The Impact of the Affordable Care Act on Milwaukee County's Behavioral Health Division

Prepared By:

Michael Bare
Research and Program Coordinator
Community Advocates Public Policy Institute

David Riemer
Senior Fellow
Community Advocates Public Policy Institute

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About the Community Advocates Public Policy Institute

Community Advocates established the Public Policy Institute to identify and carry out specific, evidence-based policy changes that will help reduce poverty and improve the quality of life for low-income individuals and families in Milwaukee and throughout Wisconsin.

The Public Policy Institute is intensely engaged in strategizing, researching, organizing, communicating, and developing policy and legislation in order to persuade policy makers to create public policies that directly help impoverished people lead better lives.

True to its name, the heart of the Community Advocates Public Policy Institute's work is advocacy. The Public Policy Institute is uniquely situated in a human services agency that serves more than 75,000 clients annually. This allows the Public Policy Institute to interact with clients and the staff who provide advocacy and supportive services.

The Public Policy Institute also joins with individuals and organizations at the local, state, and national levels to develop and implement a practical strategy to reduce poverty throughout Wisconsin. This approach includes constant monitoring and consideration of the policies and issues affecting health care, employment, housing, criminal justice and public safety, education, and prevention initiatives to ensure both the safety and success of the low-income communities in Milwaukee and throughout Wisconsin.

For more information on the Public Policy Institute, please visit: http://communityadvocates.net/ppi

I. Executive Summary

The Community Advocates Public Policy Institute has partnered with the Public Policy Forum in a project designed to advise Milwaukee County's Behavioral Health Division (BHD) on ways to strategically prepare for implementation of the Affordable Care Act (ACA). That project was launched in April 2012 with financial support from BHD and the Milwaukee County Department of Health and Human Services.

CA-PPI's role in the project was to understand, assess, and report on the impact of the ACA on BHD. This included educating BHD senior staff on the ACA. During several meetings, CA-PPI presented information and discussed a multitude of subjects related to the ACA's impact on BHD.

The ACA clearly has the potential to transform both BHD's financial outlook and the care that patients receive. Several ACA provisions are already in place and are already having an impact on BHD. For the most part, however, the effects of the ACA will occur in 2014 and future years because of timelines in the law, the opportunity provided to the State of Wisconsin to enact implementing legislation regarding Medicaid, and anticipated federal regulations, guidance, and approvals.

This report will discuss the ACA's expansion of health coverage options, its expansion of benefits, new care delivery models, and new funding opportunities. Each will be put in the context of BHD's services and patients.

Finally, this report will make recommendations on the future of BHD and how it can harness the ACA to increase Medicaid and insurance company revenue, reduce reliance on property taxes, and improve the care of the patients BHD serves. Because we do not yet know: (1) what Governor Walker, the Wisconsin Legislature, and other state policymakers will do regarding the potential expansion of Medicaid to individuals up to 133% of the federal poverty level; and (2) what the final regulations from the U.S. Department of Health and Human Services will look like with respect to the operation of Wisconsin's federally-facilitated exchanges and the details of the ACA's Essential Health Benefits package, it is not possible at this juncture to translate this report's recommendations into precise estimates with dollar figures. Even with this measure of uncertainty, however, we believe BHD can begin to take concrete steps—regarding both financing and services—to prepare for the implementation of the ACA.

II. Research Method, Limits of this Research, and Glossary of Terms

Research Method

The preparation of this report relied on interviews and conversations with Milwaukee County Behavioral Health Division staff, as well as a review of relevant literature. Full citations to sources can be found throughout this report.

Limits of this Research

This research was limited by the inability of BHD to provide data regarding eligibility and benefit characteristics—U.S. residency status, age, dependent children, custodial parent status, pregnancy, disability, family size, income, and insurance status—of the population it serves. The availability of this data would have allowed for a far more precise estimate of the impact of the ACA on BHD. With such information, for example, this report would have included a side-by-side that compares the population served, benefits provided, costs incurred, and the types and amounts of revenue received by BHD in 2011 without the ACA vs. the population that would have been served, the benefits that would have been provided, the costs that would have been incurred, and the types and amounts of revenues that would have been received by BHD in 2011 if the ACA were in effect. In the absence of such data, this report is limited to general conclusions and basic recommendations.

This research was also limited by the fact that we do not yet know: (1) what Governor Walker, the Wisconsin Legislature, and other state policymakers will do regarding the potential expansion of Medicaid to individuals up to 133% of the federal poverty level, and (2) what the final regulations from the U.S. Department of Health and Human Services will look like with respect to the operation of Wisconsin's federally-facilitated exchanges and the details of the ACA's Essential Health Benefits package. It is reasonable to assume, however, that the state's Medicaid program will *at least* be expanded to cover almost all legal residents (except those who are incarcerated) up to 100% of the federal poverty level, and may well be further expanded to cover all such persons up to 133% of the federal poverty level. It is also reasonable to assume that the decision to allow the federal government to operate the required exchanges in Wisconsin will have only a limited impact, at least in the near term, on the provision and financing of health care and, thus, only a limited impact on BHD. This report generally reflects these two assumptions.

Glossary of Acronyms

ACA – The Patient Protection and Affordable Care Act (Pub. L. No. 111-148)

BHD – Milwaukee County Behavioral Health Department

BHP – Basic Health Plan

CA-PPI – Community Advocates Public Policy Institute

DHHS – Milwaukee County Department of Health and Human Services

FPL – Federal Poverty Level

QHP – Qualified Health Plan

III. Background

The Community Advocates Public Policy Institute (CA-PPI) has partnered with the Public Policy Forum in a project designed to advise Milwaukee County's Behavioral Health Division (BHD) on ways to strategically prepare for implementation of the Affordable Care Act (ACA). The project was launched in April 2012 with financial support from BHD and the Milwaukee County Department of Health and Human Services (DHHS).

CA-PPI's role in the project was to understand, assess, and report on the impact of the ACA on BHD. This included educating BHD senior staff on the ACA. During several meetings, CA-PPI presented information and discussed a multitude of subjects related to the ACA's impact on BHD.

The ACA clearly has the potential to transform both BHD's financial outlook and the care that patients receive. Several ACA provisions are already in place and are already having an impact on BHD. For the most part, however, the effects of the ACA will occur in 2014 and future years because of timelines in the law for exchanges, the opportunity provided to the State of Wisconsin to Medicaid, and anticipated federal regulations, guidance, and approvals.

According to the Public Policy Forum's report titled "Assessing the Financial Outlook of 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)."[1]

The report explains further, "At its Mental Health Complex, Milwaukee County owns and runs an inpatient hospital consisting of five licensed 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 (PCS) that serves persons in need of emergency mental health treatment, more than 60% of whom typically are brought in by law enforcement on an Emergency Detention; a mental health Access 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."

This report will discuss the ACA's expansion of health insurance coverage options, expansion of benefits, new care delivery models, and new funding opportunities. Each will be put in the context of BHD's services and patients.

Finally, this report will make recommendations on the future of BHD and how it can harness the ACA.

[1] Henken, Rob. Allen, Vanessa. "Assessing the Financial Outlook of Milwaukee County's Behavioral Health Division." Public Policy Forum. October 2012.

IV. How Provisions of the ACA Will Affect BHD

1. Expanded Health Insurance Coverage

One of the ACA's main goals is to expand the number of people who are insured. The law achieves this goal through a combination of a tax on those who do not maintain "minimum essential coverage," an optional expansion of Medicaid for all persons up to 133% of the federal poverty level (FPL), a new Basic Health Plan (BHP) that states can create, premium subsidies for individuals between 133% and 400% of FPL who obtain private insurance coverage through health insurance exchanges, protections from insurance company discrimination, and other expansions of eligibility.

The chart below documents the patchwork effect of health coverage options available to low-income Wisconsinites after January 1, 2014. These options are available to both the uninsured and those who have health insurance coverage, depending primarily on their US residency status and income in relation to FPL. The chart does not present private insurance options other than those available through the exchanges, though it should be recognized that most Wisconsinites now receive and will continue to obtain their health insurance through employers (both private and public) outside of the exchanges. The chart also does not discuss Medicare, which is almost universally available to seniors 65 years of age and older.

