

BEHAVIORAL HEALTH

INTRODUCTION

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

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

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

The county has interpreted this language as a legal requirement to provide immediate emergency services for persons with mental illness and substance abuse disorders. That interpretation, in turn, has been defined as a requirement that the county also provide a broad range of inpatient, long-term care and outpatient services to indigent persons in order to curtail the need for emergency services and meet the more general statutory language pertaining to well-being, treatment and care.

Milwaukee County owns and runs an inpatient hospital consisting of five licensed, 24-bed units (one of which is for children and adolescents); two nursing home facilities (a 70-bed nursing home for individuals with complex needs who require long-term treatment and a 72-bed facility for individuals diagnosed with both developmental disability and serious behavioral health needs); a Psychiatric Crisis Service that serves persons in need of emergency mental health treatment, 65% of whom are brought in by law enforcement on an Emergency Detention; a Mental Health Crisis Walk-in Clinic; and an Observation Unit. It also contracts for a wide variety of community-based services, including targeted case management, community support programs, community residential services, outpatient treatment, substance abuse treatment and recovery support, crisis respite and specialized services for children and adolescents.

The total budget for BHD in 2009 was \$172 million⁶, making it the second largest budget in Milwaukee County after the Department on Aging Care Management Organization. BHD's

⁶ Beginning in 2010, BHD's budget includes approximately \$16 million in expenditures and \$14 million of property tax levy for County Health Programs, which prior to the 2010 budget existed as its own organizational unit. These programs consist of Emergency Medical Services and a \$6.8 million tax levy appropriation to the State of Wisconsin for its Badger Care Core program, which replaced the county-administered General Assistance Medical Program,

2009 property tax levy was \$57 million, again ranking it second after the Office of the Sheriff. Other key revenue sources are state/federal revenue and direct reimbursement from patient care.

BHD also is one of the county's largest functions in terms of individuals served. For example, the 2009 budget estimated BHD would handle more than 4,000 inpatient and 13,000 Psychiatric Crisis Service admissions, provide services to more than 2,000 individuals in targeted case management or the community support program, and provide community-based substance abuse services to more than 4,500 individuals.

Finally, BHD is the second largest county organizational unit in terms of its number of employees (first is the sheriff), with 859 FTEs in the 2009 budget.

BUDGET BREAKDOWN

Table 13 breaks down BHD's actual expenditures and revenue in 2008, showing both total costs and costs when legacy obligations are subtracted. This analysis shows that the Division spent \$7 million on central service charges from other county departments, \$76.7 million on its own personnel, and \$91.3 million on non-personnel expenditures, which primarily involved the purchase of mental health and substance abuse services from community providers, as well as commodities such as prescription drugs.

The analysis also shows that \$687,000 of BHD's central service charges and \$13.6 million of its personnel expenditures were not directly connected to the cost of providing or administering behavioral health services, but instead were county legacy costs distributed to the department by the central budget office. **This tells us that if a different governing body had provided the same services, secured administrative overhead at the same price, and paid the same wages and benefits to its active employees in 2008, it potentially could have administered and provided behavioral health services for \$14.3 million less if it was not responsible for BHD's share of the county's legacy costs.**

In addition, the analysis shows that if legacy costs had been distributed to BHD on the basis of its actual number of retirees, as opposed to its share of the existing county workforce, those costs would have totaled \$12.3 million. This \$12.3 million figure represents a more accurate depiction of the approximate annual county legacy obligation held by BHD. As with every other function analyzed in this report, under a change in governance these legacy costs either could be assumed by the function's new governing body, or they could remain the responsibility of county government or county taxpayers (if county government no longer existed).

Finally, in terms of the Division's overall share of the county's outstanding liabilities, its share of the county's OPEB liability is \$222.9 million, its share of the pension fund liability (consisting of both POB debt and the unfunded liability) is \$70.1 million, and total General Obligation debt on BHD facilities is \$7.9 million.

and for which the state still requires a county contribution. While Emergency Medical Services is now part of the BHD budget, it is discussed in the "Other Functions" subsection of this report.

