Milwaukee County Outpatient Behavioral Health Capacity Assessment

FINAL REPORT
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Executive Summary

Introduction

The Milwaukee County Outpatient Capacity Analysis (OCA) is the third report issued jointly by the Human Services Research Institute (HSRI), the Technical Assistance Collaborative (TAC), and the Public Policy Forum (PPF) related to the ongoing initiative by public and private sector stakeholders to redesign the mental health care delivery system in Milwaukee County. The first report analyzed system strengths and weaknesses and offered recommendations to improve system performance, and the second focused on adult inpatient bed capacity. In this report, we focus on behavioral health services that are provided outside of inpatient settings. The OCA was commissioned by the Milwaukee Health Care Partnership and was funded by a diverse array of organizations, including the Partnership, local health care and managed care entities, the State of Wisconsin, and local foundations.

The types of outpatient services inventoried in this report are clinical services and programs that are considered essential for a comprehensive system of care, especially for low-income populations. Additionally, these services are assumed to be related to demand for inpatient care. When available as part of a community-based behavioral health system, they may effectively function as an alternative to inpatient and emergency treatment.

Whereas inpatient services and the County-funded behavioral health system have relatively clearly defined boundaries, outpatient services are much more diverse and diffuse, and are delivered through a complex array of organizations and practitioners with multiple funding sources. As a result, data on outpatient services are fragmentary, complex, and incomplete. To best characterize this de facto system, this report presents a multidimensional overview of supply and demand, providing estimates of treated and untreated prevalence, measures of utilization, and an assessment of gaps and barriers to access. It concludes with a broad range of recommendations. While these recommendations emphasize the leadership role of the Milwaukee County Behavioral Health Division (BHD), they also incorporate the functions of a wide network of stakeholders.

Data sources

Corresponding to the complexity of the array of outpatient services, information presented in this report was collected from a variety of sources. Qualitative information relating to the availability and accessibility of outpatient services was obtained through a review of documents and previous reports and through interviews with stakeholders (including BHD administrators, inpatient hospital discharge planners, and administrators and staff of community programs, clinics, and agencies). Quantitative analysis draws upon two sources. The first is Medicaid claims data from July 2010 through September 2014, obtained by request from the Wisconsin Department of Health Services (DHS). These files consisted of all claims for Medicaid enrollees with a behavioral health diagnosis registered in Milwaukee County. The second source is utilization data for services funded by Milwaukee County BHD for adults and children/adolescents. Reflecting the fragmentary nature of outpatient services utilization data, missing from this report is information about the uninsured population as a whole, which was unavailable for the study (though some uninsured individuals are included in BHD utilization data).

Semi-structured interviews were conducted with a broad base of stakeholder representatives, including key DHS and BHD staff, discharge planners from BHD and local hospitals, providers of mental health and substance use services, providers of primary care (FQHCs) and other safety-net

services, as well as representatives from academia and Medicaid managed healthcare plans. Our researchers also held a consumer focus group that included individuals with lived experience and advocates who help people with mental illness and substance use disorders to navigate the health care and social service systems. Additionally, to further explore issues of access identified by stakeholders, we conducted a simulated patient or "secret shopper" campaign, where our researchers posed as individuals seeking outpatient behavioral health treatment for Medicaid enrollees. Our aim was to determine whether new clients were being accepted, whether providers accepted patients insured via Medicaid, and how quickly a new client might be seen.

Assessing supply and demand: Prevalence, provider capacity, service utilization and accessibility

Prevalence: We were able to approximate a treated prevalence rate for the Medicaid population using claims data to calculate the penetration rate (that is, the percentage of Medicaid enrollees receiving behavioral health services on a quarterly basis for the period from July 2010 through September 2014). These data indicate that while overall Medicaid enrollment increased steadily through the period—rising from about 275,000 to 315,000, or approximately 15%—the number of adults and children/adolescents receiving mental health and substance abuse services remained about the same in all categories, resulting in a net decline in the penetration rate. This suggests that the service capacity for Medicaid enrollment has not kept pace with the need; this could be the result of a lag in the response of supply to demand (in which case penetration rates may rise over time) or because of some form of market failure whereby increased demand does not prompt a corresponding increase in supply (for example, because Medicaid rates are too low to prompt expansion, in which case rates will not rise).

With respect to the general population, a recent report from DHS, entitled *Wisconsin Mental Health and Substance Abuse Needs Assessment,*[1] presents the following prevalence estimates of treated and untreated behavioral health disorders for Milwaukee County and the state:

- Number of adults with any mental illness: 135,895
- Number of adults with serious mental illness: 32,901
- Number of children with any mental illness: 34,969
- Number of children with serious emotional disturbance: 18,317
- Statewide, about 49% with any mental illness (50% of adults and 46% of children) did not access services
- The statewide treated prevalence rate for substance abuse is estimated to be about 23%

Provider capacity: Outpatient capacity in terms of provider supply may be represented in two ways: as an inventory of the total of behavioral health service providers in Milwaukee County who might potentially serve the population in question; and as provider volume (that is, the number of people actually served by various outpatient providers, which we call the "de facto" behavioral health system). An inventory may draw from lists maintained by licensing and regulatory agencies, although the complexity and fragmentation of outpatient behavioral services and the diversity of provider types presents a challenge for this approach. A list of licensed mental health and/or substance abuse outpatient provider agencies, drawn primarily from DHS records but supplemented by a few other sources, identifies 373 entities, including multiple sites operated by a single organization, that are eligible to serve Medicaid enrollees. These represent a complex array

[1] Available at https://www.dhs.wisconsin.gov/publications/p0/p00613.pdf

of organizational characteristics, including public and private ownership, for-profit and nonprofit, faith-based, hospital-affiliated and nonaffiliated, mental health and substance abuse combined or one or the other only.

Provider Volume: A simple count of facilities provides only a limited picture of overall capacity. Another approach to measuring capacity is by provider volume. In contrast to the formal "system" represented by the list of provider organizations and individual clinicians licensed to practice in Milwaukee County, the analysis of provider volume identifies who actually provides how much service to residents of the county, thereby representing the de facto behavioral health system.

For this purpose, we analyzed Medicaid claims by Medicaid provider type for the period of January through September 2014. This time frame was selected as being the most current available and reflecting the effects of Medicaid expansion. The methodology for analyzing claims is described in Appendix 1.

Providers serving Medicaid-enrolled Milwaukee County residents, Jan.-Sept. 2014

	Number of providers	Number of people served	Providers serving <10	Number people served by <10 providers
Mental health/substance abuse clinics	209	26,418[1]	110	319
Mental health/substance abuse – individual non-prescribing clinicians	300	2,929	210	666
Hospital outpatient	138	16,533	114	251
Physician – independent group practices	272	31,112	168	428
Physician – health care system group practices	16	2,125	5	25
Physician – no affiliation identified	226	3,154	184	411
Nurse practitioner – affiliated with organizations	9	306	3	17
Nurse practitioner – no affiliation identified	20	49	18	49
Federally qualified health center	15	3,150	10	32
Institutions for Mental Diseases – outpatient	8	2,459	4	8
Laboratory (drug screening)	21	2,445	13	38
Narcotic services	7	1,301	5	11
Day treatment	17	479	8	41
Health Check[1]	3	219	2	8
Health Check Other[1]	20	444	13	36
Crisis	11	1,611	11	10

[1] Wisconsin's terms for Early Periodic Screening Diagnosis and Treatment, including behavioral health.

There are several features of the information in this table that have implications for policy considerations related to outpatient capacity. First, these claims represent only Medicaid enrollees registered in Milwaukee County, yet the number of providers far exceeds the number located within the county, demonstrating that a considerable number of Milwaukee County Medicaid enrollees travel outside the boundaries of Milwaukee County in order to receive behavioral health services. This has several possible alternative interpretations for policy purposes. On the one hand, it may indicate a shortage of providers in Milwaukee County or barriers to accessing services there. Alternatively, it may simply indicate that the de facto service system is regional in nature.

A second notable feature is the large number of providers that serve very small numbers of consumers, in many cases only one or two during the period from January to September 2014. Conversely, a handful of large organizations serve a preponderance of individuals: the top three highest-volume providers together accounted for 40% of the total volume. The implication of this in a policy context is that the provider "system" is in fact bifurcated into two segments: a few large-volume providers and many smaller providers. On the one hand, this poses a challenge to integration and continuity of care. A more positive inference, however, is that these low volume providers may represent untapped potential for capacity expansion. If the reason they serve few Medicaid patients is due not to reluctance, but because they are in some sense outside the referral mainstream, then there may be potential for increasing capacity though efforts to integrate them more directly into an overall system, for example through more aggressive outreach by case managers and inpatient discharge planners.

We also analyzed BHD data for a variety of outpatient services provided directly or under contract by the County over the five-year period.

Utilization

Whereas provider volume represents capacity at the organizational level, the analysis of utilization (the number of consumers using services), via Medicaid claims as well as BHD data, considers services at the consumer level. It looks at who gets what and where, and whether these patterns change over time.

Medicaid Utilization

Based on Medicaid claims data, utilization appeared fairly stable for all provider types throughout the study period (July 2010 to September 2014). Utilization of outpatient services provided by hospitals and, in smaller numbers, by institutions for mental disease (IMDs), was fairly consistent throughout the period. By comparison, utilization numbers for services provided in licensed mental health and substance abuse clinics were much larger; these too were fairly consistent—though there was some variation, possibly due to seasonal differences. Services provided by nurse practitioners varied somewhat unpredictably, but represented relatively small numbers throughout the period. Given the widely noted problems with access to child psychiatrists in Milwaukee County, nurse practitioners may be an area for further exploration as an opportunity to increase capacity through physician extenders. Billing for children by federally qualified health centers (FQHCs) increased gradually across the period, suggesting an increasing capacity for providing behavioral health services, although there are some anomalous variations.

BHD Utilization

Data were collected for utilization of BHD adult and child mental health and substance services annually from 2011through 2014 as shown in the following tables. Additionally, for adult services, wait times from referral to admission for services were reported. Adult mental health services

reported are those accessed through BHD's Service Access to Independent Living (SAIL) program. Substance abuse services are those accessed through the Wisconsin Supports Everyone's Recovery (WIser) Choice program. Child and adolescent behavioral health services are those provided through Wraparound Milwaukee.

Generally, the number of persons admitted in all categories is quite consistent over the four-year period, with a slight drop off in 2014 for a few categories of service. Increasing wait times for admission to adult mental health services (nearly quadrupling over the four-year period) provides evidence of mounting strain on capacity and is consistent with feedback obtained from stakeholders about difficulties with access. BHD administrators attribute this trend to the significant increase in the number of requests, which nearly doubled over the period, and simultaneous decreases in provider capacity due to a variety of factors such as contract changes in 2014. BHD reports having initiated a number of measures to address this increased demand, with the expectation that wait times will be reduced. Preliminary data through August 2015 indicates a lag of about 60 days—still considerably more than 2011-2013, but a downward trend from 2014. Data on wait times for child and adolescent services were not available for this report.

Adult Mental Health Services (SAIL): Number admitted annually and median number of days between referral and admission (Note: TCM = Targeted Case Management; CSP = Community Support Program; CBRF = Community Based Residential Treatment)

	2011		2012		2013		2014	
	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission
TCM	224	17	265	28	315	49	379	67
CSP	78	22.5	102	31	115	52	141	80
CBRF	5	27	9	27	8	32.5	15	75
Day Treatment	38	15	24	16.5	39	24	44	29

Adult Substance Abuse Services (Wiser Choice): Number admitted annually and median number of days between referral and admission

	2011		2012		2013		2014	
	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission
Outpatient	1511	7.0	1148	6.0	1179	3.0	868	2.0
Day Treatment	310	6.0	224	4.0	212	3.0	198	1.0
Transitional Residential	529	7.0	329	5.0	206	4.0	312	3.0
Medically Monitored Residential	21	14.0	6	22.5	5	30.0	10	3.0
Methadone	9	25.0	14	17.5	20	0.5	81	5.0
Employment	18	7.0	179	7.0	177	6.0	126	11.0
School/Training	53	2.0	78	5.0	48	4.5	85	8.0
Housing	9	8.0	21	8.0	16	5.0	16	2.0

Child and Adolescent Mental Health and Substance Abuse Services (Wraparound Milwaukee) Units of Service and Number Served by Category of Service 2011-2014

Service Type	Unit Type	2011		2012		2013		2014	
		Units	Persons	Units	Persons	Units	Persons	Units	Persons
AODA	¼ Hour	4,172	178	3,774	150	5,162	186	5,304	181
Day Treatment	Daily	2,161	53	2,697	65	2,380	54	1,318	29
Outpatient	Hourly	37,195	1,146	42,727	1,227	47,339	1,346	46,598	1,280
Psychiatric Review/Meds	Session	3,483	906	4,521	1,046	4,758	1,097	3,847	1,031

Stakeholder interviews

To obtain "the story behind the data" and, in particular, to identify issues of access and service gaps, we conducted face-to-face and telephone interviews with dozens of community, County, and State stakeholders. We also conducted a consumer focus group that included individuals with lived experience and advocates who help people with mental illness and substance use disorders navigate the health care and social service systems.

While there was some variation in response among the stakeholders interviewed, the following emerged as consistent themes related to gaps in services and barriers to accessing outpatient behavioral health care in Milwaukee County.

- **Fragmentation**: Although, individually, many providers deliver high-quality care, services take place in "silos," resulting in problems with access, integration, and continuity of care.
- **BHD service access**: Assessment and referral processing by the Service Access to Independent Living (SAIL) program resulted in service access bottlenecks for persons with serious mental illness.
- **Dual diagnosis treatment**: Difficulties remain in terms of access to the WIser Choice Alcohol and Other Drug Abuse (AODA) program, with continuing bifurcation and duplication of mental health and AODA services despite past efforts to develop integrated treatment. (BHD comments that this bottleneck is primarily attributable to capacity limitations with contracted providers rather than delays in processing referrals.)
- **Managed care organizations**: Variation in managed care organization policies, procedures, and operational protocols creates confusion for members and providers. There were also questions about the availability of providers.
- **Role of FQHCs**: The potential but as yet underdeveloped role of FQHCs in providing behavioral health services was noted, as was a lack of integration with BHD and other behavioral health providers.
- **Case management**: Stakeholders expressed frustration and concern over the lack of readily accessible case management. (Again, BHD identifies this as a provider capacity issue.)
- **Medicaid reimbursement rates**: Stakeholders identified the low Medicaid rates for services as one of the most significant barriers to behavioral health care, with several discharge planners asserting that only a handful of providers would accept Medicaid enrollees.
- **Psychiatrist and advanced practice nurse shortages**: Barriers particularly to psychotropic medication treatment, especially for children, were widely noted, with representatives of provider organizations commenting on the challenges of recruiting and retention.
- **Primary Care Practitioners**: PCPs are a resource for treating individuals with less serious disorders, but most are reluctant to treat children, older adults, and adults with more complex behavioral health conditions, particularly with respect to prescribing psychotropic medications.
- **Telemedicine**: While several stakeholders acknowledged that telemedicine is a reimbursable service approach under Wisconsin Medicaid, only one provider was identified as offering the service.

- **Navigation and transportation**: Individuals and families who do not qualify for intensive services, including case management, find it difficult to access services within a fragmented system on their own, Stakeholders also reported a lack of convenient and accessible public transportation options as a significant barrier to care.

It should be noted that information gained from stakeholder interviews, while generally credible, constitutes anecdotal evidence that varies in consistency and in the extent to which it is supported by other types of evidence. For example, the apparent inconsistency between anecdotal accounts by discharge planners on the one hand, and the evidence from claims data and the simulated patient investigation on the other, may be explained by differences in patient types. The patients being referred by inpatient discharge planners generally represent higher levels of severity and acuity, which fewer providers may be willing to accept.

Simulated patient ("Secret Shopper") study

To further test the findings obtained from stakeholder interviews, we used a method recommended by policy makers and employed by some state Medicaid agencies. Using this method, researchers posed as potential new patients and called a subset of providers to request new-patient appointments for a mental health disorder. The goal was to obtain information about a) whether new patients were being accepted; b) whether Medicaid was accepted; and c) the length of time to the first appointment.

In general, results supported the anecdotal evidence from stakeholders about barriers to access, particularly with respect to psychiatrists (especially child psychiatrists). A notable result was the difficulty in even being able to contact a considerable proportion of providers.

Summary and recommendations

Milwaukee County's plan to outsource inpatient and emergency care provides BHD the opportunity to focus its resources and energy to ensuring the provision of high-quality community-based care, including mental health outpatient, intensive outpatient, and day treatment services. BHD can lead this effort by:

- Continuing to engage community stakeholders in promoting a vision for a transformed system of care
- Refining and expanding its strategic plan to include clearly articulated goals, objectives, action steps, and timelines for achieving the vision
- Providing tools and resources to support the envisioned change
- Creating performance and outcome measures to incent and assess change
- Identifying and addressing potential concerns as they emerge, to prevent disruption in progress
- Working with providers and other stakeholders to establish accountability for achieving specific strategic plan objectives

The following recommendations include actions and strategies that have been promoted successfully in other locales. BHD ideally would pursue these recommendations in coordination with other stakeholders to increase capacity and accessibility of outpatient behavioral services. These are discussed in more detail in the main body of the report.

- Improve BHD and private provider intake processes.
- Coordinate with FQHCs in the outpatient behavioral health system.

- Use knowledge and experience gained from initiatives involving complex populations, such as those with HIV/AIDS, to support the development of Medicaid Health Homes, including Behavioral Health Homes.
- Continue to expand Medicaid-Covered Services, notably Comprehensive Community Services (CCS) implemented in 2014.
- Foster a collaborative approach to recruiting and retaining behavioral health practitioners, especially psychiatrists and extenders.
- Increase the use of health information technology, notably the Wisconsin Statewide Health Information Network (WISHIN) (BHD notes that it has recently implemented an electronic health record system that it uses to track utilization of community-based services.)
- Expand the use of telepsychiatry.
- Build on the success of the Medical College of Wisconsin's Child Psychiatric Consultation (CPC) program and adopt a similar program for adults.
- Strengthen linkages to the Medical College of Wisconsin/University of Wisconsin-Madison's Psychiatric Residency Programs.
- Promote access to Wisconsin's Primary Care & Psychiatry Shortage Grant Program.
- Recruit and incentivize providers of medication-assisted treatment.
- Work with the state to increase Medicaid rates for behavioral health outpatient service.
- Engage Medicaid managed care organizations in addressing gaps in outpatient care.
- For each of the above recommendations, develop an action plan specifying key implementers/facilitators, other stakeholder participants, actions steps, and performance metrics.

Conclusion

The provider inventory, analysis of service utilization, and feedback from stakeholders in this phase of Milwaukee County's system redesign initiative all highlight the variety of challenges that BHD and the broader community are facing as they seek to expand community-based services, improve quality, control costs, and support recovery. These are challenges that most county-based behavioral health systems face—that is, issues of fragmentation, complexity of provider types, a rapidly changing policy environment, multiple levels of governance, and limited resources.

The bottom-line conclusion generated from this analysis of outpatient behavioral health capacity for low-income populations in Milwaukee County is a nuanced one. A key question is whether the extent of unmet need would best be reduced by a simple increase in the supply of providers, or by addressing inefficiencies and barriers to access among the array of providers currently in place. Our various data sources indicate that both are significant factors and both need to be addressed.

Moreover, as indicated in our recommendations, the most effective approach is when both factors are addressed together. An example is the shortage of child psychiatrists. There is certainly a need for more child psychiatrists, as there is throughout the nation; however, there are also possibilities for improving access and coordination of care with those in place. While various initiatives to attract psychiatrists to Milwaukee County are currently under way, a more immediately effective response to the problem may be the Child Psychiatric Consultation program, a public/private/academic/philanthropic collaboration that extends the availability of existing resources to address a local shortage.

Our analysis also indicates that stakeholder perspectives and other forms of anecdotal evidence are important for identifying areas of concern and flagging issues requiring attention, but they should not be relied on as the sole basis for remedial action. This is not to say that these sources are not reliable, but rather that the complexity of the array of outpatient behavioral health services limits the capacity to understand the full nature and scope of any feature when viewed from a single perspective.

Consequently, it is critical that the fragmentation and discontinuity of behavioral health services be addressed by establishment of comprehensive and well-integrated data systems that will provide for overall monitoring of system performance and identification of opportunities for improvement. Several of our recommendations focus on the potential benefits of increased data sharing and health information technology generally.

Finally, the analysis of Medicaid claims indicates that while enrollment was increasing during the past two years, utilization was generally declining—not only in terms of percentage, but also in counts of people served. This important finding suggests some shrinkage of capacity beginning around 2013, though to different degrees depending on the provider type. There are several possible explanations for this decrease, the most likely of which is a decreased willingness by providers to accept patients with Medicaid insurance. Assuming this explanation is accurate, stakeholders need to consider and implement strategies to address it, including potential changes to contracts between the State and managed care entities, and higher Medicaid reimbursement rates.

How the various issues of provider shortage and lack of system integration that affect capacity and accessibility are addressed and who should take the lead initiative in doing so depends on the issue; the general thrust of our recommendations, however, is that BHD, on the basis of its defined mission and statutory authority, is in the best position to define the vision and the goals for this effort and to lead in the monitoring of its progress. Ultimately, success will be determined not only by how well BHD performs in this role, but also by how well the State, private health systems, and the diverse array of other stakeholders in the community work with BHD and together as necessary partners.

Section 1
Introduction: Milwaukee County Outpatient Capacity Analysis

1.1 Purpose

The Milwaukee County Outpatient Capacity Analysis is the third report issued jointly by the Human Services Research Institute (HSRI), the Technical Assistance Collaborative (TAC), and the Public Policy Forum (PPF) related to the ongoing initiative by public and private sector stakeholders to redesign the mental health care delivery system in Milwaukee County. The purpose of the Outpatient Capacity Analysis is to provide an overview of availability, capacity, and accessibility of outpatient behavioral health clinical services for the low-income population of Milwaukee County.

The first report, released in October 2010, provided a comprehensive analysis of system strengths and weaknesses and an extensive set of recommendations designed to improve system performance.[2] Then, in September 2014, the three organizations released a report analyzing adult mental health inpatient bed capacity in Milwaukee County.[3] The purpose of that analysis was to assess the total number, type, and distribution of inpatient beds that County stakeholders would need to retain, develop, and/or reconfigure to meet future need in the community.

While this analysis of outpatient capacity is a natural extension of the previous activities, it differs in several important ways. Inpatient services have clearly defined boundaries, a small set of easily identified providers, a fairly clear definition of the need for treatment, and relatively comprehensive data systems. In contrast, outpatient behavioral health services are much more diverse and diffuse, made up of what economist Nancy Wolff characterizes as "socially complex service interventions with permeable boundaries."[4] A wide variety of services are delivered through a complex array of organizations and individual practitioners who are loosely coordinated at best, and are frequently in competition with one another. In addition, these providers and practitioners vary widely in terms of mission, type of ownership, incentives, size, staffing characteristics, target populations, and scope of activities. Therefore, an analysis of outpatient capacity is more complex and nuanced than simply enumerating facilities and available client slots and comparing these with some projection of need.

The task of assessing outpatient capacity also differs from that for inpatient services in that there are no comprehensive and integrated data systems comparable to those available for inpatient services. Consequently, our analysis necessarily draws upon diverse sources of information: Medicaid claims, Milwaukee County Behavioral Health Division (BHD) service utilization data, stakeholder interviews, and simulated patient "secret shopper" calls, as described in Appendix 1: Data Sources and Methods. Drawing on this diversity of data sources, the result is a multi-dimensional representation of outpatient behavioral health services including need (prevalence), demand (service utilization) and supply (provider inventory).

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[2] The report can be accessed at http://publicpolicyforum.org/sites/default/files/HSRIMentalHealthReport.pdf.

[3] The report can be accessed at http://publicpolicyforum.org/sites/default/files/MilwaukeeInpatientCapacity.pdf.

[4] Wolff, N. (2000). Using Randomized Controlled Trials to Evaluate Socially Complex Services: Problems, Challenges and Recommendations. *Journal of Mental Health Policy and Economics, 3*, 97-109

Finally, it should be noted that this report differs from the previous two reports produced by HSRI, TAC, and PPF in that the scope is not limited to adults and to mental health. Instead, this report also covers the outpatient system for children/adolescents and for substance abuse services.

The limited extent to which outpatient services are coordinated and integrated—in most of the United States as well as in Milwaukee County—makes it difficult to provide a definitive judgment about the extent to which unmet need is caused by a shortage of providers, various barriers to access, or inefficiency of the overall system. We do offer such judgments where they seem to be supported by the data; the overall result, however, is not a simple equation of need and demand, but rather a multi-dimensional overview of the various sources and amounts of treatment provided for low-income residents of Milwaukee County with mental health and substance abuse disorders.

These three limiting factors—provider shortages, barriers to access, and system inefficiencies—are, as noted, characteristic of behavioral health services throughout the United States. They have been addressed in some locales using various strategies that offer lessons for Milwaukee County. Additionally, stakeholders interviewed for this project offered many insights and recommendations for addressing these issues. Drawing upon these national and local sources, the report concludes with a set of recommendations for ways in which improvements in all three areas may be achieved.

