PAT STRACHOTA
STATE REPRESENTATIVE

Testimony on Family Care Legislation – 2/19/14

The bill before the committee today addresses a significant problem in the Family Care program, and we have been searching for a workable solution for the last three years.

I have worked closely with the Department of Health Services to try and come up with some kind of solution. During the budget process on the Joint Finance Committee last year, we thought we had come to a compromise. Unfortunately, it did not make it into the final budget that was signed into law.

AB 468 establishes a set of policies for Managed Care Organizations (MCOs) to follow. It requires DHS to notify the county that is fiscally responsible for an individual who has been admitted to a state mental health institution. It requires DHS to establish criteria to determine if a Family Care recipient is at a substantial risk for being admitted to a mental health institution. Under the bill, MCO's must also keep an emergency contact for all Family Care recipients and have a back-up plan in place for all Family Care recipients who are deemed to be a substantial risk of being admitted to a mental health facility. The back-up plan would include a requirement of coordination between the MCO, the county of fiscal responsibility, and a team of individuals associated with the individual to develop a plan to get that person back into a community placement as quickly as possible.

The bill also adjusts who is fiscally responsible in these special cases. The bill proposes a shared financial responsibility between the county and state for costs associated with an individual being held at a state mental health facility for extended periods of time. Currently, since the admitted individual is a part of Family Care, the MCO or the state have no incentive or "skin in the game" to get that individual out of the facility in a timely manner. The state will keep increasing daily rates to create a disincentive to have the individual remain in the facility, but the county still has no say in placing them back into the community. It is the MCO that needs to get them out.

Due to the waiver with CMS, Medicaid card services and programs cannot be used for those placed in mental health facilities. Managed Care Organizations bear no financial cost if one of their recipients is placed in a state mental health facility. This is due directly to the waiver with CMS. The bill lays out a timeframe and the shared responsibilities of the county and the state during an individual's admission to a state mental health facility:

- Day/s 1-30: county will cover 100%
- Days 31-60: county will cover 50%, state 50%
- Days 61-90: county will cover 25%, state 75%
- Days 91 and on: state 100%

Many of those that are taken to the state mental health institutions are out in the first 30 days, but there are some that can be held for a very long time. One of my constituents was held there for over 18 month before being placed back into the community. This is just one example of many. The Washington County human services director has to go to the county board to request additional funding to pay the bills of those being kept at the state facility. These situations cause serious problems for county budgets across the state. This bill before the committee today helps alleviate the burden on counties and provides a framework and financial incentives to get individuals back into their communities.

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WASHINGTON COUNTY
WISCONSIN

WASHINGTON COUNTY
HUMAN SERVICES DEPARTMENT

JIM STRACHOTA, DIRECTOR

Assembly on Aging and Long Term Care
Testimony on AB 468 Family Care.

My name is Jim Strachota, the Human Services Director of Washington County. Our County is in total support of Assembly Bill 468 which addresses on-going financial and case coordination issues facing counties with Managed Care Organizations that provide Family Care services.

Once an individual is deemed eligible for Family Care, case management and on-going services become the primary responsibility of the managed care organization (MCO). Counties then have no further role in providing services unless a crisis emerges. If the individual requires intervention that leads to a stay at one of the mental health institutes, the individual is dis-enrolled from Family Care and the County becomes financially responsible for the cost of treatment. Since the MCO is responsible for the transition plan back to the community, the County participation in transition is minimal at best. The only true role is to pay for the treatment and hope a community placement is developed. Even if the County took the initiative to develop a plan to return the person to a community setting, there is no assurance the MCO will agree to financial responsibility. Since the MCO is not responsible for any crisis and inpatient services, benefits or costs, there is an inherent disincentive for high quality care and coordination from the onset of enrollment. AB 468 is a solid step forward to rectify this problem.

AB 468 shares both the financial and planning process between the Department of Health Services, the Managed Care Organization and the designated County. AB 468 creates a team of professionals working together to insure a proper and safe community placement. The division of fiscal responsibility also invokes fairness based on the length of time a person resides at the Mental Health Institute.