Table 13: Breakdown of BHD 2008 Actual Expenditures and Revenues and Legacy Costs

BHD only	Cost to operate as county department (current practice)	Cost to operate minus legacy costs	Legacy costs	
			Using 2008 fringe allocation method*	Based on retiree history**
Administrative	\$2,649,179	\$2,390,592	\$258,587	\$250,845
Information technology	\$1,560,344	\$1,408,038	\$152,306	\$147,746
Legal counsel	\$560,773	\$506,036	\$54,737	\$53,098
Facility management	\$2,235,233	\$2,017,051	\$218,182	\$211,649
Fleet management	\$39,910	\$36,014	\$3,896	\$3,779
Central charges/overhead	\$7,045,439	\$6,357,732	\$687,707	\$667,117
Salary and wages	\$45,344,617	\$45,344,617	\$0	\$0
Social security	\$3,340,462	\$3,340,462	\$0	\$0
Employee healthcare	\$11,236,674	\$11,236,674	\$0	\$0
Employee pension	\$4,816,180	\$4,816,180	\$0	\$0
Retiree healthcare	\$11,236,674	\$0	\$11,236,674	\$9,657,866
Retiree pension	\$2,408,090	\$0	\$2,408,090	\$1,971,083
Other	(\$1,670,414)	(\$1,670,414)	\$0	\$0
Personnel costs	\$76,712,283	\$63,067,519	\$13,644,764	\$11,628,949
Non-personnel expenditures	\$91,306,906	\$91,306,906	\$0	\$0
TOTAL EXPENDITURES	\$175,064,628	\$160,732,157	\$14,332,471	\$12,296,067
State revenue	\$57,806,589	\$57,806,589	\$0	\$0
Federal revenue	\$547,080	\$547,080	\$0	\$0
Other revenue	\$68,062,270	\$68,062,270	\$0	\$0
TOTAL REVENUES	\$126,415,939	\$126,415,939	\$0	\$0
TOTAL LEVY	\$48,648,689	\$34,316,218	\$14,332,471	\$12,296,067
Unfunded OPEB liability ***	\$222,885,177	\$222,885,177	\$222,885,177	\$222,885,177
Unfunded pension liability***	\$70,139,829	\$70,139,829	\$70,139,829	\$70,139,829
Outstanding debt and interest	\$7,853,557	\$7,853,557	\$7,853,557	\$7,853,557
TOTAL LONG-TERM DEBT	\$300,878,562	\$300,878,562	\$300,878,562	\$300,878,562

* In 2008, the county distributed legacy costs evenly to all departments based on number of active employees and salary levels.

** This method distributes legacy costs according to a department's retiree history.

*** Estimated liability allocated to department is based on the department's retiree history.

POTENTIAL ALTERNATIVE SERVICE PROVIDERS

Two potential alternative governing bodies for behavioral health services in Milwaukee County are the State of Wisconsin or a new mental health authority. The following provides brief analysis of those options.

State of Wisconsin

Discussion

A state takeover of behavioral health services in Milwaukee County would be similar to state takeovers of several other major social services programs in Milwaukee County within the past decade: welfare-to-work in the late 1990s, child welfare early in this decade, and income maintenance services in 2009-10.

At first glance, such a move would run somewhat counter to national trends, however. In a recent report, the federal Center for Mental Health Services noted that “the public mental health system has shifted from centralized hospital-based institutional care administered by state agencies to decentralized community-based outpatient settings administered by county-level agencies.”⁷

In order to get a better sense of how behavioral health services are provided in other states, we examined the *Grading the States 2006* and *Grading the States 2009* reports published by the National Association of Mental Illness (NAMI). Because of their focus on individual state structures, innovations, and characteristics, the reports illustrated, to a certain degree, how each state is providing mental health services to its citizens. When the reports were ambiguous about a certain state structure, state and local government web pages were examined to obtain additional information.