1.2 Contributors and acknowledgements

The Milwaukee-based PPF served as the local consultant and fiscal agent for the project, which was funded by several private sector behavioral health system stakeholders, the Wisconsin Department of Health Services (DHS), and local foundations. A full list of financial contributors can be found in Appendix 1. HSRI and TAC served as co-researchers. HSRI and TAC are nationally recognized consulting firms that have extensive experience in providing technical assistance on mental health and related issues to government agencies, national associations, and direct service providers. As in earlier projects conducted by HSRI, TAC, and PPF, a Project Advisory Group (composed of officials from BHD and DHS as well as representatives from private behavioral health provider organizations) was actively involved, assisting the researchers in understanding factors that influence outpatient capacity and need in Milwaukee County.

1.3 Background

The first phase of the initiative by Milwaukee County to redesign its mental health system began in 2008, after wide discussions—in several forums and meetings involving advocates, administrators, consumers, and providers—of challenges for the County's mental health care delivery system and following local media coverage of related issues.

In October 2008, the Milwaukee Health Care Partnership, the Medical Society of Milwaukee County, the Faye McBeath Foundation, and the Greater Milwaukee Foundation agreed to fund a proposal developed by the Public Policy Forum to conduct planning for this effort. That project was designed to lay the groundwork for an overarching system improvement effort, exploring how other states and counties carried out similar system transformation efforts and containing a detailed plan for a comprehensive planning effort in Milwaukee County. PPF then contracted with HSRI and TAC to conduct a study as the basis for this planning initiative. The resulting report, entitled *Transforming the Adult Mental Health Delivery System in Milwaukee County*, outlined a set of 10 recommendations:

1. Downsize and redistribute inpatient capacity.
2. Involve private health systems in a more active role.
3. Reorganize crisis services and expand alternatives.

4. Reduce emergency detentions.
5. Reorganize and expand community-based services.
6. Promote a recovery-oriented system through person-centered approaches and peer supports.
7. Enhance and emphasize housing supports.
8. Ensure cultural competency.
9. Ensure trauma-informed care.
10. Enhance quality assessment and improvement programs.

Following this report, in April 2011, the Milwaukee County Board of Supervisors passed a resolution supporting efforts to redesign the Milwaukee County mental health system and creating a Mental Health Redesign and Implementation Task Force (Redesign Task Force) to provide the Board with data-driven implementation and planning initiatives based on the recommendations of various public and private entities. The Redesign Task Force first convened in July 2011, establishing a charter and delegating Action Teams to prioritize recommendations for system enhancements within key areas. The Action Teams presented their prioritized recommendations in early 2012 and received feedback and guidance from consultants from HSRI. The implementation activities were then framed within SMART goals (Specific, Measurable, Attainable, Relevant, and Timebound), which were approved by the County Board in March 2013. These goals became the work plan through 2014, guided by several action teams composed of public and private sector stakeholders.

In conjunction with early implementation of redesign strategies, PPF, HSRI, and TAC were commissioned to conduct an analysis of mental health inpatient bed capacity in the county. The resulting report, *Analysis of Adult Bed Capacity*, was published in September 2014 and contained a set of recommendations relating to the appropriate number and types of beds to meet the county's needs, the expansion of community-based services, and the role of private hospitals in meeting the need for beds.

In parallel with the inpatient bed capacity analysis, the Public Policy Forum was commissioned by the County to conduct an analysis to assess the fiscal impacts of the mental health redesign activities to date and the projected impact of the fully implemented redesign. The resulting report, *Fiscal Analysis of Mental Health Redesign in Milwaukee County*, published in March 2015,[5] provided a detailed analysis of BHD's spending and revenue performance for the 2010-2013 timeframe in the areas of emergency, inpatient, long-term care, and community-based adult mental health services. The report also included financial projections for 2017 under various adult inpatient bed scenarios to determine the amount of funds saved from inpatient reductions that could be redirected toward community-based services.

1.4 The Outpatient Capacity Analysis scope of work

As discussed in the preceding reports on inpatient capacity, there is no standard accepted formula for "right sizing" behavioral health systems—that is, for determining the proper balance between inpatient and outpatient capacity or the appropriate mix of different types of outpatient services. Any such judgment depends on how need is defined, how the array of services is configured, and how the population is affected by multiple factors specific to the local community (such as

[5] Report can be accessed at http://publicpolicyforum.org/sites/default/files/FiscalAnalysisMentalHealthRedesign.pdf.

demographics, social supports, stressors, etc.). The scope of any such analysis, therefore, will depend on the specific goals, purposes, and questions of interest.

The scope of this project is limited primarily to analysis of access, capacity, and utilization of the outpatient behavioral health (mental health and substance abuse) clinical services for low-income residents of Milwaukee County. Included in the analysis are behavioral health care services provided in the general health care sector (e.g., primary care clinics) to the extent these can be identified. The analysis is designed to address systemic issues involving service access and delivery while specifically excluding consideration of treatment philosophies and frameworks/specifics of clinical practice.

Population: While the analysis considered outpatient capacity in Milwaukee County for the general population, the focus of the report is on the capacity available to serve low-income residents who are eligible for Medicaid or who possess no insurance coverage. This target population included the entire age spectrum—children and adolescents, transition-age youth, adults, and the elderly—where feasible.

Providers: Two provider types are included in the analysis differentiated by ownership status—private (either for-profit or nonprofit) and County—with separate data sources. The first type consists of licensed Medicaid providers: mental health and substance abuse clinics, primary hospital outpatient clinics, primary care clinics (including Federally Qualified Health Centers, or FQHCs), and individual clinicians, in group or individual private practice. All of these are assessed using Medicaid claims data. The second provider type is Milwaukee County BHD, assessed using a separate data system maintained by the County.

Services and Programs: In general, the types of outpatient services inventoried are clinical services and programs, funded either by Medicaid or the County, that are considered essential for a comprehensive system of care and that may be assumed, based on expert opinion and research, to be related to demand for inpatient care—for example, psychotherapy, psychopharmacology, psychiatric day treatment, and substance abuse treatment, typically provided by licensed clinicians (psychiatrists and general practice physicians, physician assistants, advanced practice nurses, psychologists, and social workers as well as other licensed counselors). The scope therefore focuses on those clinical services that, when available as part of the community-based behavioral health system, effectively function as an alternative to inpatient treatment.

Services included in the analysis that are funded by Medicaid are identified by CPT codes, listed in Appendix 1: Data and Methods. Services funded by the County are listed below.

1.5 BHD mental health and substance abuse services

BHD funds a broad array of community-based mental health services for adults, ranging from case management to outpatient psychiatric care to community-based crisis respite. The “front door” to many of the County’s community adult mental health and substance abuse services is Community Access to Recovery Services (CARS), a County-funded and County-staffed unit that conducts needs assessments and refers clients to appropriate services. A detailed description of BHD services is provided in Section 5.

1.6 National examples of downsizing initiatives

Transforming mental health service systems from institutional to community-based care is a national trend with proven success in many states. Iowa, Pennsylvania, New York, and Massachusetts are examples of states that have successfully closed government-operated psychiatric beds/institutions. In addition, several states are involved in active *Olmstead*-related mental health settlement agreements or investigations; these include Arizona, Connecticut, Delaware, Georgia, Illinois, Kentucky, Mississippi, New Hampshire, New Jersey, North Carolina, and Oregon.

The ability for states to successfully close publicly owned hospital beds is based in part on timely planning and the availability of readily accessible community resources. For example, Pennsylvania's success at closing hospitals beds has been associated with the availability of funding for community infrastructure development and programs start-up *prior* to bed closures. Iowa's state agency recently discharged 62 people with significant community-service needs from state hospitals; it credits the success of this effort to its partnership with a team of representatives from multiple agencies that advocate for transitioning mental health patients. State government and advocacy partners, with input from family members and guardians, coordinated efforts to ensure quality placements. Discharge planning for the Iowa Mental Health Institutions included a thoughtful, systematic plan that took place over several months.[6]

1.7 Milwaukee County's statutory role in providing outpatient behavioral health services

Milwaukee County's role in providing and/or administering care and treatment to children and adults with mental health and substance abuse disorders traditionally has been guided by Chapter 51.42 of the Wisconsin Statutes. That section assigns to the county board of supervisors in each county "primary responsibility for the well-being, treatment and care of the mentally ill, developmentally disabled, alcoholic and other drug dependent citizens residing within its county and for ensuring that those individuals in need of such emergency services found within its county receive immediate emergency services."[7]

Wisconsin Act 203, adopted by the Wisconsin Legislature and Governor in April 2014, changed that framework in Milwaukee County by creating the Milwaukee County Mental Health Board (MHB) to take over from the Milwaukee County Board of Supervisors the mental health and substance abuse-related responsibilities outlined in Section 51.42. The MHB is made up of 11 individuals with expertise or experience in various facets of mental health services and administration. Members were appointed in June 2014, and the Board held its initial meeting in July 2014.

In addition to "oversee(ing) the provision of mental health programs and services in Milwaukee County," the MHB has administrative control over BHD's budget and personnel. That includes the programs and services provided by the division at the Mental Health Complex as well as the services administered by its community services branch. The MHB also is charged with approving BHD's annual budget, though the legislation stipulates that the property tax levy contained in the budget must be between $53 million and $65 million, unless a higher or lower amount is agreed to by the MHB, county executive, and county board.

[6] "With Mental Health Institutes Closed, Patients Served Elsewhere in Iowa," Erin Murphy, *Sioux City Journal*, July 12, 2015

[7] http://docs.legis.wisconsin.gov/statutes/statutes/51.pdf

Both before and after the adoption of Act 203 and the creation of the MHB, questions have been raised about the extent of Milwaukee County's statutory *mandate* to ensure the provision of a robust array of community-based behavioral health services to county residents.[8] There is little legal ambiguity about the County's mandate to ensure the provision of *emergency* behavioral health care and treatment: As noted above, Chapter 51.42 clearly states that the County must ensure that persons who need immediate emergency services receive them, and Chapter 51.15 specifies that the County must provide a place where persons taken into custody by law enforcement under an "emergency detention" can be detained, evaluated, diagnosed, and treated.[9]

However, when it comes to the community-based clinical services that are the subject of this analysis, the legal picture is murkier. Although the statutes place primary responsibility with the MHB for securing mental health and substance services for residents who need them, the statutes also limit that responsibility "to the programs, services and resources…that the (MHB) is reasonably able to provide within the limits of available state and federal funds and of county funds required to be appropriated to match state funds."[10]

This limitation—combined with other sections of the statutes that detail the responsibilities of counties in the human services realm—traditionally has led to an interpretation by Milwaukee County officials that their foremost responsibility is to provide behavioral health services for those who are deemed indigent and have no alternative means of accessing and/or paying for them. County officials traditionally have asserted that they do have the legal ability to restrict non-emergency services for those not deemed indigent, and to establish waiting lists if necessary to ensure that expenditures do not exceed available resources. They also have recognized, however, that their failure to provide for the delivery of a broad continuum of community-based mental health and substance abuse services could harm them financially by creating a greater need for the emergency services they are mandated to provide.

Act 203 also provided additional clarity with regard to the types of services Milwaukee County is to offer. The Act states that the MHB must "mak(e) a commitment to all of the following:

1. Maintaining community–based, person–centered, recovery–oriented, mental health systems
2. Maximizing comprehensive community–based services
3. Prioritizing access to community–based services and reducing reliance on institutional and inpatient care
4. Protecting the personal liberty of individuals experiencing mental illness so that they may be treated in the least restrictive environment to the greatest extent possible
5. Providing early intervention to minimize the length and depth of psychotic and other mental health episodes
6. Diverting people experiencing mental illness from the corrections system when appropriate
7. Maximizing use of mobile crisis units and crisis intervention training"

However, in light of the Statutes' acknowledgement that the County's mandate with regard to behavioral health services is limited by available resources, there is no clear answer for those

[8] The statutes are exceedingly clear that Milwaukee County does not have to be a provider of behavioral health services; where it is responsible for providing services, it may either provide those services itself or contract for their provision.

[9] Memorandum from Paul Bargren, Milwaukee County Corporation Counsel, and Colleen Foley, Deputy Corporation Counsel to BHD Administrator Pat Schroeder dated June 3, 2015.

[10] Ibid

seeking to determine the exact scope and nature of the non-emergency behavioral health services that Milwaukee County *must* provide for county residents.

1.8 Current status of the Mental Health Complex

As the Mental Health Redesign process has progressed in Milwaukee County, BHD has succeeded in reducing the patient census at the Mental Health Complex and reducing the number of admissions at its emergency room facility, which is referred to as the Psychiatric Crisis Service (PCS). Specifically, adult inpatient capacity at the County's Mental Health Complex decreased by 31% from 2010 to 2013 while PCS admissions 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. To its credit, BHD has established partnerships with community providers and other stakeholders to implement these long-term care closures.

Based on the decline in patient census at the Mental Health Complex between 2010 through 2013, BHD should have realized significant reductions in expenditures for those services. However, as described in the recent *Fiscal Analysis of Mental Health Redesign in Milwaukee County* report by PPF, total expenditures in those service areas decreased by only 4%.[11] This lack of realized savings is critical as it significantly diminishes the amount of funding available to reinvest in the expansion of community-based treatment services and supports. A comprehensive array of *readily accessible* outpatient services and supports is essential for alleviating the demand for inpatient services.

In addition, as described in the *Analysis of Adult Bed Capacity* report, issued in September 2014,[12] admissions to private inpatient psychiatric beds increased during the same time that BHD admissions decreased. The implications of this shift are relevant for outpatient service capacity. The private hospitals are required to provide aftercare within 30 days of discharge for BadgerCare Plus and SSI Medicaid HMO enrollees. As the number of enrollees admitted to private psychiatric hospitals increases, the need for these hospitals to provide timely aftercare also increases.

An additional source of uncertainty about continuity of care, at least in the short term, is the County's recently announced intent to outsource management of its remaining inpatient beds and PCS and divest itself of the Mental Health Complex. Closing the Mental Health Complex is consistent with longstanding recommendations from multiple sources, including the Mental Health Redesign Initiative and the HSRI/TAC/PPF reports. However, this huge change to the service delivery paradigm in Milwaukee County could have impacts on outpatient capacity that are difficult to predict at this time.

[11] *Fiscal Analysis of Mental Health Redesign in Milwaukee County*, Public Policy Forum, March 2015.

[12] *Analysis of Adult Bed Capacity for Milwaukee County Behavioral Health System*, prepared by the Human Services Research Institute, Technical Assistance Collaborative and Public Policy Forum, September 2014.

Section 2
Outpatient Service Need—Treated and Untreated Prevalence

This report addresses both the supply and the demand side of behavioral health in Milwaukee County. Epidemiologists describe the demand side of the equation in terms of treated and untreated prevalence. Section 5 on utilization addresses treated prevalence using consumer-level data to describe need in terms of the types of services that are received and the numbers of people who receive them. Sections 6 and 7 provide qualitative information on the need side in the form of stakeholder perspectives and a simulated patient study that explores questions of unmet need. Here, we briefly review information on the overall prevalence of behavioral health conditions in Milwaukee County.

2.1 Prevalence and planning

Prevalence is the proportion of a population with an illness or condition. In a general sense, it may be considered as a measure of need, with the gap between treated and untreated illness representing unmet need. For purposes of practical planning, however, there are a number of factors that should be taken into consideration to supplement the raw count of untreated populations. The relationship between the overall prevalence of a condition, the number of persons who have been diagnosed with the condition, and the number who have received treatment for it can vary in complex ways depending on the nature of the condition, the population, and the treatment system.

Many people with mental disorders never receive a mental health diagnosis or obtain treatment. For example, a 2005 survey of adults in California indicated that about 25% reported a need for mental health services in the past year but only about 10% actually used any services.[13]

The magnitude of the difference in the proportions of these three groups (overall prevalence, treated prevalence, and untreated prevalence) may vary depending on a variety of factors. Overall prevalence may vary depending on population characteristics such as rural or urban; however, unlike many other health conditions, the prevalence of mental health disorders has been shown to be relatively stable over time. The introduction of more effective diagnostic tools or more extensive screening, for example, reduces the difference between overall and diagnosed prevalence. Likewise, differences between diagnosed and treated disorders are influenced by system capacity and access. For most planning purposes, therefore, it is not advisable to consider only one of these measures of prevalence in isolation. Moreover, the gap between overall prevalence and treated prevalence as a measure of unmet need, though important to recognize, is usually so large that it has little utility except for long-range planning, as the resources necessary to close the gap are beyond any practical scale.

Accordingly, rather than suggesting a specific metric or formula for what would be required to address unmet need, we discuss overall prevalence and treated prevalence (as represented by utilization and penetration, discussed in Section 5) independently. This allows us to consider what each factor may contribute to future planning efforts that would involve specific actions to reduce

[13] An, R., & Sturm, R. (2010). Self-Reported Unmet Need for Mental Health Care After California's Parity Legislation. *Psychiatric Services, 61*(9), 861.

the gap between treated and untreated behavioral health conditions for Milwaukee County residents.

The unmet need for behavioral health care in Milwaukee County has been well documented in numerous reports that draw from epidemiological data, surveys, and stakeholder interviews. The Substance Abuse and Mental Health Services Administration (SAMHSA) regularly publishes reports that provide national estimates for the prevalence of treated and untreated mental health and substance abuse disorders of various kinds. With appropriate adjustments for local population characteristics, these estimates may serve as a general indication of prevalence in Milwaukee County. The epidemiological studies that are the basis of the SAMHSA reports are, of course, the product of a complex science that makes use of a variety of sophisticated methodological tools. It is not within the scope of this project to aim for the level of precision that is possible with the use of these tools; instead, the goal here is to provide a general yardstick for the extent of treated and untreated mental illness and substance abuse in the county as context for the discussion of outpatient service availability and need.

The most recent of the SAMHSA reports, with data from 2012, is the source for the estimates presented here.[14]

2.1.1 National prevalence estimates applied to Milwaukee County

According to SAMHSA, 4.2% of U.S. adults (an estimated 10.0 million individuals) reported having serious mental illness (SMI) within the year prior to being surveyed. However, this rate varies considerably according to sociodemographic characteristics. The rate for individuals whose incomes are less than 100% of the federal poverty level is 7.7%; the rate among individuals who are above the federal poverty level is less than half that, at 3.6%.[15]

The following estimates apply 2011 national epidemiological data to 2013 Milwaukee County demographic data. This allows for use of the most current population characteristics at the expense of some loss of precision that might result from changes in prevalence in the period from 2011 to 2013. This is likely to be minimal for mental health disorders, which have been found to be fairly consistent over extended periods of time. Rates for substance use disorders may be more variable, but the extent of change in a two-year period is unlikely to be extreme for present purposes.

Based on 2013 census data, the adult population (20 years and older) of Milwaukee County was 681,038. Exhibit 1 displays the national rates for mental illness and substance abuse in 2011, along with corresponding estimates for Milwaukee County.

Exhibit 1. Estimated Prevalence of Behavioral Health Disorder in Milwaukee County

	National Rate, 2011	Estimate for Milwaukee County, Based on 2013 Population Count
Any mental illness	18%	122,586
Mental illness causing serious functional impairment	4%	27,241
Substance abuse disorder	8%	54,483

[14] Substance Abuse and Mental Health Services Administration. (2013). Behavioral Health, United States, 2012. Rockville, MD: Substance Abuse and Mental Health Services Administration.

[15] SAMHSA, Center for Behavioral Health Statistics and Quality, *National Survey on Drug Use and Health*, 2013.

2.1.2 Overall prevalence of behavioral health disorder in Milwaukee County

Prevalence levels for many conditions, including behavioral health disorders, may vary considerably from one local area to another; however, obtaining fine-grained epidemiological data at the local level is difficult due to the intensive resource requirements of high-quality methods, such as diagnostic interviews with adequate sample sizes. Consequently, there is usually a tradeoff between national and state-level estimates, which have more detailed information about conditions but less about local circumstances; and more local studies, which are more limited in the information they provide due to resource constraints. For Milwaukee County, however, several studies are available that provide a fair balance between these two considerations: the Wisconsin Mental Health and Substance Abuse Needs Assessment,[16] produced by the Wisconsin Department of Health Services in 2014; and the Milwaukee County Health Care Partnership Community Health Needs Assessment,[17] which consists of three data sources: a community health survey, key informant interviews, and analysis of secondary data compiled from local, state and national sources.

Some relevant statistics for Milwaukee County from the DHS report are:

- Number of adults with any mental illness (AMI): 135,895
- Number of adults with serious mental illness (SMI): 32,901
- Number of children with AMI: 34,969
- Number of children with serious emotional disturbance 18,317
- About 49% with any mental illness (50% of adults and 46% of children) did not access services
- The statewide treated prevalence rate for substance abuse is estimated to be about 23%
- About 34% of AMI adults and 50% of AMI children were served with public (Medicaid and County) funds
- Milwaukee's inner city had among the highest number of psychiatrists needed to significantly reduce shortage

Interested readers are encouraged to review these reports for additional data on Milwaukee County service needs.

[16] Available at https://www.dhs.wisconsin.gov/publications/p0/p00613.pdf
[17] Available at http://mkehcp.org

Section 3
Outpatient Service Supply: Private and County Services

3.1 Provider inventory: Capacity as volume of services

3.1.1 The behavioral health system

The purpose of this section is to describe where low-income residents of Milwaukee County can and do obtain treatment for behavioral health disorders. In that sense, it provides a representation of the Milwaukee County outpatient behavioral health system. As noted throughout this report, however, reference to the collective sources of behavioral health services as a "system" is something of a misnomer. In actuality, people with behavioral health needs obtain treatment, services, and support from a wide variety of sources that differ along many dimensions:

- Organizational characteristics (size, governance, complexity)
- Ownership (public, nonprofit, private for-profit, faith-based, etc.)
- Revenues (public and private insurance, government support, grants,donations, etc.)
- Mission (general population, low-income, special populations such as specific ethnic groups or persons with AIDS)
- Scope of services provided (general health care as well as behavioral health care, counseling only, psychopharmacology, psychosocial support programs, etc.)

A particular challenge is the diversity of settings, especially as these include the general health care sector (e.g., primary care clinics) as well as specialty mental health and substance abuse providers. It is important to remember, therefore, that the term "service system" refers to a conceptual construct more than an organizational structure.

Given these circumstances, this inventory of behavioral health providers in Milwaukee County addresses the question of capacity at two levels of complexity. The first level is to provide a listing of specialty behavioral health service providers in the county. A list compiled from a variety of sources, but primarily the Wisconsin Department of Health Services, is provided in Appendix 4 and summarized below. Other such lists and directories are readily available; rather than replicate them here, we provide a summary description and information on where they may be obtained. The second level is a multidimensional representation of the array of services incorporating need, demand, and supply.

3.2 Provider directories

The following are sources of information about behavioral health providers in Milwaukee County:

- The Wisconsin Department of Health Services provides lists of licensed mental health and substance abuse clinicians by county at https://www.dhs.wisconsin.gov. According to these lists, Milwaukee County has 124 licensed mental health clinicians and 95 licensed substance abuse clinicians.
- List of Wisconsin individuals certified for third-party billing for mental health treatment: PDF document not organized by county at https://www.dhs.wisconsin.gov/guide/individual-third-party.pdf.

- There is also a PDF document entitled Community Mental Health Program Certification Directory by County, City, and Provider Name that lists both licensed mental health and substance abuse facilities. It is available at https://www.dhs.wisconsin.gov/guide/mh-directory.pdf. This document identifies 125 separate facilities, many having more than one branch in the county.
- Appendix 4 presents a list of licensed mental health and substance abuse clinics compiled from DHS provider lists and other sources, including the Wraparound provider directory and SAMHSA treatment locator database at https://findtreatment.samhsa.gov/. This list, which includes branch offices, consists of 374 facilities.
- Milwaukee LGBT Community Center has an online directory of mental health and substance abuse treatment resources (including psychotherapists, substance abuse programs, and support groups) at http://www.mkelgbt.org/.
- Mental Health America of Wisconsin maintains an online directory of mental health and substance treatment programs and therapists (exclusive of psychiatrists) at www.mhawisconsin.org.
- The Milwaukee Health Care Partnership has published a set of directories of area safety-net providers and federally qualified health centers at http://mkehcp.org.
- The Milwaukee County BHD website contains a directory of the Wiser Choice provider network at http://county.milwaukee.gov/ImageLibrary/Groups/Everyone/SAIL_AODA/WIserChoice_Prov_Directory_2012.pdf.
- Licensure of psychiatrists, physician assistants, psychologists and advanced practice nurses are listed separately with the Wisconsin Department of Safety and Professional Services. These lists are provided for a fee and were not available for this report.

Lists and directories do not provide a full picture of where and how behavioral health services are actually delivered. To provide this additional level of detail, we draw upon two sources of information: an analysis of Medicaid claims data, presented in Section 5, and a simulated patient (secret shopper) study described in Section 7.

Section 4
Provider Volume as a Measure of Capacity

The purpose of this section is to address the issue of outpatient capacity by presenting an overview of the providers from whom Medicaid enrollees obtain behavioral health services. The intent is to present the relative volume of people served across different provider types as a snapshot of the de facto outpatient behavioral health system serving low-income people. As a result, this section is complementary to the section on utilization, which reports on the number and percentage of the Medicaid population receiving various kinds of behavioral health services. It is important to note, therefore, that the unit of analysis in this section is *providers* as opposed to *consumers*. That is, the numbers presented here should be interpreted as the volume of clientele among providers and not the number of individuals receiving services, which is presented in Section 5.