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Family Care has demonstrated the ability to provide community services for many individuals previously without care. The population impacted by a potential placement at the Mental Health Institutes is extremely small but very costly to local County governments. An example of the fiscal impact resulting in non-budgeted property taxes in Washington County is as follows:

Actual Family Care Placement costs for 2012 and 2013

Family Care	Days	Expense
2012	504	482,549
2013	455	457,945

I have also attached a resolution passed by the Washington County Board of Supervisors on June 11, 2013,

As a representative of Washington County I thank you for the opportunity to testify and ask for passage of AB 468.

Sincerely,

Jim Strachota
Human Services Director

WASHINGTON COUNTY, WISCONSIN

Date of enactment: 6/11/13
Date of publication: 6/19/13

2013 RESOLUTION 17

Advisory Resolution Regarding Family Care Responsibility for State Institutional Placements

WHEREAS, as of January, 2013, the Wisconsin Department of Health Services has made Family Care available in 57 Wisconsin counties; and

WHEREAS, as a part of the Family Care expansion in 2008, Washington County became obligated to make a substantial annual financial contribution of County levy to the State of Wisconsin for the Family Care program; and

WHEREAS, once an individual is deemed eligible for Family Care benefits, the Family Care participant is provided services, treatment and coordination of the benefit by a Managed Care Organization (MCO); and

WHEREAS, if a Family Care participant requires mental health crisis intervention, services, treatment and/or placement in one of the State Mental Health Institutes, the participant is disenrolled from Family Care and becomes the financial and case management responsibility of the County; and

WHEREAS, once a participant is disenrolled, there is no financial or other incentive for the MCO to resume coordination of services for the individual, develop a transition plan or return the individual to the community and the County remains burdened with the financial obligations of the mental health care, services and/or placement of the individual;

NOW, THEREFORE, BE IT RESOLVED by the Washington County Board of Supervisors that the Wisconsin Counties Association propose and support legislation that would modify Wisconsin Statutes to require MCOs to assume the financial risks and responsibilities for serving individuals with mental health treatment needs, including placement at the state mental health institute's or in the alternative, allow counties to reduce, dollar for dollar, the amount of the county required annual contribution made to the State of Wisconsin, for the institute's daily rate and other costs of mental health services.

BE IT FURTHER RESOLVED that proposed legislation include a requirement that individuals placed at a State mental health institute be provided with a periodic independent review to determine appropriateness of continuing the placement and upon discharge, be automatically re-enrolled in Family Care.

BE IT FURTHER RESOLVED by the Board that the Washington County Clerk is instructed to send a copy of this advisory resolution to the Wisconsin Counties Association.

VOTE REQUIREMENT FOR PASSAGE: Majority

RESOLUTION SUMMARY: Advisory resolution regarding Family Care responsibility for state institutional placements.

APPROVED:

Kimberly A. Nass, County Attorney

Dated 6/12/13

Considered 6/11/13

Adopted 6/11/13

Ayes 28 Noes 0 Absent 2

Voice Vote

(Fiscal effect unknown.)

Introduced by members of the EXECUTIVE COMMITTEE as filed with the County Clerk.

Herbert J. Tennies, Chairperson

JEFFERSON COUNTY HUMAN SERVICES DEPARTMENT
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Assembly Committee on Aging and Long-Term Care

Public Hearing on 2/19/14 on Assembly Bill 468 relating to admission of Family Care enrollees to mental health institutes and making an appropriation

Thank you for this opportunity to testify and your consideration of this matter. I am Kathi Cauley, Jefferson County Human Services Director.

I have two main points to make this morning.

The first is, we need to consider the costs of the present system in county dollars.

Jefferson County entered into Family Care and Partnership late in 2008. I want to briefly recap what we have paid.

Our Family Care contribution through August of 2013 has been 6.1 Million dollars. This is for a county of about 82,000 people.