We found that while mental health services typically are administered at the county or regional level, the structure for delivering services varies significantly across states. For example, in Wisconsin and California, behavioral health services are provided through a county-based system. In Georgia and Idaho, services are provided on a regional or district basis. In South Carolina and Rhode Island, services are rendered through both county agencies and regional districts. Finally, in Ohio, services are provided through a system of special purpose governments.⁸

We also found that while service delivery typically is administered at the local level, many state governments play a primary role in terms of establishing statewide policies and objectives and funding mental health services at the local level to ensure consistent service levels across counties. Wisconsin appears somewhat unique in the extent to which it leaves both administration and significant funding responsibility for behavioral health services in the hands of county governments, as reflected by the following passage in NAMI’s *Grading the States 2009*:

“The state [of Wisconsin] funds services in 72 counties, but the counties provide the non-federal share of Medicaid funding and are responsible for providing or purchasing most services. Counties and localities contribute varying amounts to mental health care spending, above what the state provides. The decentralized nature of the system limits the Division of Mental Health and Substance Abuse Services’ (DMHSAS) control over local services. Availability and quality vary widely.”

Our research uncovered one example of a state that is considering moving away from a county-directed and administered human services system to a state-supervised, regionally administered approach. In Colorado, a blue ribbon committee examining significant problems in the child welfare system has recommended that those services be placed under direct state control. This recommendation is based on the belief that “the lack of consistency in guidance from the (state), performance by the counties, and data management resources has made child welfare a

⁷ Center for Mental Health Services National Advisory Council Subcommittee on Consumer/Survivor Issues found at <http://mentalhealth.samhsa.gov/cmhs/AdvisoryCouncil/attachment1.asp>

⁸ Municipalities in Colorado also have the ability to create special purpose governments to provide mental health services. As of 2006, only a few municipalities have utilized the opportunity.

‘patchwork quilt’ in Colorado, where the quality of a family’s child welfare experience is dependent on where they happen to live.”⁹

The committee’s recommendation does not stop with the child welfare function, but further suggests that all social services be provided under direct state supervision, as “child welfare is inherently dependent on the joint efforts of multiple social service modalities to meet the needs of its clients.”¹⁰ Such a suggestion may hold relevance for Milwaukee County, where some have criticized lack of coordination between the state-administered child welfare system and county-administered behavioral health system.

If the State of Wisconsin were to take over the administration of behavioral health services in Milwaukee County, it could follow the model employed for child welfare by creating a Milwaukee-based bureau (similar to the Bureau of Milwaukee Child Welfare) to act as its local service administrator. Under such an approach, it could continue to contract for community-based services while utilizing state employees to provide inpatient and other services currently provided by county employees, or it could shift to an even greater mix of contracted services. Another model would be to purchase all behavioral health services in the community (similar to the model employed for W-2) and manage those contracts from Madison.

Key pros

- Having the State of Wisconsin directly responsible for the administration of behavioral health services in Milwaukee County could improve accountability by linking the entity responsible for mandating (and significantly funding) the services with service outcomes and could improve coordination with state-administered child welfare and public assistance programs. Under the current arrangement, when issues arise regarding the quality and accessibility of behavioral health services, the county can blame the state for providing insufficient funding for a mandated service, while the state can blame the county for poor management. If the state is in charge, then it may be more compelled to provide the fiscal and/or management resources deemed necessary to achieve the service outcomes it deems important.
- It is possible that the state could bring to bear a variety of additional resources to the immensely challenging task of providing quality behavioral health services in Milwaukee County, ranging from expertise with federal funding streams, to legal resources, to additional programmatic expertise.
- Moving behavioral health services outside of county government could better shield those services from the county’s overall budget difficulties, legacy costs, competition with other county priorities, personnel rules, and poor reputation (which hurts recruitment and retention of medical and nursing personnel). Some have argued that county government is particularly ill equipped to effectively govern a mental health hospital and emergency department, which requires the type of administrative flexibility and independence that cannot be

⁹ Colorado Child Welfare Organizational Structure and Capacity Analysis Project, September 24, 2009.

¹⁰ Ibid.

accommodated under the county governance structure. State government, on the other hand, oversees its own mental health hospitals with less oversight from elected officials.

- While the state takeovers of child welfare, public assistance programs and even the General Assistance Medical Program (GAMP) have produced mixed results, the state *has* poured greater fiscal resources into these functions as part of the takeovers and, in particular, as problems have been identified. This shows that if the state is accountable for program results, it will have no choice but to provide additional funding.

