Community Mental Health & Substance Abuse (CMHSA) Scoping Paper

September 19, 2016

Management Audit Committee

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Notice on Auditing Standards: Scoping papers are not an auditing standards-based research product. Scoping papers are intended to provide the Management Audit Committee with a summary on a potential evaluation topic (including descriptions of basic agency, program, or procedural functions) on which to decide if a full program evaluation is required. This scoping paper was prepared with information obtained from the agency and staff listed. The information was not independently verified according to governmental auditing and evaluation standards.

If this topic moves forward to a full evaluation, the evaluation will be conducted as much as practicable according to generally accepted governmental auditing standards promulgated by the Comptroller General of the United States, as required by W.S. 28-8-107(e). Information contained in this paper, as well as all subsequent information gathered during the evaluation will be independently verified and reported according to the auditing standards.

Introduction

For over fifty years, the State has provided funding to community-based mental health and substance abuse centers (centers) to coordinate and provide local treatment and prevention services. In 1979, the Department of Health (Department) became the state designated mental health and substance abuse authority. Since the 1970s, the Department has worked with centers and other stakeholders, including the Legislature, to find ways of improving, expanding, and standardizing the delivery of community-based mental health and substance abuse (CMHSA) services. More recently, from 2005 through 2009, the Legislature's Select Committee on Mental Health and Substance Abuse Services (Select Committee) led efforts to re-examine local centers and re-establish and strengthen regionalized services. After the Select Committee completed its work, the emphasis and focus on regionalization diminished.

In January 2016, the Management Audit Committee (Committee) directed Legislative Service Office (LSO) Program Evaluation staff to prepare a scoping paper on the administration of community mental health and substance abuse centers services, the impact of the regionalization of services and funding, and access to care and services. Staff reviewed these areas to assist the Committee in determining if a full evaluation of the CMHSA system would be beneficial to the Legislature at this time.

Background

Origin of the CMHSA System and Service Began in the 1960s

The origin of the CMHSA system can be traced to the 1961 *Community Mental Health Services Act* (1961 Act). However, it was not until the 1961 Act was repealed and replaced with the 1979 *Community Human Services Act* (1979 Act) that the current system began in earnest. The purpose of the 1979 Act is to

> "establish, maintain, and promote the development of a comprehensive range of services in communities of the state to provide prevention of, and treatment for individuals affected by, *mental illness, substance abuse,* or developmental disabilities…" (W.S. 35-1-612; *LSO emphasis*).

Post-1979 Act CMHSA System and Services

As the State authority, the Department is permitted to enter into cooperative agreements (i.e. contracts) to provide funding to certified centers. In this capacity, the Department began acting as a pass-through entity to ensure that CMHSA system appropriations were distributed throughout the State.

During the 1990s and early 2000s, events such as Department reorganization, court decisions, lawsuits, and national trends (e.g. focus on substance abuse), redefined and changed the focus of the CMHSA system.

1992 L.C. vs Olmstead U.S. Supreme Court Decision (Olmstead)

The federal *Olmstead* ruling established that unnecessary institutionalization of persons with disabilities perpetuates the unfounded assumption that they are incapable of participating in society. Further, the nature of institutional confinement curtails a person's ability to participate in activities, such as work and education opportunities. Therefore, to prevent this type of discrimination, the Americans with Disabilities Act (ADA) requires states to serve persons with disabilities in community settings rather than in institutions.

1994 Chris S. Lawsuit and 2002 Stipulated Agreement (Wyoming)

The 1994 lawsuit, *Chris S., et. al v. Jim Geringer, et al*, resulted from allegations that appropriate facilities and services for persons with mental illness were inadequate and unavailable in Wyoming. As a result of the lawsuit, the Partnership for Resolution of Mental Health Issues in Wyoming (Partnership) was established in 1995 to address and resolve mental health services and facilities concerns in the State. In 2000, the Partnership ended and the State agreed to the 2002 Chris S. Stipulated Settlement Agreement to avoid the possibility of further lawsuits.

1990s and 2000s Focus on Substance Abuse

Starting in the 1990s, as a result of federal policy changes and new funding sources, substance abuse issues in Wyoming garnered increased attention as a serious problem needing solutions. The first State led Methamphetamine Initiative began in 1997 and subsequent legislation realigned resources and priorities to focus on increasing access to treatment and prevention services.

Prior LSO Evaluations

In 2006, LSO conducted two evaluations related to CMHSA services: *HB59: Substance Abuse Planning and Accountability* (January 2006) and *Wyoming Drug Courts* (July 2006).

HB59: Substance Abuse Planning and Accountability

The purpose of the evaluation was to examine the accumulated legislative efforts to mitigate the negative social impacts of substance abuse through the establishment of standards for treatment and prevention. These efforts culminated in the passage of 2002 HB 59, *the Substance Abuse Control Plan*, (2002 Laws, Ch. 81). The report findings centered on shortcomings in the State's delivery of

substance abuse treatment services, including disparate leadership and guidance among multiple agencies, the lack of an accepted plan, and the need for more accountability through better contracting and data reporting. The 2006 report resulted in the following five recommendations to improve service delivery in the State:

- The Legislature and Governor should agree on a single designated authority to lead state-level planning and coordination.
- If leadership responsibility for HB59 remains with WDH, the Department should elevate the duties to at least a deputy director level.
- The Legislature's and Governor's designated lead entity and collaborating partners need to adopt one comprehensive plan.
- The Substance Abuse Division should define necessary client-level data and outcomes, and structure contract provisions so that data will be uniformly reported.
- The Substance Abuse Division should follow its contracting rules by requiring complete applications and linking them to contract terms.