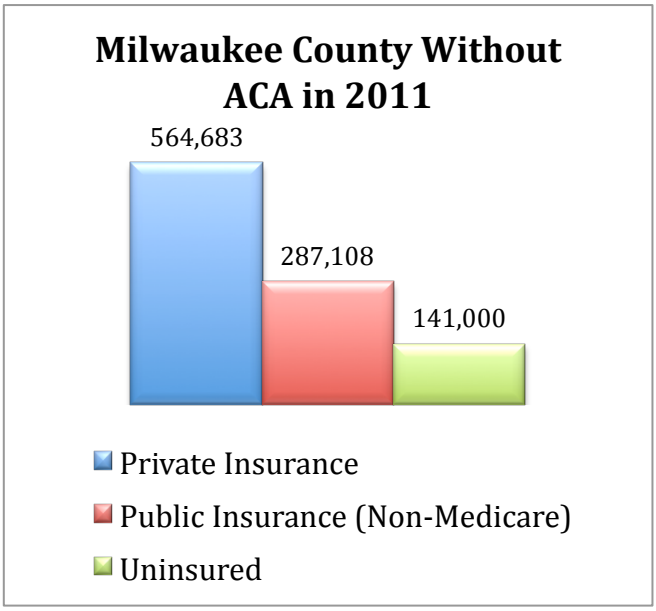
Low Income Health Coverage Options After January 1, 2014

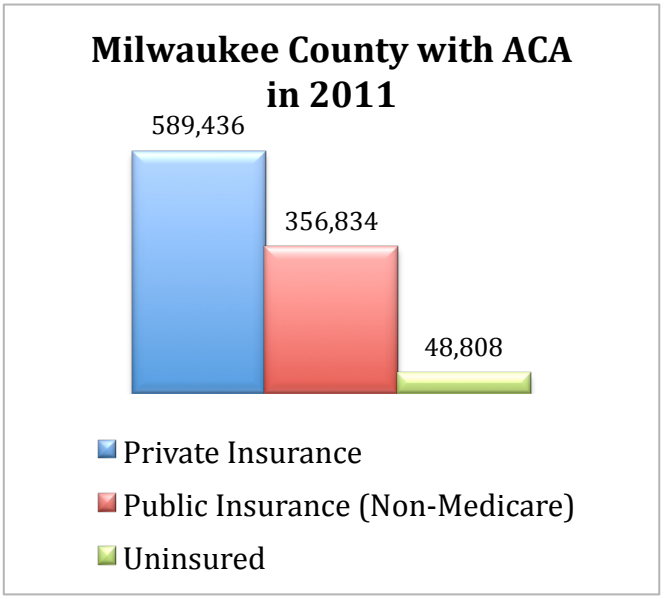
% of Federal Poverty Line	Minimum Coverage Requirement?º	Potentially Medicaid Expansion Population?	Basic Health Plan?	May Use Exchange?	Get Subsidy in Exchange?
0% to 100% - US and WI citizens	No	Yes, State Option	No	Yes	No
0% to 100% - Aliens who are lawfully present and paying taxes	No	No	No	Yes	Yes
100% to 133%	Yes*	Yes, State Option	No	Yes	Yes
134% to 200%	Yes*	No	State Option	If BHP exists No, otherwise Yes	If BHP exists No, otherwise Yes
201% to 400%	Yes*	No	No	Yes	Yes
Above 400%	Yes*	No	No	Yes	No

* Exemptions:
- Those who claim a religious exemption
- Individuals not lawfully present
- Individuals who are incarcerated
- Members of Indian tribes
- Individuals with gaps in coverage that are less than 3 months in duration
- Individuals with a monthly contribution that exceeds 8% of household income
- Individuals certified by HHS Secretary to be in a "hardship" (where no affordable plan is available)

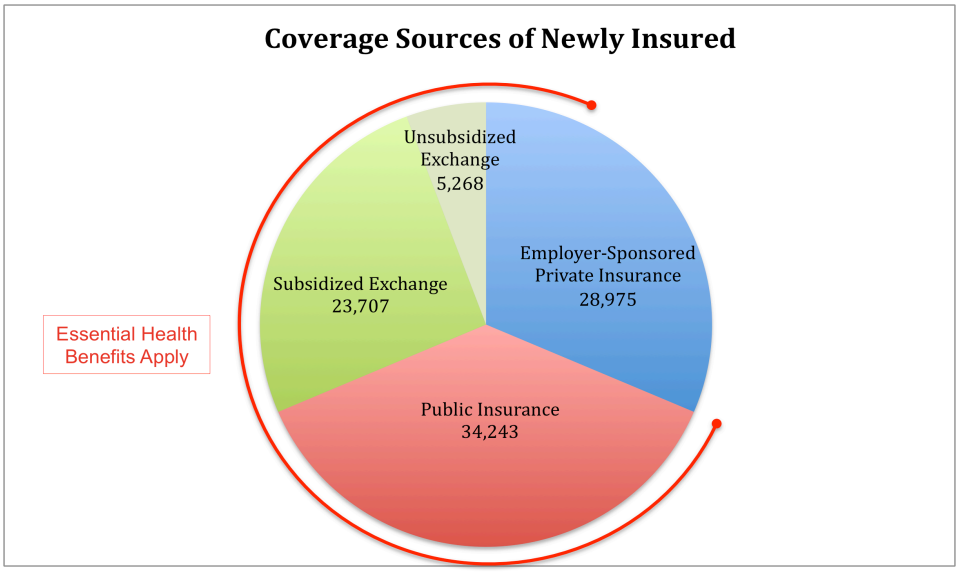
º The associated penalty applies to anyone who is non-exempt (see above) and above the tax-filing threshold (currently $9,750 individual, $19,500 couple filing jointly).

If the ACA were in effect in 2011, we estimate[2] that in Milwaukee County 69,726 more people would have had public insurance (other than Medicare), 24,753 more people would have had private insurance, and 92,192 fewer people would have been uninsured. The charts below compare the insurance status of County residents in 2011 without the ACA (status quo) with what their insurance status would be in 2011 if the ACA were in place.





The next chart provides additional estimates regarding those in Milwaukee County who would have become newly insured in 2011 if the ACA were in place. We estimate that 34,243 would move to public insurance (other than Medicare), 23,707 would move to subsidized coverage in the exchange, 5,268 would move to unsubsidized coverage in the exchange, and 28,975 would move to employer-sponsored private insurance.



[2] Estimates based on CA-PPI calculations derived from data in: Gruber, Jonathan, et al. "The Impact of the ACA on Wisconsin's Health Market." July 18, 2011. http://www.dhs.wisconsin.gov/aboutdhs/docs/WI-Final-Report-July-18-2011.pdf

We estimate[3] that, if the ACA were in effect in 2011, as many as 70,000 of the newly insured Milwaukee County residents would have obtained insurance coverage that included the Essential Health Benefits package, which will guarantee mental health and substance use disorder services.

a. Tax on Those Who Do Not Have Insurance Coverage

The ACA imposes an individual mandate, enforced via a tax, on individuals who do not have "minimum essential coverage" for health insurance. This insurance coverage mandate does not apply to individuals who: (1) are not lawfully present in the United States, (2) imprisoned, or (3) have a religious objection to health coverage. Otherwise, the ACA requires individuals—including a large segment of BHD's patients—to obtain and maintain health insurance. The mandate will thus substantially decrease the proportion of BHD's patients who are uninsured and unable to pay bills on their own and greatly increase the likelihood that BHD's patients will have health insurance and, thus, a reliable mechanism for paying the costs of their care.

b. Increased Coverage Through Expanded Medicaid Eligibility

i. General

Congress's original intent was to require states to expand Medicaid eligibility up to at least 133% of the Federal Poverty Level (FPL) for all U.S. residents. The Supreme Court, however, struck down the requirement that states must expand Medicaid eligibility up to 133% of FPL, making the expansion a choice for states.

