Public Policy Forum

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Executive Summary

Fiscal Analysis of Mental Health Redesign in Milwaukee County

About the Public Policy Forum

Milwaukee-based Public Policy Forum – which was established in 1913 as a local government watchdog – is a nonpartisan, nonprofit organization dedicated to enhancing the effectiveness of government and the development of southeastern Wisconsin through objective research of regional public policy issues.

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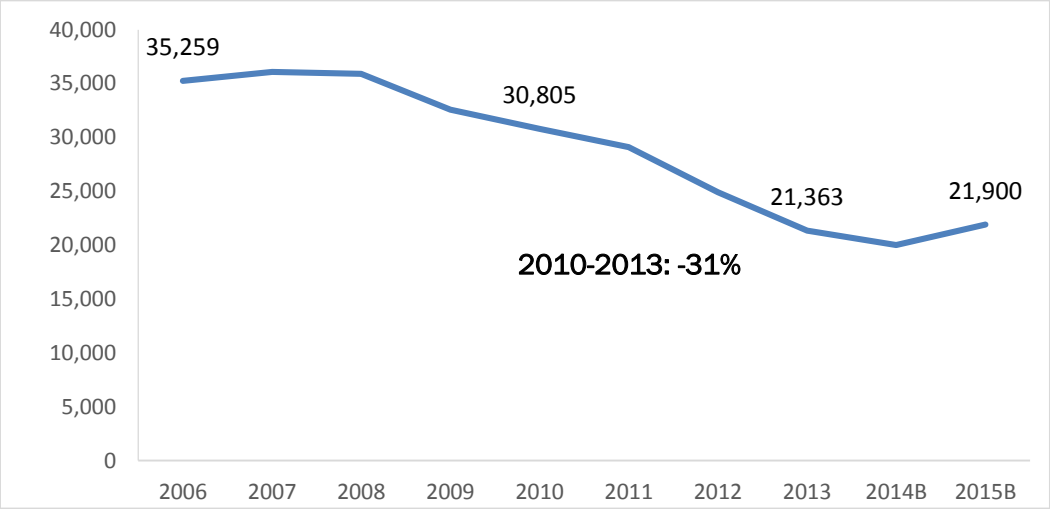
Finally, we would like to thank the Forum's former Senior Fiscal Researcher, Vanessa Allen, for her work on this project. Vanessa left the Forum in July 2014 to pursue her MBA but was the primary researcher and analyst for the section on BHD's community-based services budget prior to her departure.

Executive Summary

The mental health care system in Milwaukee County has undergone dramatic change in recent years, as County and community leaders have sought to ease reliance on emergency and inpatient care while enhancing the range and scope of community-based mental health services. Between 2010 and 2013, adult inpatient capacity at the County's Mental Health Complex decreased by 31%, while admissions at its emergency room facility (referred to as the Psychiatric Crisis Service, or PCS) dropped by 15%. In addition, the County recently closed one of its 72-bed long-term care facilities and plans to complete the closure of its second facility by the end of 2015.

Adult inpatient capacity reduction (measured by patient bed days)



On the community side, an array of new treatment and recovery-oriented services has been added, including Comprehensive Community Services (CCS), a new Medicaid benefit that seeks to reduce inpatient admissions by strengthening early intervention and treatment programs; Community Recovery Services (CRS), which offers psychosocial services such as employment, housing, and peer support to eligible Medicaid clients; and a range of new community-based crisis services.