Wyoming Drug Courts

The second evaluation looked at the operations and impact of drug courts. These courts which are not a separate or specific level of court within the judicial branch of government, but are a sentencing option that judges may choose to employ to help break an offender's cycle of substance abuse and crime. Overall, the evaluation found that data and outcome reporting was not adequate to justify perceptions of drug court success. It also found that the complexities of dual-branch administration/participation (i.e. executive and judicial branches of government) should be reviewed to balance "local ownership" of the courts, but ensure State-level standards and accountability. The report contained three recommendations:

- The Substance Abuse Division should continue to define drug court performance and outcome measures and develop uniform reporting requirements for the data it requires.
- The Legislature should consider delaying a decision to alter current grant funding process during the 2007-2008 biennium.
- The Legislature should consider authorizing a steering committee to review different administrative models, and report recommendations for a comprehensive state administrative structure for drug courts.

2005-2009 Select Committee Work

From 2005 through 2009, the Select Committee identified several concerns and findings about the CMHSA services available in the State. As a result, the Select Committee proposed recommendations

to address or mitigate these issues and concerns. The Select Committee also sponsored legislation to help improve the overall system with a focus on standardization and regionalized services.

House Bill 340 in 2005 (2005 Laws, Ch. 195) first authorized the Select Committee to, "study issues and propose legislation to provide more cost effective and accessible delivery of mental health and substance abuse services, including recommendations regarding a regional approach to providing those services." The Select Committee was to specifically review the items in Table 1, below.

Table 1
Select Committee Charge

- Funding sources and levels, including federal, state, local, and private sources
- Availability and access to services in the state, including:
  - The number of available beds in institutions and hospitals for MHSA treatment
  - The available training and levels of MHSA health care providers
  - The number of people utilizing MHSA services annually and estimates of persons needing those services who are *not* utilizing them
- Cost effective alternatives to current methods of MHSA service delivery
- Governing body structures and oversight of MHSA programs and services
- The access to care service continuum within geographic regions, including:
  - Adult, child, adolescent and family MHSA clinical services
  - Support services for co-occurring conditions
  - Use of Medicaid waivers
  - Recruitment and retention of psychiatrists and other clinical and support staff
- Accountability activities with respect to comprehensiveness and appropriateness including standards, contracting, data collection, report generation and fiscal management
- Assessment of progress made and sufficiency of MHSA services
- Possible revisions to Title 25, including improvements to procedures and cost challenges

Source: 2005 Laws, Ch. 195.

From the beginning, the Select Committee benefitted centers by focusing on regionalization of services and making funding and resources available throughout the system. During the 2006 Budget and 2007 General Sessions, the Select Committee successfully sponsored legislation that provided new appropriations to help enhance existing local services and support the development of specialized, regional services that would have been cost-prohibitive for individual communities to provide (for a more detailed explanation and status of CMHSA service regionalization, see page 12).

In 2008, the Select Committee sought to implement improvements to ensure better oversight of how the Department expended their appropriations. In 2009, the Select Committee's efforts ended as the Legislature appropriated funds to expand and enhance mental health crisis stabilization services in the Big Horn Basin and

Southeast Wyoming. By identifying priorities, providing additional resources, and working to enhance oversight, the Select Committee established a standard expectation that holds centers accountable as they provide services locally and regionally.

Program Oversight and Administration

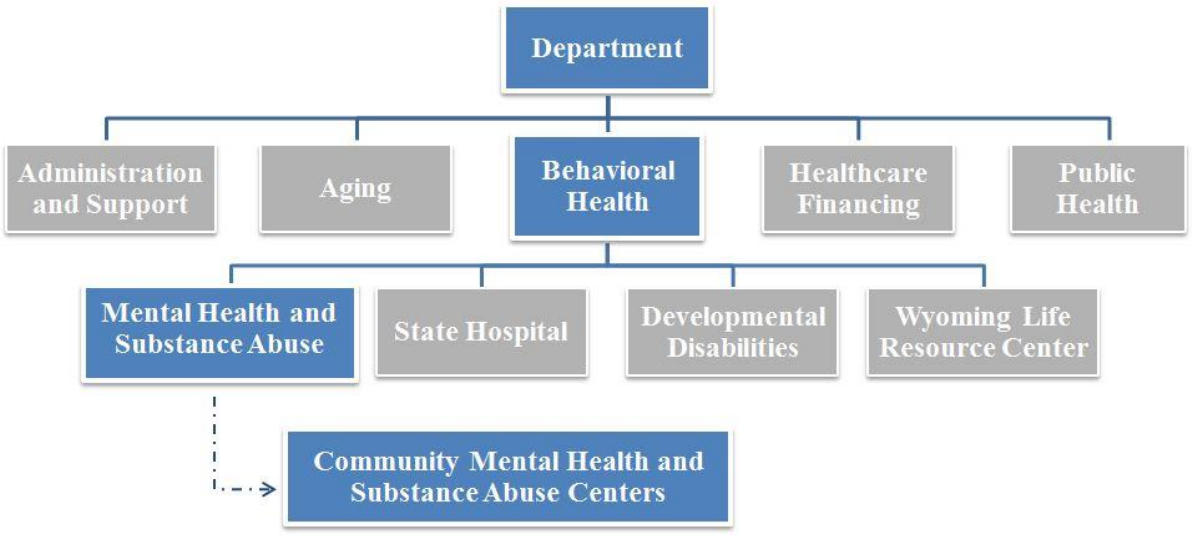
Before the 1979 Act, centers were able to go directly to the Legislature to request funding. However, after the passage of the 1979 Act, this practice was suspended and all state funds for CMHSA services were appropriated to the Department to be distributed through contracts to the centers. Since the 1970s, the Department has used several internal divisions to manage the CMHSA system, services, and associated contracts, as shown in Figure 1, below.