In addition to these county dollars, the counties also pay for the entire cost of crisis services for Family Care participants, because crisis services in not part of the Family Care benefit.

As you know, this includes the costs for Institutes of Mental Disease (IMD) admissions. These costs total $335,998 in county only dollars.

Additionally we paid for and provided crisis services for Family Care enrollees placed in our county for residential services. We are fortunate to have residential providers in our county. However, we average about 6 emergency detentions per year for Family Care enrollees from other counties. We are responsible for the costs for the first 3 days of the admission. This totals just under $36.000 for the last two years. It is also very challenging for our staff to enter these situations and for the county of residence to sort what has happened.

The second point I wanted to pontificate on this morning, is the price Family Care enrollees pay. As you know, crisis services are not part of the Family Care benefit package. Because of this, there is an inherit disincentive to provide quality services. I would ask you to consider an analogy. Imagine, if you will, that you have coronary artery disease, your insurance pays for your medications, and

checkups, but your insurance does not have to pay for the ER visit, the hospital stay, or tests needed when you have a heart attack. I think we can agree the bigger picture of quality care would become unfocused in these situations.

Yet, this is exactly what happens for Family Care enrollees. Their Care Management organization is not responsible for crisis services or costs. Further, the enrollee is dis-enrolled when admitted to an Institute of Mental Disease or incarcerated. The Care Management Organization has no requirement to provide discharge planning and coordination. When the person is discharged, he or she must be re-enrolled in Family Care. This confusing at best for the person and does not result in efficient and timely care planning. It is also an unnecessary workload increase for our Adult Disability Resource Center (ADRC's).

There is one other disincentive in the present practice I want to mention. When someone over the age of 65 is admitted to an IMD, his or her Medicare benefit usually pays for the admission, while the CMO continues to be paid. We have noticed a lack of efficiency in discharge planning in these circumstances also.

In closing, I believe we would have improved care coordination and delivery if the cost of crisis services was shared by the State and Care Management Organizations. I believe this would enhance services for Family Care enrollees, be more efficient, and ultimately save money.

Thank you for your time and consideration.

Kathi Cauley
Director
Jefferson County Human Services

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MEMORANDUM

TO: Honorable Members of the Assembly Committee on Aging and Long-Term Care

FROM: Sarah Diedrick-Kasdorf, Deputy Director of Government Affairs

DATE: February 19, 2014

SUBJECT: Support for Assembly Bill 468

The Wisconsin Counties Association (WCA) supports Assembly Bill 468 which:

- Requires the Department of Health Services (DHS) to notify a county that has financial responsibility for an individual who is receiving Family Care benefits of an enrollee's admission to a mental health institute (MHI) within 48 hours of admission.
- Requires DHS to establish criteria to determine, and then must determine, whether an enrollee is at substantial risk for being admitted to a mental health institute.
- Requires every Care Management Organization (CMO) to maintain for each enrollee a record of individuals who can be contacted in case of an emergency with the enrollee.
- For every enrollee whom DHS determines is at substantial risk of being admitted to an MHI, requires a CMO and the county in which it operates to create an emergency plan including an emergency contact and a potential placement for when the enrollee is discharged from the MHI. If an enrollee is admitted to an MHI, the financially responsible county; the county that approved the admission, if different; and the CMO must create a team comprised of certain individuals to coordinate a new placement for the enrollee.
- Requires DHS to submit to the Joint Committee on Finance (JCF) a report identifying issues relating to cost liability for counties with enrollees who are admitted to an MHI. DHS is required during the 2013-15 fiscal biennium to submit one or more requests to JCF for moneys to pay a portion of the additional costs incurred by a county to support services provided to enrollees by the MHI. If JCF releases the moneys, DHS may reimburse the county based on the length of the enrollee's stay at the MHI.

This bill addresses a number of concerns that have been raised by counties regarding the placement of MCO members / Family Care enrollees in a mental health institute.