An analysis of this type necessarily entails a considerable number of inferences and assumptions that should be kept in mind when reviewing the results. Most of these relate to the use of Medicaid claims data as a source of information about the structure and function of health and behavioral health systems. Though researchers and policy makers frequently draw upon Medicaid and Medicare claims data for these purposes, it is important to keep in mind that these data systems are designed mainly for accounting. Consequently, their structure consists of codes for diverse types of services, provider organizations, and clinician specialty differentiated not by function, but by allowed reimbursement rate. To make the jump from a system of reimbursement rates to a system of services, therefore, requires a set of complex algorithms, the nature of which requires a variety of decisions that have implications for how the characteristics of the system are represented by the results. These issues and the algorithms used in this analysis are described in more detail in Appendix 1: Data and Methods.

Another point to note: the data reported here represent outpatient capacity in the sense of actual as opposed to potential volume. Hypothetically, any provider may have the capacity to serve a higher volume than the actual number. To measure the extent of potential or unused capacity, if any exists in the system, would require information obtained through other means—provider surveys, for example—and not through Medicaid claims.

4.1 Provider volume by billing provider type (January–September 2014)

The period from January to September 2014 was selected to represent a snapshot of the system at a point in time that was long enough to insure that the distribution of service recipients across programs was representative of the system as a whole. As the most recent available data, it represents the current state of the behavioral health system as accurately as possible, particularly with respect to the impact of the Affordable Care Act. One tradeoff in this choice is the possibility that these data may be an undercount of the numbers of people served due to lag times in submitting claims, a likelihood that is suggested by a drop-off identified in the analysis of utilization. We feel this is an acceptable tradeoff given that this section focuses on relative volume of different provider types rather than trends in the numbers of individuals served, which is provided in Section 5.

The analysis identifies the total number of people treated by each provider type as a measure of the relative capacity of different components of the behavioral health system in Milwaukee County. It is important to note that the numbers in this section do not represent unduplicated counts of

individual consumers (unduplicated counts are presented in the analysis of penetration rates in Section 5). In terms of organizational capacity, it is irrelevant whether a person served is unique in the system or is also receiving services elsewhere. Billing provider type was chosen as the single Medicaid identifier that most closely represents the structure of the behavioral health system as it is usually considered within a policy context. An alternative choice might have been 'place of service' code; we decided against this option, however, as it was less descriptive of the behavioral health system (corresponding more generally to locations where general health care is provided) and because a large number of records were missing a place of service code.

Exhibit 2 presents a general overview of the number of providers by type and the numbers served by each provider type. As discussed above, these counts are based on the Medicaid claims field "provider billing type." The categories in this field include both type of organization (e.g., clinic) and type of medical professional (e.g., physician). The rationale and limitations of using the provider billing type field to characterize outpatient capacity is discussed in more detail in Appendix 1.[18]

In terms of the provider array serving Milwaukee County, several characteristics with implications for policy and planning are immediately evident from the table.

First, the number of providers far exceeds those located in Milwaukee County. For example, although Milwaukee County has only four FQHCs, there are 15 represented in the claims. (According to the list on the Wisconsin DHS website at https://www.dhs.wisconsin.gov/forwardhealth/fqhc.pdf, there are 42 FQHCs in the state.) It is evident that many Medicaid enrollees registered in Milwaukee County receive services from providers located outside of the county.

A second notable feature is that many providers—both organizations or agencies and individual clinicians—serve very small numbers of Medicaid enrollees, in many cases only one or two during the period from January to September 2014. This feature is represented in the two columns on the right-hand side of the table, which indicate the number of providers that served fewer than 10 individuals and the total number of individuals served by these providers. Conversely, a handful of large organizations serve a preponderance of individuals: the top three highest-volume providers together accounted for 40% of the total volume.

The implication of this in a policy context is that the provider "system" is in fact bifurcated into two segments: one that consists of a handful of large organizations located within Milwaukee County that serve a preponderance of individuals; and another of provider organizations, many outside of the county, that are quite numerous (representing almost one-half of the hospitals and one-third of the Mental Health/Substance Abuse clinics) but serve a smaller proportion of the population. On the one hand this poses a challenge to integration and continuity of care. On the other hand, however, if the reason that providers have low volume is that they are in some sense outside the referral mainstream, then there may be potential for increasing capacity though efforts to integrate them more directly into an overall system (e.g., through more aggressive outreach by case managers and inpatient discharge planners).

[18] It also is important to note that in the tables and charts in this section, providers are cited based on Medicaid provider identification numbers. Those identification numbers may not correspond to providers who are actually delivering the service. For example, St. Luke's Medical Center is cited as an outpatient provider, but the actual outpatient services may be delivered elsewhere in the Aurora Medical Group system.

Exhibit 2. Providers[1] serving Medicaid-enrolled Milwaukee County residents, Jan.-Sept. 2014

	Number of providers	Number of people served	Providers serving <10	Number people served by <10 providers
Mental health/substance abuse clinics	209	26,418[2]	110	319
Mental health/substance abuse – individual non-prescribing clinicians	300	2,929	210	666
Hospital outpatient	138	16,533	114	251
Physician – independent group practices	272	31,112	168	428
Physician[3] – health care system group practices	16	2,125	5	25
Physician[3] – no affiliation identified	226	3,154	184	411
Nurse practitioner – affiliated with organizations	9	306	3	17
Nurse practitioner – no affiliation identified	20	49[4]	18	49
Federally qualified health center	15	3,150	10	32
Institutions for mental diseases – outpatient	8	2,459	4	8
Laboratory (drug screening)	21	2,445	13	38
Narcotic services	7	1,301	5	11
Day treatment	17	479	8	41
Health Check[5]	3	219	2	8
Health Check Other[6]	20	444	13	36
Crisis	11	1,611	11	10

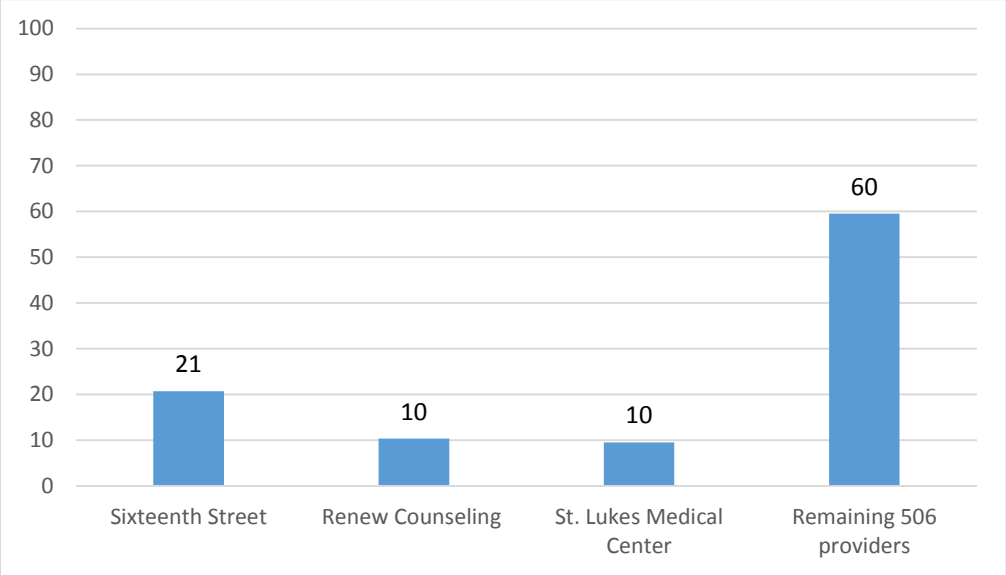
1. *As indicated by Medicaid billing provider type (see Appendix 1 for explanation)*
2. *Includes 200 people in group therapy, 189 at Sixteenth Street*
3. *Includes all sub-specialties*
4. *Excludes a single nurse practitioner in Ozaukee County serving 149 people*
5. *Early Periodic Screening and Diagnostic Treatment*
6. *Includes covered mental health services for children*

The largest individual organizations by volume in two categories, mental health/substance abuse clinics and hospital outpatient clinics, are discussed in greater detail below.

4.1.1 Mental health and substance abuse clinics

There were 509 separate organizations or individuals in the "mental health and substance abuse" provider type (the type with the highest number of members) that provided behavioral health services to Milwaukee County Medicaid enrollees between January and September of 2014. The distribution in the volume of services provided was highly skewed, with an average of 57 persons per provider but a median of only four. Approximately one-quarter of these submitted claims for only one person during this period. The top three highest-volume providers together accounted for 40% of the total volume.

Exhibit 3. Percentage of Total Persons Served (n=34,906) by Mental Health/Substance Abuse Billing Providers, January-September 2014: Top 3 by Volume vs. All Others*



* As noted above, while St. Luke's Medical Center is cited as an outpatient provider per Medicaid claims data, actual outpatient services may be delivered elsewhere in the Aurora Medical Group system.

The top 100 providers by volume (listed in Appendix 3 by numbers served) accounted for slightly more than 90% of the total (32,403) served by agencies.

4.1.2 Hospital outpatient services

Although 139 hospital outpatient clinics provided services to Milwaukee County Medicaid enrollees in the measurement period, the volume was highly concentrated: only 25 served at least 10 people (Exhibit 4), accounting for 99% of the total. Of those, the top eight accounted for 91% of the total.

Exhibit 4. Hospital Outpatient Serving at Least 10 People

Clinic	Number Served
WHEATON FRANCISCAN INC - ST JOSEPH	3385
FROEDTERT HOSPITAL	2174
COLUMBIA ST MARYS HOSPITAL	2140
AURORA ST LUKES MEDICAL CTR	1865
CHILDRENS HOSPITAL OF WISCONSIN INC	1724
WHEATON FRANCISCAN HEALTHCARE ST FRANCIS INC	1538
AURORA HEALTH CARE METRO INC	1484
AURORA WEST ALLIS MEDICAL CE	696
WHEATON FRANCISCAN WI HEART HOSPITAL AND MIDWEST S	279
WHEATON FRANCISCAN INC ELMBROOK	217
COMMUNITY MEMORIAL HOSPITAL	207
ST MARYS HOSPITAL OZAUKEE	125
WHEATON FRANCISCAN HEALTHCARE	122
WHEATON FRANCISCAN HEALTHCARE FRANKLIN, INC.	118
WAUKESHA MEMORIAL HOSPITAL INC	86
UNITED HOSPITAL SYSTEM INC	27
ST JOSEPHS COMMUNITY HOSP	18
AURORA MEDICAL CENTER GRAFTON	16
ST ELIZABETH HOSPITAL INC	14
ST MARYS HOSPITAL	13
ST AGNES HOSPITAL	11
ST VINCENT HOSPITAL	11
MERITER HOSPITAL INC	10
ST MARYS HOSP MED CENTER	10

4.2 Conclusion

In the period covered by this analysis (January to September 2014), an unduplicated count of 66,993 child and adult Medicaid enrollees residing in Milwaukee County received behavioral health services from 1,381 unique billing providers. It is important to remember that the total number by provider type does not equal the number receiving services because individuals may have received services from multiple provider types—that is, these are not unduplicated counts. Rather, they are intended to demonstrate the volume of services for each provider in terms of number of people served.

It should be noted also that not all of these providers are located in Milwaukee County. The list represents any provider of services to a Milwaukee resident. Thus, the list represents outpatient capacity for Milwaukee County in the sense of *where people actually obtain services* (the de facto service system for Milwaukee County) rather than providers exclusively located in Milwaukee. This aspect of the data is discussed in more detail in subsequent sections of this report.

Section 5
Outpatient Service Use: Penetration and Utilization

This section addresses the demand side of the equation in terms of treated prevalence, using consumer-level data to describe need in terms of the types of services that are received and the numbers of people who receive them. Data from Medicaid claims are presented first, followed by information on services funded and/or provided by Milwaukee County.

5.1 Medicaid claims data

Utilization rates and the numerator for penetration rates were constructed using claims data provided by the Wisconsin DHS. The denominator for penetration rates (total Medicaid enrollment) was obtained from the Wisconsin ForwardHealth Portal at https://www.forwardhealth.wi.gov/WIPortal. We were unable to access data on behavioral health service utilization by the uninsured population for this analysis.

5.2 Methods

Medicaid claims data for the period from July 2010 through March 2014 were analyzed to determine utilization—number of adults and children receiving mental health and substance abuse services. Types of services were identified using algorithms combining CPT procedure codes and diagnostic codes. (These algorithms are presented in Appendix 1.) Counts of services are provided at quarterly intervals. As noted above, Medicaid claims systems, designed to account for reimbursement based on fee schedules for various combinations of provider and service types, do not necessarily correspond to the structure of behavioral health systems as considered for policy and planning purposes. Thus, the Medicaid data field "billing provider type" used to differentiate among components of the service system combines codes for types of organizations (e.g., clinics) and for certain clinical professions (e.g., physicians). As a consequence, there is some unavoidable ambiguity in distinguishing between services that are provided by an individual practitioner in a private practice or in an organizational setting such as a clinic. These issues are discussed in more detail in Appendix 1.

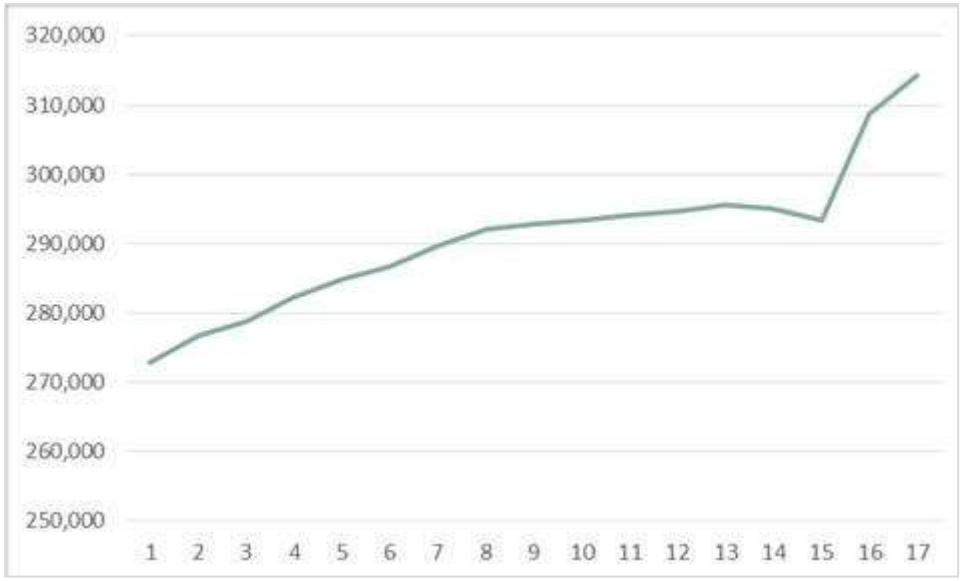
5.3 Results

5.3.1 Service penetration

Penetration refers to the proportion of the eligible population that receives a service, represented as a percentage. Exhibit 5 presents total Medicaid enrollment of Milwaukee County (children/adolescents and adults) on a quarterly basis (average for the three months in the quarter), which serves as the denominator for the treated prevalence statistics that follow. (Data tables for the following graphs are presented in Appendix 2.)

It can be seen that Medicaid enrollment increased steadily over the period of 17 quarters between July 2010 and September 2014, for a net increase of about 61,000 people across the period.

Exhibit 5. Milwaukee County Total Medicaid Enrollment, July 2010 – September 2014



Exhibits 6-9 present percentages of child/adolescent and adult Medicaid enrollees receiving mental health and substance abuse services (as indicated by diagnosis and procedure codes) on a quarterly basis. It is evident that for all categories, the percentage of Medicaid enrollees receiving services gradually increased for about eight consecutive quarters and then began to decline midway through the period of analysis, around July-September 2012. Later, in Exhibits 10 through 17, we show actual patient counts for various Medicaid-funded services.

Given that penetration rates are a function of combined utilization and total enrollment, changes in penetration rates may be due to increased enrollment, decreased utilization, or both. With respect to service capacity, increased enrollment alone with no change in utilization would indicate that capacity has not shrunk, but that it also has not responded to the increased need represented by the expanded enrollment.

The utilization data presented in Exhibits 10 through 20, which generally show relatively flat trend lines in the number of people receiving services, therefore suggest that capacity did not shrink during this period, but neither did it increase in response to increased Medicaid enrollment. (One exception may be Milwaukee County's Wraparound Milwaukee program for children and adolescents; according to Wraparound Milwaukee administrators, Wraparound enrollment recently has increased at a faster pace than total Medicaid enrollment, but we could not verify that assertion with the data provided.)

A definitive explanation for the failure of most services to expand capacity in line with increases in Medicaid enrollment cannot be determined from these data alone, but there are several possible explanations. The simplest explanation is that service use was affected by some policy change, such as more limited benefits for recent enrollees. However, the benefit package for those eligible for the Medicaid expansion that went into effect in April 2014 was not thus restricted. Another possibility is that the more recent enrollees who are responsible for the increase in Medicaid rolls during this period, including the Medicaid expansion population of childless adults with incomes less than 100% of the Federal Poverty Level, differ from their predecessors in having less need for behavioral health services. This would be a plausible explanation if more recent enrollees were known to be a

substantively different population, for example as a result of an expansion in eligibility; however, this was not the case in Wisconsin for that particular point in time.

A more likely explanation is that the system as a whole may have reached some maximum level of capacity. If that were the case, then there might be an expectation based on simple laws of supply and demand that the capacity would expand in response to the increase in potential clients. That this did not occur in the remaining eight quarters of the analysis period, however, may again have several possible explanations. For example, there may be a natural lag in provider response to increased demand; it seems unlikely, however, that any lag would be as much as the two-year period indicated by the data.

It is most likely that this finding can be attributed to one of the various widely-recognized types of health care market failures which subvert the laws of supply and demand. It may be that the low reimbursement rates for Medicaid relative to other payment sources create a disincentive for providers to change the payer mix by accepting more Medicaid clients. This possibility is supported by our findings from stakeholder interviews and a simulated patient investigation (reported in Sections 6 and 7, respectively). Another possibility is that providers' ability to expand capacity is constrained by workforce shortages, as widely reported by stakeholders. Although definitive explanations may require further investigation, these possibilities are addressed in various ways by many of the recommendations at the conclusion of this report.

Exhibit 6. Percentage of adult Medicaid enrollees receiving mental health services, by quarter (July 2010 through Sep 2014)

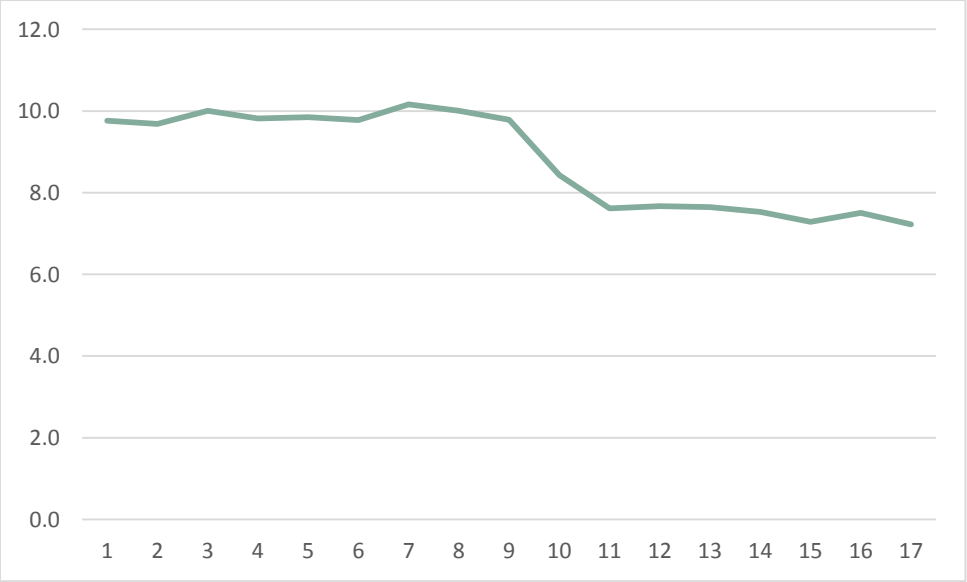


Exhibit 7. Percentage of child/adolescent Medicaid enrollees receiving mental health services, by quarter

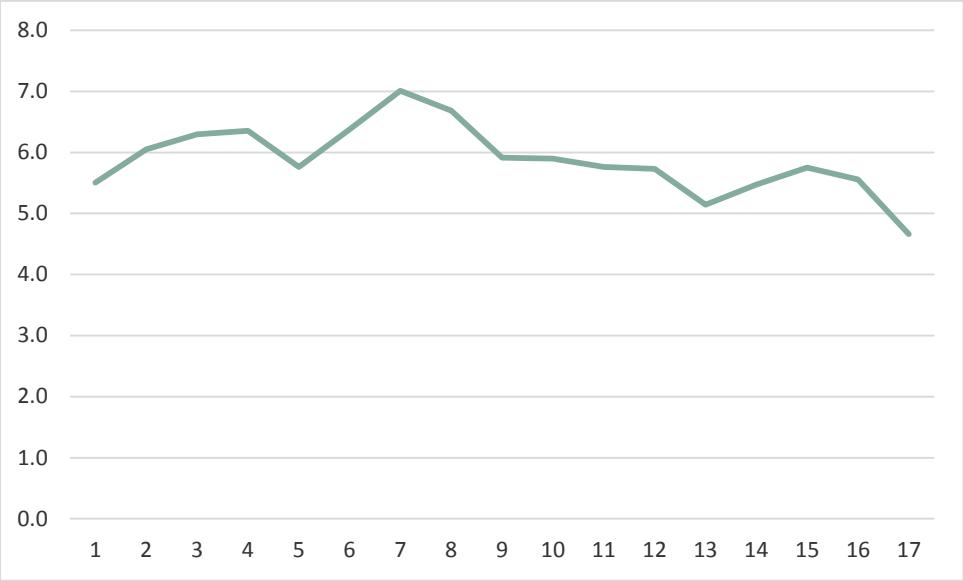


Exhibit 8. Percentage of adult Medicaid enrollees receiving substance abuse services, by quarter

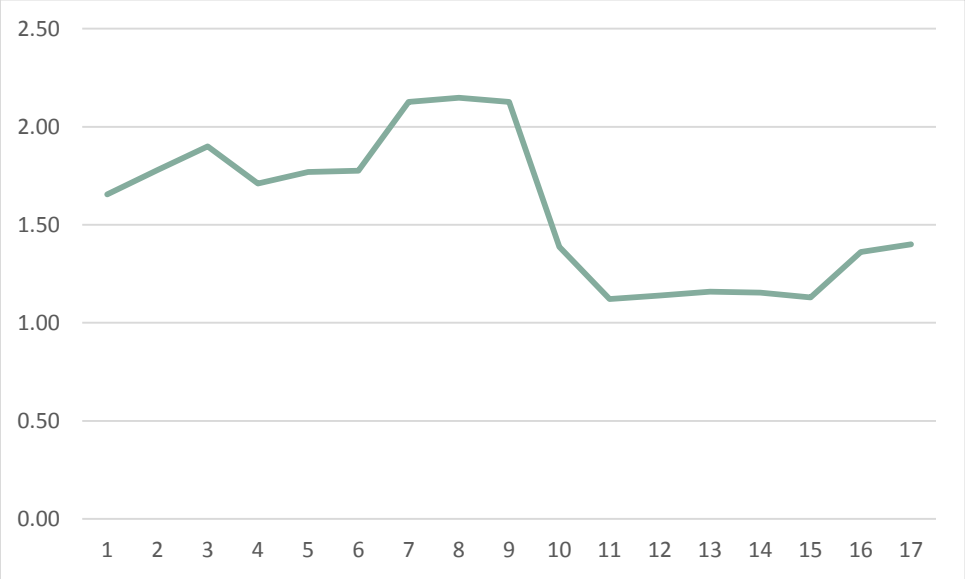


Exhibit 9. Percentage of child/adolescent Medicaid enrollees receiving substance abuse services, by quarter

While direct comparison with Medicaid penetration rates reported in other sources is difficult because of differences in methods, program characteristics, enrollee populations, etc., the rates for Milwaukee County appear to be roughly in line with those reported in other studies. For example, in a study of fee-for-service Medicaid enrollees in 13 states in 2003, 11.7% of Medicaid beneficiaries were identified as using inpatient and/or outpatient mental health or substance abuse services (10.9% and 0.7% used each of these services, respectively), with substantial variation across age and eligibility groups.[19]

5.3.2 Utilization by Medicaid provider type

Exhibits 10 through 13 display the numbers of children/adolescents and adults receiving mental health and substance abuse services each quarter from July 2010 through September 2014, by billing provider type.

As shown in Exhibit 10, billing for children by FQHCs gradually increased over the period, suggesting an increasing capacity for providing behavioral health services, although there are some anomalous variations.

Numbers for narcotic treatment for children and adults in Exhibits 10 and 11 are very small as these represent only persons who were given a primary diagnosis of mental illness. A preponderance of people using this service are given a substance abuse diagnosis, as indicated in Exhibits 12 and 13.

Outpatient services provided in hospitals and, in smaller numbers, in institutions for mental disease (IMDs), are fairly consistent throughout the period. That also is the case for the much larger

[19] Ireys, H. T., Barrett, A. L., Buck, J. A., Croghan, T. W., Au, M., & Teich, J. L. (2010). Medicaid beneficiaries using mental health or substance abuse services in fee-for-service plans in 13 states, 2003. *Psychiatr Serv, 61*(9), 871-877. doi: 10.1176/appi.ps.61.9.871

numbers for services provided in licensed Mental Health and Substance Abuse clinics—though there is some variation, possibly due to seasonal differences. Services provided by nurse practitioners vary somewhat unpredictably, but are relatively small numbers throughout the period. Given the widely noted problems with access to child psychiatrists in Milwaukee County, this may be an area for further exploration as an opportunity to increase capacity through physician extenders.