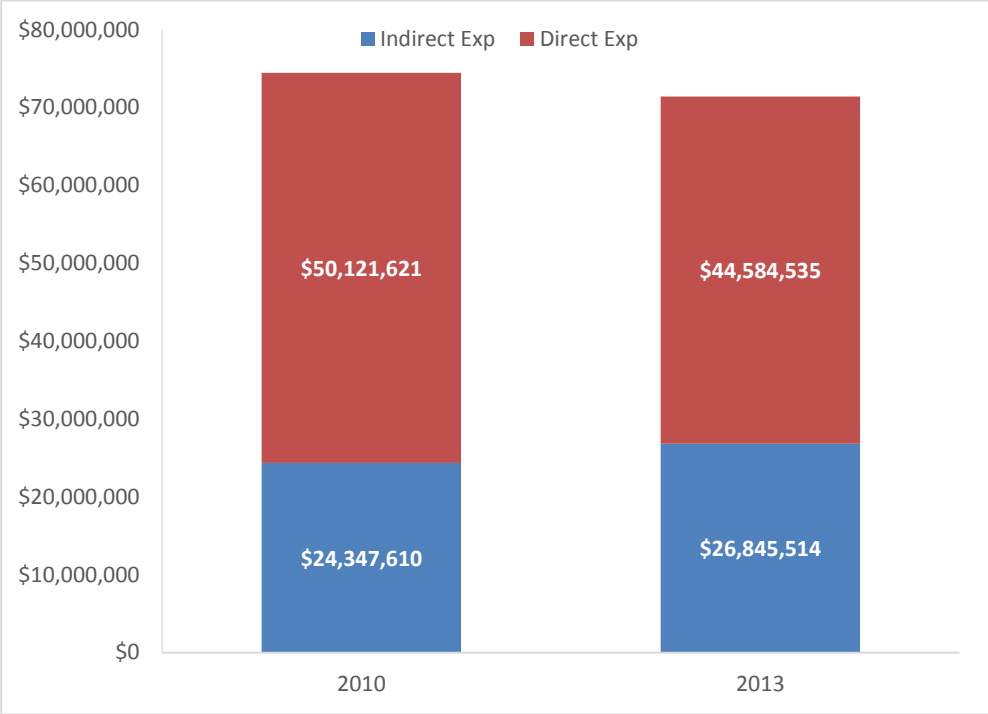
While it is relatively easy to describe these service changes, far less is known about the ***financial*** impacts of ongoing mental health redesign efforts. For example, how much is being saved on an annual basis from the vastly reduced inpatient/long-term care census? And, perhaps more important, can continued bed reductions at the Mental Health Complex generate the property tax levy savings that are likely to be required to achieve desired levels of community-based care?

In this report – commissioned by Milwaukee County and its Mental Health Redesign Task Force – the Public Policy Forum seeks to answer those questions. We do so first by assessing the fiscal impacts of the County's mental health redesign activities that have occurred to date, which we accomplish by "deconstructing" BHD's budget to isolate direct and indirect cost centers and appropriately distinguish between hospital and community-based expenditures. Then, we use that knowledge to consider how the implementation of a fully redesigned system of care will impact the Behavioral Health Division's (BHD) financial situation in the next two years.

The report begins by examining financial trends from the 2010-2013 timeframe, which was the period of time in which BHD initiated various mental health redesign strategies aimed at moving toward a community-based system of care. Our trend analysis revealed the following:

- While direct hospital-related expenditures at the Mental Health Complex decreased by $5.5 million (11%) – an amount that intuitively would appear to correlate with the decline in bed capacity – indirect costs unexpectedly increased by $2.5 million. To some degree, this was caused by factors beyond BHD's control, such as the central budget office's determination of BHD's legacy costs from retired employees, facility expenses, and charges from other departments.

Change in Mental Health Complex Expenditures, 2010-2013



- Overall staffing levels at the Mental Health Complex remained largely the same despite the reduced patient volume. We found this was largely attributed to increased staffing levels at PCS, which may have reflected a need to utilize clinical staff freed up from inpatient and long-term care downsizing to address previous understaffing at PCS.

- BHD was successful in enhancing patient revenues on a per-patient basis between 2010 and 2013, but the reduced patient census produced an overall net loss of about $3 million in patient revenue. Because that loss largely offset expenditure reductions, the County was unable to reduce its allocation of property tax levy to Mental Health Complex services.[1]

[1] In this analysis, when we refer to property tax levy we also include the County's annual Base Community Aids (BCA) allocation from the State of Wisconsin. Property tax levy and BCA are used interchangeably by the County to fill the gap between the amount spent to provide mental health services and the revenue that is recovered from patients and other sources.

