COUNTY OF MILWAUKEE
Behavioral Health Division Administration
Inter-Office Communication

DATE: May 17, 2013

TO: Supervisor Marina Dimitrijevic, Chairwoman – Milwaukee County Board

FROM: Héctor Colón, Director, Department of Health and Human Services
Prepared by Kathie Eilers, Interim Administrator, Behavioral Health Division

SUBJECT: **Report from the Director, Department of Health and Human Services, requesting authorization to add the Community Recovery Services (CRS) 1915(i) State Plan Home and Community Based Services Medicaid Benefit in Milwaukee County and to expand case management as part of CRS start-up**

Issue

In July 2012, the Milwaukee County Board of Supervisors approved adding Milwaukee County to the state plan amendment (SPA) for the 1937 Medicaid Benchmark Plan for CRS (File Number 12-575). Since that time, the Behavioral Health Division (BHD) has been in close contact with the state regarding the progress of the SPA. BHD is requesting authorization to offer CRS in Milwaukee County under the already approved 1915(i) provision of the Social Security Act.

In addition, BHD received authority from the County Board (File 12-709) to enter into a professional services contract with the Planning Council starting November 1, 2012 through December 31, 2013 for $1,114,290 to provide specific programs related to the Mental Health Redesign Initiative. The programs included Peer Specialist Pipeline, Step-Down Housing Alternative, Case Management Expansion, Individual Placement and Support (IPS) supported employment, and Supportive Housing Units. BHD is now returning to the Board to request authorization to release $275,000 of the $1.1 million in funding for case management expansion to be utilized for CRS start-up costs for care coordination and related services.

Discussion

BHD has brought several reports to the Board over the past few months to inform and foster dialogue about the CRS program. BHD is now returning to the Board to seek authorization to offer this benefit in Milwaukee County. Below is a summary of CRS services, specific information on CRS in Milwaukee County and a fiscal review of the program.

Community Recovery Services Summary

CRS is a Medicaid psychosocial rehabilitation benefit for persons with a severe and persistent mental illness, mood disorder, or other psychotic disorder. It is a voluntary benefit, meaning an individual willingly participates in CRS. The individual also must be at or below 150% of the

federal poverty level (FPL) and at a specific functioning level. CRS reimburses the following three core services:

- Community Living Support Services – assists individuals in transitioning from a supervised living situation such as a Community Based Residential Facility (CBRF) or Adult Family Homes (AFH) to their own home
- Supported Employment Services – assists individuals with managing symptoms and behaviors to acquire and maintain competitive employment (must use the evidence-based Individual Placement and Support (IPS) model)
- Use of Peers as Providers – utilizes recovery-based experiences of certified peer specialists to assist others to move towards recovery

Psychosocial rehabilitation benefits are entitlements and are a carve-out benefit from the beneficiary's Medicaid HMO. These benefits are county administered and require a 60% federal/40% local (public funds such as state revenues or tax levy) cost sharing.

Psychosocial rehabilitation benefits such as CSP, CCS, and CRS are designed to allow an individual to reach his or her maximum recovery potential within their community. In CRS, recovery is an expectation; therefore, CRS state staff in the Division of Mental Health and Substance Abuse Services (DMHSAS) work in partnership with county staff and contracted service providers to ensure that the CRS services identified in the participant's person-centered service plan are actually being delivered. The importance of this aspect of CRS cannot be overstated as it reinforces the value proposition explicitly identified in the county's contracts with its service providers. By requiring that services provided to the participant follow those specified in the plan of care, the prospects for recovery and/or positive outcomes are greatly enhanced.

The ongoing care coordination responsibilities for CRS are as follows:

- Needs-based evaluation and re-evaluation utilizing a person-centered approach
- Face-to-face assessment of an individual's support needs and capabilities
- Development of an individualized plan of care
- Supporting the participant in the plan of care development
- Assisting participants such that they have an informed choice of providers
- Assuming primary responsibility for monitoring and acting upon incident reports
- Supporting the consumer on an ongoing basis in their plan of care

CRS in Milwaukee County

Over the past few months, HHN committee members have heard informational reports from BHD on the risks and benefits of adding another psychosocial rehabilitation benefit to its continuum of care. In the past when 1915(i) was presented to the HHN committee, the concern of offering another Medicaid entitlement program was voiced from a programmatic

and fiscal perspective. CRS has been operational statewide for over two years and no participating counties have reported an expanded Medicaid population due to the implementation of CRS. In addition, the phenomena of clients moving into CRS counties from neighboring counties that do not offer CRS has not occurred.