Because the supply of psychiatrists is a critical capacity issue in Milwaukee County, in Exhibits 14 through 17 we specifically break down the numbers of people receiving mental health and substance abuse services provided by psychiatrists, identified by a specialty billing code within the Physician and Physician Group billing types. Based on the estimate of approximately 18,000 children with serious emotional disturbance in Milwaukee Country presented in Wisconsin Mental Health and Substance Abuse Needs Assessment described above (Section 2.1.2), the figure of approximately 1,500 children and adolescents served by psychiatrists (Exhibit 14) appears to verify this gap in the service system cited by many stakeholders.

It should be noted, however, that an exception to the general gap in psychiatric services for children is the success of Wraparound Milwaukee in developing and maintaining an extensive provider network with a comprehensive range of services, such that the gap in service needs for children with serious emotional disturbance is significantly less in Milwaukee County compared to most other areas in the country. Even with the critical shortage of child psychiatrists, Wraparound Milwaukee has access to four psychiatrists, making it possible for any child enrolled in Wraparound to be seen by a psychiatrist if needed according to Wraparound administrators.

NOTE: Data for Physicians, Physician Assistants and Advanced Practice Nurses from the final quarter in 2012 to the end of the measurement period appeared to be incomplete for reasons that are unclear, but possibly related to changes in coding for medication management services mandated by the Centers for Medicare and Medicaid Services (CMS) beginning in 2013. Our procedure code algorithms were designed to capture that change, but data anomalies persisted. Accordingly, we have imputed values for those quarters, based on the average for all preceding quarters.

Exhibit 10. Child/Adolescent Mental Health Services Utilization by Medicaid Provider Type

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sep
Mental Health/Substance Abuse	3873	4053	4297	4496	4145	4565	4991	4978	4414	4738	4418	4383	3835	3772	3932	4037	3594
Hospital Outpatient	521	558	588	654	625	688	730	614	618	689	712	671	508	632	715	505	469
Physician[1]	2258	2428	2687	2662	2266	2583	3141	2707	2334	2562	2562	2562	2562	2562	2562	2562	2562
Physician Group	801	1123	1134	1155	1119	1324	1424	1379	1206	1767	2319	2359	2122	2327	2448	2303	1858
Nurse Practitioner	57	61	55	55	58	57	84	84	72	65	65	65	65	65	65	65	65
Physician Assistant[1]	15	12	15	12	9	18	18	14	8	13	13	13	13	13	13	13	13
Federally Qualified Health Center	62	199	133	111	109	134	121	105	104	171	193	167	165	214	292	263	180
Institution for Mental Disease	25	44	32	47	74	68	95	79	62	38	30	42	27	61	72	20	14
Crisis Intervention	5	1	5	3	4	6	8	8	4	3	3	3	1	5	7	9	6
Therapy Group		1		4	2	3	6	4	6	2	3	14	5	3	15	1	1

[1]Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 11. Adult Mental Health Services Utilization by Medicaid Provider Type

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept
Mental Health/Substance Abuse	9096	8970	9160	9101	9282	9229	9740	9756	9581	9047	8255	8334	8159	7768	7669	8776	8727
Hospital Outpatient	974	978	1150	1268	1231	1265	1373	1160	1174	1077	1087	1130	1031	1011	602	480	490
Physician[1]	4422	4441	5123	5188	5361	5406	5770	5323	5063	5121	5121	5121	5121	5121	5121	5121	5121
Physician Group	2157	2400	2459	2433	2408	2232	2423	2508	2522	2538	3057	3223	3325	3429	3296	3563	3418
Nurse Practitioner[1]	264	264	283	307	450	486	550	631	540	463	463	463	463	463	463	463	463
Physician Assistant[1]	68	57	65	75	85	102	105	88	71	80	80	80	80	80	80	80	80
Federally Qualified Health Center	313	410	302	278	315	485	494	420	329	202	269	230	256	244	344	423	398
Institution for Mental Disease	53	51	27	39	63	62	63	60	61	28	31	24	13	29	22	10	10
Narcotic Treatment[2]	20	11	5	3	2	4	3	1	1	1							
Crisis Intervention	1077	1072	1086	1100	1091	1097	1101	1100	1102	1085	1075	1093	1091	1085	1091	1132	1132
Therapy Group	1	3	11	6	6	7	9	6	12	4	16	18	13	2	7	32	1

[1] Green shaded cells imputed (average of preceding quarters) due to missing data

[2]Numbers represent only persons receiving a primary diagnosis of mental illness (vs. substance abuse)

Exhibit 12. Child/Adolescent Substance Abuse Services Utilization by Medicaid Provider Type[1]

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept
Mental Health/Substance Abuse	25	26	26	1	27	38	39	36	42	19	17	13	12	10	18	9	6
Hospital Outpatient	1	5	6	4	4	3	5	2		2	1				1	1	
Physician[2]	25	34	26	30	25	36	30	23	29	29	29	29	29	29	29	29	29
Physician Group	13	19	15	14		12	22	9	14	16	19	19	6	20	39	7	11
Federally Qualified Health Center		1			1	1	1	1		1		1	1			1	
Institution for Mental Disease	7	7	4	27	1	1	2	2	1	1	1		1	1		1	1
Narcotic Treatment	3	1			1				1	4	4	3	3	1	1	1	3

[1]Nurse practitioner and physician assistant omitted, few than 3 per quarter

[2]Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 13. Adult Substance Abuse Services Utilization by Medicaid Provider Type

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept
Mental Health/Substance Abuse	516	438	467	477	552	596	726	719	724	610	504	480	467	436	481	592	638
Hospital Outpatient	69	97	101	80	98	93	105	74	72	76	75	80	62	66	54	50	57
Physician[1]	953	1067	1196	1080	1118	1141	1513	1445	1392	1212	1212	1212	1212	1212	1212	1212	1212
Physician Group	510	688	775	677	684	669	804	857	796	597	646	695	645	699	627	762	644
Nurse Practitioner[1]	109	115	136	108	202	170	226	255	222	159	159	159	159	159	159	159	159
Physician Assistant[1]	16	14	27	17	26	24	32	34	32	23	23	23	23	23	23	23	23
Federally Qualified Health Center	73	88	59	57	67	51	54	66	81	30	18	15	39	25	46	130	89
Institution for Mental Disease	54	62	34	41	70	83	73	59	44	38	26	23	27	28	21	22	19
Narcotic Treatment	548	543	548	547	540	515	534	560	597	615	626	671	705	728	723	963	1100
Case Management	2	2	2	1	1			2		5	5	5	5	4	4	6	5
Crisis Intervention	69	97	101	80	98	93	105	74	72	76	75	80	62	66	54	50	57
Therapy Group			2	1						1		4	1			6	1

[1]Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 14. Child/Adolescent Mental Health Services Utilization by Medicaid Provider Type: Psychiatrist Subspecialty

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept
Individual[1]	1142	1176	1305	1313	1165	1342	1540	1397	1241	1291	1291	1291	1291	1291	1291	1291	1291
Group	58	87	100	100	99	110	134	139	112	150	243	308	305	320	367	328	225

[1]Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 15. Adult Medicaid Mental Health Services Utilization by Medicaid Provider Type: Psychiatrist Subspecialty

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept
Individual[1]	2638	2687	3189	3332	3460	3536	3615	3399	3242	3233	3233	3233	3233	3233	3233	3233	3233
Group	355	375	362	405	407	302	255	319	383	499	571	537	617	637	587	487	410

[1]Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 16. Child/Adolescent Medicaid Substance Abuse Services Utilization by Medicaid Provider Type: Psychiatrist Subspecialty

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept
Individual[1]	14	14	12	8	8	5	9	9	10	10	10	10	10	10	10	10	10
Group		2	3	2	1	1		1	1	1	1	7	1	2	1	2	1

[1]Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibit 17. Adult Medicaid Substance Use Services Utilization by Medicaid Provider Type: Psychiatrist Subspecialty

	2010		2011				2012				2013				2014		
	Jul-Sep	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept	Oct-Dec	Jan-Mar	Apr-Jun	Jul-Sept
Individual[1]	197	217	233	227	264	227	263	209	205	227	227	227	227	227	227	227	227
Group	24	29	29	21	28	17	20	20	22	38	41	57	66	71	78	65	57

[1]Green shaded cells imputed (average of preceding quarters) due to missing data

Exhibits 18-20 present total numbers served by combined provider types. (Mental health services for both age groups and total are combined. Substance abuse services for the two age groups are presented separately due to differences in scale.) It should be noted that these are not unduplicated counts; that is, some individuals may receive services from more than one provider type in a quarter. As discussed above, the relatively flat trend lines demonstrate that outpatient service capacity has remained relatively stable and did not expand in response to the increase in Medicaid enrollment during the same period.

Exhibit 18. Adult, Child-Adolescent, and Total Medicaid Mental Health Service Utilization, Combined Provider Types

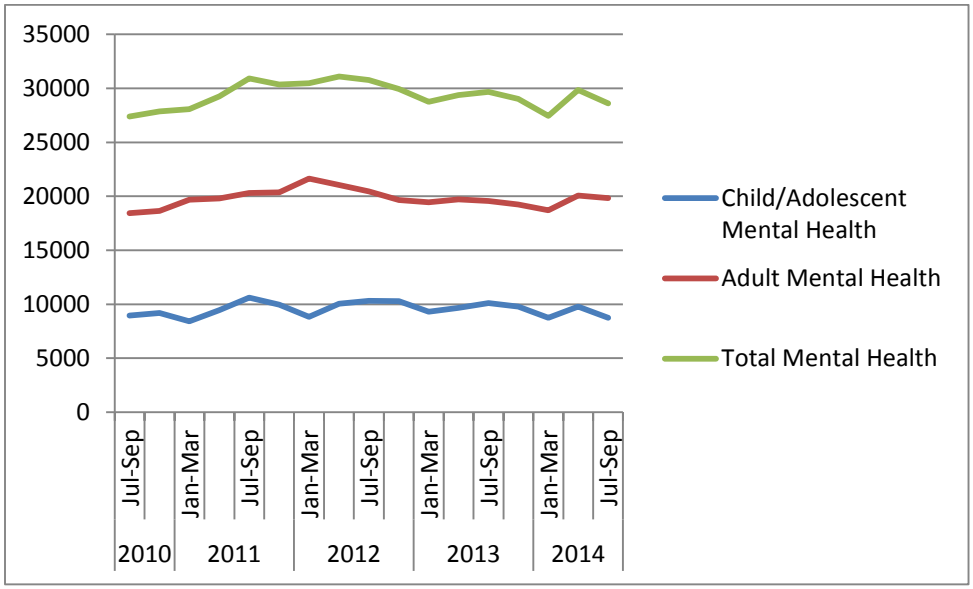


Exhibit 19. Adult Medicaid Substance Abuse Service Utilization, Combined Provider Types

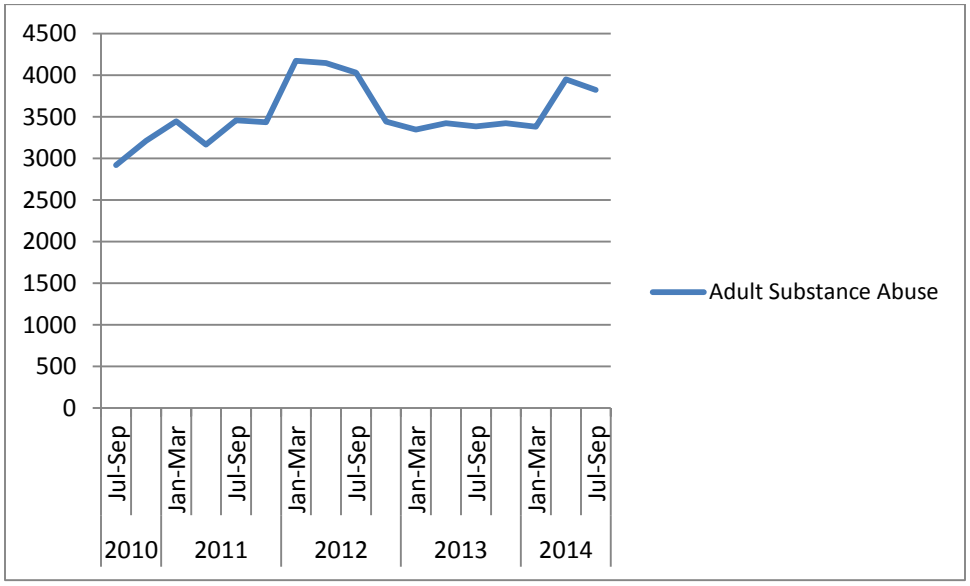
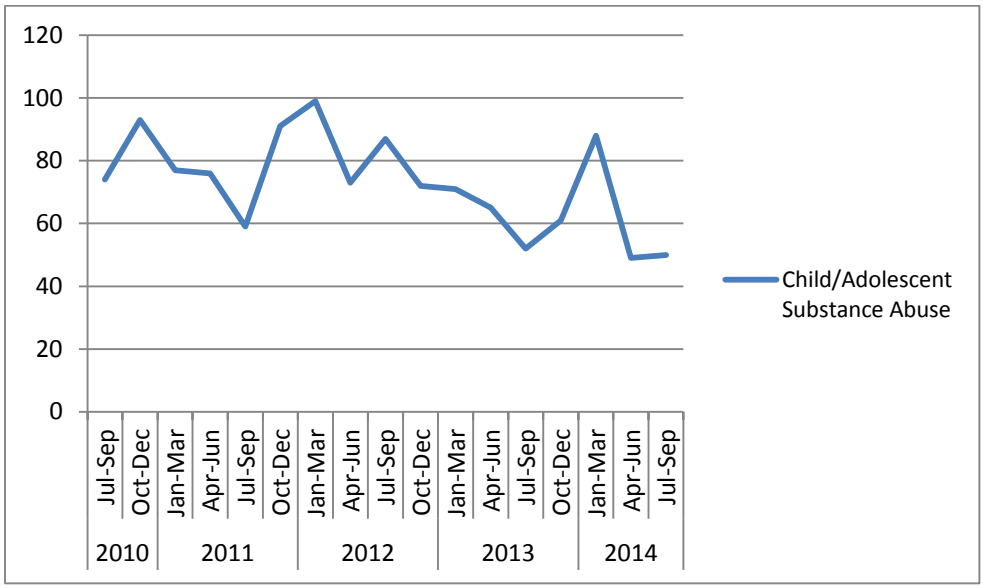


Exhibit 20. Child Medicaid Substance Abuse Service Utilization, Combined Provider Types



5.3.2.1 Medicaid service utilization summary

Because there is no standard formula to determine the "right" size or configuration of a behavioral health system, and because the array of providers serving Milwaukee County residents is so diffuse, the analysis of penetration, utilization, and volume does not readily lend itself to judgments about where there may be gaps that should be addressed, whether there is an imbalance of various types of services, etc. The stakeholder interviews provide more nuanced and reliable feedback of this kind, as indicated in the Recommendations section at the end of this report.

What these data do provide is context in the form of a general representation of the array of services and providers in Milwaukee County and an overview of who is providing how much of what kind of services—that is, the de facto behavioral health outpatient service system. Accordingly, several observations may be made:

- There is a **great deal of diversity in the type and size of providers**—from very large health care systems, to small clinics serving specialized populations, to individual clinicians or small private group practices. While this diversity presents challenges for monitoring performance and building system integrity, it does offer the benefit of flexibility, increasing the possibility for matching individual client needs with provider capabilities. To take advantage of that potential, however, some means of coordination is required, as addressed in the Recommendations section.
- A very **considerable proportion of these providers serve only a handful of people each**. These do constitute a segment of the "system's" capacity, though they account for a low volume of services. On the one hand, this suggests the possibility of barriers to access—that qualified Medicaid providers are limiting the number of Medicaid recipients in their practice—but it may also represent underutilized resources that could be leveraged to expand access.
- While it was not feasible to map the location of all providers, it is **evident that many of them, particularly in the low-volume group, are located outside Milwaukee County**. This may have a variety of implications that could be explored. It may indicate that for the Medicaid population, the county is a somewhat arbitrary boundary and that the de facto service system is in fact more regional, or it may indicate that the supply of providers within the county is inadequate.
- These alternative explanations, along with other possibilities, lead to a third observation—that the **challenges and limitations of using claims and county encounter data** demonstrate the need for a more robust, comprehensive, and integrated health information data system for effective planning and policy making.

5.3.3 BHD service utilization

BHD administers or provides a wide variety of community-based mental health services for adults through its Community Access to Recovery Services (CARS) branch, which consists of two programs, one for mental health and the other for substance abuse services. The Service Access to Independent Living (SAIL) program serves adults with mental illness by assessing individual needs and facilitating access to appropriate community services and supports. Wisconsin Supports Everyone's Recovery (WIser) Choice is the County's public alcohol and drug treatment and recovery service system. WIser Choice is open to County residents ages 18-59 with a history of alcohol or drug use, with priority given to families with children and pregnant women (regardless

of age). Individuals access the WIser Choice system by visiting one of the County's Central Intake Units (CIUs).

The summary below provides brief descriptions of each of the major community-based adult mental health services funded and/or provided by BHD that can be categorized as "clinical outpatient services" per the scope of this report.

5.3.3.1 BHD Mental Health Services

- **Outpatient services** are clinic-based services, such as medication management and one-on-one or group therapy. The County traditionally has contracted with two providers for outpatient services: the Medical College of Wisconsin and Outreach Community Health Centers. However, BHD and the Medical College will be ending their contractual relationship at the end of 2015 and may instead convert to a fee-for-service relationship. In addition, the County runs a drop-in Access Clinic at the Mental Health Complex that is staffed by County personnel. The County Access Clinic is not strictly comparable to the other two outpatient settings, as it provides assessment and referral services in addition to outpatient treatment. Among these referrals are those to agencies participating in the MHOP (Mental Health Outpatient, see below) program, which provides outpatient therapy on a fee-for-service basis, in contrast to contracted outpatient providers.The Access Clinic has been described as an urgent care setting for individuals with ongoing mental health concerns. It is limited to uninsured indigent individuals, while clients with some form of insurance (including Medicaid) are referred to the other two outpatient providers.
- **The Community Support Program** (CSP) offers comprehensive case management that also involves intense clinical treatment. The County staffed two CSPs and contracted for additional CSP services with six community providers until this year, when the remaining County CSPs were eliminated and the County began contracting for all CSP services.
- **Community Recovery Services** (CRS) is a mental health benefit created in the 2009-11 state budget that offers psychosocial services such as employment, housing, and peer support to eligible Medicaid clients. CRS focuses on assessment, development of an individualized plan of care, and support for the consumer in his or her plan of care. An individual can participate in CRS and other programs such as CSP at the same time, maximizing his or her opportunity for recovery and independence. The program began at the start of 2014.
- **Comprehensive Community Services** (CCS) is a new Medicaid benefit that, according to the State, seeks to reduce inpatient admissions by strengthening the array of county resources in early intervention and treatment. CCS also provides services for those with co-occurring mental health and substance use disorders, as well as for those with substance use disorders alone. CCS funds a wide array of services, including medication management, psychotherapy, employment training, and life skills training. In its initial implementation, CCS expenses will be fully funded by the federal and state governments. BHD began its CCS program in August 2014.
- **MHOP** is a non-residential treatment service totaling less than 12 hours of counseling per patient per week, which provides a variety of evaluation, diagnostic, crisis, and treatment services. Services include medication management, individual counseling, and intervention and may include group and family therapy and referral to other services that may occur over an extended period. There are six providers of Mental Health Outpatient services in the CARS network. Outpatient services were provided to 476 individuals in 2014.

- **Day Treatment** is intensive treatment for individuals 18 years of age and older who have complex and co-occurring disorders, provided in a community milieu Monday through Friday, with 24-hour crisis interventions available through links to the Milwaukee County Crisis Line. CARS psychologists facilitate 60 treatment groups per week – via the Dialectical Behavior Therapy Treatment Team and the Recovery and Stabilization Treatment Team – plus monthly recovery planning conferences with clients, their families, and other involved providers. The capacity of the program is 22 to 28 clients, based on acuity and risk concerns. There were 59 clients served in 2014.

5.3.3.2 BHD Addiction Services

- **Outpatient** is a non-residential treatment service totaling less than 12 hours of counseling per patient per week, which provides a variety of evaluation, diagnostic, crisis and treatment services relating to substance abuse to ameliorate negative symptoms and restore effective functioning. Services include individual counseling and intervention and may include group and family therapy and referral to non−substance abuse services that may occur over an extended period. There are 33 providers of Outpatient services in the CARS network. Outpatient services were provided to 2,628 individuals in 2014.
- **Day Treatment** is a medically monitored and non−residential substance abuse treatment service which consists of regularly scheduled sessions of various modalities, such as individual and group counseling and case management, provided under the supervision of a physician. Services are provided in a scheduled number of sessions per day and week, with each patient receiving a minimum of 12 hours of counseling per week. There are 15 providers of Day Treatment services in the CARS network. There were 309 individuals engaged in Day Treatment services in 2014.
- **Medication Assisted Treatment** (MAT) in Milwaukee County has expanded in terms of providers, types of clients served, and additional services provided to the population. Vivitrol providers for both the insured and uninsured populations in the CARS network expanded in 2014, while CARS also continued to work closely with contracted Methadone clinics. As of February 2015, all clients presenting to a CIU are now assessed to determine if they meet MAT criteria and are given information about the different choices. There are three providers of MAT in the CARS network. There were 279 individuals who received MAT in 2014.

BHD also provides a range of support (psychosocial) services – e.g., case management, recovery support, and residential programs – that are outside of our focus on core outpatient clinical services.

As an approximation of the gap between available capacity and demand for major SAIL-authorized services, Exhibit 21 presents the number of new SAIL admissions for the 2011-2014 timeframe and the median number of days from the initial request for services to admission. The list of services includes not only CSP and Day Treatment (described above), but also Targeted Case Management (TCM) and Community-Based Residential Facilities (CBRFs), despite the fact that those services do not meet the definition of "clinical" services used in this report. We include those services here simply as an illustration of service volumes and wait times for the primary services accessed through SAIL. Also, the table does not include persons who declined or were deemed inappropriate for services. It should be noted that SAIL does not ordinarily refer clients to outpatient care except insofar as outpatient therapy occurs as a part of a broader service package (as with CSP), and nearly all requests to SAIL are for individuals already receiving some form of psychiatric care.

Exhibit 21. SAIL New Admissions and Median Number of Days From Request To Admission

	2011		2012		2013		2014	
	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission
TCM	224	17	265	28	315	49	379	67
CSP	78	22.5	102	31	115	52	141	80
CBRF	5	27	9	27	8	32.5	15	75
Day Treat-ment	38	15	24	16.5	39	24	44	29

The bottlenecks in obtaining CSP services described by stakeholders are evident in the near quadrupling of the number of days between request and admission from 2011 to 2014. BHD officials attribute this trend to the significant increase in the number of requests, which nearly doubled over the period. As noted above, BHD has initiated a number of measures to address this increased demand, with the expectation that wait times will be reduced. Preliminary data through August 2015 indicate a lag of about 60 days—still considerably more than 2011-2013, but a downward trend from the previous year.

Exhibit 22 presents the number of admission and mean days from request to admission to BHD's substance abuse services, also known as WIser Choice, excluding admissions to detoxification and the Intoxicated Driver Program, and no-shows. In contrast to wait times for SAIL services, wait times have declined significantly for most WIser Choice service categories over the past four years, with the exception of employment and school/training services. The data also indicate a relatively sharp decrease in the number of admissions to outpatient and day treatment over the 2011-2014 timeframe.

Exhibit 22. WIser Choice Median Days from CIU Screen to Admission

	2011		2012		2013		2014	
	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission	Number Admitted	Days Request to Admission
Outpatient	1511	7.0	1148	6.0	1179	3.0	868	2.0
Day Treatment	310	6.0	224	4.0	212	3.0	198	1.0
Transitional Residential	529	7.0	329	5.0	206	4.0	312	3.0
Medically Monitored Residential	21	14.0	6	22.5	5	30.0	10	3.0
Methadone	9	25.0	14	17.5	20	0.5	81	5.0
Employment	18	7.0	179	7.0	177	6.0	126	11.0
School/ Training	53	2.0	78	5.0	48	4.5	85	8.0
Housing	9	8.0	21	8.0	16	5.0	16	2.0

Exhibit 23 presents trends for units of service and number of children served by Wraparound Milwaukee. Except for a slight decline in 2014 from the previous year, both units of service and numbers of persons served generally increased during the period. (Data on wait times for admission were not available for this report).

Exhibit 23. Wraparound Milwaukee Units of Service and Number Served by Category of Service 2011-2014

Service Type	Unit Type	2011		2012		2013		2014	
		Units	Persons	Units	Persons	Units	Persons	Units	Persons
AODA	**¼ Hour**	4,172	178	3,774	150	5,162	186	5,304	181
Day Treatment	**Daily**	2,161	53	2,697	65	2,380	54	1,318	29
Outpatient	**Hourly**	37,195	1,146	42,727	1,227	47,339	1,346	46,598	1,280
Psychiatric Review/Meds	**Session**	3,483	906	4,521	1,046	4,758	1,097	3,847	1,031

As the above tables demonstrate, the number of adults receiving mental health services and children receiving mental health and substance abuse services through BHD was fairly consistent over the four-year period, with a slight decline in some categories in 2014. The increased wait times for adult mental health services, however, indicates some strain on capacity of those services, though preliminary data for 2015 reported by BHD suggest that is being alleviated to some extent. The sharp decline in admissions for most categories of substance abuse services, with the exception of methadone treatment, also may indicate that there are capacity constraints. These trends should be monitored closely.

