STATUS OF BUSINESS IN THE LEGISLATURE

PERIOD ENDING **MAY 1, 2014**

2013-14 Regular Session

ASSEMBLY STATUS

ASSEMBLY BILLS

928 have been Introduced in the Assembly, of which
194 have been Enacted into Law, of which
2 have been Partially Vetoed by the Governor
682 have Failed Passage pursuant to SJR 1
52 have Failed Concurrence pursuant to SJR 1

ASSEMBLY JOINT RESOLUTIONS

124 have been Introduced in the Assembly, of which
49 have been Enrolled
64 have Failed Adoption pursuant to SJR 1
11 have Failed Concurrence pursuant to SJR 1

ASSEMBLY RESOLUTIONS

28 have been Introduced in the Assembly, of which
16 have been Adopted
12 have Failed Adoption pursuant to SJR 1

SENATE BILLS

195 have been Received from the Senate, of which
180 have been Concurred In
1 has been Amended and Concurred In as Amended
14 have Failed Concurrence pursuant to SJR 1

SENATE JOINT RESOLUTIONS

64 have been Received from the Senate, of which
50 have been Concurred In
14 have Failed Concurrence pursuant to SJR 1

SENATE STATUS

SENATE BILLS

699 have been Introduced in the Senate, of which
179 have been Enacted into Law, of which
2 have been Partially Vetoed by the Governor
1 has been Vetoed in its Entirety by the Governor
504 have Failed Passage pursuant to SJR 1
15 have Failed Concurrence pursuant to SJR 1

SENATE JOINT RESOLUTIONS

90 have been Introduced in the Senate, of which
50 have been Enrolled
26 have Failed Adoption pursuant to SJR 1
14 have Failed Concurrence pursuant to SJR 1

SENATE RESOLUTIONS

9 have been Introduced in the Senate, of which
7 have been Adopted
2 have Failed Adoption pursuant to SJR 1

ASSEMBLY BILLS

246 have been Received from the Assembly, of which
194 have been Concurred In
52 have Failed Concurrence pursuant to SJR 1

ASSEMBLY JOINT RESOLUTIONS

60 have been Received from the Assembly, of which
49 have been Concurred In
1 has been Amended and Concurred In as Amended
10 have Failed Concurrence pursuant to SJR 1

EXECUTIVE APPOINTMENTS

310 have been Received in the Senate, of which
26 are in Committee
4 have been Reported, Available for Scheduling
16 have been Withdrawn by the Governor
264 have been Confirmed

PROFESSIONAL STANDARDS COUNCIL FOR TEACHERS APPOINTMENTS

18 have been Received in the Senate, of which
4 have been withdrawn
14 has been Confirmed

EXECUTIVE APPOINTMENTS

2 have been Received in the Senate, of which
2 have been Confirmed

October 2013 Special Session

ASSEMBLY STATUS

ASSEMBLY BILLS

4 have been Introduced in the Assembly, of which
1 has been Enacted into Law
3 have Failed Passage pursuant to SJR 1

SENATE BILLS

3 have been Received from the Senate, of which
3 have been Concurred In

SENATE STATUS

SENATE BILLS

4 have been Introduced in the Senate, of which
3 have been Enacted into Law
1 has Failed Passage pursuant to SJR 1

ASSEMBLY BILLS

1 has been Received from the Assembly, of which
1 has been Concurred In

December 2013 Special Session

ASSEMBLY STATUS

ASSEMBLY BILLS

1 has been Introduced in the Assembly, of which
1 has been Enacted into Law

SENATE STATUS

SENATE BILLS

1 has been Introduced in the Senate, of which
1 has Failed Passage pursuant to SJR 1

ASSEMBLY BILLS

1 has been Received from the Assembly, of which
1 has been Concurred In

January 2014 Special Session

ASSEMBLY STATUS

ASSEMBLY BILLS

2 have been Introduced in the Assembly, of which
1 has been Enacted into Law
1 has Failed Concurrence pursuant to SJR 1

SENATE BILLS

1 has been Received from the Senate
1 has been Concurred In

SENATE STATUS

SENATE BILLS

2 have been Introduced in the Senate, of which
1 has been Enacted into Law
1 has Failed Passage pursuant to SJR 1

ASSEMBLY BILLS

2 has been Received from the Assembly, of which
1 has been Concurred In
1 has Failed Concurrence In pursuant to SJR 1

WISCONSIN LEGISLATIVE COUNCIL
ACT MEMO

2013 Wisconsin Act 203 [2013 Senate Bill 565]	Milwaukee County Mental Health

2013 Wisconsin Act 203 (the Act) makes various changes relating to Milwaukee County mental health functions, programs, and services and creates the Milwaukee County Mental Health Board (MCMHB). Under the Act, the MCMHB is initially constituted as a state entity and transitions to become a county entity on January 1, 2015.