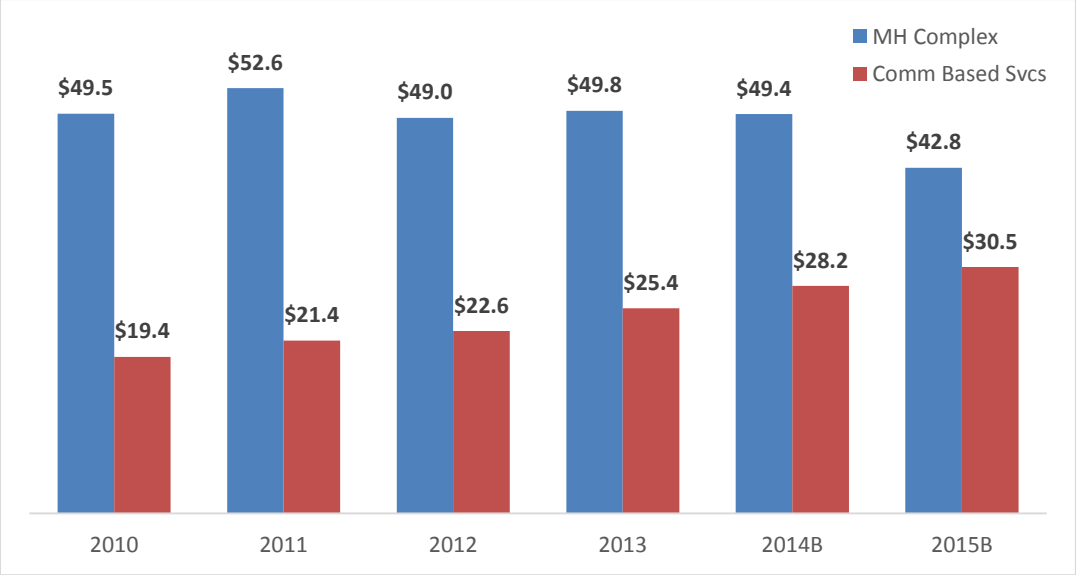
- BHD was able to increase its investment in community-based services during the 2010-2013 timeframe, with expenditures growing by $3.9 million (12%). However, BHD's community services as a whole became more dependent on property tax resources, which increased by $6 million. Because levy savings did not materialize from Mental Health Complex downsizing, those additional resources came from other parts of County government and/or general increases in the tax levy.

Overall, our trend analysis found that a key objective of mental health redesign – to use inpatient and long-term care downsizing as a means of freeing up property tax resources to invest in community-based services – had not been achieved as of the end of 2013.

We then turned to the 2014 and 2015 budgets to determine whether any of the trends observed for the previous four years had reversed, and whether additional savings associated with continued Mental Health Complex downsizing in those years were being generated for reinvestment in community-based services. The 2014 and 2015 budgets were characterized by even greater downsizing than had occurred the previous four years, including the closure of both long-term care facilities by the end of 2015; and by increased investment in community-based services.

We found that the financial benefits associated with these sharper declines in patient census had indeed become more pronounced. For example, property tax levy expenditures for Mental Health Complex service areas were budgeted to fall by about $7 million (14%) in 2015 when compared with 2013 actual amounts. However, the potential for greater savings still was limited by BHD's inability to substantially reduce indirect costs, which were projected to decline by only 4%; and by substantial budgeted reductions in patient revenue in conjunction with the reduced census. We also observed that increased staffing and expenditure levels at PCS continued to partially offset inpatient and long-term care savings.

