2016 Milwaukee County Behavioral Health Division Budget Request

June 29, 2015

Hello Mental Health Board Members:

The following questions were received on June 23rd from Mary Neubauer, Milwaukee Mental Health Task Force Co-chair & Representative on Milwaukee County Mental Health Board.

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. Provide a breakout of 2016 budget data for each of three major program areas: Adult Community Services, Wraparound, and Community Crisis Services. The 2016 budget combines these three program areas without a breakout. A breakout by program area is needed to compare with 2015 and see how the budgets have changed. The Finance Committee report in May included this type of breakout – please provide this for the budget document.

Attachment 1 provides detail on the 2016 request by program, and includes both 2014 actual data, as well as 2015 budget. Variance from 2015 to 2016 is reflected.

2. Provide a breakout of the staff positions being added and eliminated – this used to be provided with the BHD budget.

Attachment 2 provides a detailed description of positions being added and removed within the 2016 budget. Please note that a significant portion of these reductions reflect the closure of Rehab Central and the subsequent reductions in those positions.

3. If BHD is planning to close the hospital within the next few years, why is the county moving forward with Joint Commission Accreditation, which has significant costs in time and resources. What is the target date for achieving this Accreditation? It has been in process for many years.

- Joint Commission accreditation reflects a commitment to a set of organizational and performance standards that support quality and safety of care and organizational practices. The use of these standards assists the organization in evaluating, measuring, and improving performance. The decision to pursue Joint Commission accreditation has been a goal over the past several years. The Mental Health Board endorsed that goal at a meeting in 2015. A mock survey is being conducted in August 2015 to measure progress in our improvement in processes and achievement of the standards. It will be of value for the Mental Health Board to offer feedback on whether to officially apply for accreditation, in light of the pending RFP for acute services. Regardless of a decision to apply or not for JC accreditation the JC standards of care

for our patients and the organization are valuable and will continue to be applied throughout BHD.

4. Page 4 – Adult Crisis Services – please provide the following:

- Adult day treatment – total unduplicated client count for Adult Day Treatment

  In 2014, 54 clients received services in the BHD Adult Day Treatment program.

- PCS: How many people show up at PCS vs the number of people actually "admitted" at PCS?

  100% of individuals that present themselves at PCS are seen by a physician. In 2014, 28% of individuals at PCS were admitted to either Obs, Acute Adult, or CAIS. 12% were referred to private facilities and 10% were referred to detox.

- Re Crisis Mobiles, how many were requested vs how many were completed?

  100% of Crisis Mobile calls are followed-up on by the Crisis Mobile Team by phone and/or in person. In some cases, the mobile is no longer necessary by the time the clinicians are able to arrive on scene and complete the mobile.

- Number of mobiles requested by law enforcement- this goes up by only 25 for 2016. Given that a new CART team is being funded, and comments from law enforcement that there is a significant unmet need, what is there such a small increase?

  The updated "2016 Budget" projections for number of mobiles requested by law enforcement is 688. This change will be included with a list of technical corrections for MCMHB to approve with the budget on July 9th, 2015.

- Access clinic:
  Why isn't the data related to access clinics included in community services since they will be part of the community hubs?

  The Access Clinics are one of several community-based services overseen by the Crisis Services at BHD.

  The 2016 Number Served in the Access Clinic is a dramatic reduction – from 6576 to 1428. Given the numbers dropping off BadgerCare in Milwaukee County (likely due to failure to get annual check-up) there is a strong probability that the number of uninsured will increase. What is your contingency plan?

  The Access Clinics will continue to have enough resources dedicated them to support the potential increase in numbers of indigent individuals needing access to outpatient psychiatric services.

- Expenditures for Adult Crisis services increase by 2.3 million while the project number of people

served decreases dramatically. This is very troubling and seems to be due to a huge increase in cross charges. What is the plan for reducing this burden which takes away funding from direct service.

The $2.3M is related to several factors including the salary changes recommended by the HR job evaluation review and equity studies and equity adjustment. BHD staff salaries had not been adjusted to market comparable ranges in several years, and we are glad to say they are now parallel with the market. The increased cost also includes health, pension, and legacy costs as allocated by the County. BHD overhead expense is constantly reviewed and reduced when feasible. The 2015 budget included an overhead reduction at BHD of $1M. Additionally, BHD continues to work with the County to revise cost allocation basis and reduce costs allocated to BHD as a result of downsizing efforts. The 2016 budget includes a significant reduction in allocated legacy costs compared to 2015.