Figure 1
Simplified Timeline of Department Divisions That Oversee Centers

Source: Legislative Service Office analysis of information provided by the Department of Health.

The Behavioral Health Division (Division) began overseeing the CMHSA system and services for the Department in the 2010s. The current flow of funds from the Department to the centers is shown in Figure 2, below.

Figure 2
Simplified Flow of Funds, Department to Centers



Source: Legislative Service Office analysis of information provided by the Department of Health.

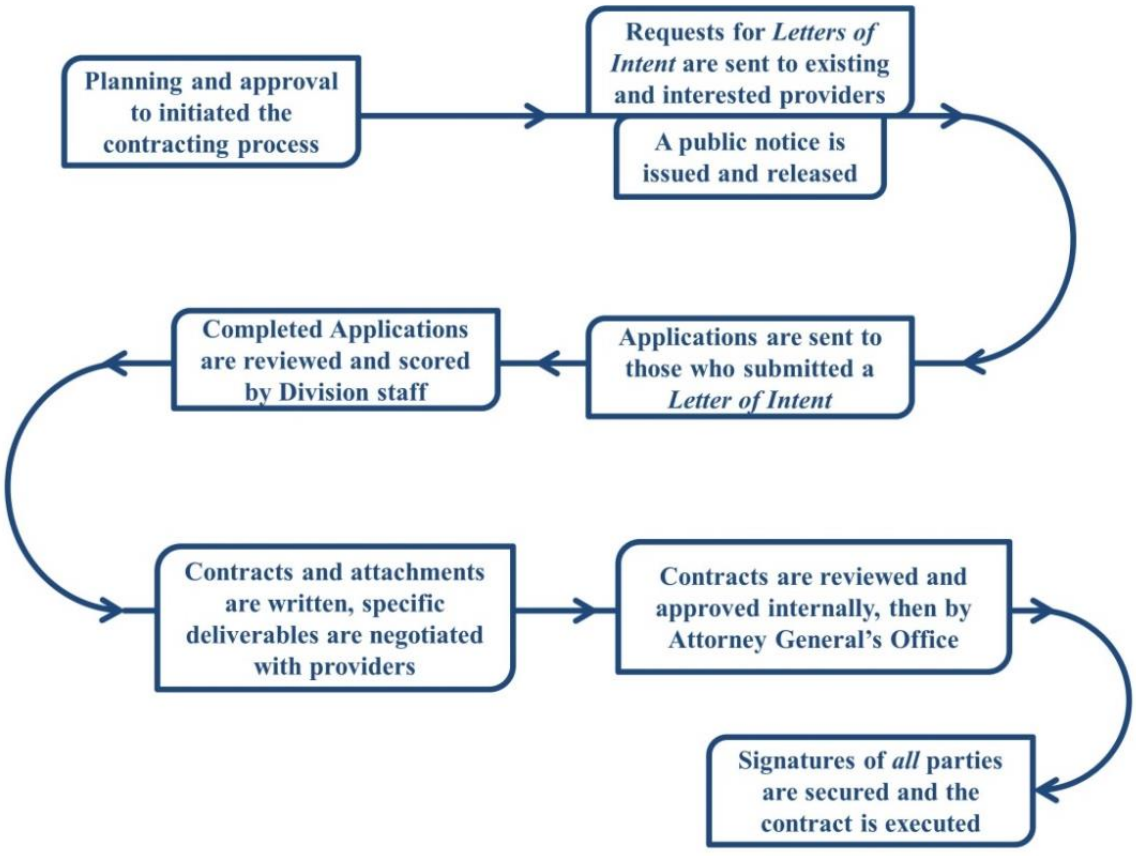
Contract Processes and Procedures

The Division enters into performance-based contracts for services, where it requires centers to provide specific services and meet negotiated deliverables. The current application and contracting processes can be found in three chapters of the Division Personnel and Program Quality Rules (1992 Rules):

- Chapter V – Application for Funds
- Chapter VI – Selection of Providers
- Chapter VII – The Contract for Funded Services

The 1992 Rules provide details regarding how providers can express their interest in becoming state-funded centers, the requirements for the Division to consider an application complete, the screening and selection process, policies regarding competing applications, and the contracting procedures. Figure 3, below, is an abbreviated explanation of the current processes as outlined in rules from initial application through contract execution.

Figure 3
Wyoming Department of Health Contracting Process with Centers



Source: Legislative Service Office analysis of information provided by the Department of Health.