Adult Mental Health Tax Levy Expenditures, 2010-2013 Actual and 2014-2015 Budget (millions)

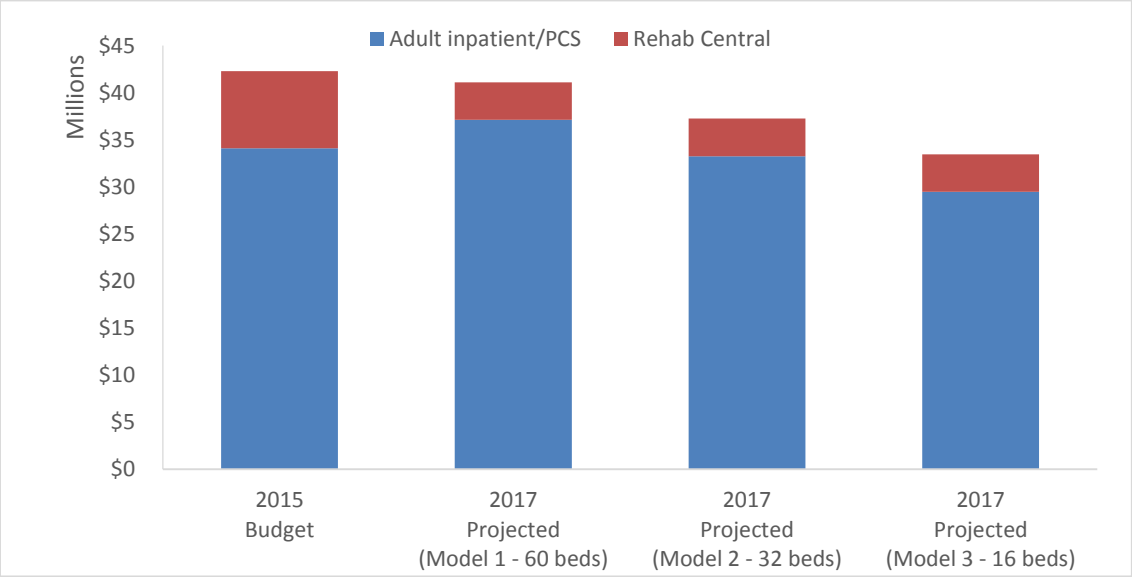


Finally, we used the information and insights gained from our trend analysis to conduct financial modeling that allowed us to estimate the financial impacts of 60-, 32-, and 16-bed adult inpatient scenarios. For each of our models, we took into account both the financial impacts associated with each bed capacity scenario, plus a calculation of the ongoing savings that would result from the closure of the Rehab Central long-term care facility in 2015.

Our modeling showed that BHD would need about $3 million of additional property tax levy in 2017 to support the two remaining Mental Health Complex functions (adult inpatient and PCS) than it budgeted for those functions in 2015. However, because $4.2 million in net savings would be derived from the closure of Rehab Central, there would be a total of about $1.2 million available for community reinvestment under that scenario in 2017. We also found that BHD could generate a $5 million property tax levy savings in 2017 (when compared to the 2015 budget) by downsizing from 60 to 32 adult inpatient beds, and an $8.8 million savings by downsizing to 16 adult inpatient beds. Again, both of those savings amounts include the positive fiscal impact associated with the closure of Rehab Central.

A key question is whether an investment of the projected savings from the 32- and 16-bed scenarios in community-based services would be sufficient to appropriately offset the increased need for such services in light of reduced inpatient bed capacity. We were unable to determine the answer to that question, but suggested that BHD should ascertain the types and scope of enhanced community-based services that might be implemented to make such a determination.

Projection of 2017 Mental Health Complex Tax Levy Spending Under Different Bed Scenarios



* While the Rehab Central long-term care facility will be closed in 2017, we still show a Rehab Central expenditure in 2017 in this figure. This is attributed to $4 million in needed BCA/levy expenditures to support Rehab Central clients in community settings and to pay remaining legacy costs.

Our modeling exercise not only revealed the amount of estimated savings that could be achieved through continued bed reductions, but also highlighted the fundamental constraints that will continue to impact BHD's financial future:

1. The Mental Health Complex's indirect costs are only loosely linked to its bed capacity, and this factor will continue to curtail overall savings that can be achieved with future downsizing initiatives.