Under current law, counties pay the non-federal share of costs (approximately 40 percent) for individuals under the age of 22 or age 65 or older who are admitted to a state mental health institute. Counties are responsible for 100 percent of the costs of care for individuals placed in a MHI between the ages of 22 and 64. Under current practice an individual who participates in the Family Care program is disenrolled from the program once admitted to a mental health institute (due to a prohibition on the use of MA funding for IMD costs between 22 and 64). The individual then becomes the financial responsibility of their home county.

Unfortunately, over the years there have been instances in which the home, or financially responsible, county was unaware that a Family Care enrollee was admitted to a state mental health institute until the county was billed for the service. This occurs most often in situations in which a Family Care enrollee is placed in an out-of-home setting outside of their home county and the enrollee experiences a mental health crisis. With MHI charges approaching $1,000 per day, the financial hit to a county can be quite substantial (one county reported 14 such placements representing 417 days of care). Therefore, the 48-hour notification provision contained in Assembly Bill 468 is crucial.

Counties have also raised concern regarding the length of stay of Family Care enrollees in the mental health institutes. Once an individual is disenrolled from the MCO, there is no incentive for the MCO to work with counties on discharge planning. This oftentimes leads to an increased length of stay in a mental health institute for former Family Care enrollees compared to non-Family Care placements. One county reported that in 2013 the average length of stay in a MHI for Family Care members was 88 days, 20 days longer than non-Family Care placements. It is also not uncommon for a county to be notified that an individual is ready for discharge but the MCO does not have a community placement available to meet their needs. Every additional day in the MHI is a significant cost to the home county and a disservice to the former Family Care enrollee who is ready for community placement.

However, finances represent only a small portion of why counties support this bill. A significant portion of this legislative session has been devoted to improving mental health services within the state, including increased use of mobile crisis teams to avoid emergency detentions / placements. In many respects, this bill takes that concept one step further by taking a proactive approach to identify Family Care enrollees who are at substantial risk of placement in a mental health institute and develop an emergency plan should a crisis arise. The plan not only aids in diverting a potential emergency placement, but if a placement must be made for the health and safety of the individual involved, counties and the MCO must work together to coordinate a new placement for the enrollee to ensure placement back in the community as soon as the individual is ready for discharge.

Over the years, efforts have been made to address these issues. Unfortunately, there has yet to be a resolution. This bill is a good first step in addressing the financial issues plaguing counties with the disenrollment of Family Care members who are placed in a MHI, while at the same time improving the quality of care to MCO members by pre-planning for crisis situations and requiring all parties work together to return an individual to a community setting as soon as they are ready.

WCA respectfully requests your support for Assembly Bill 468.

Thank you for considering our comments.

disabilityrights | WISCONSIN

Testimony Regarding AB 468
Assembly Committee on Aging and Long Term Care Feb.19,2014
Kristin Kerschensteiner, Managing Attorney
Disability Rights Wisconsin

Rep. Endsley and members of the Committee, thank you for this opportunity to share DRW's perspective on proposed Assembly Bill 468. I am Kristin Kerschensteiner, Managing Attorney at Disability Rights Wisconsin, designated under state law as Wisconsin's federally mandated Protection and Advocacy agency for Wisconsin. I have spent a large portion of my legal career working on issues related to mental health and the rights of persons living with mental illness, including a number of legal challenges to mental health commitment statues and practices. Additionally, DRW is responsible for this state's Family Care Independent Ombudsman Program for members under 60. Although I am not part of that program, as Managing Attorney of the Protection and Advocacy community and institutions team I have been involved in a number of cases referred to the P&A by DRW Family Care Ombudsmen working with a client who has ended up in one of the state's two mental health institutes under an emergency detention and for whom there does not appear to be a clear path for return to the community.

