led to the practice of having the agencies bill Medicaid directly to ensure that agencies received payment. With a return to centralized billing, agencies are again experienced long delays of many months in being paid. What new safeguards will be put in place to ensure timely billing payment? These are small non-profits which cannot afford to wait months and months for payment – their survival is on the line.

BHD holds the Medicaid Certification for the State/Community Medicaid programs and billing needs to be performed by BHD under its National Provider Identification (NPI) numbers. In the fourth quarter of 2015, BHD will transition provider billing to a new EMR system. This system will allow providers to enter services electronically and directly into a portal that will be loaded into the BHD system to be billed to the State for services rendered. This will allow BHD to monitor services, clinical documentation, and billing for regulatory compliance. Although BHD will review the submissions and denial reports, the accurate, timely, and proper submission of claims is the responsibility of the provider. Incorrect billing resulting in denials and delays is the

providers' responsibility. BHD will make every effort to partner with the provider community and provide assistance when possible to work thru billing issues. Current delays, are largely due to the on-going transition to the new billing platform. It is BHD's expectation that delays will not exist once the new EMR system is implemented unless claims are denied for reasons outside the control of BHD.

The answer regarding CCS implementation raises many more questions. Unlike other county administered programs such as CSP and TCM, CCS is not implemented by contracting with providers. CCS is administered in a fee-for-service environment where the providers are assuming the most risk not the county. How can performance based contracting be implemented for a fee for service program? In addition, there is no local share contributed to CCS by the county, so the county "keeping" the Medicaid revenue is not possible with a cost-based reimbursement structure because they reimburse the interim Medicaid rates that were established by the state. Finally, can you provide more background on the 5% withholding that you indicate is a state established rate? Is there a DHS memo that explains this?

Performance based contracting is currently in development. Under this structure providers will need to meet certain compliance measures to receive full award of the contract. Additionally, if quality standards and measures are exceeded there may be opportunity to receive payment greater than the contract value. Likewise if these standards are not met, sanctions could be imposed resulting in payment less than full value of the contract. Implementation of new agency contracts will not make use of the 5% administrative fee. Because all Medicaid services will be on the BHD client ledger, BHD will keep all Medicaid reimbursement. Agency payments will be based solely upon the BHD/Agency contract. Part of the performance standards in these contracts will be accurate and complete Medicaid billing.

BHD will bill the State for CCS and maintain revenue collected. This does not impact payments to providers as they will be paid under a pay for performance fee for service contract structure. As long as providers meet compliance and quality standard providers will receive full contract value. BHD recognizes that CCS is paid on an interim rate. However, there is an annual reconciliation process to ensure that costs are covered

Behavioral Health Division (Combined Results)
2016 Preliminary Budget - Final Request

BHD Combined

	2014 ACT	2015 ADOP	2016 Request	2016/2015 Var
Revenue				
Revenue	101,262,075	98,159,653	107,075,624	8,915,971
BCA	22,016,595	22,336,586	22,336,586	-
Total Revenue	123,278,670	120,496,239	129,412,210	8,915,971
Expense				
Personnel Services	42,007,924	36,792,423	36,345,109	(447,314)
Fringe Benefits	26,838,393	26,378,495	25,521,793	(856,702)
Commodities/Services	21,688,758	17,337,901	14,217,643	(3,120,258)
Contract Services[1]	84,547,797	98,799,493	111,203,358	12,403,865
Capital Outlay	581,203	576,500	1,129,000	552,500
Cross Charges	37,452,123	38,645,931	42,488,209	3,842,278
Abatements	(42,487,138)	(38,935,163)	(42,393,561)	(3,458,398)
Total Expenditures	170,629,060	179,595,580	188,511,551	8,915,971
Tax Levy	47,350,390	59,099,341	59,099,341	-
Contribution to Reserves	10,164,804			
	57,515,194	59,099,341	59,099,341	-

1) Wraparound's $1,124,648 contribution to reserves is budgeted on this line

Behavioral Health Division (Hospital Only)
2016 Preliminary Budget - Final Request