BHD has been working closely with the state DMHSAS in preparation for the possibility of offering CRS in Milwaukee County. CRS allows for co-participation in other psychosocial rehabilitation benefits and services such as Community Support Program (CSP), Comprehensive Community Services (CCS), and Targeted Case Management (TCM) services. An eligible individual can also self-identify and direct his or her own participation in CRS. An example of this may be an individual that is residing in a community-based residential facility (CBRF) that is not receiving services in CSP or TCM yet but wants to participate in CRS. All clients would select a recovery support coordinator (RSC) for case management services that includes care coordination services and the completion of the Medicaid required service or recovery plan.

BHD has taken preparatory steps necessary to administer CRS. In July 2012, the Community Services Branch (CSB) in partnership with DMHSAS offered person-centered care training to our CSP, TCM, and Recovery Support Coordination (RSC) agencies. Nineteen of those agencies then conducted a quality improvement change project using continuous quality improvement principles to ensure that person-centered care exists within their respective agencies. All agencies that participated in this quality improvement initiative had change teams that included a clinical coordinator, a case manager or front line staff, and an individual currently participating in services. In January 2013, those agencies showcased the outcome of their change projects through storyboards that were on display at BHD with all members of the change team present. CSB again offered the person centered care training in March 2013 to residential treatment providers including CBRF providers.

In July 2012, BHD applied for and received funding from DMHSAS for infrastructure development for the use of peers as providers. This allowed BHD to host an Employer Summit to provide partner agencies information on employing peers. In addition, BHD provided financial assistance to individuals to sit for the peer specialist certification examination and offered preparatory study groups in partnership with Our Space prior to the examination. In January 2013, BHD, in partnership with the Community Linkages Action Team of the Mental Health Redesign Task Force, sponsored a two-day Individual Placement and Support (IPS) supported employment workshop that covered the IPS principles and fidelity. A follow-up IPS implementation meeting was held in April 2013 with four agencies agreeing to begin the steps of offering IPS. David Lynde, MSW, LICSW, a supported employment consultant from Dartmouth University Psychiatric Research Center, provided the training and technical assistance in Milwaukee County.

In January 2013, the Division of Housing announced the Pathways to Permanent Housing Program to assist individuals in transitioning from a CBRF to a less restrictive setting. In order

to ensure a safe and successful transition for individuals as they move from a CBRF to a more independent setting, person-centered decision making serves as the foundation of this transition. This program should be operational within the month. Lastly, CSB submitted to DMHSAS the single coordinated care plan (SCCP) currently used by RSCs to develop an individualized plan of care or recovery plan for individuals participating in services delivered through CSB. DMHSAS approved the use of this plan as the individualized plan of care for CRS.

Finally, adding CRS to the county service array and case management expansion are goals of the Mental Health Redesign and Implementation Task Force. BHD has worked with the Continuum of Care Action Team of the Mental Health Redesign and Implementation Task Force in exploring the risks and benefits of implementing CRS under 1915i.

Fiscal Implications of CRS

Since CRS' inception statewide, there are 16 counties and 17 service delivery areas offering CRS. As counties began to offer CRS, the first service that was offered to eligible individuals was the Community Living Support Services (CLSS) for residents of CBRFs or AFH's. This allowed counties the ability to generate some savings for the cost of residential services and therefore, created the ability for the reinvestment of specific revenues into other CRS services for Medicaid beneficiaries. It is the desire of Milwaukee County to use a similar implementation approach to CRS and ensure that program administration can occur in a budget neutral manner as to reduce the fiscal risk to the county. The table below summarizes the anticipated 2013 revenues and costs for the program:

2013 Projected Revenues and Costs	**# of anticipated clients enrolled in 2013**	**Additional Revenue and Costs**
CBRF	66	$540,740
TCM	30	$3,485
TOTAL for 2013	**96**	**$544,225**
Additional Start-Up funds being Requested		$275,000
TOTAL ANTICIPATED REVENUE		**$819,225**
Additional Case Management Costs		$240,000
Additional Staff Costs[1]		$120,225
Additional Care Coordination and related services costs		$275,000
Contingency for increased enrollment		$184,000
TOTAL ANTICIPATED COSTS		**$819,225**

[1] BHD is working with HR to identify additional staff resources associated with CRS. BHD will return to the Board, if needed, to create new staff either through a separate action in 2013 or through the 2014 budget process.