- Crisis Services has a new initiative to follow up with patients post discharge. This includes $95,000 for peer specialist services. How many FTEs will this fund?

  Projected 2.0 FTE's.

5. Inpatient Services – pages 6 -7

- The number of patient days decreases in 2016 – why do expenditures go up by over $5 million?
  - The $5.3 million increase in expenditures in Acute Services is related to the following:
    - $3.8m in increased cross charges
    - $2.3million increased personnel costs
    - $800k decrease in commodities-services (largely due to changes in dietary and pharmacy models)

- Why does the budget project an increase in the number of patients returning to Acute Adult within 30 days?

  Based on updated projections, the "2015 Budget" and "2016 Budget" numbers for recidivism in Acute Adult Inpatient units should be 12.2%. This is consistent with the national average. These changes will be included with a list of technical corrections for the MCMHB to approve with the budget on July 9th, 2015.

- The narrative references the multidisciplinary team providing inpatient services but does not mention Certified Peer Specialists (CPS) - and in recent months the vendor has not retained the number of CPS funded by the contract. What is the plan for use of CPS on inpatient units in 2016?
  - The Certified Peer Specialists (CPS) will be incorporated into the multi-disciplinary approach to care throughout the system including in-patient. The strategic plan indicates there is an evaluation and restructure needed to address a comprehensive Case Management (CM)/Utilization Review (UR) care model throughout BHD. The role of the CPS will be included in the Case Management model that includes physicians,

nursing, social workers, and certified peer specialists in a collaborative process of assessment, planning, facilitation, care coordination, evaluating, and advocacy for all comprehensive services through communication and available resources to promote safe, high quality, cost-effective care.

- One page the budget assumes an additional $2,483,413 in revenue due in part to increased collection. How much of this figure is projected to come from increased collection? Given that the majority of patients are very low income and most were hospitalized involuntarily, an aggressive collections process raises many concerns. It is unlikely to bring in much revenue and very likely to damage the mental health of the patients it targets - and damage their credit histories.

  Revenue - $2.1 M of $2.5M increase due to improved write off and revenue recognition processes internally, no actual change in collection policies from patients.

- The narrative on page 7 references a LEAN process but does not define the acronym. What is LEAN?

  - LEAN is a methodology or process that uses teams to improve efficiencies across an organization. LEAN originated from manufacturing organizations and since 2002 has begun improving efficiencies in various organizations including healthcare organizations. BHD is using this process along with the Plan-Do-Study-Act Process Improvement Model to eliminate non-value added activities to save time and resources. For example, the LEAN methodology is being used to restructure, organize, and manage the BHD contracting process.

- BHD quality plan and Scorecard. Can you provide baseline data for the scorecard and benchmarks that will be used. Is there a budget component?

  A BHD **Draft** balanced scorecard is being developed that includes available national benchmarks along with individual program performance measures. The Mental Health Board scorecard will be the overarching guide in creating program specific operational (clinical and financial) performance measures. The performance measures will guide leadership in sound decision-making using valid and reliable data across the system.

6. Community Access to Recovery Services – pages 8 - 11

- The Activity Data for Community Services is incomplete – it does not include the majority of adult community mental health services. Please provide total unduplicated client count for community mental health programs for 2014 Actual, 2015 Budget and 2016 budget including TCM, CRS, CSP, CCS, crisis resource center, CLASP, group homes, crisis stabilization houses (respite). This data should be included in all future budgets. Have there been waiting lists during 2014 – 2015 for any of these programs and if so how many people are waiting?

Year	**2014**	**2015 (proj)**	**2016 (proj)**

Targeted Case Management			
Capacity	1292	1292	1292
# served	1505	1578	1655
Community Support Program			
Capacity	1340	1340	1340
# served	1392	1384	1384
CLASP			
Capacity	150	150	150
# served	243	246	246
CRS	140	55	30
CCS	92	245	560
Crisis Stabilization	391	400	400

- How many people are currently enrolled in CRS? What is future direction for CRS and how will this be determined?