OVERVIEW

The Act does all of the following:

- Transfers control of all mental health functions, programs, and services in Milwaukee County, including those relating to alcohol and other drug abuse, to the newly created MCMHB.
- Directs the Governor to make provisional appointments to the MCMHB by June 9, 2014, and specifies that the provisional appointees may exercise all the powers and duties of their office. The MCMHB may begin to exercise jurisdiction over all mental health functions, programs, and services as soon as the Governor has made all the provisional appointments.
- Specifies that the MCMHB becomes a county entity on January 1, 2015. The Milwaukee County executive must re-appoint the same members to the MCMHB after it transitions to a county entity.
- Specifies how the budget for mental health in Milwaukee County will be developed, and requires the county to maintain effort regarding the amount of community aids funding it allocates for mental health, sets upper and lower limits on the amount of tax levy that may be budgeted for mental health.

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- Prohibits the Milwaukee County Board of Supervisors (county board) from forming policies regarding mental health or mental health institutions, programs, or services.
- Requires the Department of Health Services (DHS) to perform or arrange for an operational and programmatic audit of the Behavioral Health Division of the Milwaukee County Department of Health and Human Services, the psychiatric hospital of the Milwaukee County Mental Health Complex, and the related behavioral health programs. A report containing recommendations for inpatient mental health treatment in Milwaukee County must be completed by December 1, 2014.
- Requires the county executive to nominate an individual to be a transition liaison to assist the MCMHB in the transition of oversight functions. The individual must have knowledge of the mental health systems of Milwaukee County and the services it provides. The nomination is subject to the approval of the MCMHB.
- Specifies that the MCMHB must make a commitment to community-based service delivery.
- Provides that the county board retains the primary responsibility for the well-being, treatment, and care of the developmentally disabled citizens residing within Milwaukee County, and for ensuring they receive emergency services when needed, except where the responsibility is delegated explicitly to the MCMHB.

These major provisions of the Act are described in greater detail below.

The Act also makes numerous statutory modifications necessary to implement the transfer of the functions and responsibilities relating to mental health in Milwaukee County that are currently carried out by the county board to the MCMHB. This memo does not describe all of those provisions.

CREATION OF THE MILWAUKEE COUNTY MENTAL HEALTH BOARD

The Act creates the MCMHB, which is attached to the Department of Health Services (DHS) for limited purposes.[1] The county board must arrange for payment of the expenses of the MCMHB from the Milwaukee County mental health budget under an agreement between the county board and DHS.

Method of Appointment of Members; Provisional Appointments

Under the Act, the Governor must nominate the members of the MCMHB (other than the *ex officio* members) and the nominations must be confirmed by the Senate. The Governor must consult with the county executive when nominating the voting members of the MCMHB.

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[1] A board attached to a department for limited purposes exercises its powers, duties, and functions prescribed by law independently of the head of the department. Budgeting, program coordination, and related management functions are performed under the direction and supervision of the head of the department or independent agency. [See s. 15.03, Stats.]

The Act directs the Governor to make provisional appointments, which may take effect before Senate confirmation, within 60 days after the Act goes into effect. The individuals appointed in this manner may exercise all of the powers granted to MCMHB members, and the appointments remain in force until they are either withdrawn by the Governor or acted upon by the Senate. If confirmed by the Senate, they continue for the remainder of the term.

If a provisional appointment is rejected by the Senate, the appointment lapses and the Governor must nominate another individual to the position. In this situation, the nomination is subject to confirmation by the Senate. If the Governor withdraws a provisional appointment before it is acted on by the Senate, he may make another provisional appointment to the position.

MCMHB Membership

The Act specifies that the MCMHB is made up of 11 voting members and two non-voting members. Nine of the voting members are nominated by the Governor; and two are ex officio. The non-voting members are health care providers employed by an institution of higher education, also nominated by the Governor.

The members of the MCMHB, other than the ex officio members, are appointed for four-year terms.

The Act requires the county executive and the county board to submit lists of suggested appointees for several board positions. The county executive and county board must solicit suggestions for appointees from numerous organizations. Any person submitting suggestions or nominations for board members, must attempt to ensure that individuals suggested are among the most-qualified and experienced in their field.

No board member may be an employee of Milwaukee County at the time of nomination, and no board member may be a lobbyist or hold an elected office. The Act also imposes restrictions on certain political activities of board members.