Key cons

- The community-based services upon which the county's behavioral health system is largely built might be best administered, delivered and overseen by entities that are close to the community, and not based in Madison.
- While Milwaukee County's behavioral health services have come under intense scrutiny in recent years, the county also has achieved success. For example, the county has administered an award-winning program for children and adolescents with mental illness (Wraparound Milwaukee) and its Wiser Choice substance abuse treatment program has been nationally acclaimed. Transferring administration of behavioral health programs to the state could result in the loss of talented administrators, clinicians and front-line workers who have produced positive results.
- The State of Wisconsin has its own serious budget woes, and those woes could produce funding challenges that are at least equal to those currently faced by the Milwaukee County behavioral health system.
- Despite state takeovers, significant problems still exist in Milwaukee County's child welfare and public assistance programs, and even the conversion from GAMP to Badger Care has been problematic. This may indicate that the state is no better equipped than the county to administer these programs. Some also might argue that if the state had provided the same fiscal resources to the county as it did for itself, then the county's performance may have exceeded that of the state.

Key logistical questions/obstacles

- In 2008, Milwaukee County spent \$34 million of local property taxes to support non-legacy behavioral health services. State officials would need to decide whether the state would be willing to spend that amount, whether it would intercept an equivalent amount of Community Aids and/or shared revenue from the county as it does for child welfare, or whether it would seek a direct payment from the county as it does for income maintenance. If Milwaukee County government is eliminated, then the state would need to determine whether *it* would fill the gap, or instead attempt to assess county taxpayers for an equivalent amount.
- BHD has one of the highest legacy liabilities of any county function, amounting to approximately \$12 million annually for the cost of health care and pensions for BHD retirees,

and nearly \$8 million in outstanding debt on BHD facilities. The state would need to determine whether those costs would be left with the county (or its taxpayers in the case of elimination) as they were for the child welfare takeover, or whether it would assume them.

- Notwithstanding the fiscal implications, the state would need to determine whether, in light of its own variety of major challenges, state government has the capacity and will to take on Milwaukee County's most complicated and challenging human services responsibility which involves, among other things, dozens of community-based contracts and more than 800 full-time employees. If its solution to easing the complexity would be to purchase all behavioral health services from private hospitals and other community-based providers, then it would have to determine whether sufficient community capacity and willingness to provide those services exists.
- The state's 71 other counties also have bitterly complained about unfunded or underfunded human services mandates. A consideration for the state would be whether, to the extent it was willing to assume financial and programmatic responsibility for this underfunded mandate in Milwaukee County, it could justify not doing so in other counties.

Milwaukee County Mental Health Authority

Discussion

Just as policymakers and community leaders have discussed establishment of a separate board or authority to administer airports in Milwaukee County, a separate board or authority to administer behavioral health services in the county also could be considered.

Ohio employs such an approach, with mental health services administered by a system of 54 mental health boards (similar in structure and purpose to special authorities or districts). Boards typically consist of 18 volunteer members appointed by a mix of county and state officials. For example, the 18-member Alcohol, Drug Addiction and Mental Health Services Board of Cuyahoga County has 10 of its members appointed by the Board of County Commissioners, four by the Ohio Department of Mental Health, and four by the Ohio Department of Alcohol and Drug Addiction Services.

The overall system, while administered by the local boards, is supervised by the Ohio Department of Mental Health and the Ohio Department of Alcohol and Drug Addiction Services. Because of this structure, the system is financed by a combination of federal, state and local dollars.¹¹ In particular, the boards are able to levy a local property tax within their jurisdiction to partially cover the costs of services and administration subject to a vote of the jurisdiction's citizens at regular intervals. The State of Ohio also provides a significant portion of each board's annual budget.

¹¹ Honeck, Jon. 2009. "Proposed Funding Levels Push Community Mental Health System to Brink of Collapse." The Center for Community Solutions June: 1-4.