  There are currently 55 individuals enrolled in CRS. Each individual currently enrolled in CRS is being reviewed for potential enrollment in CCS. If the individual is eligible for CCS, this option will be presented to the individual for possible selection. For any individuals not eligible for CCS, they will continue to receive services through CRS.

- As noted earlier in this document, a breakout by program area (Adult community services, Wraparound, Crisis) is needed to be able to compare the 2016 budget with 2015 and see how the budgets have changed.

  These data are found in attachment 1.

- AODA services are reduced by $1.1 million (page 10) but the number of people served is only going down by 200 (page 8). Since the AODA levy amount is being reduced by $1.1 million, what will be the impact on all services including Recovery Support Coordinators (RSCs)? We hear in the community that there is a now a crisis with access to AODA treatment in Milwaukee County following the loss of federal grants which funded AODA, and this budget proposes further reductions. Given the major reduction in funding in 2015 (loss of federal grants) and further loss of funding proposed for 2016, how will this be funded?

  The change in funding is based upon 2014 and 2015 utilization to date. Many of the services previously funded are Medicaid billable services. Additionally, it should be noted that there is also $270,000 in the budget to continue to fund AODA services for individuals involved in the Drug Treatment Courts and Family Drug Treatment Court.

- The BHD Executive Team is proposing relocating community services to the community. What opportunities will be provided for stakeholder input as this proposal is further developed? The Cultural Intelligence Redesign Work Group had proposed three community hubs – north side, south side, and central city? Will these recommendations be considered?

We are in the very early stages of planning this new model, which is aligned and consistent with the vision of the Mental Health Redesign initiative and ongoing community feedback from many sources. A representative of the Cultural Intelligence Redesign Work Group meet with the BHD Executive Team and reviewed the proposal created by the work group. These recommendations were taken into consideration for the initial planning of the proposed community hubs. As planning continues for these hubs, there will be opportunity for stakeholder input.

- The County proposes to increase enrollment in CCS to 560 by end of 2016. Where can we obtain a copy of the CCS plan with enrollment projections?

  CCS enrollment projections were stated in the Administrators Update Report of the Mental Health Board packet for the June 25th, 2015 meeting. We have approximately 89 individuals currently fully enrolled in CCS (this number advances weekly). About 35 individuals have been referred to agencies and are in the enrollment process with those providers. About 61 individuals are in the enrollment process and have expressed desire for a specific agency. They are awaiting placement as those agencies hire staff to create greater capacity. We hope to have about 100 more individuals enrolled by the end of 2015. Projections for 2016 are to enroll about 85 people per quarter -- a number that is driven by the capacity at both BHD and the provider agencies.

- The budget includes investments for new CBRFs. How many beds will these provide? How many of these are for residents of Rehab Central who are relocating to the community? What capacity will be available moving forward for people with complex needs who need longer term support?

  These CBRF's are being added to increase capacity within our community for individuals with complex needs who need various supports. One CBRF will be focused to provide services to individuals whom have both mental health and substance abuse needs. The other CBRF is being designed to provide care and support to women with histories of trauma. It is currently estimated that this will provide 10-12 beds. Additionally, two CBRF's are being built in 2015 to service individuals with complex needs who need longer term support.

- $750,000 is dedicated to the End Homeless Model. How many individuals will this serve in 2016? What is the long term estimate of the number of people who will ultimately be served to 'end" homelessness – and the timeline.

  The project will provide services to 75 chronically homeless individuals in the first year with a goal of serving 300 people over 3 years."

- $290,000 for peer support and clinician services through a community provider. What services and what provider?

  This is the funded amount for the new initiative to follow up with patients post-discharge: $195,000 for two Crisis Mobile Team clinicians and $95,000 for additional peer specialists from CLASP provided by LaCausa Inc.

- P. 10 why will WIMCR revenue go up by $1,110,277? If due to CCS, can you provide the specific

projections?

WIMCR is budgeted at $3.4 million across BHD, a total increase of $1.7 million. The 2016 budgeted WIMCR increases are due to changes in the cost reporting methodology from the State of Wisconsin and based on current WIMCR reimbursement trends.