Section 6
Outpatient Capacity and Access: Stakeholder Perspectives

While the review of documents and multiple sources of data were essential to gaining an understanding of behavioral health service provision and utilization in Milwaukee County, input from individuals who participate in and experience the system is another essential source of information. We conducted face-to-face and telephone interviews with dozens of community, County, and State stakeholders. These individuals were identified by suggestions from the study advisory group, our experience gleaned from our previous work on Milwaukee County behavioral health issues, and suggestions from interviewees themselves.

Between March and June 2015, interviews were conducted with a broad base of stakeholder representatives, including key Wisconsin Department of Health Services and County BHD staff, discharge planners from BHD and local hospitals, representatives of mental health and substance use provider organizations, FQHCs and other safety-net providers, academia, and Medicaid managed healthcare plans. We also conducted a consumer focus group that included individuals with lived experience and advocates who help people with mental illness and substance use disorders navigate the health care and social service systems.

6.1 Results

While there was some variation in response among the stakeholders interviewed, consistent themes emerged. The following issues were perceived by most as gaps in care or barriers to accessing outpatient behavioral health care in Milwaukee County.

6.1.1 System fragmentation

Stakeholders consistently described services in Milwaukee County to be cumbersome to access and 'siloed'. Persons interviewed often described individuals and agencies that are "doing good things," but absent communication with, or connection to, the rest of the behavioral health system.

6.1.1.1 BHD

As noted above, adults in Milwaukee County with serious mental health disorders who require long-term community support must receive an assessment and/or referral to a variety of services through Service Access to Independent Living (SAIL). "Qualified mental health providers" may also conduct an assessment but are required to submit a completed referral form for services to SAIL for approval and authorization. While SAIL is justifiably intended to provide uniform application of eligibility criteria for services, we heard from multiple stakeholders that SAIL is not as responsive as desired when individuals have an immediate need to access care. (BHD suggests this perception may in fact be related to the inability of individuals to be enrolled immediately and notes having studied the referral process with the goal of decreasing wait times and improving access to services.)

The WIser Choice Alcohol and Other Drug Abuse (AODA) program is Milwaukee County's public alcohol and drug treatment and recovery service system for individuals not enrolled in an HMO. Individuals who want or need access to the WIser Choice system must visit a County-contracted Central Intake Units (CIU) to be assessed and determined eligible for services. Stakeholders noted

the need for improvement in this intake system, with some suggesting that the system creates redundancy by requiring individuals who have been assessed as needing treatment by qualified treatment professionals to travel to a CIU for approval. BHD notes that the CIUs have a comprehensive screen that determines an individual's needs – and what level of service is required to meet those needs – based upon evidence-based screening tools and assessments, and that this comprehensive assessment also is necessary to compile data required by funding sources.

Access to treatment for co-occurring mental health and substance use disorders also was described as limited. In spite of efforts to provide integrated treatment, stakeholders asserted that the mental health and AODA systems and services continue to operate separately with redundant processes for accessing services. (BHD notes that CARS has recently implemented an electronic health record system that provides a uniform intake assessment process – this system may not have been in place or may have been very newly implemented at the time we conducted our stakeholder interviews.)

6.1.1.2 Medicaid Managed Care

Most Medicaid recipients must enroll with a Managed Care Organization (MCO). There are eight MCOs serving Milwaukee County. Stakeholders reported that while all MCOs are bound by the same DHS contractual requirements, there are differences in their policies, procedures, and operational protocols—differences that lead to confusion for members and providers. In addition, stakeholders commented that the published MCO provider networks are misleading in that listed providers often have little capacity to accept new patients within required timeframes and there are questions about the extent to which DHS holds MCOs accountable for contractual network adequacy requirements.

6.1.1.3 FQHCs

FQHCs play a vital and growing role in meeting the needs of Milwaukee County residents with varying degrees of behavioral health needs, serving as a safety net for the uninsured and underinsured. However, behavioral health capacity among most FQHCs is limited to clinical services such as evaluation, therapy, and medication management, with no direct access to longer-term treatment and the psychosocial services and supports provided by BHD. FQHCs also reported little interaction or communication with BHD. The Centers appear to be operating parallel to, not as a part of, the behavioral health system.

6.1.2 Access to case management

Stakeholders expressed frustration and concern over the lack of readily accessible case management. Case management is often part of a "service bundle" available for individuals with the most serious and chronic conditions. Stakeholders reported that individuals are maintained on caseloads far longer than intended, providing few openings for new referrals. The high degree of fragmentation in the behavioral health system makes it especially challenging for individuals and families to access the services and supports they need absent case management and case coordination.

6.1.3 Access barriers due to Medicaid reimbursement rates

In addition to the physical inconvenience of Medicaid provider geographic locations (noted by stakeholders and indicated by the number of providers outside Milwaukee County), stakeholders identified the low Medicaid rates for services as one of the most significant barriers to behavioral health care, with several discharge planners asserting that there were only four mental health agencies in Milwaukee County that readily accepted Medicaid recipients for services. The limited

number of providers accepting Medicaid recipients was said to result in lengthy wait times for outpatient treatment, including access to medications, which contributes to increased demands on emergency departments and readmissions to inpatient psychiatric beds. The apparent inconsistency between these anecdotal accounts by discharge planners on the one hand, and the evidence from claims data and the simulated patient investigation (discussed in the next section) on the other, may be explained by differences in patient types. The patients being referred by inpatient discharge planners generally represent higher levels of severity and acuity, which fewer providers may be willing to accept.

6.1.4 Shortage of psychiatrists (children, older adults, complex conditions)

All providers and payers identified the lack of access to psychiatrists as a barrier to care in Milwaukee County. While the shortage of psychiatry is a national problem, the designation of one third of Milwaukee County as a Mental Health Professional Shortage Area further underscores the seriousness of the problem.

The Milwaukee County FQHCs have had some success in obtaining psychiatric capacity; however, directors reported lengthy recruitment efforts, challenges due to salary expectations, and problems with retention. One center reported a three-year effort to attract and hire a psychiatrist. Also, the FQHCs appear to be competing with each other and the rest of the provider agencies in Milwaukee for psychiatrists and advanced practice registered nurses (APRNs).

Primary care practitioners are serving as a resource for treating individuals with less serious disorders, but most are not comfortable treating children, older adults, and adults with more complex behavioral health conditions, particularly with respect to prescribing psychotropic medications. Telepsychiatry is a means by which primary care practitioners can access consultation from a child psychiatrist for assistance in diagnosing and treating patients presenting with mental health needs, thereby enhancing their skills and comfort level with treating children and adolescents. Early identification and treatment of mental health and substance use disorders is key to preventing further progression of the conditions. The Child Psychiatry Consultation Initiative discussed in Section 8 is one program that has helped in ameliorating this problem by enhancing the behavioral health competencies of primary care providers.

6.1.5 Use of alternative psychiatric practitioners

Some private providers and FQHCs reported interest in the use of physician assistants and APRNs with psychiatric specialty to help address the shortage of psychiatrists. The scope of practice for PAs and APRNs includes the provision of diagnoses, treatment recommendations, and the prescription of non-controlled substances for the treatment of psychiatric and substance use disorders, thereby providing relief for the demand for psychiatric appointments. This may be a limited solution, however, as agencies that have attempted to recruit APRN's and PA's reported that they are also in short supply in Wisconsin and can therefore command higher salaries than their agencies are able to afford.

6.1.6 Use of telemedicine

While several stakeholders acknowledged that telemedicine is a reimbursable service approach under Wisconsin Medicaid, only one provider was identified as offering the service. Stakeholders did not speak highly of the approach, indicating that the agency offering telepsychiatry was relying on psychiatrists from another country to deliver the service.

6.1.7 Navigation and transportation

As described earlier in this section, stakeholders consistently described services in Milwaukee County to be cumbersome to access and 'siloed'. Individuals and families who do not qualify for intensive services, including case management, may not know what services are available, if they are eligible to receive the services , and how to access them. Professionals within the system expressed difficulty with accessing services for their patients. Public transportation was reported by stakeholders to be a significant barrier to care. Currently, BHD provides services at the Mental Health Complex, which is neither centrally located nor easily accessible by transit for most of the population. This situation should be improved significantly with the planned addition by BHD of facilities in the northern and southern parts of Milwaukee County.

Section 7
Outpatient Capacity and Access: Simulated Patient (Secret Shopper) Investigation

To supplement the quantitative data and stakeholder interviews described previously, we also employed a method for investigating access to Medicaid programs recommended by the U.S. Department of Health & Human Services. The method is known as simulated patient (or "secret shopper"[20]), and it is employed in a variety of studies for that purpose.[21,22]

Under this approach, staff from HSRI represented themselves as individuals seeking outpatient behavioral health treatment to confirm whether new clients were being accepted, whether providers accepted patients whose source of insurance was Medicaid, and the length of wait time to the first appointment. Callers used a standardized script that was reviewed by three experienced clinicians to ensure that there was no content that might trigger a crisis-type response or indicate a highly acute need for care. Callers did not actually schedule an appointment once the required information was obtained.

From the Medicaid claims data and provider inventory lists, a sample of providers was randomly selected from five categories: clinics (licensed as mental health/substance abuse or hospital outpatient), FQHCs, psychiatrists, specialty child psychiatrists, and private practice clinicians (primarily social workers and psychologists). The clinic category was further divided into two subcategories. The first, "billing clinics," included those who had served significant numbers of Medicaid clients in 2014, as described in Section 4. The second, “non-billing clinics,” included those having served few or none. Clinics in the group that billed in 2014 included some outside Milwaukee County; those in the non-billing group all were located in Milwaukee County.

A total of 249 organizations or individuals were targeted for calls: 77 billing clinics, 51 non-billing clinics, 3 FQHCs, 28 psychiatrists, 11 child psychiatrists, and 79 private practice clinicians. As shown in Exhibit 28, callers succeeded in contacting a total of 142 (57%) after making at least three calls. The inability to reach nearly half the targeted providers after three calls may indicate problems with access, although it should be noted that this issue arose most prominently with regard to private practitioners (of whom 30 of the 79 could not be reached). In contrast, our callers were able to contact all of the billing clinics.

Most of the billing clinics and all of the private practice clinicians were accepting new referrals. Only about half the non-billing clinics, on the other hand, were accepting new patients, and about the same proportion were accepting Medicaid. This may cast doubt on the possibility (discussed in Section 4) that providers with little or no Medicaid billing may represent underutilized capacity.

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[20] Department of Health and Human Services Office of Inspector General. (2014a). Access to care: provider availability in Medicaid managed care. Washington DC.
Department of Health and Human Services Office of Inspector General. (2014b). State standards for access to care. Washington DC.

[21] Polsky, D., Richards, M., Basseyn, S., Wissoker, D., Kenney, G. M., Zuckerman, S., & Rhodes, K. V. (2015). Appointment availability after increases in Medicaid payments for primary care. *N Engl J Med, 372*(6), 537-545. doi: 10.1056/NEJMsa1413299

[22] Tipirneni, R., Rhodes, K. V., Hayward, R. A., Lichtenstein, R. L., Reamer, E. N., & Davis, M. M. (2015). Primary Care Appointment Availability For New Medicaid Patients Increased After Medicaid Expansion In Michigan. *Health Aff (Millwood), 34*(8), 1399-1406. doi: 10.1377/hlthaff.2014.1425

Whether or not this is the case should be determined by efforts by discharge planners and other stakeholders to engage these organizations, as discussed in the Recommendations section.

The fact that only about 70% of the clinics that were represented in the 2014 billing data indicate they are accepting Medicaid is somewhat anomalous, as claims data indicate they did accept patients with Medicaid in 2014. The discrepancy may be explained in part by the number for whom information could not be obtained, although nine did indicate they were not accepting Medicaid. This suggests the possibility of more restricted access in the past year.

Wait times (days to first appointment) ranged considerably for all categories, but the average was lowest for private practice. The extreme range, even for the billing clinics, is noteworthy, suggesting that capacity varies on a case by case basis, but the median (representing 29 clinics) of only 10 days suggests that access and capacity may be less constrained than perceived by many stakeholders. For clinics, the longer wait times for non-billing clinics is again evidence weighing against the possibility that these providers represent potential for increasing capacity, though this merits further exploration. For psychiatrists, it was not possible for the most part to obtain a definite wait time, as most required that a new patient first identify a primary care provider before an appointment was offered. Informally, a number of those contacted indicated that wait times, once a PCP referral was obtained, would be considerable—"around 6 months," for example —a clear illustration of the shortage of psychiatrists, especially for children.

(Other reasons that some providers in all categories did not provide an estimated wait time was a requirement to first supply a Medicaid enrollee number or to submit medical records.)

Exhibit 24. Simulated Patient (Secret shopper) results: provider type, accepting new patient and Medicaid insurance, and time to appointment

Provider type	Accept new patients	% accept new patients	Accept Medicaid	% Accept Medicaid	Days to Appointment
Billing Clinic/ Practice (contacted 58)	54	93	41 (7 unknown)	71	Mean 15 Median 10 Range 1-60
Non-billing Clinic/Practice (contacted 27)	14	52	13	48	Mean 37 Median 30 Range 5-75
Psychiatrist (contacted 18)	13	72	10 (5 unknown)	56	PCP required
Child psychiatrist (contacted 8)	7	88	8	100	6-12 months PCP required
Private practice (contacted 31)	31	100	24	77	Mean 11 Median 7 Range 1-49

These results suggest that more providers may be accepting new Medicaid patients than some key informants have perceived, although the availability of psychiatrists is clearly limited. Also, the inability of callers to contact a considerable number of private practice providers indicates that accessibility would be an issue if these providers do, in fact, represent untapped capacity. The number of providers who failed to return calls is indicative of the barriers to access encountered by individuals seeking to obtain behavioral health services.

Section 8
Summary and Recommendations: Seizing the Opportunity to Guide and Support System Transformation

The provider inventory, analysis of service access and utilization, and feedback from stakeholders all highlight the variety of challenges that BHD and the broader community are facing as they seek to redesign the system to expand community-based services, improve quality, control costs, and support recovery. For the most part, these are challenges that are common to behavioral health systems in most localities—that is, issues of fragmentation, complexity of provider types, a rapidly changing policy environment, multiple levels of governance, and limited resources.

These issues appear to contribute to the current disarray of outpatient behavioral services in Milwaukee County. Perhaps a result of BHD's historical role as a predominant service provider, the agency has operated more in the role of providing direct service than in the role of establishing direction for a county-based behavioral health system. In reality, there are multiple sub-systems delivering behavioral health care in Milwaukee County, such as the BHD system for the uninsured, the Medicaid managed care system, the primary care system, the system of FQHCs – all serving individuals with behavioral health needs.

There is little coordination or communication among providers and agencies in these systems, which may or may not serve the same populations. These systems function independently from, if not in competition with, each other. Yet, individuals in need of services rarely need services from only one sub-system. Changes can and often do occur in Medicaid eligibility, covered benefits, enrollment in managed care plans and/or insurance coverage, resulting in the need for a more comprehensive and coordinated "touch" with the behavioral health system at large. The absence of such a cohesive system results in disconnected and bifurcated care.

The likely outsourcing of the management of County-run inpatient and emergency room services at the Mental Health Complex provides BHD the opportunity to refocus its resources and energy on coordinating and defining standards of quality and accessibility for the provision of community-based care, including mental health outpatient, intensive outpatient, and day treatment services. A change in expectations for service delivery may not be intuitive for providers or payers, and often requires education and re-training. BHD can facilitate that effort by:

- Enhancing its recently developed strategic plan with clearly articulated goals, objectives, action steps, and timelines geared toward achieving the vision
- Providing tools and resources to support the envisioned change
- Creating performance and outcome measures to incentivize and assess change
- Identifying and addressing potential concerns as they emerge, to prevent disruption in progress
- Working with providers and other stakeholders to establish accountability for achieving specific strategic plan objectives

BHD has had success in the past with directing and supporting the infusion of the evidence-based practice of "trauma-informed care" into treatment services in Milwaukee County. Similarly, the agency now has the opportunity to promote expectations for access to and the delivery of outpatient mental health and substance use disorder services.

The existence of this array of challenges does not mean the County and its stakeholder partners are not making progress along the path set out at the beginning of the redesign initiative. Yet, drawing on successful strategies that have emerged and continue to emerge across the country, we offer a variety of recommendations that could improve access to outpatient behavioral health services and the quality of the care they offer. Putting most of these recommendations into effect would require not only that BHD provide leadership in quality assurance and facilitator functions, but also that other stakeholders in the Milwaukee County behavioral health system, including the State of Wisconsin, assume specific responsibilities and accountabilities.

8.1 Adopt processes and policies that improve access to outpatient care

8.1.1 Coordinate and communicate behavioral health outpatient services capacity

Our data findings suggest that lack of access to outpatient behavioral health services may not be as much a function of lack of capacity as much as identification, navigation, and allocation of the capacity that exists. A recommended first step is to reach out to providers/agencies serving only a small number of individual members of the "public system" to determine their interest in and willingness to serve additional clients, as well as reasons they may not be interested in expanding services to these members. If available capacity is identified, then the information should be communicated throughout the county, to be accessed for individuals in need regardless of payer source. If barriers or concerns to expanding capacity to uninsured or Medicaid-funded consumers are identified, the payers will then know what actions will need to be taken to address these concerns, such as resolving inadequate rates or cumbersome intake processes.

Milwaukee residents also may benefit from enhanced support to access the services they need. While IMPACT provides information about services and supports, individuals in need of behavioral health services my need an additional "touch" to assist in accessing those services. While full-blown case management may not be necessary, "service connectors" or "system navigators" may be a worthy investment to assure individuals are able to access the care they need before their situation reaches a longer-term or crisis stage.

8.1.2 Leverage and promote federal initiatives

Disseminating information about, and facilitating implementation of, evidence-based practices and emerging funding strategies could be a valuable role for BHD. An example of a federal initiative that BHD may wish to leverage and promote at the local level is the implementation of Coordinated Specialty Care (CSC) programs, a set of core services delivered as team-based care that has proven to be effective in mitigating the effects of psychotic disorders on youth and young adults when implemented early in the onset of the disorders. Individuals who experience a first episode of psychosis may be served by BHD, Medicaid, or private insurance. By taking the lead in disseminating information about the impact of CSC to all service providers and payers, BHD efforts may have a measurable impact on reducing debilitation and further decompensation. For other providers, we recommend that all payers examine their policies and identify payment options for evidence-based approaches related to the early identification of psychotic disorders and options for recommended treatment for first episodes of psychosis, including team-based care, recovery-oriented psychotherapy, family psychoeducation, supported employment and supported education, pharmacotherapy, care coordination, and case management.

8.1.3 Improve intake processes

Many states and communities have departed from narrow points of entry into services, maximizing the opportunity to identify and engage individuals in need of services wherever they may be encountered. In county-administered service systems, the county is responsible for insuring that limited resources are used to support individuals "most in need" or who meet eligibility criteria. However, this can be accomplished by overseeing and monitoring data and performance rather than serving as the direct gate-keeper, as BHD currently does.

We heard repeatedly from stakeholders (including both consumers and providers) that BHD's intake processes for SAIL and WIser Choice are in need of improvement. BHD has noted that bottlenecks and delays did occur with regard to SAIL in 2014 due a record number of requests for services (including a number of clients previously served in BHD's long-term care units), staff vacancies, insufficient contracted TCM and CSP capacity to meet demand, and discontinuation of two BHD-operated CSP programs. BHD has recognized these issues and taken a number of remedial actions that already have resulted in improvements. Moreover, Comprehensive Community Services has been expanding, offering another alternative for community services in addition to the existing ones.

We commend BHD's recent progress, though it is not possible for us to determine whether that progress is sufficient to meet the concerns repeatedly raised by stakeholders. We recommend continued close monitoring by BHD, including collection and dissemination of performance data to stakeholders.

8.1.4 Private provider intake policies

As described by the discharge planners we interviewed, provider policies that require an individual to keep a certain number of therapy appointments or to change therapists in order to see a psychiatrist are impeding access to outpatient care. This may be especially true for individuals with serious mental health and substance use disorders, who struggle with keeping appointments and navigating system requirements without direct support or assistance from a case manager or peer specialist. Providers have legitimate reasons to maximize outpatient clinic productivity; employing or contracting for professional staff, particularly psychiatrists, is costly, and the loss of revenue from missed appointments can be a significant drain on provider budgets. However, there are alternative strategies to decrease missed outpatient appointments, including:

- Outreach to case managers and care coordinators to assist clients in keeping appointments
- Appointment reminders, such as text messages and phone calls a day before the scheduled appointment
- Tracking missed appointments to identify trends or patterns
- Over-booking appointments, based on the trending information
- Maintaining some level of "same-day" capacity. The longer patients have to wait to get appointments, the more likely they are to not keep the appointment. While, according to the National Council for Behavioral Health, a same-day appointment has a 10% chance of not being kept, almost 25% of patients with *next-day* appointments cancel or simply do not show up. Offering same-day access improves operational efficiencies, avoids revenue loss, and allows clinicians to spend more time engaging patients in treatment.[23]

[23] National Council for Behavioral Health, *Same Day Access to Behavioral Health Services*

In the event that individuals contact a provider agency but cannot be given an intake appointment, a warm hand-off, whereby the provider contacted connects the individual in need of service with another agency that may be able to serve them, can increase the likelihood that the individual will obtain an appointment and not drop out of service altogether. This may be a challenge to implement, however, in a complex service system where an individual may have multiple care managers. Consequently, this approach may depend on prior implementation of some of the other recommendations for enhancing system integration.

8.1.5 Increase the use of health information technology

The Wisconsin Statewide Health Information Network (WISHIN) has launched WISHIN Pulse—a health information exchange technology that gives health care providers secure access to their patients' medical information across systems and locations. While it is unlikely that all providers will use the same electronic health record, WISHIN Pulse creates a HIPAA-compliant *community* health record that provides an aggregated summary view of a patient's health information from all providers who have seen the individual. Rather than making treatment decisions based on only the information obtained by a treating provider or agency, the technology enhances clinical decision making by allowing community providers to "communicate, collaborate, and coordinate patient care" with timely access to all available treatment information.

Health providers and payers across the country are exploring opportunities to access and share health care information in real time. WISHIN Pulse technology would allow BHD staff and contracted outpatient and community service providers to upload delivered services to the WISHIN Pulse platform. BHD staff and contracted providers would benefit from learning about the availability of information via WISHIN and from training on how to access the information. Sharing behavioral health clinical information via this secure technology should contribute to more effective and efficient outpatient service delivery and better outcomes for recipients.

While WISHIN supports information exchange among providers, it is not clear that the technology supports information sharing among behavioral health care payers, such as the Medicaid MCOs. Individuals with serious behavioral health conditions often experience changes in eligibility and plan enrollment, leaving plans to manage and coordinate care with gaps in information about services a member may have received. The Milwaukee County behavioral health system would benefit from the ability not only to share information among providers, but to do so among payers as well. We recommend exploration of the ability for WISHIN Pulse to interface with the Medicaid MCOs' information systems.

8.2 Strategies to increase outpatient service capacity

8.2.1 Recognize and embrace FQHCs and similar health centers as participants in the outpatient behavioral health system

Outpatient service capacity is expanding outside of traditional behavioral health provider agencies in Milwaukee County. Individuals receiving primary health care at the Sixteenth Street Community Health Center (CHC), Progressive CHC, Outreach CHC, Milwaukee Health Services, and at similar community-based health centers like the Gerald L. Ignace Indian Health Center, Inc., now have greater access to behavioral health treatment. Embracing expansion of health centers offers important benefits for the residents and the behavioral health system in Milwaukee.

One of the primary benefits of expanding behavioral health service capacity in the FQHCs is the opportunity to integrate behavioral health care with comprehensive patient-centered medical homes for low-income individuals. The benefits of integrated care are well-established; individuals

with behavioral health conditions experience high rates of serious health conditions such as diabetes, heart failure, and hypertension, but they often are unwilling or unable to access consistent primary care. In addition, a high percentage of individuals presenting at emergency departments with acute medical symptoms often are suffering with undiagnosed and/or untreated anxiety, depression, substance use, and other behavioral health disorders.

The Primary Care Access Study, commissioned by the Milwaukee Health Care Partnership in 2008, found that people without access to primary care were more apt to use emergency department services when they needed care. For a 12-month period between 2006 and 2007, the Partnership study found that about 47% of all emergency visits (170,142 visits) were avoidable, and could have been addressed in a primary care medical home. Approximately 100,000 of these so-called "primary care treatable" visits were made by low-income Medicaid enrollees and uninsured individuals. According to the study, emergency department care is more than five times as costly as primary care.[24]

FQHCs and similar health centers serve as patient-centered medical homes (PCMHs), providing integrated medical, behavioral, dental, and vision care, as well as care coordination. By identifying mental health disorders and providing treatment earlier in their progression, this approach means that individuals are less likely to deteriorate and require services from the more formalized behavioral health system. In addition, the Centers report that stigma is not as big a concern for individuals seeking mental health treatment at their locations; patients view the treatment as similar to seeing the doctor for primary care visits. This is particularly important for certain racial and ethnic groups whose cultures do not embrace Western medicine's approach to mental health treatment.