While the boards are responsible for financing and administering mental health services, they are legally prohibited from directly providing the services. The revenue raised and received by the boards is used to pay community groups, organizations, nonprofits, and hospitals to provide behavioral health services in the community. Thus, the Ohio approach allows for local discretion in system design and service delivery while also including supplemental state aid and direction. Advocates support this system by arguing that “local communities are best able to identify their unique needs and to plan and administer services.”¹²

Ohio’s mental health care system has been in place for more than 40 years and has received significant positive ratings from NAMI when compared to other states.¹³ However, the system has been hindered by funding problems in recent years. Because state assistance can consist of 25-35% of any board’s budget, financial constraints on the state budget can have a significant impact on board revenue. Several boards, especially those serving large cities, have been forced to reduce services in recent years because state contributions have decreased significantly.

Also, the ability of citizens to customize the level of services available within their district through periodic property tax levy votes has created a scenario in which several jurisdictions provide little additional financing above what is offered by the state. Overall, in fact, there has been a wide variation in the amount and quality of offered services among Ohio districts. Board tax levies range from a mill rate of .30 to 5.21, while 14 districts do not have a tax levy. Several boards utilize alternate funding sources such as state and federal aid, grants, and donations to provide sufficient mental health services in counties with low or no levies.

Key pros

- Creation of a new authority to administer behavioral health services in Milwaukee County could retain a critical role in system design and service delivery for local citizens while freeing behavioral health services from the weight of the county’s overall budget difficulties, legacy costs, competition with other priorities, personnel rules, labor contract obligations, and poor reputation (which hurts recruitment and retention of medical and nursing personnel). In particular, if all mental health services (including inpatient and emergency) were purchased from community providers as they are in Ohio, removal of the county’s bureaucratic regulations could allow those services to be administered more effectively.
- Housing the behavioral health function in a separate authority could heighten prospects for non-public funding from foundations and other sources to support substance abuse treatment, supportive housing and other critical system elements.
- Having the authority board directly supervised by the State of Wisconsin could improve accountability by vesting state government with greater responsibility for outcomes. Also, this governance structure could improve administration by eliminating redundant oversight by two major governments with their own budget timelines, administrative rules and laws.

¹² National Alliance on Mental Illness. 2009. “Values.” http://www.oacbha.org/about_us/values.html. 17 August 2009.

¹³ NAMI, *Grading the States*, 2006 and 2009.

Key cons

- If the authority board was granted authority to levy taxes without a vote of the electorate, then local taxing and spending on behavioral health services could increase because of lack of competition with other locally funded services, which forces policymakers to prioritize among a wide variety of programs and services and make difficult spending choices.
- On the other hand, if a vote of the electorate was required to establish the county property tax or other tax levy to support behavioral health services, then it is possible that funding for those services could suffer because of the potential unwillingness of voters to support a set of services from which all would not directly benefit.
- It could be argued that Milwaukee County already has enough separate governmental or quasi-governmental agencies, and creation of a new behavioral health authority simply would create another layer of unneeded government bureaucracy.

Key logistical questions/obstacles

- In developing legislation authorizing creation of a behavioral health board or authority in Milwaukee County, the state would need to determine whether the new authority would assume responsibility for BHD's legacy liabilities and the outstanding debt on BHD facilities. This decision would have a significant impact on the amount of funding needed to operate the authority.
- The authorizing legislation would need to determine whether, to the extent the new authority would be a direct provider of services, county workers would be employed by the authority and, if so, whether county labor contracts would remain in force.
- The authorizing legislation would need to determine whether former county workers employed by the new authority would be able to remain in the county pension system and receive county health insurance and other benefits, whether they would become members of the state retirement system and receive health care and other benefits from the state, or whether a new benefits structure would need to be created within the authority.
- The composition of the board overseeing the authority would need to receive careful deliberation by state officials, who would need to determine whether it should be appointed or elected, whether it would be paid or volunteer, the necessary qualifications of board members, and whether a citizen board could be constructed to have the necessary expertise and experience to oversee both a budget and menu of services as large and complex as that currently in place in Milwaukee County.
- State officials would need to determine whether it would be possible to grant an independent authority the legal means to bill for Medicaid reimbursement, receive a license to run a mental health hospital and nursing homes, apply for grant funding from the federal government, etc.