The voting members of the MCMHB must collectively possess cultural competency and reflect the population that is serviced by the Milwaukee County mental health system. "Cultural competency" means the ability to understand and act respectfully toward, in a cultural context, the beliefs, interpersonal styles, attitudes, and behaviors of persons and families of various cultures, including persons and families who receive mental health services in Milwaukee County and persons and families who provide mental health services in Milwaukee County.

Voting Members of the MCMHB

The Act specifies that the MCMHB has the following 11 voting members:

- **Two individuals who must each be either a psychiatrist or psychologist**. The Governor must choose these members from lists of individuals suggested by the county board.

At least one of these positions must be filled by a psychologist. In other words, there may be two psychologists, or one psychologist and one psychiatrist in these positions, but not two psychiatrists.

The county board must provide one list of four suggested individuals for each position, and must solicit suggestions for individuals to fill these positions from organizations including the Wisconsin Medical Society, the Medical Society of Milwaukee, the Wisconsin Psychological Association, and the Wisconsin Psychiatric Association. For one of the positions, the county board must also solicit suggestions from the Wisconsin Association of Family and Children's Agencies for individuals who specialize in a full continuum of behavioral health services for children. For the other position, the county board must also solicit suggestions from the Milwaukee Co-Occurring Competency Cadre for individuals who specialize in a full continuum of behavioral health services for adults.

- **A representative of the community who is a consumer of mental health services**. The Governor must choose this member from a list of four individuals suggested by the county board. The county board must solicit suggestions for individuals to fill this position who have experienced mental illness or substance abuse, from organizations including Warmline, the Milwaukee Mental Health Task Force, and the Milwaukee Co-Occurring Competency Cadre.

- **A psychiatric mental health advanced practice nurse.** The Governor must choose this member from a list of four individuals suggested by the county board. The county board must solicit suggestions from organizations, including the Wisconsin Nurses Association for individuals who specialize in a full continuum of behavioral health and medical services including emergency detention, inpatient, residential, transitional, partial hospitalization, intensive outpatient, and wraparound community-based services.

- **An individual specializing in finance and administration**. The Governor must choose this member from a list of four individuals suggested by the county executive. The county executive must solicit suggestions for individuals to fill this position from organizations including the Wisconsin Hospital Association, the Wisconsin County Human Services Association, and the Public Policy Forum, for individuals with experience in analyzing healthcare operating expenses, revenues, and reimbursement, knowledge of public and private funding and systems, and expertise in financial restructuring for sustainability.

- **A health care provider with experience in the delivery of substance abuse services.** The Governor must choose this member from a list of four individuals suggested by the county executive. The county executive must solicit suggestions for individuals to fill this position from organizations including the Wisconsin Nurses Association, and the Milwaukee Co-Occurring Competency Cadre for health care providers with experience in the delivery of substance abuse services.

- **An individual with legal expertise**. The Governor must choose this member from a list of four individuals suggested by the county executive. The county executive must solicit suggestions for individuals to fill this position from organizations

including the Legal Aid Society of Milwaukee, Legal Action of Wisconsin, Community Justice Counsel, and Disability Rights Wisconsin for individuals who have legal expertise specializing in emergency detention regulatory requirements including policies, procedures, provider responsibilities, and patient rights.

- **A health care provider representing community-based mental health service providers**. The Governor must choose this member from a list of four individuals suggested by the county board. The county board must solicit suggestions from organizations including the Wisconsin Nurses Association, the Milwaukee Health Care Partnership, the Milwaukee Mental Health Task Force, and the Milwaukee Co-Occurring Competency Cadre for four health care providers representing community-based mental health service providers.

- **An individual who is a consumer or family member representing community-based mental health service providers**. The Governor must choose this member from a list of four individuals suggested by the county executive. The county executive must solicit suggestions for this position from organizations including the Milwaukee Health Care Partnership, the Milwaukee Mental Health Task Force, and the Milwaukee Co-Occurring Competency Cadre for four consumers or family members representing community-based mental health service providers.

- **The chairperson of the Milwaukee County community programs board** or his or her designee. If the chairperson of the county community programs board is an elected official, he or she shall designate a member of the county community programs board who is not an elected official to be a member of the MCMHB.

- **The chairperson of the Milwaukee Mental Health Task Force**, or his or her designee.