In Wisconsin, Medicaid currently covers all children (BadgerCare+), pregnant women up to 300% of FPL (BadgerCare+), parents/caretakers of children under 19 up to 200% of FPL (BadgerCare+), and adults without dependent children up to 200% of FPL (BaderCare+ Core Plan).[4] The BadgerCare+ Core Plan's enrollment has been capped and suspended for the last couple of years.[5] The ACA requires, through a maintenance of effort provision, that the state keep its Medicaid eligibility through 2014 at the level it was at when the law was passed in 2010. For children, the state is required to keep its eligibility static through 2019.[6]

Should states expand their Medicaid programs to cover all who are eligible up to 133% of FPL, the cost of "newly eligible" enrollees will be paid for with generously enhanced federal reimbursement rates (FMAP) of 100% for 2014 through 2016, 95% in 2017, 94% in 2018, 93% in 2019, and 90% thereafter.[7] In addition, if Congress reauthorizes SCHIP, states will receive a 23% increase in the SCHIP FMAP for 2016 through 2019.[8] For Wisconsin, the SCHIP FMAP rate will rise from a mid-70% figure to a mid-90% figure. This means that states that expand their Medicaid programs up to 133% of FPL will not see a significant increase in state spending due to the very large increase in Medicaid eligibility and enrollment that the ACA permits. It is likely that Wisconsin may actually experience a *decrease* in its Medicaid costs associated with expanding eligibility up to 133% of FPL.

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[3] Estimates based on CA-PPI calculations derived from data in: Gruber, Jonathan, et al. "The Impact of the ACA on Wisconsin's Health Market." July 18, 2011. http://www.dhs.wisconsin.gov/aboutdhs/docs/WI-Final-Report-July-18-2011.pdf

[4] "U.S. Supreme Court Decision on the Federal Affordable Care Act." Wisconisn Legislative Council Information Memorandum. July 2012.

[5] "BadgerCare+ Core." Wisconsin Department of Health Services. http://www.dhs.wisconsin.gov/badgercareplus/core/index.htm

[6] Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[7] Id.

[8] Id.

Wisconsin's next biannual budget will set the state's Medicaid eligibility levels. As of the date of this report, it is unclear whether Governor Walker will seek an expansion of Medicaid eligibility. It is unclear whether the Wisconsin Legislature would approve an expansion. It is important to note that the BadgerCare+ and BadgerCare+ Core waivers expire at the end of 2013. It is also important to recognize that the U.S. Department of Health and Human Services has linked the enhanced federal reimbursement rates (mentioned above) to specific calendar years. Thus, if Wisconsin opts to delay the expansion of its Medicaid program until 2017, for example, it would not receive 100% reimbursement for 2017 and the following two years (with declines in FMAP to follow), but rather would immediately begin to experience the reduced reimbursement rate of 95% that is scheduled for calendar year 2017 (with further declines in FMAP to follow).

An expansion of Wisconsin's Medicaid programs would dramatically impact the care provided and revenue collected at BHD and should be monitored closely before the County completes its 2014 budget discussions. If the state decides not to expand Medicaid, some individuals would still gain insurance through the individual exchange where they would also be eligible for premium subsidies, some would continue with the level of coverage they had, and some would continue to be uninsured. The state government is likely to complete action on the Medicaid expansion question by July of 2014, thus allowing BHD, the Milwaukee County Department of Health and Human Services, the County Executive and the County Board to plan for the expansion—assuming it happens—before they make final decisions on the County's 2014 budget.

ii. Possibility of Future Modification of IMD Exclusion

BHD is an "institution for mental disease" (IMD), as defined by Section 1905(i) of the Social Security Act (42 U.S.C. 1396d(i)). An IMD is "a hospital, nursing facility, or other institution of more than 16 beds, that is primarily engaged in providing diagnosis, treatment, or care of persons with mental diseases, including medical attention, nursing care, and related services."[9] IMDs are inpatient facilities that are excluded from federal Medicaid matching funds for patients ages 22 to 64. The federal government is generally prohibited from providing Medicaid funding for patients served by IMDs. This federal law was intended to ensure that states, either with their own funds or through a mixture of state and local funds, pay for the care of inpatient mental health services.[10]

The ACA stipulates, however, that under a "demonstration project," eligible states can receive federal Medicaid matching funds if they provide payment to privately owned and operated IMDs that have more than 16 beds. This allows for limited federal and state funding of mentally ill patients who are between ages 22 and 64, and whose care and treatment was previously excluded from Medicaid payments under the Social Security Act.[11]

The demonstration project will last three years. It designates $75 million in Medicaid funds, which must remain available through December 2015 and will only be distributed to eligible states while under the demonstration.[12] States' funding is dependent upon adequate data reporting as required by the U.S. Secretary of Health and Human Services. States must also explain how they will hold private institutions accountable for determining that patients have been adequately helped.[13]

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[9] "Compilation of Social Security Laws." Social Security Administration. http://www.ssa.gov/OP_Home/ssact/title19/1905.htm

[10] Id.

[11] "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[12] Id.

[13] Id.

Patient recipients must be enrolled Medicaid beneficiaries, be between the ages of 21 and 65, and require the care needed to treat an emergency psychological condition.[14]

It should also be emphasized that, at least for the purposes of the demonstration, the IMD waiver was made available only to privately owned and operated IMDs, and Wisconsin is not participating in the demonstration.

To become eligible, states completed a competitive application process and were then selected by the Secretary of Health and Human Services. The Secretary selected states in such a way so as to ensure an "appropriate national balance in the geographic distribution of such projects."[15] She selected 12 states to participate in the demonstration: Alabama, California, Connecticut, District of Columbia, Illinois, Maine, Maryland, Missouri, North Carolina, Rhode Island, Washington, and West Virginia.[16]

The outcome of the demonstration will be used to "assess whether this expansion of Medicaid coverage to include certain emergency services provided in non-government inpatient psychiatric hospitals improves access to, and quality of, medically necessary care, discharge planning by participating hospitals, and Medicaid costs and utilization." The Centers for Medicare & Medicaid Services (CMS), will be responsible for advising Congress on whether it should permanently amend or reverse the IMD Exclusion as laid out in the Social Security Act.[17]

Thus, the ACA has no immediate impact on BHD's IMD exclusion. This is, however, a legislative issue that should be monitored moving forward. If the experience of the 12 states that CMS chose to participate in this demonstration indicates that eliminating or modifying the general IMD exclusion will improve access or quality, lower costs, or both, BHD may wish to work with the State of Wisconsin and the state's congressional delegation to pursue an across-the-board change in federal policy regarding Medicaid reimbursement of IMDs. Such a policy change would have to address the issue of whether Medicaid reimbursement for IMDs would extend to both privately owned and operated IMDs and publicly owned and operated IMDs.

In the past, BHD has partnered with a private provider to work around the IMD exclusion. The County should explore this option again as it may be a viable option for increasing its Medicaid reimbursement revenue.

c. Possible Coverage Via a Basic Health Plan Option

The ACA's Basic Health Plan is an optional health coverage plan that allows states to offer a private insurance plan to consumers with incomes between 134% and 200% of the FPL, in lieu of offering these individuals coverage through either Medicaid or the individual exchange. The plan is paid for with federal funds that individuals would be entitled to through the individual exchange as premium subsidies (federal income tax credits). Specifically, states get to spend: "[T]he amount the Secretary [of the Department of Health and Human Services] determines is equal to [the sum of] 95 percent of the premium tax credits [available in the individual exchange] […], and the cost-sharing reductions under section 1402, that would have been provided for the fiscal year to eligible individuals enrolled in

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[14] "Affordable Care Act Psychiatric Emergency Demonstration." Catalog of Federal Domestic Assistance. https://www.cfda.gov/?s=program&mode=form&tab=step1&id=719bc26f7f43f1b1cafe32592ff80a2e

[15] Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[16] "Medicaid Emergency Psychiatric Demonstration." Centers for Medicare and Medicaid Services. http://innovations.cms.gov/initiatives/medicaid-emergency-psychiatric-demo/index.html

[17] "Medicaid Emergency Psychiatric Demonstration – Demonstration Design and Solicitation." Centers for Medicare and Medicaid Services. http://innovations.cms.gov/Files/x/MedicaidEmerPsy_solicitation.pdf

standard health plans in the State if such eligible individuals were allowed to enroll in qualified health plans through an Exchange…."[18]

It is unclear whether Wisconsin will establish a Basic Health Plan. If it does, it would be the only affordable health coverage option available to those between 134% and 200% of the FPL. Individuals who are eligible for the Basic Health Plan would be *in*eligible for both Medicaid and tax subsidies through the exchange.