Start-up funds for case management services are included in the $1.1 million Planning Council allocation. Based on the Medicaid requirement that the nonfederal share must be public funds and private agencies may not provide the nonfederal share for CRS services, BHD is requesting that $275,000 in funds be directed from the Planning Council to BHD. These budgeted funds will be placed in the fee-for-service network so that a client can select a provider agency for case management and related CRS services.

BHD has been working with the Office of the Comptroller to identify potential options to reduce the County's fiscal exposure such as a risk reserve or contingency fund and, as noted above, BHD is including contingency funds in the financial projects to address increased enrollment or other unanticipated costs. Cities of similar size and demographics such as Minneapolis, St. Louis, and Philadelphia have established risk reserves or contingency funds as a strategy to reduce the financial risk associated with the implementation of psychosocial rehabilitation entitlement benefit offered through Medicaid. BHD plans to maintain the tax levy dedicated to the existing funded BHD programs (CBRF, TCM and CSP) at least through the start-up phase so that any federal revenue received for service reimbursement could be used to establish a risk reserve, pending approval by the County Board and County Executive. BHD has also identified potential match revenues for CRS including tax levy used for the client's CBRF residential placement and the requested start-up funds for case management services.

Initial estimates have identified 1,760 BHD clients that meet the eligibility criteria for CRS. This however, does not mean that all 1,760 will choose to participate. In addition, BHD has been working closely with the State to learn from the experience of other counties and is working to identify the number of clients in Milwaukee County that would be eligible for this entitlement benefit. Because CRS is a recovery benefit that offers enhanced services to existing clients, the other counties offering CRS have not experienced large increases in the number of clients enrolled in their programs. BHD realizes that it is the responsibility of the administering county to grow the CRS program guided by the Medicaid Handbook and successful submission of individualized recovery plans that are accepted and approved by the state.

BHD is working closely with the state to ensure that all efforts are made to correctly bill for services rendered and capture as much revenue as possible. As is the case in most programs, there will be a learning curve and adjustments will need to be implemented. BHD has worked hard over the past year to identify, anticipate and mitigate the risks associated with this program. Much of this was accomplished by seeking out and addressing lessons learned by participating counties throughout the state. BHD program and fiscal staff have made site visits to neighboring counties that offer CRS and they have participated in numerous phone calls and discussions at the Wisconsin County Human Services Association Behavioral Health Policy Advisory Committee.

One critical theme that was clearly conveyed through BHD's outreach to other counties was the importance of Medicaid documentation. CSB staff and DHHS Contract Administration staff

participated in a Medicaid documentation workshop sponsored by the state on the responsibility of the counties that offer Medicaid benefits. As the roll out of electronic medical records continues to CSB, Medicaid billing will be brought back in-house and the county will directly bill Medicaid for CRS and other county-specific Medicaid benefits. The Quality Assurance department within CSB is fully staffed and will be actively involved with providers to assure compliance through the auditing of CRS. A Medicaid documentation workshop will be offered to providers on the requirements for Medicaid billing. Other means of mitigating the fiscal exposure of the county may be the addition of staff in BHD that are specifically dedicated to Medicaid billing, managing CRS, and providing administrative coordination functions for the program.

As the program is implemented, BHD will return to the Board with updates.

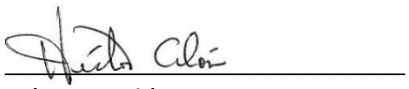
Recommendation

It is recommended that the Milwaukee County Board of Supervisors authorize the Director, DHHS, or his designee, to allow BHD to implement the CRS 1915(i) program in Milwaukee County and offer this Medicaid recovery benefit to individuals that request to participate in CRS. It is also recommended that the Milwaukee County Board of Supervisors authorize the release of $275,000 from the $1.1 million in Planning Council funds to be utilized for CRS start-up costs for care coordination and related services.

Fiscal Effect

There is no tax levy effect associated with this initiative. A fiscal note form is attached.

Respectfully Submitted,



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