Although the Division has not updated its rules since 1992, contemporary practices and procedures are incorporated into each center contract to ensure that services delivered are in compliance with modern practices, standards, and expectations.

Contracted Services

In the contracts with centers, the Division identifies required outpatient services that each provider must make available to clients, such as case management, clinical assessment, or therapy. The Division also identifies permitted optional services, such as day treatment or recreation/socialization. Specialized and residential services, like crisis stabilization, mental health community living environments, or social detoxification programs, are provided regionally, as determined by the Division.

Deliverables and Accountability

Within each contract, centers are held to negotiated deliverables. While there are some general requirements the Division expects of all providers, some deliverables are dependent upon specific services (e.g. outpatient service).

Examples of general requirement deliverables for all providers:

- Access to Quality of Life supports (e.g. transportation costs for clients associated with receiving CMHSA services)
- Adherence to regional MOUs
- Maintain appropriate national accreditations

Examples of specific outpatient service deliverables include:

- A minimum number of hours of service
- Performance, efficiency – average cost of outpatient services and penetration rates
- Performance, effectiveness – demonstrate a treatment completion rate of 60% or higher
- Performance, access – wait times for treatment services
- Performance, satisfaction – Client self-reported overall satisfaction with services received

Department and Division Funding

Prior to 2014, all CMHSA services were accounted for in a single budget unit, which, according to the Division, made budgeting and tracking expenditures difficult. Starting with the BFY2015-2016 budget request, the Division used, and continues to use, four primary budget units for the different MHSA services categories: Unit 2506 – Outpatient Mental Health, Unit 2507 – Outpatient Substance Abuse, Unit 2508 – Residential Mental Health, and Unit 2509 – Residential Substance Abuse.

In addition to these four units, other existing budget units also support the delivery of statewide CMHSA services, including court supervised treatment (formerly called drug courts), and recovery supports. Recovery supports include initiatives that enhance or complement primary treatment services to improve individuals' functioning (e.g. Peer Specialists, Veteran Outreach and Advocacy, and transitions from homelessness). Table 2, below, provides a summary of the BFY2015-2016 and BFY2017-2018 Governor's base biennial requests for CMHSA services (not including supplemental requests).

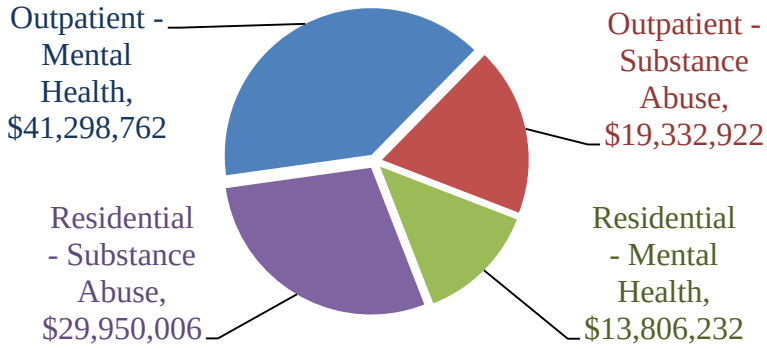
Table 2
Division Budget Requests for Units Related to CMHSA,
FY2015-2016 and FY2017-2018 Biennia

Budget Unit		FY2015-2016	FY2017-2018
2501	Behavioral Health Administration	$2,483,874	$3,492,020
2502	Recovery Supports	$24,688,366	$16,324,887
2503	Court Supervised Treatment (Drug Courts)	$8,551,487	$8,569,238
2506	Outpatient - Mental Health	$41,979,734	$41,298,762
2507	Outpatient - Substance Abuse	$18,883,079	$19,332,922
2508	Residential - Mental Health	$11,223,518	$13,806,232
2509	Residential - Substance Abuse	$26,638,163	$29,950,006
	Total	$134,448,221	$132,774,067

Source: Legislative Service Office analysis of Department of Health budget information.

As illustrated in Figure 4, below, for the FY2017-2018 biennium, the largest single category of funds contracted with centers is for Outpatient Mental Health services, such as individual and family therapies and medication management. Overall, of these four base service categories, mental health services account for approximately $55.1 million, or 53%, of the $104.3 million requested for the FY2017-2018 biennium.

Figure 4
FY2017-2018 MHSA Service Units



Source: Legislative Service Office analysis of Department of Health information.

June 2016 Governor Proposed Budget Reductions

In response to the recent drops in State revenues, in June 2016, the Governor requested all agencies propose budget reductions for the FY2017-2018 biennium. Table 3, below, contains the Governor's budget reduction recommendations for CMHSA services from the State General Fund (GF) and federal funds (FF).

Table 3
FY2017-2018 Governor Budget Reduction Summary for CMHSA Services

Unit	Program	% Cut	Total Budget (GF and FF)	GF Reduction	FF Reduction
2502	Recovery Supports	15.13%	$16,804,621	$2542,070	$0
2503	Court Supervised Treatment	14.00%	$8,569,238	$1,200,000	$0
2506	Outpatient MH Treatment	10.46%	$41,298,762	$4,061,907	$256,920
2507	Outpatient SA Treatment	12.50%	$19,332,922	$828,971	$1,588,233
2508	Residential MH Treatment	11.70%	$13,806,232	$1,357,901	$256,920
2509	Residential SA Treatment	13.71%	$29,950,006	$2,517,426	$1,588,233
	Total	12.48%	$129,761,781.00	$12,508,275.00	$3,690,306.00

Source: Legislative Service Office analysis of information provided by the Department of Health.