If Wisconsin's policymakers begin to seriously explore the creation of a Basic Health Plan, BHD may wish to become actively involved to ensure that—compared to the alternatives of Medicaid or coverage through an exchange—the relatively low-income individuals who instead receive their health insurance through a Basic Health Plan experience no deterioration in access to, or the quality of, mental health or substance use disorder services. BHD may also wish to monitor the experience of other states that have adopted a Basic Health Plan if Wisconsin chooses not to, again for the purpose of assessing whether the exercise of this option makes access and quality better or worse with respect to mental health and substance use disorder services.

d. Coverage Through Health Insurance Exchanges

The ACA requires each state to have health insurance marketplaces—called exchanges—for the individual market (American Health Benefit Exchange) and the small group market (SHOP Exchange, for firms up to 100 full-time employees, unless Wisconsin chooses to limit this to firms of up to 50 full-time employees for the first two years). Exchanges will begin to function in late 2013, with exchange-facilitated insurance coverage beginning in 2014. Due to Governor Walker's decision to defer to the federal government on exchange establishment, the U.S. Department of Health and Human Services has no alternative but to establish a federally-facilitated exchange in Wisconsin.

The exchanges will act as a traffic cop for residents seeking health insurance, directing applicants to the right door for Medicaid, Medicare, the Basic Health Plan (if applicable), private insurance, etc. The exchanges are also a marketplace where applicants can "shop around" and compare "qualified health plans" (QHP). Beginning in 2014, as many as 1.5 million Wisconsinites may use the exchanges to access health coverage. Should the state elect to include large employers in the exchange after 2017, as many as 4.5 million Wisconsinites may use the exchanges.[19]

The law requires exchanges (regardless of who operates them) to:

- Consult during the design, implementation, and operational phases of the exchange with six types of stakeholders;
- Certify, re-certify, and de-certify qualified health plans;
- Designate navigators in compliance with the ACA; and
- Establish enrollment procedures (online portal, phone help line, and a path for agents and brokers).[20]

Generally, individuals with incomes between 100% and 400% of the FPL who are purchasing insurance through the individual exchange will be eligible for federal premium subsidies. These subsidies, which are delivered in the form of "refundable" federal income tax credits, will help lower-income participants in the exchange to pay more than 85% of the cost of their health insurance premiums. A calculator developed by the Kaiser Family Foundation, for example, found that a 19-year old

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[18] Sec. 1331. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[19] Estimates based on CA-PPI calculations derived from data in: Gruber, Jonathan, et al. "The Impact of the ACA on Wisconsin's Health Market." July 18, 2011. http://www.dhs.wisconsin.gov/aboutdhs/docs/WI-Final-Report-July-18-2011.pdf

[20] "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

adult at 134% of FPL would receive a subsidy of $2,919 per year to help buy an insurance plan costing $3,391 per year—in other words, this individual would receive an 86% subsidy for a plan with an actuarial value of 94% (which means the plan, on average, would pay for 94% of all health care costs).[21] The calculator estimates that a 64-year old adult at 134% of FPL would receive a $9,700 subsidy towards an insurance plan costing $10,172—in other words, a 95% subsidy for a plan that has a 94% actuarial value.[22] As incomes rise, the subsidy declines on a "sliding scale" formula, Subsidies of this magnitude will help a significant number of BHD's patients to afford health insurance.

It is possible that the federal government will require the exchanges to interface with local and county governments that provide health care. BHD should monitor and review any regulations related to federally-facilitated exchanges concerning the interaction between local/county governments and exchanges.[23] Even if federal regulations do not require, authorize, or even mention this interface, BHD should consider advocating for exchange policies that will benefit the individuals that BHD serves, particularly during the fluid federally-facilitated exchanges' establishment period, when it may be easier to obtain more favorable policies.

e. Protections from Insurance Company Discrimination

The ACA includes several provisions designed to protect consumers from insurance company discrimination and abuses.

Insurance companies already can no longer limit or deny coverage to children under 19 due to a pre-existing condition.[24] The same prohibition against restricting coverage due to pre-existing conditions will be true for adults beginning in 2014.[25] Before 2014, those adults can participate in the Pre-Existing Condition Insurance Plan.[26]

The law also ends lifetime and annual limits on coverage for all new health plans.[27] It ends the ability of insurance companies to withdraw one's coverage. And enrollees in health plans may now ask an insurer to reconsider its denial of coverage.[28]

Insurance companies must now publicly justify any unreasonable rate hikes. They may spend no more than 20% of premiums collected on administrative costs for individual and small group plans, and may spend no more than 15% of premiums collected on administrative costs in large group plans.[29]

The law also removes insurance company barriers to emergency services. Enrollees can seek emergency care at a hospital outside of the health plan's network. This may expand the population that seeks emergency services from BHD,[30] but it is not likely to significantly impact BHD.

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[21] See "Health Reform Subsidy Calculator," Kaiser Family Foundation. http://healthreform.kff.org/subsidycalculator.aspx
[22] *Id.*
[23] State Senator Kathleen Vine out (D-Alma) introduced legislation (Wisconsin Senate Bill 273) that would have required the exchanges to include a strong prisoner transition process and coordinate between the exchange, Medicaid and other governmental health institutions including county-run substance use disorder and mental health facilities.
[24] "Children's Pre-Existing Conditions." http://www.healthcare.gov/law/features/rights/childrens-pre-existing-conditions/index.html
[25] Popper, Richard. "Covering More Uninsured Americans Who Have Pre-Existing Conditions." Health Care Blog. http://www.healthcare.gov/blog/2011/02/pcip-enrollment.html
[26] "Preexisting Condition Insurance Plan." Department of Health and Human Services. http://www.healthcare.gov/law/features/choices/pre-existing-condition-insurance-plan/index.html
[27] "Lifetime & Annual Limits." Department of Health and Human Services. http://www.healthcare.gov/law/features/costs/limits/index.html
[28] "Patients' Bill of Rights." Department of Health and Human Services. http://www.healthcare.gov/law/features/rights/bill-of-rights/index.html
[29] "Value for Your Premium Dollar." Department of Health and Human Services. http://www.healthcare.gov/law/features/costs/value-for-premium/index.html

BHD should be aware of these new protections so that it can help ensure that those who are now able to get insurance coverage are indeed covered and do not face arbitrary cut-offs of benefits.

f. Other Expanded Eligibility Provisions

i. CLASS Act

The ACA included a long-term care program called the Community Living Assistance Services and Supports Act (CLASS Act). It was intended to be a voluntary long-term care insurance program that serves adults with multiple functional limitations, or cognitive impairments who have: (1) paid monthly premiums for at least five years, and (2) been employed during three of those five years.[31]

The Obama Administration indefinitely suspended the CLASS Act in October of 2011, citing concerns about its sustainability. The ACA required that the Secretary of Health and Human Services formulate a plan to ensure that the program would be financially solvent for at least 75 years, a stipulation Secretary Sebelius and HHS were unable to guarantee after extensive review.[32]

Though not implemented, the CLASS Act has not been officially repealed. In February of 2012, the House of Representatives voted to do so; the Senate has yet to take similar action.[33]

Should this provision of the ACA be revisited, it may have an impact on the long-term care patients at BHD. However, it is unlikely this law will ever be implemented.

ii. Young Adult Coverage

The ACA allows parents to keep their dependent children on their health plans until age 26. This provision will allow more of BHD's young patients to be insured and afford treatment. BHD should be aware of this new provision of the law and ensure that those young adult patients who are now able to get insurance coverage through their parents are indeed covered.