Our discussions with FQHC leaders indicated that while efforts are being made to expand the behavioral health capacity of FQHCs in Milwaukee County so they can effectively integrate behavioral health into the PCMH model, several challenges exist, including a lack of clinicians and poor coordination with BHD. Concerted efforts to address those issues by public and private stakeholders would help to alleviate the stress on BHD and reduce the overutilization of unnecessary and costly ED visits for behavioral health-related issues. Recommendations for increasing access to behavioral health clinicians are provided further below.

A second benefit of FQHCs is that Wisconsin, like many other states, reimburses Medicaid outpatient procedures at FQHCs using a prospective payment system. Under this system, health centers receive a fixed, per-visit payment for any visit by a patient with Medicaid, regardless of the length or intensity of the visit. Prospective payment reimbursement (PPS) differs from Medicaid fee-for-service (FFS) reimbursement in two important ways. First, the per-visit rate for the Medicaid PPS is specific to the individual health center location. Second, beginning in FY2002 and each year thereafter, the per-visit rate is based on the previous year's rate, adjusted by the Medicare Economic Index (MEI) for primary care and *any change in the FQHC's scope of services.*[25] Unlike the Medicaid FFS rates, which are set well-below the amount needed to cover costs and are rarely increased, PPS rates allow FQHCs to cover their costs and to subsidize care for the uninsured.

8.2.2 Medicaid health homes

The Affordable Care Act provides states the opportunity to improve care coordination and care management for Medicaid beneficiaries with complex needs through health homes. Health homes integrate physical and behavioral health care and long-term services and supports for high-need,

[24] http://mkehcp.org/access-2/primary-care/
[25] http://www.nachc.com/medicaid-prospective-payment-system.cfm

high-cost Medicaid populations with the goal of improving health care quality and reducing costs. In addition to improving the quality of care and reducing fragmentation of care, states can receive enhanced federal financial participation (90%) for the first eight quarters of health home implementation.[26] To be eligible for a Medicaid health home, an individual must have two chronic conditions, have one chronic condition and be at risk for another, or have a serious mental illness.

The goal of the Medicaid health home state plan option is to promote access to and coordination of care. Health homes may be: (1) physically located in primary care or behavioral health providers' offices; (2) created "virtually," with a designated point of accountability for holistic services with intensive care coordination; or (3) located in other settings that suit beneficiaries' needs. Providers use person-centered care planning and coordination/integration of services to reduce fragmentation of care. Health homes must provide six core services, based on person-centered plans of care, linked as appropriate and feasible by health information technology:

- Comprehensive care management;
- Care coordination;
- Health promotion;
- Comprehensive transitional care and follow-up;
- Individual and family support; and
- Referral to community and social support services.

According to the Center for Health Care Strategies,[27] early adopters of Medicaid health homes have learned important lessons about designing and implementing health homes for individuals with complex care needs. Lessons which seem highly relevant for behavioral health services in Milwaukee County include:

- The knowledge and experience working with complex populations should be used to guide design of the health home services, aligning payment models with policy goals to advance payment modernization;
- Health home providers need support to achieve culture change; and
- Health home providers need to invest in access to real-time data to support effective care coordination.

8.2.2.1 Wisconsin's Health Home SPA for Persons with HIV/AIDS

Wisconsin is in its third year of implementation of Health Homes for individuals with HIV/AIDS in Brown, Kenosha, Milwaukee, and Dane Counties. The AIDS Resource Center of Wisconsin (ARCW) has adopted the AIDS/HIV medical home model to improve the quality of care it provides, attain better health outcomes, and reduce costs. ARCW provides direct health care services, including medical, dental, and behavioral health visits, as well as care management and connection to social services.

ARCW uses an electronic health record (EHR) to track medical care and social services. Each patient has a dedicated primary care provider and can also access oral health and behavioral health care at the Center. ARCW focuses on both the physical and social determinants of health. Onsite at ARCW, patients can meet with pharmacists, legal experts, and social service providers and access services such as medication management, housing support, food pantries, and case management.

[26] Center for Health Care Strategies, Fact Sheet, August 2015.
[27] Ibid

Since implementing the medical home, ARCW has seen improvements in outcomes. Currently, 76% of ARCW patients on HIV medication have an undetectable viral load; the national average is about 25%.[28]

8.2.2.2 TLS High Acuity Behavioral Health Medical Home

Transitional Living Services (TLS) is proposing to serve as a behavioral health patient-centered medical home (BH PCMH), integrating primary medical care and care coordination into its behavioral health practice. While integrating behavioral health services into PCMHs works well for individuals with low to moderate behavioral health conditions, individuals with more severe and chronic conditions are more likely to trust their care to the behavioral health provider with whom they have an established relationship. According to SAMHSA, patients enrolled in integrated care experience a decrease in emergency department and inpatient services use, a decrease in overall health costs, and improvement in health outcomes.[29] Practitioners in the Whole Health Group (the BH PCMH brand) promote full clinical integration with service recipients participating in the development of a patient-centered plan written in conjunction with their assigned care manager. In addition, practitioners will be expected to consistently share information, assessments and clinical data supporting continuous coordinated care. Both the ARCW and TLS initiatives can serve as models for other providers in Milwaukee County.

8.2.3 Fully implement Medicaid-covered services

The outpatient behavioral health system would benefit from an even more intensive effort by BHD to fully implement all available services, particularly services for which DHS is providing a full or substantial match of Federal funds with little or no cost to the County. For example, Comprehensive Community Services (CCS) provides a comprehensive service array for individuals that need more intensive service than Targeted Case Management but not as intense as the Community Support Program. However, BHD has faced obstacles in its efforts to rapidly implement CCS. As a result, individuals needing more than Targeted Case Management who do not qualify for the Community Support Program may not be receiving all the services and supports they need. Additionally, some stakeholders suggested that individuals who could be stepped down from the Community Support Program remain in that program longer than necessary, resulting in a lack of openings for others who need that level and intensity of services.

In addition, while Community Recovery Services (CRS), which are more psychosocial in nature, were not a focus of this study, it appears that these services also may be underdeveloped in Milwaukee County. CRS entails community living support, supported employment, and peer support services authorized via Wisconsin's Medicaid State Plan Amendment. These services are intended to facilitate each recipient's recovery by augmenting clinical services and case management with outcome-based services that are individualized based on the needs identified through a comprehensive assessment and a person-centered planning process. Individuals working towards recovery through receipt of CRS are less likely to need intensive treatment services and interventions. Access to CRS would likely alleviate some demand on outpatient clinical services and it would be beneficial for BHD to intensify its efforts to enroll more individuals in this program, as well. Similar to CCS, DHS currently is providing the matching Federal funds with no cost to the County.

[28] http://www.hrsa.gov/healthit/healthitgranteespotlight/hivmedicalhome2013/index.html
[29] http://www.integration.samhsa.gov/research#integrated care

Many states and communities across the country are refinancing the delivery of services to maximize Medicaid revenue. State and local funding is stretched to the limit, while demand for services continues to increase. We understand that BHD's 2016 budget proposes to expand CCS with the goal of enrolling 560 individuals by the end of 2016. We recommend that BHD continue its efforts to work with DHS to resolve barriers to implementation of Medicaid reimbursable services (such as CCS and CRS). Maximizing Federal Medicaid revenues would be a helpful solution for freeing up resources that could be used to cover non-Medicaid-eligible adults and to pay for additional services that contribute to positive healthcare outcomes, such as stable and affordable housing. In addition, we support BHD's proposal to add additional staff (which will be 100% cost-reimbursable) to enhance implementation of Medicaid maximization efforts.

8.2.4 Facilitate collaborative workforce recruitment and retention strategies

Behavioral health providers and primary care organizations potentially would benefit from a collaborative approach to recruiting and retaining behavioral health practitioners, thereby increasing outpatient service capacity. Currently, BHD, provider agencies, and health systems compete with each other for staff. By sharing and integrating recruitment efforts and pooling resources, agencies may be able to cast a wider net and attract more behavioral health professionals to work in Milwaukee County, and reduce competition within the county for the limited candidates who are available.

The Medical College of Wisconsin (MCW) and University of Wisconsin-Madison (UW-Madison) take in about 17 new psychiatry residents each year. Starting in July 2017, MCW will take an additional seven residents. BHD should explore existing connections to the universities to ensure that the county has maximum participation with the psychiatric residency programs and to encourage expansion of community residency programs.

In addition, the Primary Care & Psychiatry Shortage Grant Program encourages primary care physicians and psychiatrists to locate in medically underserved areas of Wisconsin by providing service-based financial assistance to state residents who have graduated from a Wisconsin medical school and completed a medical residency training program (with a primary care or psychiatry emphasis) in Wisconsin. After meeting these eligibility criteria, physicians may begin claiming the financial assistance if they then go on to practice primary care medicine or psychiatry (including child psychiatry) in a medically underserved area of the state. The program is funded with a one-time, $2 million appropriation, of which $1 million is directed to psychiatrists. An estimated 17 psychiatrists may receive annual grant payments over a three-year period.[30] Given that one-third of Milwaukee County is designated as a MH-HPSA, psychiatrists who agree to practice in that part of the county would qualify for this assistance.

We recommend a collaborative effort among BHD and private providers to identify needed human resources, and to facilitate access to Wisconsin's psychiatric resource support. While BHD is moving away from being a direct provider of services, its potential new focus on ensuring coordination among service providers and access to high-quality care would dictate that it also provide leadership in issues related to the behavioral health workforce in Milwaukee County, such as coordination of efforts to increase recruitment of APNs.

[30] http://www.wafp.org/Advocacy/primary-care-psychiatry-shortage-grant-program.html

8.3 Increase access to psychiatric capacity

Stakeholders consistently reported lengthy waits for outpatient psychiatric appointments, especially for children and for older adults; for example, discharge planners reported six-month wait times for psychiatric appointments for older adults with Medicare coverage. It remains unclear to what extent the solution would be simply to increase the number of psychiatrists in Milwaukee County, versus increasing the effectiveness and efficiency of existing capacity. Regardless, there are strategies, both nationally recognized and local, that would increase access to psychiatry in Milwaukee County, including the following.

8.3.1 Expand the use of telepsychiatry

Telepsychiatry is a nationally recognized approach to increasing access to psychiatric care. A literature review was conducted, based on findings published from 60 scholarly sources within the past 12 years, to assess the use of telepsychiatry in the United States.[31] The review concluded that telepsychiatry was effective in treating individuals with a variety of mental health conditions. The review determined that treatment delivered using telemedicine was comparable to face-to-face service delivery and that most persons receiving telepsychiatry were satisfied with their level of care.[32] Given that Wisconsin Medicaid covers the approach, we would highly recommend the pursuit of expanded use of telemedicine in Milwaukee County.

8.3.2 Build on the success of the Medical College of Wisconsin's Child Psychiatric Consultation (CPC) program and adopt a similar program for adults

The Child Psychiatric Consultation program is increasing access to psychiatric capacity by expanding the scope of behavioral health diagnostic and treatment practice for children and building primary care practitioners' behavioral health competencies. The CPC program provides pediatricians and family practice physicians a formal process to call or email an on-call psychiatrist for advice and expertise on how to diagnose and/or treat a child who presents with signs or symptoms of a behavioral health disorder. The psychiatrist responds within 15 minutes to a phone call, and within at least 24 hours to an email. Since the program began in February, 24 clinics with 145 providers in Milwaukee County have signed up. Access to timely consultation with a child psychiatrist allows the PCP to provide prompt treatment for the child as opposed to placing the child on a several-month waiting list to see a specialist. Early identification and treatment of mental health disorders in children/adolescents can prevent progression to more serious, lifelong disabilities. The CPC Program began as a pilot supported through funding from the Charles E. Kubly Foundation for two years before it received $1 million in state funding.

Similarly, "Grand rounds," or case consultations led by psychiatrists with groups of primary care providers, have proven effective for treating adults with behavioral health needs. An example is Project ECHO out of New Mexico.[33] Although originally developed to address shortages of medical specialists, the approach has been successfully adapted to shoring up PCPs' expertise in diagnosing and treating behavioral health disorders.

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[31] http://perspectives.ahima.org/telepsychiatry-in-the-21st-century-transforming-healthcare-with-technology/#.VczTOmd3vIU

[32] http://perspectives.ahima.org/telepsychiatry-in-the-21st-century-transforming-healthcare-with-technology/#.VczTOmd3vIU

[33]http://echo.unm.edu/about-echo/

8.4 Address gaps in substance use disorder treatment

8.4.1 Recruit and incentivize providers of medication assisted treatment

Medication assisted treatment (MAT) is the use of medications in combination with counseling and other behavioral therapies to provide treatment for substance use disorders. The medication used includes methadone, buprenorphine (Subutex®), buprenorphine and naloxone (Suboxone®), and naltrexone (Vivitrol®). MAT is a Chapter 51 identified service that Milwaukee County is responsible to provide within available resources. Discharge planners reported difficulty with assisting patients in accessing MAT, particularly Suboxone. In addition, many stakeholders reported that physicians in Milwaukee often require cash payment for buprenorphine, a practice that prohibits access for individuals with limited income, including pregnant females.

Research shows that medication-assisted treatment is an effective way to manage substance abuse and help individuals return to productive lives.[34] MAT also has been identified by the Milwaukee Lifecourse Initiative for Healthy Families' project on Infant Mortality Reduction as a treatment to improve birth outcomes for pregnant women suffering from addiction. State and federally certified Opioid Treatment Programs are the only organizations authorized to provide methadone maintenance treatment. However, physicians who have completed a federally required training program and acquired a necessary Drug Enforcement Agency identification number are able to start in-office treatment and provide prescriptions for buprenorphine, Suboxone and Vivitrol, thereby reducing stress on the formalized SUD outpatient service system.

We recommend that BHD collaborate with the Milwaukee County Chapter of the Wisconsin Medical Society and health care partners to promote greater access to buprenorphine and Suboxone in Milwaukee. Providers should adopt strategies to enhance monitoring of compliance with use as prescribed to detect diversion and abuse. We recommend a targeted expansion of practitioners who will treat Medicaid recipients and persons with limited income.

8.5 Enhance cooperation between Milwaukee County and the State

The Wisconsin Department of Health Services can be instrumental in facilitating implementation of several of the recommendations. Given the degree to which state Medicaid agencies fund behavioral services, nationally and in Milwaukee County, it is essential that DHS be an active partner in efforts to enhance access to outpatient services for low-income individuals in Milwaukee County.

8.5.1 Increase Medicaid rates for behavioral health outpatient services

A recent report by the Wisconsin Hospital Association cites Kaiser Family Foundation data that indicate Medicaid spending overall for services to adults in Wisconsin is the sixth lowest in the nation, and the overall spend for services to children is *the* lowest in the nation.[35] Interviewees for this study consistently confirmed that the low rates for Medicaid reimbursement for behavioral health services were a barrier to provider participation. Any effort to increase the number of behavioral health providers willing to serve Medicaid recipients must contemplate this issue.

While low outpatient rates may appear to maintain or reduce costs to the Medicaid program, they may in fact increase costs overall. For example, the lack of adequate outpatient, intensive outpatient, and partial-hospital program capacity was identified as contributing to increased

[34] https://www.dhs.wisconsin.gov/aoda/methadone.htm
[35] "Medicaid and Hospitals & Health Systems: The Wisconsin Story," B. Potter, May 5, 2015.

utilization of inpatient and emergency department services—which are reimbursed at much higher rates than outpatient treatment options. By increasing outpatient rates, DHS likely could increase outpatient service capacity and reduce demand for more costly high-end services.

8.5.2 Engage Medicaid managed care organizations in addressing gaps in outpatient care

We recommend that DHS assess the adequacy of its contract language for behavioral health services, considering the use of 'requirements' versus 'suggestions' for the MCOs to enhance the Department's ability to monitor and enforce compliance. Also, consistent with CMS' proposed rule for Medicaid Managed Care,[36] the contracts should contain operational standards for network adequacy, access to care, and the provision of care coordination. Finally, DHS should assess if contract monitoring activity is sufficient to ensure MCOs are complying with contract requirements.

Results from the Simulated Patient Intake Request calls indicated that:

- 23.4% of providers contacted did not respond to three phone calls requesting an appointment
- Only 61% of the providers contacted were accepting new Medicaid patients
- 6.1% of providers had closed their offices or moved to another location

Any of these results could decrease the likelihood that an individual needing outpatient services would get access to such care. Given that the MCOs also are responsible for more costly levels of care, this information presents an opportunity for planning to further assess the adequacy of their provider networks. DHS' contract includes a Pay for Performance program, withholding a percentage of the capitation payment (2.5% for 2015) to be earned back by the MCO.[37] MCOs are able to earn this withhold back by meeting quality performance targets for a specific set of measures (as described in the HMO P4P Guide for FY2015). The Hospital Access measure contains indicators relevant for outpatient services: readmission to an inpatient setting within 30 days from discharge and a mental health follow-up visit within 30 days of discharge from an inpatient setting.[38] The MCOs should work with their network providers to identify and address issues that impact their ability to meet these performance targets, and to develop and implement solutions.

In addition, each MCO is required to develop and implement program initiatives to address the specific clinical needs of its enrolled population served under its DHS contract. These priority areas may include clinical and non-clinical Performance Improvement Projects, which present another opportunity for MCOs to influence the array and delivery of outpatient services in the county.

MCOs participating in Medicaid managed care throughout the country have been effective in expanding behavioral health provider networks in order to meet access standards and improve care for their members. Strategies employed by these plans that could also be effective in Milwaukee County include:

- Targeting rate increases to address particular service needs, such as for psychiatrists and day treatment services. MCOs are not bound by Medicaid fee-for-service rates and can attract additional providers for their networks with higher rates.

[36] https://s3.amazonaws.com/public-inspection.federalregister.gov/2015-12965.pdf
[37] https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Managed%20Care%20Organization/Providers/providerContracts.htm.spage
[38] Measurement Year (MY) 2015 Hospital Pay-for-Performance Guide, April 2014.

- Reducing administrative requirements and streamlining authorization processes to reduce administrative burden for providers.
- Providing financial incentives to cover start-up costs for, and to promote the use of, telepsychiatry.
- Providing reimbursement for recovery supports and services, including stable housing. There is a growing body of research which indicates that while these supports may not be identified as health care or clinical services, they are proven to be effective in reducing the need for more intensive treatment interventions and enhancing the positive outcomes of more traditional behavioral and primary health care.

8.5.3 Develop processes for addressing each recommendation of the *Outpatient Capacity Analysis* report

Most of the recommendations above will require action by multiple stakeholders in Milwaukee County's system of behavioral health services. For this to occur, we recommend that BHD organize an outpatient services work group with other key stakeholders identified in this report (including DHS) that would be tasked with identifying a primary implementer/coordinator for each recommendation deemed worthy of pursuit, as well as developing action steps, performance metrics, assigned responsibilities, and performance monitoring procedures. It is not within our capacity to determine which party should fulfill the implementer/coordinator role for each recommendation, but Exhibit 25 provides an example of what this process might yield for each.

Exhibit 25. Action Plan for Addressing OCA Report Recommendation

Recommendation	Key Implementer	Action Steps	Performance Metrics
Coordinate and communicate behavioral health outpatient services capacity: identify and allocate existing capacity	BHD	• Identify low-volume Medicaid providers • Assess willingness and capability to increase number of Medicaid clients • Develop process for communicating availability throughout the system	• Number of Medicaid providers identified, contacted • Number indicating willingness to accept Medicaid referrals • Number of referral sources receiving information • Number of new referrals made

8.6 Conclusion

The bottom-line conclusion generated from this analysis of outpatient behavioral health capacity for low-income populations in Milwaukee County is a nuanced one, as there is no clear determination as to whether the extent of unmet need would best be reduced by a simple increase in the supply of providers, or by addressing inefficiencies and barriers to access among the array of providers currently in place. Our various data sources indicate that both are significant factors and both need to be addressed.

Moreover, as indicated in our recommendations, the most effective approach is when both factors are addressed together. An example is the shortage of child psychiatrists. There certainly is a need for more child psychiatrists in Milwaukee County, as there is throughout the nation, but there also are proven possibilities for improving access and coordination of care with those in place. While various initiatives to attract psychiatrists to Milwaukee County are currently underway, a more immediately effective response may be the Child Psychiatric Consultation program, a collaboration

of public/private/academic/philanthropic entities that extends the availability of existing resources to address a local shortage.

While data limitations preclude our ability to make definitive determinations as to the causes and effects of outpatient access challenges, several salient points are suggested from the data:

- **Stakeholder perspectives and other forms of anecdotal evidence are important for identifying areas of concern and flagging issues requiring attention, but they should not be relied upon as the sole basis for remedial action**. This is not to say that these sources are not reliable, but rather that the complexity of the array of outpatient behavioral health services limits the capacity to understand the full nature and scope of any feature when viewed from a single perspective.
- **Corresponding to the fragmentation and discontinuity of the behavioral health services is a lack of comprehensive and well-integrated data systems that would provide for overall monitoring of system performance and identification of opportunities for improvement.** Several of our recommendations focus on the potential benefits of increased data sharing and health information technology generally. Implementing enhanced data systems and data sharing requires an investment of resources and a commitment to cooperation among the full spectrum of stakeholders. This is where BHD can play a prominent role – both as an assembler of resources and as a promoter of cooperation.
- **Services for the Medicaid population are characterized by a handful of high-volume provider organizations and a much larger number of various types of organizations and individual clinicians that serve a small number of clients, with a minimal amount of coordination among this range of providers**. Given this variability and loose structure, it is possible that improvements in communication and coordination could positively impact capacity just as much as an increase in provider supply. For example, small-volume providers may represent untapped potential for capacity expansion, and better communication to discharge planners regarding open slots among larger providers could prove similarly beneficial. This is another area in which BHD could take the lead – as the entity that ensures stakeholders have access to updated lists of providers and that a system is in place to share information regarding provider capacity to serve Medicaid recipients.
- **The analysis of Medicaid claims indicates that there was some shrinkage of capacity beginning around 2013, though to different degrees depending on the provider type.** There are several possible explanations for this decrease, the most likely of which is a decreased willingness to accept patients with Medicaid insurance. This finding should produce an intensified effort by the Wisconsin Department of Health Services – as well as the managed care organizations with whom it contracts – to understand the extent to which insufficient reimbursement rates are the primary contributor, and/or what might be done to alter this paradigm irrespective of rate increases.

How the various issues of provider shortage and lack of system integration that affect capacity and accessibility are addressed and who should take the lead initiative in doing so depends on the issue; the general thrust of our recommendations, however, is that BHD, on the basis of its defined mission and statutory authority, is in the best position to define the vision and the goals for this effort and to lead the monitoring of its progress. Ultimately, success will be determined not only by how well BHD performs in this role, but also by how well the State, private health systems, and the diverse array of other stakeholders in the community work with BHD and together as necessary partners.

Appendix 1:
Project Funders, Data Sources, and Methods

The following organizations contributed funding for the Milwaukee County Outpatient Capacity Analysis:

Milwaukee Health Care Partnership
Greater Milwaukee Foundation
Charles E. Kubly Foundation
Wisconsin Department of Health Services
Rogers Memorial Hospital
United Way of Greater Milwaukee & Waukesha County
Anthem
Children's Community Health Plan
iCare
Managed Health Services
TLS Behavioral Health
UnitedHealthcare

Data Sources

Information presented in this report was collected from a variety of sources. Qualitative information relating to the availability and accessibility of outpatient services was obtained by a review of documents and previous reports and through interviews with stakeholders (including BHD administrators, inpatient hospital discharge planners, and administrators and staff of community programs, clinics, and agencies). Quantitative analysis primarily utilized Medicaid claims data from July 2010 through September 2014, obtained by request from the Wisconsin Department of Health Services. These files consisted of all claims for Medicaid enrollees with a behavioral health diagnosis who were registered in Milwaukee County.

Stakeholder Interviews

Semi-structured interviews were conducted with a broad base of stakeholder representatives, including the following:

- Wisconsin Department of Health Services and Milwaukee County Behavioral Health Division staff
- Discharge planners from BHD and local hospitals
- BHD community services team
- Consumers and advocates
- Staff of provider organizations including mental health and substance abuse clinics and hospital outpatient clinics
- Medicaid HMOs
- Federally Qualified Health Centers (FQHCs)
- Community-based service providers

Consumer Focus Group/Secret Shopper Study

Our researchers also held a consumer focus group that included individuals with lived experience and advocates who help people with mental illness and substance use disorders navigate the health care and social service systems. To triangulate with anecdotal evidence provided by stakeholders regarding access to services, we conducted a simulated patient or "secret shopper" study, where our researchers posed as individuals seeking outpatient behavioral health treatment. The aim of this exercise was to determine the extent to which providers were accepting new clients, whether they were accepting Medicaid insurance, and the length of wait time to a first appointment.

County Behavioral Health Data

Milwaukee County BHD provided service utilization data for all County-funded behavioral health services from 2011 through 2014. Data on selected services (particularly those representing clinical services, consistent with the overall focus of this report) are presented in Section 5.3.3.

Medicaid Claims

Medicaid claims data for the period from July 2010 through September 2014 were analyzed to determine penetration (the percentage of the total number of Medicaid enrollees that used behavioral health services in a given quarter), utilization (number of people receiving various types of services), and volume (number of people served by various types of providers). Claims data were provided by Wisconsin DHS; Medicaid enrollment counts, for the penetration rate denominator, were obtained from the Wisconsin ForwardHealth Portal at https://www.forwardhealth.wi.gov/**WIPortal.**

METHODS

The following provides details of the various aspects of the Medicaid claims data analysis, including challenges and limitations.