The reduction proposal states that reductions would be taken from the treatment contracts with the centers.

Center Funding

Currently, Medicaid and State General Fund block grants (i.e. contracts) are the primary payers for CMHSA services in the State. Additional, smaller funding sources include Tobacco Trust funds as well as federal grant dollars, primarily for residential and outpatient substance abuse services. Medicaid reimburses any enrolled center that treats Medicaid clients for behavioral health services deemed medically necessary. State funded block grants (i.e. contracts) are only available to a select group of Division-approved centers.

2017 State Contracted Centers

For FY2017, the Division has contracted with twelve centers that provide both mental health and substance abuse services, four centers that only offer substance abuse treatment and services, and two centers that focus on mental health services, for a total of eighteen distinct centers, shown in Table 4, on the next page.

Table 4
FY2017 State Contracts with Centers, by Service Category

Center	County(ies) Served	FY2017 Services		
		Mental Health	***Substance Abuse***	***Total***
Behavioral Health Services of Campbell County	Campbell	$1,805,068	$362,889	$2,167,957
Big Horn Basin Counseling Services	Big Horn	$529,597	$288,539	$818,136
Carbon County Counseling	Carbon	$1,101,741	$221,828	$1,323,569
Central Wyoming Counseling Center	Natrona	$2,901,511	$6,053,097	$8,954,608
Cloud Peak Counseling Center	Washakie	$1,286,976	$252,500	$1,539,476
Curran Seeley Foundation	Teton	$0	$701,487	$701,487
Fremont Counseling Service	Fremont	$1,627,236	$558,120	$2,185,356
High Country Behavioral Health	Lincoln, Sublette, Uinta	$1,960,375	$564,542	$2,524,917
Hot Springs County Counseling Services	Hot Springs	$338,359	$141,548	$479,907
Jackson Hole Community Counseling Center	Teton	$839,221	$0	$839,221
Northern Wyoming Mental Health Center	Crook, Johnson, Sheridan, Weston	$2,334,595	$792,317	$3,126,912
Pathfinder	Laramie	$0	$488,906	$488,906
Peak Wellness Center	Albany, Goshen, Laramie, Platte	$7,532,211	$3,805,762	$11,337,973
Solutions for Life	Converse, Natrona	$1,190,728	$252,664	$1,443,392
Southwest Counseling Service	Sweetwater	$3,887,003	$5,761,572	$9,648,575
The Center for Hope (Volunteers of America)	Fremont	$0	$4,286,789	$4,286,789
Cedar Mountain Center (West Park Hospital)	Park	$0	$1,050,528	$1,050,528
Yellowstone Behavioral Health Center	Park	$1,721,739	$0	$1,721,739
Total		**$29,078,860**	**$25,605,588**	**$54,639,448**

Source: Legislative Service Office analysis of information provided by the Department of Health.

Current Funding Model for Centers

Since the start of the current CMHSA system with the 1979 Act, statutes have not identified a specific funding formula or model for centers' reimbursement. Starting in the 1980s, Division staff, working with centers and other stakeholders, created the current funding model, which includes two components:

- **Base payments**. These payments are made to each center and represent the minimum amount necessary to operate an office with a support staff (i.e. "keep the lights on"). Centers' base payment amounts have increased over the years from the original amount, $20,000 per year, to the current amount, $90,000 per year.
- **Population payments.** In addition to base payments, centers are also awarded funding based on the population of the service area where they operate.

The Division contracts with centers to provide specific required services in their communities and regions. To comply with contracts, centers must deliver an agreed upon quantity of service units for each of the required services, commonly referred to as "service hours." The current calculation to determine the annual contracted amount for centers is as follows:

[mandated service hours/units] multiplied by [$87 per service hour]

The Division pays the total calculated amount to the provider in twelve monthly installments over the course of the fiscal year.

Department Concerns with the Current Funding Model

Under the current model, funds are contracted to centers based on the delivery of a specified quantity of service hours each year, and does not take into account the actual cost of service delivery, case severity, or acuity of the individual. Outside influences, or changes to the program, can compound these issues.

For example, the Legislature specified in Footnote 13 of the Department of Health section of the 2014 Budget Bill, that State general funds and tobacco trust funds should be the payer of last resort for CMHSA services. In 2015, the Legislature amended this footnote to ensure that Medicaid reimbursed services were not counted towards centers' required service hours. Anecdotal information suggested that this requirement negatively impacted at least one center and the original and amended Footnote 13 were not reauthorized in the 2016 Budget Bill.

Regionalization of CMHSA Services

Pursuant to the 1992 Department Behavioral Health Personnel and Program Quality Rules (1992 Rules), the Division was required to separate the State into regions for the maintenance, operation, and delivery of comprehensive community services.