2. Expanded Benefits

The ACA also expands health insurance benefits in several ways. It establishes a new "Essential Health Benefits Package" that applies to Medicaid, the Basic Health Plan, and plans sold in the individual and small group markets (whether such plans are offered inside or outside of the exchanges). The ACA also requires Medicaid, Medicare, and private insurance plans to pay the full cost of certain prevention and wellness services that BHD provides. Though not discussed in this report, BHD should also be aware of and weigh in on any potential changes to federal mental health parity requirements.

a. Essential Health Benefits Package

The ACA requires Medicaid, the Basic Health Plan, and plans sold in the individual and small group markets (whether inside and outside of the exchanges) to provide coverage for "essential health

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[30] "Doctor Choice and ER Access." Department of Health and Human Services. http://www.healthcare.gov/law/features/rights/doctor-choice/index.html

[31] Sec. 8001. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[32] Khan, Human. "Obama Drops Long-Term Health Program." ABC News. 14 October, 2011. http://abcnews.go.com/blogs/politics/2011/10/obama-administration-drops-long-term-health-care-program

[33] Abrams, Jim. "House Votes to Repeal CLASS Act, Part of 2010 Health Care Law." Huffington Post. 1 Febraury, 2012. http://www.huffingtonpost.com/2012/02/01/class-act-repeal_n_1248430.html

benefits."[34] The "essential health benefits" requirements do not apply to large group plans, unless after 2017 the state elects to make its Small Business Health Options Program (SHOP) exchange available to larger employers with 100 or more employees and such firms utilize the SHOP exchange to provide coverage.

The Affordable Care Act defines essential health benefits to "include at least the following general categories and the items and services covered within the categories:

- ambulatory patient services;
- emergency services;
- hospitalization;
- maternity and newborn care;
- mental health and substance use disorder services, including behavioral health treatment;
- prescription drugs;
- rehabilitative and habilitative services and devices;
- laboratory services;
- preventive and wellness services and chronic disease management; and
- pediatric services, including oral and vision care."

The law explicitly includes "mental health and substance use disorder services, including behavioral health treatment"[35] in the list of essential health benefits. This is especially important to BHD and the patients it serves who are enrolled in Medicaid and individual and small group health plans. BHD stands to potentially receive new revenue for the services it provides to Medicaid enrollees and persons covered by individual and small group plans.

Neither the ACA itself, nor the federal regulations and guidelines that the U.S. Department of Health and Human Services has issued thus far, fully explain what types of "mental health and substance use disorder services" are included within that category of service. The Department will soon promulgate regulations that provide further insight, but even those regulations may leave some questions unanswered.

However, one important step that the Department has taken to clarify the meaning of "mental health and substance use disorder services" has been the Department's assertion that, at least for insurance plans sold through the exchanges, these (and other) benefits will have the meaning that they have in each state's "benchmark" plan. The Department has also established a process for determining what each state's "benchmark" plan happens to be.

Like all other states, Wisconsin will soon be required to choose a "benchmark" plan for the essential health benefits package. According to a summary of the intended approach of the U.S. Department of Health and Human Services: "[S]tates would have the flexibility to select a benchmark plan that reflects the scope of services offered by a 'typical employer plan.' This approach would give states the flexibility to select a plan that would best meet the needs of their citizens. States would choose one of the following benchmark health insurance plans:

- One of the three largest small group plans in the state by enrollment;
- One of the three largest state employee health plans by enrollment;
- One of the three largest federal employee health plan options by enrollment; or
- The largest HMO plan offered in the state's commercial market by enrollment.

[34] Sec. 1302. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[35] Sec. 1302. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

"If states choose not to select a benchmark, HHS intends to propose that the default benchmark will be the small group plan with the largest enrollment in the state."[36]

It is not clear whether Wisconsin will make this choice. It is not even clear whether the Wisconsin Office of the Commissioner of Insurance or Wisconsin Department of Health Services have done research on the choices. Federal regulations have yet to be released, but an earlier "bulletin" indicated the deadline for the benchmark decision would be the end of September of 2012. That deadline (if it was indeed a deadline) has now passed. The state has indicated it is awaiting further regulations from the federal government before making any decision. Whether Wisconsin will select a "benchmark" plan even after the promulgation of federal regulations remains to be seen.

This is a policy that BHD should closely monitor and work hard to influence. It relates directly to which of BHD's health services will in fact be covered by those enrolled in Medicaid, a Basic Health Plan, and individual and small group health insurance plans. It thus bears directly on which services BHD can bill for. BHD should actively work with the state—and, if the state takes a pass, with the federal government—to establish a "benchmark" plan for Wisconsin that broadly defines covered benefits for mental health and substance use disorder services to include case management, family psychological education, chronic illness management, recovery, etc.

b. Prevention and Wellness Coverage

The ACA establishes access for adults enrolled in Medicaid to receive preventive services with no out-of-pocket costs. For any preventive services to be free to the patient, the United States Prevention Services Task Force (USPSTF) must assign it a grade of "A" or "B."

The ACA also establishes prevention and wellness benefits for Medicare beneficiaries. It establishes coverage of annual "wellness visits" for Medicare beneficiaries. This section of the ACA also makes several references to the USPSTF recommendations, specifically regarding which services should be offered as part of prevention and wellness visits.[37] The law removes all out-of-pocket costs for Medicare beneficiaries, thus guaranteeing first dollar coverage, for all prevention and wellness services with "A" or "B" ratings from the USPSTF.[38] Finally, the law gives the Secretary of HHS the authority to modify or eliminate coverage of preventive and wellness services that are not consistent with the recommendations of the USPSTF.[39]

Any preventive health services that BHD provides to Medicaid enrollees, Medicare beneficiaries, and those enrolled in new private insurance plans may now be free to BHD's patients as a result of the ACA. BHD should be aware of which preventive health services it will not be receiving payment for directly from the patient, and which preventive health services will instead be paid for by Medicaid, Medicare, or private insurance.

3. Care Delivery

The ACA offers several ways that BHD (and the County as a whole) could transform the way it delivers health care. These include potentially becoming a "navigator" that assists patients in finding

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[36] "Essential Health Benefits." Department of Health and Human Services. http://www.healthcare.gov/news/factsheets/2011/12/essential-health-benefits12162011a.html

[37] Sec. 4103. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[38] Sec. 4104. "Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[39] Sec. 4105. Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

health coverage, and establishing a Medicaid Health Home or Medicare Accountable Care Organization that coordinates care.

a. Health Navigators

The exchanges established by the ACA are required to fund and award grants to "navigators" that will educate the public on the exchanges, distribute "fair and impartial information," facilitate enrollment, and provide referrals to those with complaints and questions about health plans. These navigators "may include trade, industry, and professional associations, commercial fishing industry organizations, ranching and farming organizations, community and consumer-focused nonprofit groups, chambers of commerce, unions, resource partners of the Small Business Administration, other licensed insurance agents and brokers."[40] Navigators will have the ability to screen and refer patients to the proper door for health coverage. Since BHD performs a function similar to this for its patients, BHD may be able to formalize the program as a "navigator" and apply for approval—and funding—of its "navigator" function.

While the ACA does not formally list government agencies such as BHD as entities that might become navigators, the law does not preclude a government agency such as BHD from performing the navigator role. This is a determination that will have to be made once an exchange authority is established in Wisconsin. BHD should monitor the policies developed for federally-facilitated exchanges, to ensure (at the very least) that the option of having BHD serve as a navigator is not prohibited or discouraged.

b. Medicaid Health Home Option

The ACA establishes the Medicaid health home model, which is a care delivery option for Medicaid providers. Recipients of health home services must have at least two chronic conditions, or one chronic condition with a risk of a second chronic condition, or one serious and persistent mental health condition. "Chronic condition" is a term defined by the Secretary, but includes by law: mental health conditions, substance use disorders, asthma, diabetes, heart disease, and being overweight as evidenced by having a Body Mass Index (BMI) over 25. States began implementing health homes on January 1, 2011. The federal government will pay 90% of the costs of the care during the first eight fiscal years that the state's plan is in effect.[41]

BHD should be in dialogue with the Wisconsin Department of Health Services about this care delivery model as it may be a viable option for some of BHD's services. Specifically, BHD should explore creating a behavioral health home model. A prime candidate is its state-certified Community Support Program (CSP), which provides intense case management services, nursing and psychiatric services to thousands of people in Milwaukee County at several locations every year. Several states have already implemented Medicaid behavioral health homes.[42]

c. Accountable Care Organization Option

An Accountable Care Organization (ACO) is a Medicare coordinated care delivery model. According to the Department of Health and Human Services, "ACOs create incentives for health care