Services: The types of services included in the analysis of penetration and utilization are clinical services and programs—for example, psychotherapy, psychopharmacology, psychiatric day treatment, and substance abuse treatment, typically provided by licensed clinicians (psychiatrists and general practice physicians, physician assistants, advanced practice nurses, psychologists, and social workers, as well as other licensed counselors). The scope therefore incorporates those clinical services that, when available as part of the community-based behavioral health system, effectively function as an alternative to inpatient treatment. Consistent with standard practices in health care services research using Medicaid or Medicare claims, specific services were identified using algorithms combining codes from the Current Procedural Terminology (CPT) and the Diagnostic and Statistical Manual of Mental Disorders 5th addition (DSM-V). These algorithms are presented in the table below. Some CPT codes are unique to behavioral health (e.g., "psychotherapy") and therefore require no accompanying DSM code, whereas others, such as "office visit," may be for treatment of a wide variety of health conditions; therefore, to identify, for example, treatment of depression in a primary care clinic, an accompanying behavioral health diagnosis is necessary.

Providers: The type of provider was identified using codes in the field "billing provider type." The list of codes used in the analysis is presented in Exhibit 26. This approach presents certain challenges and imposes certain limitations as follows.

Limitations and challenges of using Medicaid claims to represent a behavioral health system: Though researchers and policy makers frequently draw upon Medicaid and Medicare claims data for the purpose of analyzing various functions of health care systems, it is important to keep in mind that these data systems are designed for a quite different purpose: as accounting systems for tracking payments made at various reimbursement rates determined by complex combinations of service and provider type. Accordingly, the structure of Medicaid claims files consists of codes for diverse types of services, provider organizations, and clinician specialty differentiated not by function, but by allowed reimbursement rate—corresponding only partially to the structure of health and behavioral health systems as they are usually considered in a policy context.

This is less of a challenge when the unit of analysis is at the level of the individual patient rather than the provider. Constructing a file with records of specific services provided to individual patients, perhaps characterized by particular diagnostic groupings, is relatively straightforward. Grouping providers in some way that corresponds to policy discussions, however, entails a considerable number of inferences and compromises that should be kept in mind when reviewing the results.

A particular challenge in classifying provider types using claims data is how to represent the multi-level relationship between organizations and individual practitioners that is typical of behavioral health and general health care systems, whereby practitioners may be either nested within organizations or functioning more or less autonomously (private practice). For the purposes of this analysis, we have chosen to use the Medicaid claims field of "billing provider" as the closest approximation of how the structure and functions of the behavioral health system are usually considered within a policy context. (An alternative choice might have been Place of Service code; we decided against this option, however, as it was less descriptive of the behavioral health system, corresponding more generally to locations where general health care is provided, and because a large number of records were missing a place of service code.)

Consequently, there is a certain amount of unavoidable ambiguity, notably in the ability to distinguish between services that are provided by an individual practitioner in a private practice or services provided in an organizational setting such as a clinic. Thus, while the overall volume of services provided is accurate (these are unduplicated counts) the proportion by different components of the system is imprecise to some degree.

CPT/DSM V Algorithms for Penetration, Utilization and Provider Volume Analysis

Analyses consisted of counts of people served monthly (aggregated into quarters) broken out first by: 1) billing provider type and, in the case of three provider types, by additional billing provider specialty (yellow highlight in the table below); 2) child versus adult; and 3) diagnostic group (mental health vs. substance abuse) as indicated by ICD-9 code: mental health ICD-9 290-302 and 306 to 316, substance abuse 303-305.[39]

For some provider types it is necessary to select out behavioral health services (exclude general medical care) by using a combination of the following procedure (CPT) and ICD-9 codes: CPT codes 99201-99215 or 90801-90899 in combination with the aforementioned ICD codes for mental health and substance abuse. For other providers this selection is unnecessary as all services are behavioral health. Exhibit 29 presents these configurations.

[39] For ICD code descriptions, see http://www.icd9data.com

Change in medication management codes used by psychiatrists in 2013

A change in CPT coding in 2013 had a significant effect on behavioral health that may explain some anomalies in the data reported here. Prior to 2013, psychiatrists used code 90862 for medication management. Beginning in 2013, this was eliminated and psychiatrists were instead required to use evaluation and management (E/M) codes for pharmacologic management for a patient. The purpose of this was to establish concordance between psychiatrists and other physicians. We attempted to accommodate this change by incorporating E/M codes into the algorithm, but the sharp drop-off in identified services suggests that this does not adequately reflect the change in coding.

Exhibit 26. Algorithms used to identify provider type and service

Billing Provider Type		Procedure (CPT) and Diagnosis (ICD) combination
1	Hospital	CPT 99201-99215 **AND** CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
9	Nurse practitioner	CPT 99201-99215 **AND** CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
10	Physician assistant	CPT 99201-99215 **AND** CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
11	Mental Health and Substance Abuse Services	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
17	Therapy Group / Group	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
21	Case Management	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
31	Physician	CPT 99201-99215 **AND** CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
	Specialty 339 (Psychiatrist)	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
33	Physician Group	CPT 99201-99215 **AND** CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
	Specialty 339 (Psychiatrist)	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
52	Narcotic Treatment Service	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
58	Institution for Mental Disease 740 Specialty Mental Health	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)
75	Federally Qualified Health Center (FQHC)	CPT 99201-99215 **AND** CPT 90801– 90899 by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)

80	Crisis Intervention/CCS/ CSP	Any procedure by diagnostic group ICD-9 290-302 and 306 to 316 (mental health) **OR** ICD-9 303-305 (substance abuse)

Appendix 2: Penetration Rate Data Tables

Exhibit 27 is the data table for the penetration rate graphs presented in Section 5. It presents figures for total enrollment quarterly during the measurement period (July 2010-September 2014). Exhibit 28 presents penetration rates for mental health services for adults and children. Exhibit 29 presents penetration rates for substance abuse services for adults and children. These data are discussed in Section 5.

Exhibit 27. Adult and Child Total Medicaid Enrollment, July 2010 – September 2014

	2010 Jul-Sep	2010 Oct-Dec	2011 Jan-Mar	2011 Apr-Jun	2011 Jul-Sep	2011 Oct-Dec	2012 Jan-Mar	2012 Apr-Jun	2012 Jul-Sep
child	114,578	115,515	115,914	117,493	118,583	118,983	120,197	121,326	122,803
adult	158,357	161,207	162,885	164,792	166,198	167,712	169,400	170,794	170,038
total	272,934	276,722	278,799	282,285	284,780	286,695	289,597	292,121	292,841
	2012 Oct-Dec	**2013 Jan-Mar**	**2013 Apr-Jun**	**2013 Jul-Sep**	**2013 Oct-Dec**	**2014 Jan-Mar**	**2014 Apr-Jun**	**2014 Jul-Sep**	
child	122,631	122,760	122,705	123,169	122,100	121,208	123,562	125,082	
adult	170,653	171,374	171,881	172,373	172,980	172,121	185,104	189,236	
total	293,284	294,134	294,586	295,542	295,080	293,329	308,666	314,318	

Exhibit 28. Penetration rates for mental health services, by quarter

	Jan-Mar		Apr-Jun		July-Sep		Oct-Dec	
	n	%	n	%	n	%	n	%
2010								
child					6,307	5.5	6,987	6.0
adult					15,462	9.8	15,610	9.7
2011								
child	7,297	6.3	7,464	6.4	6,833	5.8	7,583	6.4
adult	16,298	10.0	16,182	9.8	16,373	9.9	16,402	9.8
2012								
child	8,426	7.0	8,110	6.7	7,260	5.9	7,233	5.9
adult	17,216	10.2	17,093	10.0	16,642	9.8	14,392	8.4
2013								
child	7,072	5.8	7,034	5.7	6,338	5.1	6,682	5.5
adult	13,046	7.6	13,182	7.7	13,177	7.6	13,021	7.5
2014								
child	6,970	5.8	6,865	5.6	5,831	4.7		
adult	12,536	7.3	13,900	7.5	13,677	7.2		

Exhibit 29. Penetration rates for substance abuse services, by quarter

	Jan-Mar		Apr-Jun		July-Sep		Oct-Dec	
	n	%	n	%	n	%	n	%
2010								
child					63	0.05	85	0.07
adult					2,622	1.66	2,869	1.78
2011								
child	66	0.06	70	0.06	62	0.05	93	0.08
adult	3,095	1.90	2,818	1.71	2,941	1.77	2,979	1.78
2012								
child	94	0.08	73	0.06	81	0.07	51	0.04
adult	3,602	2.13	3,668	2.15	3,616	2.13	2,368	1.39
2013								
child	42	0.03	38	0.03	27	0.02	33	0.03
adult	1,922	1.12	1,957	1.14	1,997	1.16	1,995	1.15
2014								
child	61	0.05	21	0.02	20	0.02		
adult	1,943	1.13	2,520	1.36	2,649	1.40		

Appendix 3: Top 100 Providers by Volume

Exhibit 30, on the following pages, presents the top 100 provider organizations by volume (numbers served). The billing provider type "mental health and substance use clinic" accounted for slightly over 90% of the total (or 32,403) served by agencies. This count excludes 2,503 persons for whom services were billed by individual clinicians using the mental health/substance abuse billing provider type. Most of these practitioners were likely on the staff of a clinic, but some may have been in private practice. For a discussion of the difference between organizations and individual practitioners, see Appendix 1: Data and Methods.

Exhibit 30. Top 100 agencies by volume (of total 207) with numbers served (32,087 served in total)

Agency	Number Served	Agency	Number Served
SIXTEENTH STREET COMMUNITY	7213	BEHAVIORAL MEDICINE CENTER	226
RENEW COUNSELING SERVICES	3600	WILLOWGLEN ACADEMY OUTPATIENT CLINIC	213
ST LUKES MEDICAL CENTER OUTPATIENT BEHAVIORAL HEALTH	3320	MILWAUKEE HEALTH SERVICE SYSTEMS	211
OUTREACH COMMUNITY HEALTH CENTERS	1523	ST LUKES SOUTH SHORE	209
ACACIA MENTAL HEALTH CLINIC LLC	1421	AIDS RESOURCE CENTER OF WI	206
MCW DEPARTMENT OF PSYCHIATRY	945	THE BRIDGE HEALTH CLINICS & RESEARCH CENTERS, INC.	199
SHOREHAVEN BEHAVIORAL HEALTH	942	COLUMBIA ST MARYS BEHAVIORAL MEDICINE	198
BEHAVIORAL HEALTH SERVICES	864	FROEDTERT PHYSICIAN PARTNERS	192
HORIZON HEALTHCARE, INC	686	CHILDREN'S HOSPITAL OF WISCONSIN	184
SEBASTIAN FAMILY PSYCHOLOGY PRACTICE LLC	641	FOKUS FAMILY SERVICES LLC	183
MILWAUKEE HEALTH SERVICE SYS	394	ACHIEVEMENTASSOCIATESLTD	181
REACH INC COMPREHENSIVE MENTAL HEALTH CLINIC	386	PROFESSIONAL SERVICES GROUP INC	180
ROGERS MEMORIAL HOSPITA	382	CHILD ADOLESCENT FAMILY&	179
AMERICAN BEHAVIORAL CLINICS	379	AMRI COUNSELING SERVICES LLC	163
TLS BEHAVIORAL HEALTH	371	FAMILY OPTIONS COUNSELING LLC	151
CHILDRENS SERVICE SOCIETY OF WISCONSIN	325	AURORA PSYCHIATRIC HOSPITAL	147
CORNERSTONE COUNSELINGSERVIC	303	LA CAUSA INC	145
APPLIED THERAPIES AND WELLNESS CENTER SC	277	PSYCARE MILWAUKEE LLC	144
WISCONSIN COMMUNITY SERVICES	271	COMPREHENSIVE CLINICAL & CONSULTING SERVICES INC	142
MILWAUKEE COUNTY MENTALHEALT	252	STRESS MANAGEMENT & MENTAL HEALTH CLINICS	140
ALTERNATIVESIN PSYCHOLOGICA	244	AURORA BAYCARE	128
AURORA FAMILY SERVICE INC	242	NORTH SHORE PSYCHOTHERAPY ASSOC III	125
FORWARD CHOICES LLC	242	RELEVANCE COUNSELING SERVICES	124
JEWISH FAMILY SERVICES INC	236	DISCOVERY & RECOVERY CLINIC	122

AGENCY	NUMBER SERVED	AGENCY	NUMBER SERVED
GATEWAY TO CHANGE	102	PSYCHIATRIC SERVICES	41
OMNI ENRICHMENT INC	102	ADKINS COUNSELING SERVICES LLC	40
CATHOLIC CHARITIES	100	ELMBROOK FAMILY COUNSELING CENTER	39
PENFIELD CHILDREN'S CENTER	96	MEDINA'S WAY	39
AURORA MEDICAL GROUP INC	95	AURORA BEHAVIORAL HEALTH	38
THE BRIDGE HEALTH CLINICS & RESEARCH CENTERS, INC	93	TURCOTT MEDICAL AND PSYCH ASSOCIATES	38
META HOUSE INC	89	M & S CLINICAL SERVICESINC	35
NORTHSHORE CLINIC & CONSULTANTS	89	PATHWAYS COUNSELING CENTER	30
HORIZON HEALTHCARE INC	80	THE POWER OF CHANGE INC	30
AURORA MEDICAL GROUP BEHAVIO	78	FAMILY SERVICE OF WAUKESHA	26
CHRISTIAN FAMILY COUNSELING	77	WAUKESHA COUNTY HEALTH&	26
MINDSTAR COUNSELING LLC	73	CENTER FOR QUALITY COMMUNITY LIFE, INC.	25
TOTTY AND ASSOCIATES	73	ASSOCIATED WOMEN PSYCHOTHERAPISTS	24
GRO FAMILY SERVICES	71	CAREER YOUTHDEVELOPMENT	24
SHORE COUNSELING & CONSULTING	68	ANNE HUEBNER & ASSOCIATES LLC	23
WI EARLY AUTISM PROJECT	62	EMPATHETIC COUNSELING SERVICES INC	19
HEALTH PSYCHOLOGY ASSOCIATES	61	HARVEST CONSULTING COMPANY, LLC	18
LIGHTHOUSE CLINIC LLC	60	LIFE SPAN PSYCHOLOGICAL SERVICES LLC	17
BEHRENS PSYCHOTHERAPY SERVICES, LLC	59	GENESIS MILWAUKEE OUTPATIENT CLINIC	16
GUEST HOUSE COUNSELING CLINIC	56	CURRENT INITIATIVES COUNSELING SERVICE LLC	15
NEERAJ AGRAWAL CLINIC LTD	56	ANGELS COUNSELING & THERAPY SERVICE	14
LUTHERAN COUNSELING & FAMILY	55	RAWHIDE YOUTH & FAMILY COUNSELING SERVICES	13
WEST GROVE CLINIC LLC	55	WORD OF HOPE MINISTRIES, INC.	13
CHRISTIAN LIFE COUNSELING	54	SHECAR SUBSTANCE ABUSE MENTAL HEALTH OUTPATIENT TR	12
EBB TIDE THERAPY	51	FAMILY DEVELOPMENT CENTER	11
RAVENSWOOD CLINIC INC	44	THE COUNSELING CENTER OF MILWAUKEE INC	11

Appendix 4: Milwaukee County Mental Health and Substance Abuse Clinics and Wraparound Vendors

The following is a list of mental health and substance abuse clinics licensed by DHS, supplemented by sources indicated by the following color coding.

Yellow highlight: list provided by DHS but not DHS online provider list

Purple highlight: In SAMHSA Behavioral Health Treatment Facility database but not DHS online provider list

Green highlight: In Wraparound Provider list but not DHS online provider list, excluding some vendor types e.g. transportation and group homes

Non-highlighted: Complete DHS provider list

Columns MH and SA indicate Mental Health and/or Substance Abuse as identified by DHS. WA indicates Wraparound provider

Provider Organization	Street	MH	SA	WA
16TH STREET BEHAVIORAL HEALTH CENTER	1032 S. 16TH STREET	x		
2ND CENTURY	2187 S 85TH STREET		x	
A STRONG FOUNDATION COUNSELING SERVICES, LLC	4447 N OAKLAND AVENUE	x	x	
ACACIA MENTAL HEALTH CLINIC, LLC	5228 W FOND DU LAC AVE	x	x	
ACACIA MENTAL HEALTH CLINIC, LLC	2931 S KINNICKINNIC AVENUE			
ACACIA MENTAL HEALTH CLINIC, LLC	1840 N FARWELL, #306D			
ACACIA MENTAL HEALTH CLINIC, LLC	6040 WEST LISBON AVE STE #102			
ACHIEVEMENT ASSOCIATES, LTD.	11040 WEST BLUEMOUND RD	x	x	
ACS CLINICAL SERVICE, LLC - MILWAUKEE BRANCH	2266 N PROSPECT AVE SUITES 204 & 520			
ADKINS COUNSELING SERVICES	6001 W CENTER STREET #105	x	x	x
AFFILIATED WELLNESS GROUP	4650 N PORT WASHINGTON RD			
AJA COUNSELING CENTER				
AIDS RESOURCE CENTER OF WISCONSIN	820 N. PLANKINTON AVENUE	x	x	
ALLIANCE INDIVIDUAL & FAMILY SERVICES LLC	5600 WEST BROWN DEER RD #216	x		x
ALLIED MENTAL HEALTH & REHABILITATION CNLCS	4425 W WOOLWORTH AVENUE			
ALTERNATIVES IN PSYCH CONSULT	5757 WEST OKLAHOMA AVE		x	x
ALTERNATIVES IN PSYCHOLOGICAL CONSULTATION, S.C.	10045 W LISBON AVENUE, #221	x		

Provider Organization	Street	MH	SA	WA
ALTERNATIVES IN PSYCHOLOGICAL CONSULTATION, SC	10045 W LISBON AVENUE			
AMERICAN BEHAVIORAL CLINICS-BLUEMOUND #1	10424 W BLUEMOUND ROAD			
AMERICAN BEHAVIORAL CLINICS-BLUEMOUND #2	9720 W BLUEMOUND ROAD			
AMERICAN BEHAVIORAL CLINICS-LAYTON	7330 W LAYTON AVENUE			
AMRI COUNSELING SERVICES, LLC	4001 WEST CAPITOL DRIVE	x	x	
ANGELS COUNSELING & THERAPY SERVICE	10701 WEST NORTH AVE STE #205	x		x
ANU FAMILY SERVICES, INC.				
APPLIED THERAPIES AND WELLNESS CENTER SC	1033 N MAYFAIR ROAD, #305	x	x	
ARC MILWAUKEE WOMEN'S PROGRAM	1022 W MADISON STREET			
ARO COUNSELING CENTERS, INC	6815 W CAPITOL DRIVE			
ASSOCIATED MENTAL HEALTH CONSULTANTS, INC.				
ASSOCIATED THERAPIES	8989 N. PT. WASHINGTON RD #220	x		
AUDUBON TECHNOLOGY & COMMUNICATION CENTER	3300 SOUTH 39TH STREET			
AURORA BEHAVIORAL HEALTH - FRANKLIN	9200 W. LOOMIS ROAD, #217	x	x	
AURORA BEHAVIORAL HEALTH - NORTH SHORE	6980 N. PORT WASHINGTON, #202	x	x	
AURORA BEHAVIORAL HEALTH CENTER WAUWATOSA	1220 DEWEY AVENUE	x		
AURORA BEHAVIORAL HEALTH CENTER - SINAI	1020 N 12TH ST 4TH FLOOR	x		
AURORA BEHAVIORAL HEALTH CENTER - WOMEN'S PAVILION	2424 S 90TH STREET SUITE 502	x		
AURORA BEHAVIORAL HEALTH CENTER-LAKESHORE	3611 CHICAGO AVE		x	
AURORA FAMILY SERVICE, INC.	3200 W HIGHLAND BOULEVARD	x		x
AURORA HEALTH CARE METRO, INC. DBA AURORA ST. LUKE'S SOUTH SHORE	5900 S. LAKE DRIVE	x		
AURORA PSYCHIATRIC HOSPITAL INC	1220 DEWEY AVENUE	x	x	
AURORA PSYCHIATRIC HOSPITAL CHEMICAL DEPENDENCY SERVICES	1220 DEWEY AVENUE			
AURORA BEHAVIORAL HEALTH CENTER AURORA WEST ALLIS POT	2424 SOUTH 90TH STREET			
BEHAVIORAL CONSULTANTS, INC.				
BEHRENS PSYCHOTHERAPY SERVICES, LLC	2321 E CAPITOL DRIVE, #400	x		
BELL THERAPY - SOUTH 68TH STREET	2858 SOUTH 68TH STREET	x		
BELL THERAPY COMMUNITY SUPPORT PROGRAM SOUTH	4420 SOUTH 108TH STREET	x		
BELL THERAPY, INC	5555 N 51ST STREET			
BELL THERAPY, INC. - DAY ONE	4065 N. 35TH STREET	x		
BELL THERAPY, INC. COMMUNITY SUPPORT PROGRAM - NORTH	4929 W. FOND DU LAC AVENUE	x		

Provider Organization	Street	MH	SA	WA
BELL THERAPY, INC. - C.S.P. SOUTH (WILLOWGLEN)				
BELWOOD LTD./BELL THERAPY	5151 W SILVER SPRING, W WING B25	x		
BENEDICT CENTER WOMEN'S HARM REDUCTION PROGRAM	135 W WELLS STREET, #700		x	
BRACY PSYCHOLOGICAL SERVICE & STRESS MGM INSTITUT				
CAREER YOUTH DEVELOPMENT, INC.	2603 N. MARTIN LUTHER KING DR.	x	x	
CARMELITE HOME FOR BOYS	1214 KAVANAUGH PLACE			x
CATHOLIC CHARITIES OF THE ARCHDIOCESE OF MILWAUKEE, INC.	2021 N. 60TH STREET	x		
CEDAR CREEK FAMILY COUNSELING, INC.	9910 WEST LAYTON AVE SUITE 2	x	x	
CENTER FOR QUALITY COMMUNITY LIFE, INC. (CQCL)	6830 W VILLARD AVENUE, #300	x	x	
CHAI POINT	1400 NORTH PROSPECT AVENUE			
CHILD, ADOLESCENT, FAMILY & MARRIAGE THERAPY ASSOCIATES	230 W WELLS ST, STE 630	x		
CHILDREN'S HOSPITAL OF MILWAUKEE	1020 N. 12TH STREET, 5TH FLOOR	x		
CHILDREN'S HOSPITAL OF WISCONSIN	9000 W. WISCONSIN AVENUE	x		x
CHILDREN'S SERVICE SOCIETY OF WISCONSIN	620 S 76TH SREET, #120	x		x
CHILDYNAMICS, LLC	11904 W. NORTH AVENUE, #110	x		x
CHILEDA INSTITUTE, INC.				
CHRISTIAN FAMILY COUNSELING-RISEN SAVIOR	9505 BROWN DEER RD			
CHRISTIAN FAMILY COUNSELING	1214 SOUTH 8TH STREET			
CHRISTIAN FAMILY COUNSELING	2345 NORTH 25TH STREET			
CHRISTIAN FAMILY COUNSELING	9555 SOUTH HOWELL AVENUE SUITE 750			
CLEMENT J ZABLOCKI VAMC MENTAL HEALTH DIVISION	5000 WEST NATIONAL AVENUE			
CITY TRANSFORMATION CLINIC NORTH	1442 NORTH FARWELL AVENUE, SUITE 300		x	
COLUMBIA ST. MARY'S BEHAVIORAL MEDICINE - MILWAUKEE	2323 N LAKE DRIVE, 7TH FLOOR	x	x	
COLUMBIA WEST CLINIC	10950 W CAPITOL DRIVE			
COMPREHENSIVE CLINICAL & CONSULTING SERVICES, INC.	7161 N. PORT WASHINGTON RD	x		
COMPREHENSIVE CLINICAL & CONSULTING SVS	4131 W LOOMIS RD SUITE 240			
CORNERSTONE COUNSELING SERVICES, INC	5007 S HOWELL AVENUE, SUITE 350			
CORNERSTONE COUNSELING SERVICES, INC.	10850 W PARK PLACE, #100			
CORNERSTONE COUNSELING SERVICES, INC.	4811 S 76TH STREET			
CORNERSTONE COUNSELING SERVICES, INC.	5555 N PORT WASHINGTON ROAD, #200			
CORNERSTONE COUNSELING SERVICES	16535 WEST BLUEMOUND ROAD			