2. Because key components of BHD's indirect cost structure are linked to its existing facility and its treatment as a regular department of Milwaukee County government, there is little it can do to reduce indirect costs without changes to those two circumstances.

3. While BHD can continue to generate sizable direct cost savings from additional reductions in adult inpatient bed capacity, the direct cost pressures associated with continued operation of PCS at its existing capacity will erode those savings and reduce the amounts available for community reinvestment.

The report concludes with five observations derived from our modeling and trend analysis:

- **Milwaukee County leaders should contemplate a new financial structure for the Mental Health Complex that sets it apart from the rest of Milwaukee County government.**

  As long as the Mental Health Complex continues to be subject to charges from other County departments and central service allocations from the central budget office, it is likely to receive only limited benefit from bed capacity and associated staffing reductions. An argument could be made – particularly in light of BHD's new governance structure that has it reporting to a new Mental Health Board – that the additional step of segregating BHD's finances from the rest of Milwaukee County government should occur, or that it should be placed under a separate mental health district or authority. Should this approach prove unworkable from an accounting, legal, or logistical perspective, then the County budget office and BHD at least should consider reforming internal budgeting and accounting practices to better isolate costs and revenues associated with BHD's various service areas.

- **Milwaukee County and State of Wisconsin leaders need to work jointly to address BHD's facility needs and questions.**

  Our analysis confirms what Milwaukee County leaders have known for quite some time: that facility costs at the existing facility are influenced most prominently not by the amount of square footage that BHD occupies for its hospital-related operations, but instead by its continued need to service and maintain the entire sprawling Mental Health Complex regardless of inpatient bed capacity, and by cost factors associated with its use of County facilities staff to do so. Furthermore, BHD officials have cited millions of dollars of needed repairs at the existing Complex, which have been deferred pending consideration of a possible new facility. It is unclear how those needs will be addressed given that recent state legislation places BHD operations spending under the purview of the Mental Health Board, but leaves capital and debt service costs under the purview of the County Board.

- **The future size, mission, and location of PCS will be central to any decision-making regarding adult inpatient bed capacity and a potential new facility.**

  An often overlooked issue in BHD's consideration of its optimal inpatient capacity and the possible construction of a new facility is the future size, scope, and operation of PCS. Our analysis shows that as long as PCS maintains its approximate current patient volume and staffing, then its costs are likely to continue to grow with inflation, thus partially offsetting any savings accrued from inpatient downsizing. In determining possible downsizing options and the size and location of a new facility, therefore, County and Mental Health Board leaders also should be considering how PCS will function in the future.

- **BHD should develop effective and transparent ways to measure the impacts of its community investments on inpatient and PCS demand and to track and project community-based service costs.**

  It will be tempting to view an opportunity to generate almost $9 million in annual savings from a 16-bed scenario as too promising to ignore, and to simply assume that by reinvesting those dollars in community-based services an appropriate balance of services can be created. We suggest, however, that the ability to safely downsize in such a substantial manner will be predicated on whether community-based investments truly decrease demand for inpatient care, and that a performance measurement system be developed to provide insight into that question before substantial additional downsizing occurs. Similarly, we recommend that BHD develop the financial data collection and reporting mechanisms that will be required to appropriately model future year community-based expenditures and revenues and guide decision-making on future investment options.

- **BHD needs more detailed analysis of its revenue structure and revenue opportunities to guide bed capacity decisions.**

  While BHD has made great progress in implementing a new electronic medical records system and improving its revenue collection practices, it would benefit from greater capacity to conduct sophisticated analysis of revenue trends and its patient mix. BHD also would benefit from additional expertise on Medicaid and Affordable Care Act issues and opportunities to help it appropriately gauge the impacts of major changes in its service design and delivery. Consequently, we suggest that BHD and the Mental Health Board consider options for developing the capacity to better monitor and analyze BHD's revenue performance, and to produce the types of revenue profiles and analyses that will be critical to determining the pros and cons of different bed capacity options.