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[40] Sec. 1311. Patient Protection and Affordable Care Act." Pub. L. No. 111-148. http://www.ncsl.org/documents/health/ppaca-consolidated.pdf

[41] "Health Homes." Centers for Medicare and Medicaid Services. http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Long-Term-Services-and-Support/Integrating-Care/Health-Homes/Health-Homes.html

[42] For one example, see Missouri: "Health Care Home." Missouri Department of Mental Health. http://dmh.mo.gov/about/chiefclinicalofficer/healthcarehome.htm

providers to work together to treat an individual patient across care settings – including doctor's offices, hospitals, and long-term care facilities. The Medicare Shared Savings Program will reward ACOs that lower growth in health care costs while meeting performance standards on quality of care and putting patients first. Patient and provider participation in an ACO is purely voluntary."[43]

According to rules proposed by the federal government, "[A]n ACO refers to a group of providers and suppliers of services (e.g., hospitals, physicians, and others involved in patient care) that will work together to coordinate care for the patients they serve with Original Medicare (that is, those who are not in a Medicare Advantage private plan). The goal of an ACO is to deliver seamless, high quality care for Medicare beneficiaries. The ACO would be a patient-centered organization where the patient and providers are true partners in care decisions."

According to Ron Manderscheid, an expert on behavioral health delivery and Executive Director of the National Association of County Behavioral Health and Developmental Disability Directors, "Last year, CMS issued final regulations governing Accountable Care Organizations (ACOs) under Medicare. These final regulations recognize hospitals, primary care practices, federally qualified health centers (FQHCs), and rural health centers as qualified entities to form ACOs. They do not, however, recognize behavioral healthcare provider organizations as qualified entities." Thus, Manderscheid recommends that behavioral health providers think creatively about how to form or be a part of an ACO.[44]

Several Wisconsin providers have already become ACOs. It is not within the scope of this analysis to determine how BHD could qualify to be an ACO or whether it should. BHD should, however, conduct an analysis to determine whether it may be able to improve its service to patients, increase funding opportunities, or both, if it becomes an ACO alone or in partnership with an outside ACO.

4. Funding Opportunities

The ACA includes billions of dollars for infrastructure investment, workforce development, health care improvement, and research. BHD should examine the opportunities and apply for funding it may qualify for.

[43] "Accountable Care Organizations: Improving Care Coordination for People with Medicare." http://www.healthcare.gov/news/factsheets/2011/03/accountablecare03312011a.html

[44] Mandersheid, Ron. "Are you Prepared to Lead ACOs from the Rear." Behavioral Health Care. 11 October, 2012. http://www.behavioral.net/blogs/ron-manderscheid/are-you-prepared-lead-acos-rear

V. Recommendations

The ACA is an extremely complex law with wide-ranging impacts on Milwaukee County. Its implementation offers an opportunity to reevaluate Milwaukee County's continuum of mental health and substance use disorder services, and identify policy changes that could improve its services, increase revenues, and potentially lower property taxes. Following are three major sets of recommendations that, if followed, will assist Milwaukee County in making optimal use of the ACA to achieve these service, revenue, and tax goals.

1. Gather Relevant Data

BHD will need to gather relevant data on the *number of insured* County residents after implementation of the ACA, and the *services* that insurance will make available to them. It is imperative that the County quickly gathers the data and dollars associated with these two variables.

The increase in the *number of insured* County residents will occur primarily because of: (1) the likely expansion of Medicaid coverage beginning January 1, 2014, to a much larger number of adults without dependent children who have incomes up to 133% of FPL, and (2) the provision to persons between 133% and 400% of FPL of sliding-scale premium subsidies if they use the ACA's exchanges to buy qualified health plans.

The impact on the scope of *services* that will be covered by insurance will occur because Medicaid enrollees, those participating in a state Basic Health Plan (if one is created), and all individuals who obtain insurance in the individual and small group markets, will have coverage that includes the ten benefits included in Essential Health Benefits package.

BHD and Milwaukee County need to generate current and reliable data on the potential impact of the ACA that will assist BHD leadership and County policymakers in formulating future decisions. Such data should include the following information about BHD's current patients:

1. U.S. residency status;
2. Age;
3. Dependent children (number and ages);
4. Custodial parent status;
5. Pregnancy status;
6. Disability status (potential qualification for Medicaid or Medicare coverage);
7. Family size and income (thus, percent of the Federal Poverty Level);
8. Insurance status (uninsured, Medicaid, Medicare, private insurance, or other coverage); and
9. The extent to which each patient's insurance covers mental health and substance use disorder treatment.

County policymakers, including those in BHD, the Department of Health and Human Services, the County Executive, and the County Board, will be unable to respond in an informed manner to the ACA's impact on the County unless they have a projection of which of BHD's current patients will:

1. Continue to have health insurance (and if so, what type);
2. Gain insurance coverage once the ACA becomes law, and, if so, which type of coverage;
3. Remain uninsured, despite the ACA;
4. Obtain coverage (whether newly insured or already insured) that includes the Essential Health Benefits package that provides insurance-financed coverage of their mental health and substance use disorder treatment; and

5. Have no insurance-financed coverage (whether newly insured, already insured, or uninsured) of their mental health and substance use disorder treatment, either because the ACA's Essential Health Benefits package does not cover the particular form of treatment they need or simply because the ACA does not apply to such individuals at all.

With such data, it will be possible to: make more informed decisions about the future role of BHD in helping the residents of Milwaukee County obtain mental health and substance use disorder services, understand the new and changing flows in revenues that will be available to pay for both non-BHD and BHD services, and make plausible estimates about the need to use property tax dollars to pay for certain Milwaukee County residents to obtain certain types of mental health and substance use disorder services. Such data will also greatly increase the prospect that the policymakers and stakeholders who are involved in discussions about the future of BHD will be able to make evidence-based decisions about whether BHD should continue operating as it is, reduce/downsize services, or move services entirely to community-based or private providers.

Without such data, much of the future of the County's mental health and substance use disorder treatment redesign effort will be largely guesswork.

2. General Recommendations for BHD

Regardless of the longer-term decisions that must be made about BHD's future role, BHD and the County will wish to make prudent shorter-term decisions about the impact of the ACA. To improve the quality of such shorter-term decisions, BHD and the County should take immediate action to better understand the complexities of the ACA and shape the law's implementation in Wisconsin to meet the needs of BHD, County government, and Milwaukee County taxpayers.

Following are seven specific steps that the County should take:

a. Full-Time ACA Coordinator

Several health care providers of BHD's size in Wisconsin have added a full-time position to examine the law and prepare for its impacts. The County should consider assigning a staff person the full-time responsibility of: (1) analyzing how the law will impact BHD (and the rest of the County), (2) following legislative and regulatory developments (including those related to quality measures at inpatient psychiatric facilities,[45] and many others), and (3) developing and implementing plans to manage any changes that impact BHD in ways that allow BHD to improve County residents' access to mental health and substance use disorder treatment, improve the quality of care that BHD itself delivers, and increase the per-patient revenue that BHD is able to obtain from Medicaid, Medicare, and private insurance. While many of the ACA's changes do not take full effect until 2014, the County should begin preparing now and through 2013.

b. Carefully Consider New Programs and Growing Current Programs

County policymakers should carefully consider any new programs and growing any current programs. Policymakers and the new full-time ACA coordinator should vet any changes or additions to ensure that they fit the context of the ACA and its changes to BHD's service role.

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[45] "CMS Proposals to Improve Quality of Care During Hospital Inpatient Stays." Centers for Medicare and Medicaid Services. http://www.cms.gov/apps/media/press/factsheet.asp?Counter=4346

c. Advocate for the Medicaid Expansion and Health Homes

Milwaukee County should actively advocate for an expansion of Wisconsin's Medicaid program up to 133% of the FPL. BHD could potentially increase its patient care revenue by millions of dollars every year, and this population would be able to seek affordable treatment.