Provider Organization	Street	MH	SA	WA
COUNSELING AND TRANSITION CENTER		x		
CLINICARE CORPORATION MILWAUKEE ACADEMY	9501 WATERTOWN PLANK ROAD			
CREATIVE CONSULTING & COUNSELING SEVICES	2728 N PROSPECT			
CREATIVE FAMILY SERVICE	6040 WEST LISBON AVENUE, SUITE 206	x	x	
CRISIS RESOURCE CENTER	5409 W VILLARD AVE			
CRISIS RESOURCE CENTER	2057 S 14TH STREET			
CURRENT INITIATIVES COUNSELING SERVICE LLC	6815 WEST CAPITOL DR SUITE 207	x	x	x
DAY ONE - SILVER SPRING CENTER	5555 NORTH 51ST BLVD	x		
D AND S HEALING CENTER	310 EAST BUFFALO STREET			
DIANNE FRANCES MFA MS LPC	10520 WEST BLUEMOND ROAD			
DISCOVERY AND RECOVERY CLINIC INC	4402 SOUTH 68TH STREET	x		
DLO PARTNERS LLC DBA BRIGHTSIDE MENTAL HEALTH	3073 S CHASE AVE	x		
DOMINION BEHAVIORAL HEALTH SERVICES, LLC				
EAU CLAIRE ACADEMY				
EBB TIDE THERAPY	2821 N 4TH STREET RM 144	x	x	
EMPATHETIC COUNSELING SERVICES INC.	5501 W BURLEIGH ST	x	x	
EMPATHETIC COUNSELING SERVICES SOUTH	551 WEST HISTORIC MITCHELL ST			
EULOPIA FAMILY SERVICES, INC.				
EXODUS FAMILY SERVICES, LLC				
EXPRESS YOURSELF MILWAUKEE, INC.				
FAMILY AND CHILDREN'S CENTER, INC.				
FAMILY CRISIS COUNSELING				
FAMILY COUNSELING CENTER LLC	8112 WEST BLUEMOUND ROAD			
FAMILY OPTIONS COUNSELING, LLC	3015 N 114TH STREET	x		x
FAMILY WORKS PROGRAMS, INC.				
FOKUS FAMILY SERVICES	2821 N. 4TH STREET, #139	x	x	
FOREVER FREE SUBSTANCE ABUSE & MENTAL HEALTH TREATMENT CENTER	724 S LAYTON BLVD			
FORWARD CHOICES LLC	6040 W LISBON AVENUE, #103	x		x
GATEWAY FAMILY HEALTH CENTER	801 S 70TH STREET			
GATEWAY FAMILY HEALTH CENTER	801 S 70TH STREET			
GATEWAY TO CHANGE	2319 W. CAPITOL DRIVE	x	x	

Provider Organization	Street	MH	SA	WA
GENESIS BEHAVIORAL SERVICES, INC. MEN'S AODA RESIDENTIAL	2436 N. 50TH STREET		x	
GENESIS DETOXIFICATION CENTER	2835 N 32ND STREET		x	
GENESIS MILWAUKEE OUTPATIENT CLINIC	230 W WELLS STREET, #312	x	x	
GENESIS WOMEN'S RESIDENTIAL PROGRAM	5427 W. VILLARD STREET		x	
GERALD L IGNACE INDIAN HEALTH CENTER	1711 SOUTH 11TH STREET	x		
GREAT LAKES BEHAVIORAL HEALTH	10201 WEST LINCOLN AVE			
GREENSQUARE DEVELOPMENTAL SPECIALISTS	7300 SOUTH 13TH STREET	x		
GREENSQUARE DEVELOPMENTAL SPECIALISTS	6791 N GREEN BAY ROAD			
GRO FAMILY SERVICES	6400 WEST CAPITOL DRIVE	x	x	
GUEST HOUSE COUNSELING CLINIC	1216 N. 13TH STREET	x	x	
HEALTH PSYCHOLOGY ASSOCIATES	5007 S HOWELL, #350			
HALE-RICHLEN CENTER FOR PSYCHIATRY (THE)				
HARMONY SOCIAL SERVICES CPA, INC.				
HARPER HOUSE-NEHEMIAH PROJECT				
HEALTH PSYCHOLOGY ASSOCIATES, SC	5555 N PORT WASHINGTON DR SUITE 200	x		
HIGHLAND COMMONS	6700 WEST BELOIT RD			
HOPE FORTIS SCHOOL	3601 N PORT WASHINGTON ROAD			
HOPE PRIMA SCHOOL	2345 N 25TH STREET			
HORIZON HEALTHCARE	5408 W BURLEIGH ST			
HORIZON HEALTHCARE INC	4650 S HOWELL AVENUE	x	x	
HORIZON HEALTHCARE, INC	5408 W BURLEIGH ST			
HOUSE OF JABEZ, LLC				
HOUSE OF LOVE II				
HUMAN DEVELOPMENT CENTER, INC.				
ICF CONSULTANTS, INC.				
IMPACT, ALCOHOL & OTHER DRUG ABUSE SERVICE	3970 NORTH OAKLAND AVE			
IMPACT, ALCOHOL AND OTHER DRUG ABUSE SERVICE, INC	6737 W WASHINGTON STREET, #2225		x	
INTEGRATED DEVELOPMENT SERVICES	217 W. DUNWOOD ROAD			
INTEGRITY FAMILY SERVICES, LLC				
JEWISH FAMILY SERVICES	1300 N. JACKSON STREET	x		
JEWISH FAMILY SVS - BAYSHORE	5800 N BAYSHORE DRIVE			

Provider Organization	Street	MH	SA	WA
JEWISH FAMILY SVS - BRADLEY CROSSING	4375 WEST BRADLEY ROAD			
JEWISH FAMILY SVS BROWN DEER ELEMENTARY	5757 WEST DEAN ROAD			
JEWISH FAMILY SVS CENTRAL CITY CYBERSCHOOL	4301 NORTH 44TH ST			
JEWISH FAMILY SVS NATIVITY JESUIT MIDDLE SCHOOL	1515 SOUTH 15TH STREET			
JEWISH FAMILY SVS-BROWN DEER MIDDLE/HIGH SCHOOL	8060 NORTH 60TH STREET			
JEWISH FAMILY SVS-NORTH POINT LIGHTHOUSE CHARTER	4200 WEST DOUGLAS AVENUE			
JEWISH HOME AND CARE CENTER, INC.	1414 NORTH PROSPECT AVENUE			
JUSTICE POINT	821 WEST STATE STREET, ROOM 417			
KIDS DISCOVER SUCCESS THERAPEUTICS, LLC				
KIDS IN TRANSITION, INC	2821 NORTH 4TH STREET STE #208		x	
LA CAUSA COMMUNITY ENRICHMENT CENTER	804 W GREENFIELD AVE			
LA CAUSA, INC SOCIAL SERVICES	1212 SOUTH 70TH STREET, SUITE 115A			
LA CAUSA, INC.	1212 S 70TH ST #115A	x	x	x
LAD LAKE CROSSROADS TO INDEPENDENCE GH				
LAD LAKE -ST. ROSE STAGES				
LAD LAKE, INC.				
LAD LAKE-ST. ROSE				
LAKESHORE CLINIC LTD/ROBERT DRIES PHD	8112 W BLUEMOUND RD			
LAKESHORE CLINIC, LTD.	3510 N OAKLAND AVENUE, #206			
LCFS-ST JOHN LUTHERAN CHURCH	4850 S LAKE DRIVE			
LIFE CHANGING MINISTRIES INC.	7315 NORTH TEUTONIA AVENUE		x	
LIFE-SPAN PSYCHOLOGICAL SERVICES, LLC	2266 N PROSPECT AVENUE, #503			
LIGHTHOUSE CLINIC	11803 W NORTH AVENUE, #207			
LIGHTHOUSE CLINIC, LLC	2524 E WEBSTER PLACE, #203	x		
LOCKETT ENTERPRISE BEHAVIORAL HEALTH SERVICES	230 W WELLS STREET, SUITE 214	x	x	
LOVE AND CARE COMMUNITY CENTER LLC	3975 NORTH 68TH STREET SUITE #205	x		
LUTHERAN COUNSELING AND FAMILY SERVICES OF WISCONSIN	3800 N. MAYFAIR ROAD	x	x	x
LUTHERAN COUNSELING & FAMILY SERVICES OF WI				
LUTHERAN SOCIAL SERVICES-HOMME HOME Y&F PROGRAMS				
M & S CLINICAL SERVICES, INC.	2821 NORTH 4TH ST #516	x	x	
MAPLEGROVE TREATMENT CENTER	1455 97TH STREET	x		

Provider Organization	Street	MH	SA	WA
MARQUETTE NEIGHBORHOOD HEALTH CENTER	1834 W WISCONSIN AVENUE, #100			
MARTIN LUTHER KING-HERITAGE HEALTH CENTER	2555 N MARTIN LUTHER KING JR DRIVE			
MATT TALBOT RECOVERY CENTER	2613 W. NORTH AVENUE		x	
MATT TALBOT RECOVERY SERVICES, INC (FIRST STEP COMMUNITY RECOVERY CENTER)	2835 N 32ND STREET			
MATTERS OF THE SPIRIT, LLC	6815 WEST CAPITOL DRIVE, SUITE 112			
MCFI DBA TLS BEHAVIORAL HEALTH	1040 S 70TH STREET			
MCW DEPARTMENT OF PSYCHIATRY CLINICS AT TOSA	1155 N MAYFAIR ROAD	x	x	
MD THERAPY	6815 W CAPITOL DRIVE, #208	x	x	x
MENTAL HEALTH AMERICA OF WISCONSIN				
MEDINA'S WAY	6815 WEST CAPITAL DRIVE #202	x		
MEDINAS WAY 2	1101-1107 WEST NATIONAL AVE			
META HOUSE, INC (SHOREWOOD CAMPUS) AKA META III	3924-26 N. MARYLAND AVENUE		x	
META HOUSE, INC (SOUTH CAMPUS) AKA RIVERWEST	2618 N. BREMEN STREET		x	
META HOUSE, INC.	2625 N WEIL STREET	x	x	
META HOUSE, INC. (NORTH CAMPUS)	2626 N. BREMEN STREET	x	x	
MILWAUKEE ACADEMY	9501 WATERTOWN PLANK ROAD			
MILWAUKEE ACADEMY/CLINICARE				
MILWAUKEE CENTER FOR INDEPENDENCE	2020 W WELLS STREET			x
MILWAUKEE CENTER FOR INDEPENDENCE DBA TLS BEHAVIORAL HEALTH	1040 S. 70TH STREET	x		
MILWAUKEE CENTER FOR INDEPENDENCE DBA TLS BEHAVIORAL HEALTH	1040 S. 70TH STREET	x		
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION	9455 WATERTOWN PLANK ROAD	x		
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIV PSYCHIATRIC CRISIS SERVS/ADMISSION CTR	9499 WEST WATERTOWN PLANK ROAD			
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIV WRAPAROUND MILWAUKEE	9201 WEST WATERTOWN PLANK ROAD			
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION - SOUTHSIDE CSP	1201 WEST MITCHELL STREET	x		
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION MOBILE URGENT TREATMENT TEAM	9201 WATERTOWN PLANK ROAD	x		
MILWAUKEE COUNTY BEHAVIORAL HEALTH DIVISION-DOWNTOWN CSP	1220 WEST VLIET ST SUITE #304	x		
MILWAUKEE COUNTY COMPREHENSIVE COMMUNITY SERVICES PROGRAM	9201 WEST WATERTOWN PLANK ROAD			
MILWAUKEE HEALTH SERVICE SYSTEMS DBA RIVER'S SHORE CLINIC	3707 N RICHARDS STREET		x	
MILWAUKEE HEALTH SERVICE SYSTEMS II	4800 S 10TH STREET #1		x	
MILWAUKEE HEALTH SERVICES, INC. DBA BEHAVIORAL HEALTH SERVICES CENTER	8200 W SILVER SPRING DRIVE	x		

Provider Organization	Street	MH	SA	WA
MILWAUKEE HEALTH SERVICES, INC.	140 N. HINE AVENUE			
MILWAUKEE MENTAL HEALTH ASSOCIATES		x	x	
MILWAUKEE MENTAL HEALTH ASSOCIATES COMMUNITY SUPPORT PROGRAM	4957 W FOND DU LAC AVENUE	x		
MINDSTAR COUNSELING, LLC	6114 W CAPITOL DRIVE, SUITE 102	x		x
MT. CASTLE TRANSITIONAL LIVING SERVICES				
MULTI-CULTURAL COUNSELING SERVICES II INC, DBA RENEW COUNSELING SERVICES	6815 W CAPITOL DR SUITE #105	x	x	
MWCCA BEHAVIORAL HEALTH CLINIC	728 NORTH JAMES LOVELL ST	x	x	
NAKODA COGNITIVE BEHAVIORAL SERVS LLC	204 EAST CAPITOL DRIVE			
NERVIG, MARY				
NEW BEGINNINGS MENTAL HEALTH CLINIC, LLC	6754 W BELOIT RD	x		
NEW CHOICES, LLC	3565 N MARTIN LUTHER KING DR	x	x	x
NEW CONCEPT SELF DEV. CTR/CSS				
NEW HORIZON CENTER CRISIS/MENTORING SERVICES, LLC				
NEW LEAF THERAPIES LLC	4465 N OAKLAND AVE STE 400 D	x		x
NEW LIFE COUNSELING & FAMILY SOCIAL SERVICE AGENCY, INC.	2811 W NORTH AVE			
NEW LIFE COUNSELING & FAMILY SOCIAL SERVICE AGENCY, INC.	1442 N FARWELL, SUITE 300			
NEW PROSPECTS COUNSELING SERVICES	1219 NORTH CASS STREET			
NEXDAY	3333 SOUTH HOWELL AVE			
NORRIS ADOLESCENT CENTER				
NORTH SHORE PSYCHOTHERAPY ASSOCIATES	5800 N BAYSHORE DRIVE #A250	x		x
NORTHERN CROSSING BEHAVIORAL HEALTH SERVICES LLC	5303 WEST NORTH AVENUE			
NORTHSHORE CLINIC & CONSULTANTS	207 E BUFFALO STREET, #510			
NORTHSHORE CLINIC & CONSULTANTS	2363 S 102ND STREET, #203			
NORTHSORE CLINIC & CONSULTANTS INC	207 E BUFFALO STREET #300			
NORTHWEST PASSAGE LTD.				
OCONOMOWOC DEVELOPMENTAL TRAINING CTR. OF WI LLC				
OLIVER WENDALL HOLMES SCHOOL	2463 NORTH BUFFUM STREET			
OMNI ENRICHMENT, INC.	3020 W. VLIET STREET	x	x	
OUTREACH COMMUNITY HEALTH CENTER	711 W CAPITOL DRIVE		x	
OUTREACH COMMUNITY HEALTH CENTER, INC. RECOVERY CSP	711 W. CAPITOL DRIVE	x		
OUTREACH COMMUNITY HEALTH CENTERS INC	210 W CAPITOL DRIVE	x		

Provider Organization	Street	MH	SA	WA
OUTREACH COMMUNITY HEALTH CENTERS, INC	711 W CAPITOL DRIVE			
PARADIGM ENRICHMENT SERVICES, INC.	6110 WEST CAPITOL DRIVE MILWAUKEE	x	x	
PARK WEST SOCIAL & PSYCHOTHERAPY SERVICES INC	2772 N MARTIN LUTHER KING DRIVE #102	x		x
PARKWAY CLINIC	2906 S 20TH STREET			
PASTORAL COUNSELING SERVICE OF THE GREATER MILWAUKEE AREA	2825 N MAYFAIR ROAD SUITE 101	x		
PATHFINDERS MILWAUKEE, INC	4200 N HOLTON STREET, #400	x		x
PATHFINDERS FOR RUNAWAYS	1614 EAST KANE PLACE			
PATHWAYS COUNSELING CENTER				
PENFIELD CHILDREN'S CENTER	833 N 26TH STREET	x		x
PERFORMANCE ENHANCEMENT HEALTH SERVICES, SC	8800 SOUTH 102ND ST #103	x	x	
POSITIVE OUTLOOK CLINICAL SERVICES LLC	4345 NORTH 60TH STREET	x	x	x
PRO MARK CLINIC	4380 N RICHARDS STREET			
PROFESSIONAL READJUSTMENT OUTREACH CONSULTANT GROUP	4222 WEST CAPITOL DRIVE STE LL	x	x	
PROFESSIONAL SERVICES GROUP, INC.	1126 S 70TH STREET			x
PROJECT ACCESS, INC. CSP	823 S 60TH STREET	x		
PROJECT EXCEL-CCC (WCS)				
PSYCARE-MILWAUKEE LLC	633 W. WISCONSIN AVENUE, #1810	x		x
PSYCHIATRIC CONSULTANTS & THERAPISTS, SC	1220 DEWEY AVENUE			
PSYCHOLOGICAL AND COUNSELING SERVICES	7300 S 13TH STREET, #201			
QAM - QUALITY ADDICTION MANAGEMENT	1610 MILLER PARKWAY		x	
QUAD/GRAPHICS	555 S 108TH STREET			
RAVENSWOOD CLINIC	2266 N. PROSPECT AVENUE, #326	x	x	
RAWHIDE YOUTH & FAMILY COUNSELING SVS	5555 N PORT WASHINGTON RD STE 207			x
REACH, INC. COMPREHENSIVE MENTAL HEALTH CLINIC	4550 W BRADLEY ROAD	x	x	x
RELEVANCE COUNSELING SERVICES	3635 W OKLAHOMA AVENUE	x		
RENEW COUNSELING SERVICES	1225 W. MITCHELL STREET, #223	x	x	
REVIVE YOUTH AND FAMILY CENTER I				
REVIVE YOUTH AND FAMILY CENTER II				
RIGHT TURN II				
RIGHT TURN, INC.				
ROGERS MEMORIAL HOSPITAL	2448 SOUTH 102ND ST RM #200	x	x	

Provider Organization	Street	MH	SA	WA
ROGERS MEMORIAL HOSPITAL - CHILD & ADOLESCENT DAY TREATMENT	4555 W SCHROEDER DRIVE	x	x	
ROGERS MEMORIAL HOSPITAL - MILWAUKEE	11101 W. LINCOLN AVENUE	x	x	
ROOTS COUNSELING SERVICES	1863 N FARWELL AVE		x	
RUNNING REBELS COMMUNITY ORGANIZATION				
SANKOFA BEHAVIORAL & COMMUNITY HEALTH	500 W SILVER SPRING DR. SUITE K-200			
SEBASTIAN FAMILY PSYCHOLOGY	2745 W LAYTON AVE, STE 203			
SEBASTIAN FAMILY PSYCHOLOGY PRACTICE, LLC	1720 W FLORIST AVENUE, #125	x	x	x
SHECAR SUBSTANCE ABUSE/MENTAL HEALTH OUTPATIENT TREATMENT CENTER, LLC	2821 N 4TH STREET, #305	x	x	x
SHERRY, KENNETH E., PH.D./FIRST STEP CLINIC, INC.				
SHORE COUNSELING & CONSULTING CLINIC	6110 N PORT WASHINGTON ROAD	x		
SHORE COUNSELING & CONSULTING CLINIC	700 WEST VIRGINIA ST			
SHORE COUNSELING AND CONSULTING CLINIC	2600 N MAYFAIR ROAD, #650			
SHOREHAVEN BEHAVIORAL HEALTH INC	2727 W CLEVELAND AVE	x	x	x
SHOREHAVEN BEHAVIORAL HEALTH INC	4370 SOUTH 76TH STREET			
SHOREHAVEN BEHAVIORAL HEALTH, INC	3900 W BROWN DEER ROAD #200			
SIXTEENTH STREET COMMUNITY HEALTH CENTERS, INC.				
SOCIAL DEVELOPMENT COMMISSION YOUTH & FAMILY DEVELOPMENT PROGRAM	4041 N. RICHARDS STREET	x	x	x
SOUTHEAST CAMPUS	3333 S HOWELL AVENUE			
SAINT A	8901 WEST CAPITOL DRIVE			x
ST CHARLES - FAMILY DEVELOP CTR	151 S 84TH STREET			
ST CHARLES YOUTH & FAMILY SERVICES, INC	4757 N 76TH STREET			x
SAINT FRANCIS HOSPITAL OHIO BUILDING	3267 SOUTH 16TH STREET			
ST MARCUS SCHOOL	2215 N. PALMER STREET			
ST PETER LUTHERAN SCHOOL	1214 S 8TH STREET			
ST. CHARLES YOUTH & FAMILY SERVICES - FAMILY DEVELOPMENT CENTER	4757 N. 76TH STREET	x	x	
ST. LUKE'S MEDICAL CENTER OUTPATIENT BEHAVIORAL HEALTH CLINIC	2900 W OKLAHOMA AVENUE	x	x	
SAINT LUKES SOUTH SHORE BEHAVIORAL HEALTH	5900 SOUTH LAKE DRIVE			
ST. ROSE YOUTH & FAMILY CENTER	3801 N. 88TH STREET	x	x	x
SILVER SPRING PSYCHOTHERAPY ASSOCIATES	5215 NORTH IRONWOOD ROAD			
SOUTHWEST KEY PROGRAMS, INC.				
SOLUTIONS BEHAVIORAL HEALTH GROUP	10702 WEST BURLEIGH STREET			

Provider Organization	Street	MH	SA	WA
SPAHN CLINICAL SERVICES				
STAGES- ST. ROSE				
STRESS MANAGEMENT & MENTAL HEALTH CLINICS	5225 N. IRONWOOD LANE, #102	x		
STRESS MANAGEMENT AND MENTAL HEALTH CLINICS	10201 W LINCOLN AVENUE, #308	x		
TEEN CHALLENGE WISCONSIN ROBBY DAWSON HOME FOR WOMEN	727 NORTH 31ST STREET			
THE BRIDGE HEALTH CLINICS & RESEARCH CENTERS	611 WEST NATIONAL AVE #400	x	x	x
THE BRIDGE HEALTH CLINICS @ COMMUNITY ADVOCATES	728 NORTH JAMES LOVELL ST		x	
THE HUMAN DEVELOPMENT CENTER, INC.	6833 WEST FOND DU LAC AVE	x		
THE KELLEY CLINIC	1216 N. PROSPECT AVENUE	x		
THE POWER OF CHANGE INC BEHAVIORAL SERVICES	2821 N 4TH STREET SUITE 145	x	x	
THE REDI CLINIC - A DIVISION OF PATHWAY CLINIC, SC	2300 N MAYFAIR ROAD, #425	x		
THRIVE TREATMENT SERVICES, LLC				
TOMORROW'S FUTURE PHASE II				
TOTTY AND ASSOCIATES	7251 W NORTH AVENUE	x		x
TRANSFORMATIONSERVICES	835 N 23RD STREET, #212		x	
TRILLIUM CARE GROUP LLC	4811 S 76TH ST, #309			
TURCOTT MEDICAL AND PSYCHIATRIC ASSOCIATES	2600 N. MAYFAIR ROAD, #785	x		
UNITED COMMUNITY CENTER	604 W SCOTT STREET	x	x	
UNITED COMMUNITY CENTER	1100 S 6TH STREET, 3RD FLOOR		x	
UNITED COMMUNITY CENTER ART	1100 S 6TH STREET, 3RD FLOOR			
UNITED COMMUNITY CENTER LATINAS UNIDAS	1123 SOUTH 6TH STREET		x	
UNITED HANDS ACROSS THE CITY 'KEEPING DREAMS ALIVE', INC	2140 SOUTH 19TH STREET	x	x	
VALENTIN CLINIC	1220 DEWEY AVENUE	x	x	
V.I.C. LIVING CENTER, LLC				
WAKE UP PROGRAM, LLC				
WAUWATOSA THERAPIES, LLC				
WATER TOWER VIEW	3983 S PRAIRIE HILL LANE			
WCS-MILWAUKEE COUNTY DAY REPORTING CENTER	1673 S 9TH ST, BASEMENT		x	
WEST GROVE CLINIC	10012 WEST CAPITOL DRIVE #101	x	x	
WEST GROVE CLINIC LLC	11121 W NORTH AVENUE, #220			
WESTCARE WISCONSIN, INC.	335 WEST WRIGHT STREET		x	

Provider Organization	Street	MH	SA	WA
WHEATON FRAN BEHAV HEALTH - ST. FRANCIS	5650 N GREEN BAY AVENUE, #200			
WHEATON FRANCISAN BEHAVIORAL HEALTH - FRANKLIN	9969 S 27TH STREET			
WHEATON FRANCISCAN BEHAVIORAL HEALTH ST. FRANCIS HOSPITAL	3237 S 16TH STREET #200	x	x	
WHEATON FRANCISCAN BEHAVIORAL HEALTH - ST. JOSEPH REGIONAL MEDICAL CENTER	5000 W CHAMBERS ST #P210	x	x	
WILLOWGLEN ACADEMY	5555 NORTH 51ST BLVD			
WILLOWGLEN ACADEMY - CSP NORTH	4941 W FOND DU LAC AVE			
WILLOWGLEN ACADEMY - DAY ONE EAST	6414 W. FOND DU LAC AVE			
WILLOWGLEN ACADEMY OUTPATIENT CLINIC	4065 NORTH 35TH STREET STE # N100	x	x	
WILLOWGLEN COMMUNITY CARE				
WISCONSIN COMMUNITY SERVICES	3732 W WISCONSIN AVE. SUITE 200			
WISCONSIN COMMUNITY SERVICES OUTPATIENT MENTAL HEALTH PROGRAM	3734 W. WISCONSIN AVENUE	x		
WISCONSIN COMMUNITY SERVICES THE JOSHUA GLOVER CENTER	2105 N. BOOTH STREET		x	
WISCONSIN COMMUNITY SERVICES THURGOOD MARSHALL HOUSE	1914 N. 6TH STREET		x	
WISCONSIN COMMUNITY SERVICES UNLIMITED POTENTIALS	230 W. WELLS STREET, #500	x	x	
WISCONSIN COMMUNITY SERVICES-COMMUNITY SUPPORT PROGRAM	3734 W. WISCONSIN AVENUE	x		
WLCFS-CHRISTIAN FAMILY COUNSELING	9555 S HOWELL AVENUE, #750			
WORD OF HOPE MINISTRIES ATODA PROGRAM	2677 N 40TH STREET		x	