2 Medicaid billing questions:

- In the past, providers who had county contracts billed Medicaid directly, which gave them control over ensuring timely billing. The county is now changing their procedure and has a centralized process where the county bills Medicaid on behalf of the providers. This has caused significant delays in provider reimbursement. The long lag in processing billings has raised concerns about how denials will be handled. There are only 365 days to bill Medicaid – to date the county has taken a number of months to submit these bills. Who handles denial process if the claim is denied? Will the county use levy to cover any denials or will they go after providers? A frequent reason for a denial can be because of a change in Medicaid eligibility. What is the reconciliation process for providers?

  Over the last year the County has been implementing a new billing module. The transition to the new system has resulted in some billing delays. However, we expect the implementation to be completed during the fourth quarter of 2015. These delays should not occur after the new system is implemented. The denial process will be overseen by the County. When errors exist the agency responsible will be contracted to correct the error and resubmit the claim. Tax levy will not be used to subsidize denied claims.

  The County is currently reviewing the Medicaid eligibility process. This will include review of all new clients for Medicaid eligibility, tracking of Medicaid review dates and assistance with Medicaid reviews and review of all claims denied for termed insurance and reprocessing under the current Medicaid 90 day grace period.

- CCS is supposed to be cost based reimbursement. Provider submits their claims for their actual costs. However, the county has implemented a policy of withholding 5% on any claims for their administrative costs. Are providers supposed to submit their claims of actual costs plus 5%?

  The current 5% withholding is a State established rate that allows for the county to cover the cost of billing and program administration. Billing and program administration are part of the cost of the CCS program.

  However, the County is moving to a pay for performance based contract. Under this contract, agencies will be paid a based rate with the ability to earn or lose additional payments based on meeting specific contract performance measures. Once implemented, the County will bill Medicaid for the services and keep the Medicaid revenue. The agency will have been made whole by the pay for performance rate they are paid.

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

Staff Changes 2016 Budget versus 2015 Budget

Title #	Description	Change
7	Office Supp Asst 2	(6.2)
40	Adm Asst NR	(1.0)
42	Clerical Asst 1	(3.2)
66	Secretarial Asst	(1.0)
2000	Unit Clerk	(0.9)
4041	Fiscal Asst 2	(0.8)
4505	Program Evaluator	1.0
6300	Materials Distrib Clerk	(0.5)
13370	Hosp Maint Wrkr MHC	(0.8)
15501	Dietitian 1	(1.0)
15640	Dietitian Supervisor	(1.0)
36249	Supervisor Office Management	1.0
38200	Psychiatric Soc Wkr Mgr	(1.0)
43840	Nursing Asst 1 Mh	(31.0)
43890	Psych LPN MHC	(5.2)
44500	RN	(3.1)
44611	Comm Service Nurse	(0.3)
44740	RN 2 - MDS	(0.2)
45110	Nursing Prog Coord	(0.9)
45115	Nursing Adm Coord-PR 29M	(1.0)
45135	Adm Coord BH	1.0
45760	Adv Prac Nurse Prescriber	(0.5)
50772	BH Staff Psychiatrist	0.5
52115	Med Staff Coordinator	1.0
53290	Cert Occ Therapy Asst	(2.1)
53356	Rehabilitation Coordinator	(1.0)
53357	Rehab Services Supervisor	(1.0)
53460	Occupational Therapist	(3.7)
53960	Music Therapist	(0.5)
55421	Care Coordinator Wraparound	(2.0)
56661	Comm Support Prog Coord	(0.2)
56900	Psych Soc Wkr	(2.3)
56996	Psych Soc Wkr CSP	(0.2)
57093	BH Clinical ProgDir Psychology	(3.0)
57761	Integrated Service Coor	4.0
59025	BH Emer Serv Clinician	3.0
65347	Analyst Human Services Program	(1.0)
80039	Deputy AdministratorOutpatient	1.0
80043	Exdir2-Assthospadm2-Mhc	(1.0)
80079	Exdir1-Acuteinptsvsdir	(1.0)
80101	Chief Officer Clinical	1.0
80108	Exdir2-Assoc Dir Clin Compl	(1.0)
80103	Chief Quality Officer	1.0
89520	Asst Hosp Admtr 1	(1.0)
21011	Sr Budget Analyst	2.0
Grand Total		(64.0)

Central Rehab Closure	(50.3)
CSP - South	(4.2)
All Other	(9.5)
Total Change	(64.0)