In the 1992 Rules, Chapter III, Section 1(a), the Division provided a list of specific considerations to take into account to ensure that the regions were realistic and appropriately defined geographic areas. These specific considerations included:

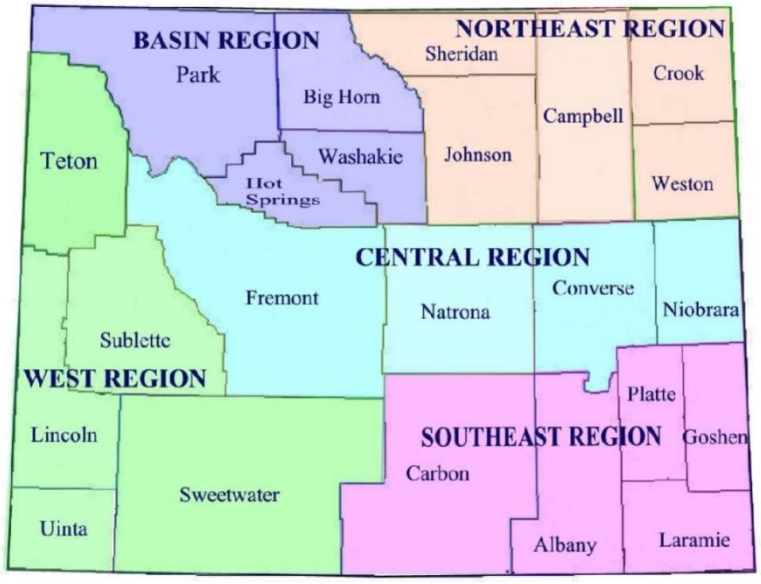
(i) Physical geographic characteristics and barriers
(ii) Population base
(iii) Service needs of population
(iv) Presently existing services available
(v) County or multi-county organization and support
(vi) Accessibility to services
(vii) Residential patterns
(viii) Economic and social groupings
(ix) Available transportation systems

According to the Division, the purpose of regionalization was to:

- Provide a continuum of care within each region
- Transform the system so that all citizens have equal access to CMHSA treatment and supports
- Develop a statewide service system as opposed to pockets of services in various locations
- Ensure that services are comparable within regions and across regions

The Division designated regions are shown in Figure 5, below. Regions are also designated by 2009 Laws, Chapter 13, Section 2.

Figure 5
Map of Department Designated Regions



Source: Department of Health 2010 Mental Health and Substance Abuse Gaps Analysis Report, published December 2010.

Determining Who Will Provide Regional Services Today

As discussed above, during its active years (2005-2009), the Select Committee expressed interest in regionalization as a means to

provide services that could not be independently supported in each community or county due to service costs and low population base. Through regionalization the Select Committee sought to ensure a statewide, accessible, consistent continuum of services. Regionalization was established with the expectation that providers within each region would collaborate and develop coordinated plans that included an array of uniform services accessible throughout the region, and comparable to services provided within every other region.

Current Division requirements specify that prior to submitting a funding application, center applicants must meet with their regional partners to discuss and determine how and where certain services will be delivered. Once the parties reach consensus, decisions regarding who will provide regional services are articulated in a region-specific Memorandum of Understanding (MOU), which is submitted as an attachment to each center's funding application.

The Division has, as needed, specified what content should be included in the regional MOUs and has articulated these expectations on the application.

Some services are designated as required or optional regional services. Examples include the following:

- Required CMHSA Regional Services
  - Mental health – Community Housing
  - Substance abuse – Residential treatment services
- Optional CMHSA Regional Services
  - Mental health - Crisis stabilization services
  - Mental health - Residential treatment for persons with co-occurring disorders
  - Substance abuse –Residential treatment services
  - Substance abuse –Detoxification services
  - Substance abuse –Medically monitored intensive inpatient treatment
  - Substance abuse –Transition housing

Regionalization is different today from when the Select Committee renewed its regionalization efforts ten years ago. Starting in 2010, shortly after the Select Committee ceased its work, the CMHSA regional system began to decline due to budget reductions, elimination or reduction of services (e.g. early intervention and respite care), and regional conflicts between individual community centers. However, remnants of the system (e.g. regional MOUs and specific services, such as crisis stabilization) do still exist.

Impact of Centers and the CMHSA System

Determining the impact of centers and the services they provide is research that cannot be completed during a scoping review. However, the following resources were identified as possible sources of information and data that could be reviewed during a full evaluation. These sources might help identify who accesses and uses CMHSA services, where these services are most prevalently used, and where existing, unidentified needs exist.

Wyoming Client Information System (WCIS)

In an effort to increase the accountability of how the Division expends funds for CMHSA services, in conjunction with a need for quantifiable reporting data, the Select Committee assisted in enhancing the Wyoming Client Information System (WCIS). WCIS collects client level data from all state funded centers. Specifically, WCIS collects demographic and service data for each encounter a client has with the State, including their movements between agencies or programs. Centers are responsible for transmitting client data to WCIS in accordance with contract requirements.

The Department does have a few concerns with the WCIS:

- Due to delays in data entry, information in the system is not "real-time" (e.g. the system does not always match what is occurring day-to-day)
- Input data is unreliable, with common data errors including duplicate client identification numbers and erroneous client income information
- WCIS does not communicate with other systems, such as those related to Medicaid, and requires manual processes
- WCIS is self-contained and does not include local hospital, DOC, or other stakeholder data

The Department worked with its Medicaid vendor to build a new system for processing Title 25 payments, known as an all claims database. This database will send information through the new Medicaid Management Information System (MMIS), which was anticipated to launch August 1, 2016. The Department anticipates its first data reports in early September 2016. A goal of the Department is to eventually integrate data from the CMHSA system and WCIS into the MMIS.