BHD should be in dialogue with the Wisconsin Department of Health Services about the possibility of establishing Medicaid Health Homes for some of its services. This care delivery model may be a viable option for some of BHD's services, including its CSP locations.

d. Coping with the IMD Exclusion

The ACA has no immediate impact on BHD's IMD exclusion, though future legislation may result from a demonstration project included in the ACA. This is a legislative issue that BHD should monitor moving forward. If the experience of the 12 states that CMS chose to participate in the ACA's IMD demonstration project indicates that eliminating or modifying the general IMD exclusion will improve access or quality, lower costs, or both, BHD may wish to work with the State of Wisconsin and the state's congressional delegation to pursue an across-the-board change in federal policy regarding Medicaid reimbursement of IMDs.

The County should also explore the prospect of partnering with a private provider in order to avoid the IMD exclusion.

e. Monitor Exchange Implementation and Become A Navigator

It is possible that the federal government would require the exchanges to interface with local and county governments that provide health care. BHD should monitor and review any federal regulations related to Wisconsin's federally-facilitated exchanges for these developments. Even if federal regulations do not require, authorize, or even mention this interface, BHD should consider advocating for exchange policies that will benefit the individuals that BHD serves, particularly during the fluid period at the beginning of Wisconsin's exchange experience when it may be easier to obtain more favorable policies.

Milwaukee County should also carefully consider applying to be a navigator when the regulations are available from the federally-facilitated exchange authority, and if an analysis shows it would be in BHD's interest. We suspect that becoming a navigator would help increase BHD's revenues and the level of care that patients receive. Accordingly, BHD should monitor the policies developed for federally-facilitated exchanges, to ensure (at the very least) that the option of having BHD serve as a navigator is not prohibited or discouraged. As a part of the planning to become a navigator, BHD should examine and update its screening processes at each patient entry point so that the processes line up with eligibility standards and patient protections established by the ACA.

f. Be Aware of and Responsive to Changes to Covered Benefits

BHD should monitor any changes to federal mental health parity requirements. It is unclear as of the date of this report how the federal mental health parity law interacts with the ACA.

BHD should monitor any developments related to the essential health benefits package, because it relates directly to which of its health services will be covered by those enrolled in Medicaid, a Basic Health Plan, and individual and small group health insurance plans, and it relates directly to which services it can bill for.

Many of the preventive health services that BHD provides to Medicaid enrollees, Medicare beneficiaries, and those enrolled in new private insurance plans may now be free to BHD's patients as a

result of the ACA. BHD should be aware of which services it will not be receiving revenue for directly from the patient.

g. Explore Enhancing BHD's Revenue Using the ACA

BHD should examine the possibility of paying out-of-pocket costs that patients cannot afford if doing so would on balance yield greater patient revenues.

Finally, BHD should persistently examine new funding opportunities created by the ACA for potential revenue and new programs.

3. Determine BHD's Future Target Population and Core Services

In light of the ACA and good data, County policymakers should reevaluate two policy decisions: BHD's target care population, and its role in mental health and substance use disorder services.

a. Clarify BHD's Target Care Population

The County must decide how best to target its limited resources to two groups:

- Those individuals who (despite their coverage under ACA) Milwaukee's non-BHD providers can never be expected to provide adequate treatment for their mental illnesses and substance use disorders; and
- Those individuals who will have no ACA-based insurance coverage at all for mental health or substance use disorder treatment.

There is a case to be made that *anyone* who has health coverage (whether Medicaid, private policies, self-insured employers, or Medicare) for mental health and substance use disorders, and needs mental health or substance use disorder treatment, should be covered by their insurers with no involvement from BHD. We know, however, that *some* within this group—certainly in the short term, and possibly in the long run—will not obtain timely and adequate treatment through their insurers' arrangements with private (i.e., non-BHD) providers, for most or even any of the mental health or substance use disorder treatment they need.

BHD therefore should take the following steps with respect to Milwaukee County residents who have health insurance that covers mental health and substance use disorder treatment:

- Define in advance which groups of insured individuals are in fact likely to obtain excellent-to-adequate insurance-financed treatment for their mental health illnesses or substance use disorder through their insurers' chosen providers, encourage and expect those individuals to use such non-BHD providers, but be prepared to serve those individuals on the condition that BHD is reimbursed 100% for its costs; and
- Define in advance the group of individuals who, though insured, are *not* likely to obtain excellent-to-adequate insurance-financed coverage for their mental illnesses or substance use disorders through their insurers' chosen providers, and:
    - To the extent their insurers and providers *could* change the way they diagnose and treat mental health or substance use disorders so as in the future to provide them with excellent-to-adequate treatment, pressure the insurers and providers to improve their processes so that BHD need not be involved; but

- To the extent such insurers and providers continue to provide inadequate treatment, be prepared to serve those individuals on the condition that BHD is reimbursed 100% for its costs.

BHD's primary target patient population, however, should be those who will face significant barriers to getting insurance and affordable care. This population includes:

- Those transitioning out of incarceration and who, to the extent the State of Wisconsin fails to establish a robust system to immediately enroll them in Medicaid or private insurance upon release, are uninsured and, thus, have no insurance-based coverage—at least temporarily—for treatment of any mental illnesses or substance use disorders;
- Those who are not lawfully present in the United States, but nonetheless must be given emergency services; and
- Other low-income individuals who are uninsured because they are ineligible for Medicaid, do not qualify for subsidies in the exchanges, or for other reasons.

These populations will be unlikely to be able to access mental health and substance use disorder services elsewhere. BHD must be prepared to estimate in advance the numbers in each group, and be prepared to serve them. BHD should simultaneously seek to reduce their numbers, e.g., by working with the Wisconsin Department of Corrections and the state's exchanges (administered by the federal government for the foreseeable future) to increase the probability that those transitioning out of incarceration are enrolled in Medicaid or exchange-facilitated subsidized coverage immediately upon their release. BHD and the County will need to acknowledge, and deal with the reality, that many people in Milwaukee County could fall into gaps in the emerging health insurance system, and that among this group a portion will need mental health and substance use disorder treatment and yet have no insurance mechanism whatsoever to pay the bill. With private providers unlikely to step up and fill the gap, BHD must be prepared to play this role.

b. Clarify BHD's Service Role

County policymakers must also determine the *types* of mental health and substance use disorder services that BHD should provide, and how to provide the highest-quality services at the lowest feasible cost, with respect to all three groups: (1) the overwhelming majority of Milwaukee County residents who will have health insurance *and* insurance-financed coverage for mental health and substance use disorder treatment once the ACA takes effect in 2014, (2) the smaller group of residents who will have insurance but *no* insurance-financed coverage of mental health and substance use disorder treatment,[46] and (3) the residual group of uninsured residents.

An argument can be made that the ACA might eliminate the need for BHD to provide services to almost everyone. Michael Hogan, Ph.D., who is the Commissioner of the New York State Office of Mental Health, has made the argument: "If the new federal law equalizing coverage for mental conditions with that for medical-surgical care works as hoped, there may no longer be a need for a public system to handle mental health in the long run."[47]

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[46] Typically because their insurance coverage is not via Medicaid, the individual or small group market, or Medicare—all of which require coverage of mental health and substance use disorder treatment—but through larger employers who offer bare-bone insurance benefits that exclude mental health and substance use disorder treatment. It must be remembered that Wisconsin and federal parity requirements only apply to these larger employers *if* they offer mental health and substance use disorder treatment in the first place. Under both state and federal law, however, larger employers are free *not* to offer such coverage. While many do so, some do not.

[47] Hogan, Michael. "Will We Need a Separate Mental Health System in the Future?" Mental Health news. Vol. 14 No. 4. Fall 2012. http://www.mhnews.org/back_issues/MHN-Fall2012.pdf

Currently, Chapters 46 and 51 of the Wisconsin Statutes clearly mandate a role for Milwaukee County in behavioral health services, but those laws were written at a time when:

- Many Wisconsinites lacked health insurance;
- Health insurance often did not cover mental health and substance use disorder services;
- The insurance-based provision of these services (if and when it occurred) was often not on a parity basis; and
- The ACA did not exist.

In short, much of the context for Chapters 46 and 51 has dramatically altered. Given the nature of that alteration, it is improbable that BHD's role should remain the same. BHD leadership and County policymakers should undertake a thoughtful examination of whether and how BHD's role should change.