DRW agrees with the Governor's assessment in his veto message for a prior iteration of this current bill that the proposal appears to only create a short-term, stop-gap remedy for counties but does little to address the ongoing, complex issues that hamper the placement of individuals with long-term care and mental health treatment needs in the most appropriate setting. On the other hand, DRW also feels the same frustration that some of you and the counties you represent are experiencing with the slow to nonexistent growth of community provider capacity for these individuals. Nor do we see evidence of sufficient expertise and resources in either the MCO's or DHS committed to aggressively respond to crisis situations and successfully deal with the complex needs of many of the individuals who are ending up in the institutes.

What DRW has experienced as a typical scenario in our advocacy work with Family Care members between 22 and 64, begins with an individual who is residing in a group home and who becomes aggressive toward peers or staff. Unfortunately, the only "crisis plan" in too many of these situations, relies on calling law enforcement and setting the emergency detention process in motion. Under existing mental health law (Wis. Stats §51.15(2)) law enforcement must contact the county of residence for the individual and receive approval before transporting the person to a mental health institute. Even if the individual is not taken to the mental health institute in an emergency detention situation, the county must still approve the admission. [Wis. Stats §51.05(2) and 51.10(1).

Therefore, if the mental health law is followed the county should know about the impending admission and will have to approve it. Often the situation has spun too far out of control, and the county may believe it has no choice but to use the mental health institutes as a last resort.

DRW has raised questions with the Department of Health Services regarding the development of resources and expertise to respond to these "crisis stabilization" cases, as opposed simply

allowing the county to continue these admissions with reduced financial exposure and therefore less incentive to be diligent in developing a less restrictive community placement.

DRW is cautiously optimistic that there are solutions being explored by DHS, such as the 11/19/13 DLTC memo on diversion services for people in this type of situation, increase the ability of the state Centers respond more quickly to emergency situations, and encouraging cooperation between MCO's to pool resources regionally to develop cooperative regional community based crisis beds as an alternative to the mental health institutes Although there are cases where the individual does have a serious and persistent mental illness, the majority of situations that DRW hears about are individuals with either developmental or intellectual disabilities who are exhibiting aggressive, out of control physical behavior. The institutes are not the appropriate place for treating this type of individuals, once the initial stabilization has occurred.

DRW is encouraged that the DHS has included developed more robust requirements to begin discharge planning prior to admission to the state Center's Intense Treatment Program beds. However, this does change the fact that there continues to be a lack of appropriate community residential placement options for people with complex needs. DRW believes that there needs to be an intentional development of these options, and we would like to see DHS invest targeted resources into development of community placements that will have the flexibility and funding to adequately serve complex needs. Targeted monies should be used to create placements with a focus on incentivizing the MCO's to develop the needed continuum of services and participate in efforts to move the individual back to a successful plan in the community.

The proposed legislation seems to do nothing to shift the MCO and providers's self interests away from continuing the current practice of relying on the emergency detention process to deal with behavioral crises. However, what it does do is remove the incentive of the counties to push for appropriate discharge planning. Nothing in this proposal changes the fact that adults in the civil units at Mendota and Winnebago Mental Health Institutes are invariable in the process of being committed, or are already committed, to the care, custody and control of the county. The mental health commitment judge sets the maximum level of restriction in the commitment order, but the law requires that then the county must take charge of the planning and movement of the individual from placement to placement. DRW is concerned about an increased potential for ADA "Olmstead" violations for individuals who the mental health institute considers to be ready for a less restrictive setting, but who encounter resistance from a county that has reached the zero financial liability level, as well as an MCO facing pressure to keep costs down and who does not want to serve such a challenging, high cost individual.

Finally, I believe that calculation of the fiscal impact estimate of this bill is likely under estimated. At the end of January 2014, the manner in which Medicaid reimbursement was determined for emergency mental health services like the mental health institutes was changed in order to comply with federal rules. For example, the estimate is based on the costs for 45 individuals admitted to a mental health institute between 2011 and 2013 who remained there for more than 30 days. Of those 45, 18 were between 22 and 64 and the institute could not seek Medicaid reimbursement for them. The remaining 27 were considered eligible for reimbursement through federal Medicaid financial participation. Under the rule effective

February 1st, DHS estimates that 20% of those individuals who had been eligible for Medicaid coverage prior to this would not now be eligible for the 60% federal Medicaid match. This is due the ruling that does not allow Medicaid to pay for emergency services where an individual is determined to be a danger to others but not to themselves. This exclusion may likely prove to be even more prevalent in the situation I described earlier than DHS's general estimate.