BHD Hospital

	2014 ACT	2015 ADOP	2016 Request	2016/2015 Var
Revenue				
Revenue	28,013,824	21,913,452	22,712,466	799,014
BCA	7,700,026	7,700,026	7,700,026	-
Total Revenue	35,713,850	29,613,478	30,412,492	799,014
Expense				
Personnel Services	34,207,950	29,974,409	29,386,458	(587,951)
Fringe Benefits	22,028,913	21,234,091	20,675,902	(558,189)
Commodities/Services	19,733,802	15,596,509	12,817,733	(2,778,776)
Contract Services	3,088,310	3,199,158	2,178,738	(1,020,420)
Capital Outlay	581,203	531,500	230,500	(301,000)
Cross Charges	31,921,591	32,585,189	35,227,908	2,642,719
Abatements	(31,879,204)	(29,064,573)	(31,311,611)	(2,247,038)
Total Expenditures	79,682,564	74,056,283	69,205,628	(4,850,655)
Tax Levy	43,968,714	44,442,805	38,793,136	(5,649,669)

Behavioral Health Division (CSB Only)
2016 Preliminary Budget - Final Request

BHD Community Service Branch

	2014 ACT	2015 ADOP	2016 Request	2016/2015 Var
Revenue				
Revenue	26,509,481	30,761,253	37,676,831	6,915,578
BCA	14,316,569	14,636,560	14,636,560	-
Total Revenue	40,826,050	45,397,813	52,313,391	6,915,578
Expense				
Personnel Services	5,563,858	4,212,562	4,240,033	27,471
Fringe Benefits	3,387,607	3,479,014	2,944,149	(534,865)
Commodities/Services	1,723,419	1,584,733	1,180,934	(403,799)
Contract Services	32,528,912	47,837,164	58,892,930	11,055,766
Capital Outlay		45,000	898,500	853,500
Cross Charges	3,532,875	3,694,259	4,463,050	768,791
Abatements	(48,327)	(70,000)		70,000
Total Expenditures	46,688,344	60,782,732	72,619,596	11,836,864
Tax Levy	5,862,294	15,384,919	20,306,205	4,921,286

Behavioral Health Division (WRAP Only)
2016 Preliminary Budget - Final Request

BHD WRAP

	2014 ACT	2015 ADOP	2016 Request	2016/2015 Var
Revenue				
Revenue	46,738,770	45,484,948	46,686,327	1,201,379
Reserves Contrib from				-
Total Revenue	46,738,770	45,484,948	46,686,327	1,201,379
Expense				
Personnel Services	2,236,116	2,605,452	2,718,618	113,166
Fringe Benefits	1,421,873	1,665,390	1,901,742	236,352
Commodities/Services	231,537	156,659	218,976	62,317
Contract Services[1]	48,930,575	47,763,171	50,131,690	2,368,519
Capital Outlay				-
Cross Charges	1,997,658	2,366,483	2,797,251	430,768
Abatements	(10,559,607)	(9,800,590)	(11,081,950)	(1,281,360)
Total Expenditures	44,258,151	44,756,565	46,686,327	1,929,762
Reserves Contrib to				
Tax Levy	(2,480,619)	(728,383)	-	728,383

1) Wraparound's $1,124,648 contribution to reserves is budgeted on this line

Behavioral Health Division (low orgs 6444, 6445, 6446, 6447)
2016 Preliminary Budget - Final Request

Community Crisis Services *

	2014 ACT	2015 ADOP	2016 Request	2016/2015 Var
Revenue				
Revenue	217,520	-	-	-
Reserves Contrib from				-
Total Revenue	217,520	-	-	-
Expense				
Personnel Services	1,011,144	1,951,581	2,249,421	297,840
Fringe Benefits	483,075	1,368,466	1,577,270	208,804
Commodities/Services	13,093	834,530	437,466	(397,064)
Contract Services	122,464	996,145	3,250,873	2,254,728
Capital Outlay				-
Cross Charges	1,243,951	1,572,002	1,725,276	153,274
Abatements	-	-	-	-
Total Expenditures	2,873,728	6,722,724	9,240,306	2,517,582
Reserves Contrib to				
Tax Levy	2,656,208	6,722,724	9,240,306	2,517,582

*Financials above are also included in "Community Service Branch and Hospital pages.
Totals here are duplicated to show "Community Crisis Services" as requested.