2010 Gaps Analysis

The Gaps Analysis Report examined the condition of statewide mental health and substances abuse services as of September 2010. The 2010 report was the result of a request to update a 2006 version of the report, which garnered substantial legislative

attention and support. The Department created the report using provider and stakeholder interviews and information from the WCIS to analyze and understand client access and utilization of services. The report included a review of a number of successful practices as well as opportunities for improvement and growth.

2014 Quality Improvement Reports

Pursuant to 2006 Laws, Ch. 40 (House Bill 91), the Division was required to monitor and report on the CMHSA system, annually, as an accountability measure created by the Select Committee. However, the Legislature removed this provision from statute in 2015. The Department submitted the last Quality Management report on October 1, 2014.

Information from this once-required annual report provided statewide CMHSA services data and summary information. As a majority of the information in the 2014 Report was created using existing Division data, recreation of specific elements or areas of interest could be possible during an evaluation.

Examples of relevant data from the FY2014 Report included:

- Percent of clients who increased their Global Assessment of Functioning (GAF) scores by more than 5 points
- Average cost per client – Mental Health Outpatient
- Percent of clients who felt treatment was appropriate
- Statewide MHSA penetration rates
- MHSA clients living at home
- Client Demographic and FY2014 MH statistics – 16,489 clients were provided services, 45% were male, and 23% had a co-occurring substance abuse disorder
- Client Demographic and FY2014 SA statistics – 7,067 clients were provided services, 67% were male, and 34% had a co-occurring mental health disorder

2015 and 2016 Joint Subcommittee to Review Title 25 Issues

Wyoming Statutes under Title 25, Chapter 10, Emergency Detention and Involuntary Hospitalization, provides the legal process where a police officer or authorized examiner may detain a person thought to be a danger to him or herself or to others, or who is unable to meet basic needs as a result of a mental illness. If evidence is found that satisfies the criteria for detention, then a person may be detained, in appropriate facilities, for up to 72 hours. Once detained, a person must be examined by a licenses health care or mental health professional examiner within 24 hours. According to the Division, being detained does not mean a person is under arrest and individual civil rights are continued during an emergency detention.

As emergency detentions and involuntary hospitalization are legal processes, even though treatments may be provided, these services are not specifically designed as an entrée into treatment. Costs associated with Title 25 and the fiscal responsibilities of local communities (i.e. counties) and the State are articulated in statute.

Starting in 2015, and continuing through the 2016 interim, the Legislature's Management Council authorized a joint subcommittee to review Title 25 issues (Subcommittee). The Subcommittee functions as a taskforce with joint executive and legislative branch membership. The Subcommittee was directed to review involuntary hospitalizations with an emphasis placed on funding and system entry issues.

During the 2016 Budget Session, the Joint Labor, Health, and Social Services Interim Committee (Joint Labor) successfully sponsored Senate File 58, at the recommendation of the Subcommittee, which authorizes the use of directed outpatient commitment as an alternative to in-patient hospitalization. As of the writing of this scoping paper, the 2016 Subcommittee anticipates having legislative recommendations for potential Joint Labor sponsorship for the 2017 General Session.

Payment Reform

Priority Populations

For mental health include children and adolescents with Serious Emotional Disturbance (SED), adults with Serious Mental Illness (SMI), and veterans.

For substance abuse, in order of priority, includes pregnant intravenous drug users, pregnant women, intravenous drug users, women, and women with dependent children, and veterans.

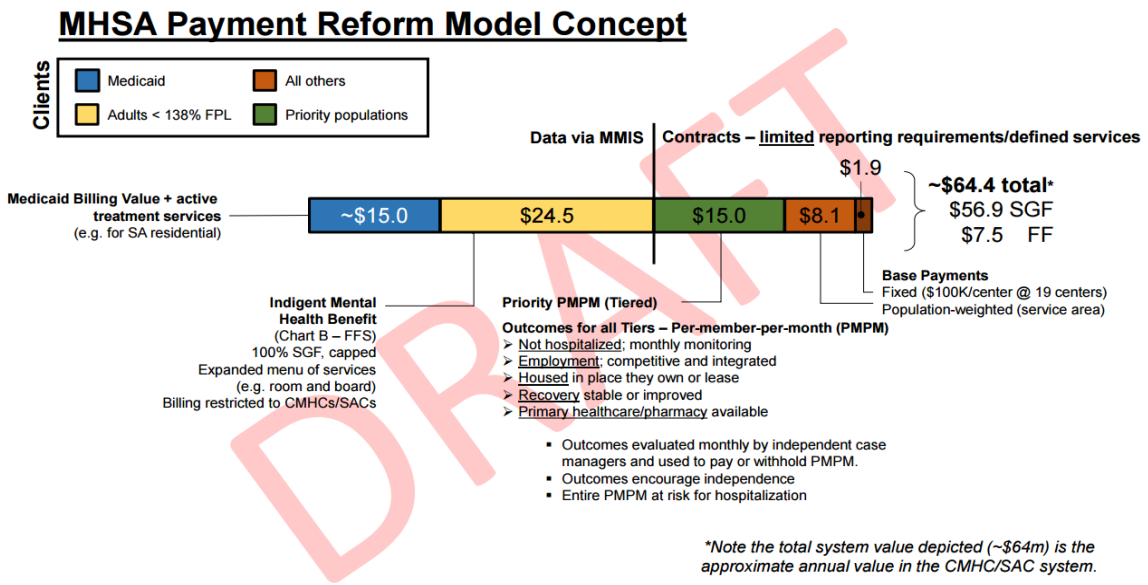
The Department began working on CMHSA service payment reform as a means to address the high utilization and high costs associated with Title 25. The goal of payment reform is to create a funding system where centers are incentivized to provide services to higher need and higher cost clients in order to ensure that they have access to necessary care and treatment at the local level. The intent is to provide services before these individuals experience a crisis that may require involuntary detention and/or hospitalization. The Department is also working with stakeholders to develop a "gatekeeper" pilot program, authorized in 2016 Laws, Ch. 102, to assist communities and priority population clients (see definitions at the left) with the Title 25 process. Payment reform will help to align services and payments with the needs and risks of priority populations.