In sum, those parts of the bill that emphasize emergency crisis planning and requiring the immediate assembling of a discharge planning team upon admission to an institute are certainly good ideas, targeted at working towards a long term solution to this complicated problem. However, shifting the financial responsibility away from the both the Counties and MCO's will only worsen the problem, not resolve it.

Thank you again for your time and attention.

Contact: Kit Kerschensteiner or Lisa Pugh (608) 267-0214

Survival Coalition
of Wisconsin Disability Organizations

101 East Wilson Street, Room 219, Madison, Wisconsin 53703
Voice: 608/266-7826 Fax: 608/267-3906

February 18, 2014

Assembly Committee on Aging and Long Term Care
Representative Endsley, Chair
State Capitol, Room 219 North
Madison, WI 53708

Dear Rep. Endsley and members of the Committee:

Thank you for the opportunity to comment on proposed Assembly Bill 468.

The Survival Coalition is a cross-disability coalition of more than 30 state and local organizations and groups focused on changing and improving policies and practices that support people with disabilities of all ages to be full participants in community life.

Survival Coalition supports the provision that requires the Mental Health Institution to notify counties when a Family Care enrollee is admitted. Advocates also agree that preventative steps that can help avoid acute crises or contribute to a timely and effective resolution are a good strategy and investment. Establishing risk criteria and requiring an emergency crises response plan that includes identification of placements where an individual can be returned to the community for high risk individuals are good first steps.

In times of acute mental health or health care crisis, a lack of community support capacity is resulting in people being placed and treated in costly institutional settings. Some people with complex mental health needs are being involuntarily committed, and are held for long periods of time in costly mental health institutions because there are no appropriate community supports available through Managed Care Organizations (MCOs). In some cases, people with challenging behaviors but who do not have mental health conditions that meet the criteria for institutionalization are being institutionalized in psychiatric facilities; which may be contrary to the regulations governing such facilities.. This bill does not address the critical need for increased community support capacity to ensure that people with complex mental health needs can live in the community safely.

While MCOs are required to participate in developing emergency response plans for individuals in their care under the bill, once a person is admitted to a mental health institute the role of the MCO disappears. In its current form, Survival Coalition is concerned that this bill incentivizes MCOs placement and abandonment of people in institutions without any financial accountability to the county/state on the MCO's part or any responsibility for the MCO to facilitate community placements for clients released from mental health institutions. Without a financial incentive for MCOs to participate in moving the person back into the community, we are concerned MCOs may use institutions as a mechanism to deposit clients with challenging behaviors and transfer all costs to

the state. We are further concerned that solely focusing on which part of government should be paying the institution's bill detracts from the question of whether institutional care is appropriate for the individual and does nothing to resolve the lack of community support capacity that would ultimately be better for the individual as well as more cost-effective for the state.

Survival Coalition recommends that you incentivize MCOs to develop the needed continuum of services that enable people to safely live in the community. Committing people to the most expensive, restrictive setting (e.g. a mental health institution) should be an option of last resort, not a decision because no community alternative exists.

Survival Coalition looks forward to continuing to work for substantive improvements in quality community supports for people with disabilities.

Thank you for your consideration,

Sincerely,
Survival Co-Chairs:

Maureen Ryan, moryan@charter.net; (608) 444-3842;
Beth Swedeen, beth.swedeen@wisconsin.gov; (608) 266-1166;
Kristin M. Kerschensteiner, kitk@drwi.org; (608) 267-0214

Survival Coalition Issue Teams: education, employment, housing, long term care for Adults, long term care for children, mental health, transportation, workforce, voting, Medicaid and health care.