The prior section of this report discussed whether, in light of the ACA, it is now appropriate for BHD to modify its target population, i.e., change *who* it serves. In light of the ACA, it is now equally appropriate for BHD to modify the *types* of mental health and substance use disorder services it provides, i.e., change *how* it serves.

i. Insured Persons with Mental Health and Substance Use Disorder Coverage

The starting point is to determine, for the first of the three groups discussed above—that is, for those who will have insurance that includes coverage for mental health and substance use disorder treatment—how BHD should interact with this group's insurance plans and the plans' mental health and substance use disorder treatment providers. BHD has four choices:

- **Be an Advocate:** Help such individuals to gain timely access and quality services from their insurance-financed providers of mental health and substance use disorder treatment, but not be a provider itself;
- **Be an Insurance-Financed Provider:** Contract with the individuals' insurers to be *the* approved provider, or be *among* the set of approved providers, that deliver mental health and substance use disorder treatment, per agreements that cover BHD's full costs;
- **Be a Fallback Provider:** If advocacy does not produce adequate results and even though the individuals' insurers have not entered into contracts with BHD, nonetheless be a "fallback" provider that does what insurance-financed providers have failed to do by delivering needed, timely, high-quality mental health and substance use disorder treatment… and then try to obtain payments from the insurers that cover BHD's full costs, but recognize that insurers will often either refuse to pay or pay less than full cost, requiring County taxpayers to make up the difference; or
- **Cover Uncovered Services:** To the extent that insured individuals in this group do not have insurance-financed coverage for specific *levels* of needed mental health or substance use disorder treatment—particularly inpatient services or long-term care services—then BHD has little alternative but to step in and be available to provide these uncovered services.

With respect to this final role, BHD should still seek to capture payments from individuals' insurers on the ground that the insurers will save money in the long run (for acute care and covered mental health and substance use disorder services) if they pay BHD for its provision of uncovered mental health and substance use disorder services. BHD should also seek to capture out-of-pocket payment from the individuals who receive these uncovered services to the extent they have an ability to pay. Setting up

efficient programs for maximizing "voluntary" collections from insurers, and billing individuals fairly on a sliding scale, will be important.

Ultimately, however, for many of the individuals who receive such uncovered services, BHD will be unable to obtain either voluntary payments from insurers or out-of-pocket payments from the individuals in question that equal BHD's cost of service. Thus, the only way for BHD to provide uncovered services will be to obtain a subsidy, either from state funds (as is currently the case for TANF-eligible individuals receiving SUD services) or the County's property tax levy.

To minimize this subsidy, Milwaukee County should work aggressively to: (1) pressure the U.S. Department of Health and Human Services to formulate an expansive definition of the Essential Health Benefits package's definition of required mental health and substance use disorder services that covers inpatient, outpatient, and long-term care services to the fullest extent possible; (2) pressure state Medicaid administrators and elected leaders to adopt the same expansive definition; and (3) pressure the federal administrators of Wisconsin's health insurance exchanges to adopt the same expansive definition for Qualified Health Plans. At the same time, BHD and the County need to assume that (at least for several years, and perhaps indefinitely) federal and state policies are likely to exclude coverage for some of the most important—and most costly—mental health and substance use disorder treatment services that Milwaukee residents need and BHD has historically provided. Thus, the challenge is to simultaneously push for federal and state policies that reduce the number, scope, and cost of uncovered services, while simultaneously preparing to deliver and finance those services in an appropriate manner.

ii. Insured Persons without Mental Health and Substance Use Disorder Coverage and Uninsured Persons

For this pair of groups, BHD's role is clearer, but more costly. If the individual's insurance does not cover mental health and substance use disorder treatment at all, or if the individual is uninsured, then BHD will need to be available to provide all levels of mental health and substance use disorder services.

As noted above, BHD should still seek to capture payments from individuals' insurers, on the ground that the insurers will save money in the long run (for acute care and covered mental health) if they pay BHD for its provision of uncovered mental health and substance use disorder services. BHD should also seek to capture out-of-pocket payments from the individuals who receive these uncovered services, to the extent they have an ability to pay. Again, as noted above, setting up efficient programs for maximizing "voluntary" collections from insurers, and billing individuals fairly on a sliding scale, will be important.

Ultimately, however, BHD will be unable to obtain either voluntary payment from insurers or out-of-pocket payments from the individuals in question that equal BHD's cost of service. Thus, the only way for BHD to provide appropriate mental health and substance use disorder services (outpatient, inpatient, and long-term care) to this group will be to obtain a subsidy, either from state funds or the County's property tax levy.

c. Repositioning BHD

The enactment of the ACA, its validation by the U.S. Supreme Court, and the ramifications of the results of the 2012 elections, requires BHD to chart a new course.

The first step is to get good data—ACA-relevant data that will explain *who* has insurance, and what *type* of mental health and substance use disorder treatment their insurance will pay for. Without such data, BHD and Milwaukee County are sailing on the ocean in a storm without a compass.

The second step is to use good data to make clear decisions. The ACA will change who BHD serves. The ACA will change what services BHD provides. The law will reduce the number of people in

Milwaukee county who need to rely on BHD for mental health and substance use disorder treatment, and it will alter the financing mechanisms available to pay both non-BHD providers and BHD for certain kinds of treatment.

Helping Milwaukee County residents who do have insurance-financed coverage for mental health and substance use disorder treatment to find the best available providers, even if those providers have no connection with BHD itself, is potentially an important role for BHD to play in the new environment.

But the ACA's structure means that BHD will continue to directly serve many people in Milwaukee County. The extent and magnitude of such services, however, should be planned for in a strategic manner. Some who have insurance-financed coverage for mental health and substance use disorder treatment, many who lack such coverage (because of either limitations in their insurance or, simply, lack of any health insurance), and those that state mandates require BHD to be responsible, will continue to turn to BHD for mental health and substance use disorder treatment.

BHD must develop a clear and coherent plan for: (1) *how* to serve as an advisor and advocate for people in Milwaukee County who need mental health and substance use disorder services, even if BHD itself does not provide them; (2) *who* BHD itself will continue to serve in the future; (3) what *types* or *levels* of service BHD will provide; (4) *how* the cost of services that insurance does not pick up will be financed; and (5) what *part* of that non-insurance financing must fall on the County property tax. BHD and County policymakers will then have to explain, implement, and correct this plan on an ongoing basis.

VI. Conclusion

The ACA will greatly transform the scope and nature of health insurance coverage and health care delivery in Milwaukee County, and it will greatly expand the number of County residents who have health insurance coverage.

The law will also change the benefits received by those with Medicaid, Medicare, and individual and small group plans when the Essential Health Benefits package is fully implemented, and new consumer and patient protections are put in place. In particular, it will substantially increase the number whose insurance covers mental health and substance use disorder treatment.

The law has the potential to transform how some care is delivered, especially in Medicaid and Medicare settings.

All of these changes will significantly alter the way in which County residents seek and receive mental health and substance use disorder treatment, and the way that treatment is paid for.

In particular, these changes will have a major impact on both the scope of insurance-financed services provided by BHD, and the revenue it collects. In the short term, BHD should continue to systematically gather data and analyze the exact impacts so that it is ready to respond to each provision of the law. In the longer term, BHD and County policymakers need to engage in a fundamental examination of: (1) the populations BHD should serve in the future, and (2) what services BHD should provide, so that the overall system of providing the residents of Milwaukee County with mental health and substance use disorder treatment services becomes more integrated with the overall health care residents receive, produces better outcomes, and imposes a lower burden on the local property tax.

The ACA is not a panacea that will automatically bring about all of these good results, but it is a powerful tool whose potential should be fully explored and utilized.

VII. Contact Information

Please feel free to contact the authors:

Michael Bare
Research and Program Coordinator
Community Advocates Public Policy Institute
728 N. James Lovell Street
Milwaukee, WI 53233
Phone: 414.270.2976
E-Mail: mbare@communityadvocates.net

David Riemer
Senior Fellow
Community Advocates Public Policy Institute
728 N. James Lovell Street
Milwaukee, WI 53233
Phone: 414.270.2943
E-Mail: driemermil@yahoo.com

To learn more about the authors, visit:

http://communityadvocates.net/ppi/who_we_are/