Payment reform discussions began in January 2016, and the Department and Division have been working with staff, centers, consumers, advocates, and other stakeholders, including the Subcommittee and Joint Labor, throughout the year. The target completion and implementation date for payment reform is July 2017, to coincide with FY2018 contacts.

Department Proposed Model

As of July 2016, the preliminary funding model proposed by the Department includes maintaining the block grant base payments to centers and introduces a new system for conditional payments. These conditional payments would be distributed on a per-member, per-month basis and would be directly linked with the achievement of specified outcomes (e.g. non-hospitalization of individuals, finding housing, finding employment, etc.). Figure 6, below, summarizes the Department's model.

Figure 6
Draft Model of MHSA Payment Reform



Source: Department of Health information as presented to the Joint Subcommittee on Title 25 Issues (July 2016).

Title 7 – CMHSA Services and the Criminal Justice System

The Department, Division, and centers have a variety of duties and responsibilities associated with the adult and juvenile criminal justice systems, aside from ongoing coordination and collaboration efforts to provide needed community-based services.

Criminal Evaluations

Under Title 7, Chapter 11 (Adult Criminal Evaluations) and Title 14, Chapter 6 (Juvenile Evaluations), the Department, through the Wyoming State Hospital (WSH), centers, and other contractors, conducts five types of criminal evaluations:

- Competency to stand trial
- Competency restoration
- Mental state at the time of offense
- Not guilty by reason of mental illness
- Risk assessments

Evaluations are conducted by licensed health care professionals as defined in statute, such as a licensed psychiatrist or psychologist.

The Department employs and contracts with several forensic evaluators to conduct these evaluations, which can take place at the WSH or other adequate facilities designated by a court. At the local level, centers may provide these forensic services and evaluations in jails and detention centers.

Court Supervised Treatment Program

Title 7, Chapter 13, Article 16, Court Supervised Treatment Program (or Drug Courts), is a sentencing alternative that the judicial system can use in cases dealing with substance abuse to help participants break the cycle of addiction and crime. Eligible participants must be admitted to the program and comply with rigorous standards and requirements, such as frequent drug testing and supervision, in order to graduate from the program and complete their sentence. The local programs operate independently from each other and through their respective court systems determine eligibility, procedures, incentives, and sanctions for participants.

Criminal Justice System Impact on Centers

The costs and associated roles of centers in relation to the criminal justice system may increase in the coming years. For example, the Governor's June 2016 budget reductions for FY2017-2018 biennium will impact the Department of Corrections (DOC) similarly to the Department, resulting in a reevaluation of priorities and funding allocations. Given the budget reductions, DOC has eliminated and/or reduced its substance abuse treatment services in certain areas. For example, the Wyoming Honor Farm's seventy-four bed residential treatment facility was recently closed. Individuals who were in treatment and those on the waiting list to receive treatment will have to be accommodated either in other DOC facilities, or in suitable centers throughout the State.

Possible Evaluation Areas and Questions

Should the Management Audit Committee choose to move forward with a full evaluation, possible questions and areas of focus could include, but may not be limited to, the following topics and questions:

1. **Department administrative processes leading to contracts with centers**
    a. Are all administrative processes and requirements (e.g. for contracts) consistent from provider-to-provider and region-to-region?
    b. How does the Department take into consideration variations in center and community characteristics (e.g. location or population) during these administrative processes?
2. **Regional impact and needs assessment**
    a. What has been the impact of regionalization on the CMHSA system and services and are there still service gaps and unmet needs?
    b. What progress, or lack thereof, has been made on the issues addressed by the Select Committee from 2005 through 2009?
3. **Possible impacts of payment reform on the system**
    a. What benchmarks or standards have been established to evaluate the effects of the Department's payment reform on service delivery, access (e.g. center viability), and outcomes (e.g. expected or projected decrease in Title 25 costs)?
4. **Review of the CMHSA System Data and Reporting**
    a. How has data gathering and reporting evolved since the 2006 HB59 evaluation and Select Committee changes and is it sufficient to report progress and outcome measures of the CMHSA system (e.g. effectiveness of services for Wyoming residents)?
    b. How does the Department track and verify that state contracted services hours are not supported by multiple payment methods (e.g. Medicaid reimbursement, private insurance, and State General Funds)?