Non-Voting Members of the MCMHB

The Act specifies that the MCMHB has the following two non-voting members:

- **One health care provider who is an employee of a higher education institution suggested by the Medical College of Wisconsin and one health care provider who is an employee of a higher education institution suggested by the University of Wisconsin-Madison**. These individuals must specialize in community-based, recovery-oriented mental health systems, maximizing comprehensive community-based services, prioritizing access to community-based services and reducing reliance on institutional and inpatient care, 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, providing early intervention to minimize the length and depth of psychotic and other mental health episodes, diverting people from the corrections system, when appropriate, or maximizing the use of mobile crisis units and crisis intervention training.

The Governor must solicit suggestions from the Medical College of Wisconsin and the University of Wisconsin-Madison for individuals to fill these positions.

Removal from the Board

The Governor may remove any board member for cause and must remove any member who violates the prohibitions against lobbying, political activity, being employed by Milwaukee County or holding elective office, described above.

If the county executive suggested a member for nomination, the county executive may remove the member for neglect of duty, misconduct, malfeasance in office, failure to attend four board meetings in one year, or failure to attend two board meetings within one year without providing advance notice to the chairperson of the board.

The county board has the same authority with regard to board members that it suggested for nomination.

TRANSITION OF MCMHB TO A COUNTY ENTITY

Under the Act, the MCMHB is reconstituted as a Milwaukee County entity on January 1, 2015. All statutory references to the state MCMHB are repealed as of that date, and Milwaukee County is required to establish the MCMHB, a county entity, on that date. The MCMHB as a county entity has all of the same functions, authority, and responsibility as does the state MCMHB.

Re-Appointment of Individuals Serving as Members of State Board Required

The Act requires the county executive to appoint all of the individuals who are serving on the state MCMHB on January 1, 2015 to the new county MCMHB. After those individuals serve the remainder of their terms, the county executive will make all future appointments to the MCMHB. The county executive is also authorized to make appointments in the case of any vacancies. Appointments by the county executive are not subject to approval of the county board.

Membership Requirements; Future Appointments; Removal

The required qualifications for membership on the county MCMHB are the same as those which apply to the state MCMHB. As discussed above, the county executive must appoint all of the members of the state MCMHB to the county MCMHB. After those terms expire, or in the case of any vacancies, the county executive carries out the appointment functions that the Governor carries out under the Act for establishment of the state MCMHB. The county executive must solicit suggestions from the same groups as the Governor must under the Act, but the county executive is not required to choose from among those suggestions. The county executive must select from the lists of suggested individuals provided by the county board.

If the county board chooses to suggest a member of the MCMHB for reappointment to his or her position, the county board is not required to solicit suggestions from organizations and is not required to submit an additional three suggestions to the county executive for that appointment.

If the county executive chooses to reappoint a member of the MCMHB to his or her position, he or she is not required to solicit suggestions from organizations for that appointment.

No individual may serve more than two consecutive terms in a membership position for which suggestions for nomination are made by the same individual or entity, unless one of their three terms is for less than two years. An individual who has served the maximum number of consecutive terms is eligible to be suggested for nomination as a member of the MCMHB after 12 months have elapsed since the end of their most recent term.

The county executive may, for cause, remove any board member for whom the county executive solicited suggestions for nominations and must remove any member who violates the prohibitions against lobbying, political activity, being employed by Milwaukee County, or holding elective office.

If the county board suggested a member for nomination, the county board may remove the member for cause.

Requirements Applicable to MCMHB as a County Entity

The Act specifies that the following provisions that apply to the state MCMHB under the Act will continue to apply to the MCMHB when it becomes a county entity:

- **Meetings**. The MCMHB must hold at least six meetings per year, one of which must be a public hearing in Milwaukee County.
- **Selection of Chairperson**. At its first meeting in each year, the MCMHB must elect a chairperson, vice chairperson, and secretary each of whom may be reelected for successive terms.
- **Quorum**. A majority of the membership of a board constitutes a quorum to do business and, unless a more restrictive provision is adopted by the MCMHB. A majority of a quorum may act in any matter within the jurisdiction of the MCMHB.
- **Reimbursement for Expenses; Compensation**. The members of the MCMHB are reimbursed for their actual and necessary expenses incurred in the performance of their duties. The members receive no compensation for their services.
- **Code of Ethics for Local Government Officials**. The Act specifies that after the transition of the MCMHB to a county entity, the members of the MCMHB will become local public officials subject to the Code of Ethics for Local Government Officials. [s. 19.59, Stats.]
- **Transfer of Jurisdiction Over Mental Health Functions to the County MCMHB**

The Act authorizes the state MCMHB, with approval of the DHS Secretary, to transfer to itself jurisdiction over any Milwaukee County function, service, or program that pertains to mental health or is highly integrated with mental health services and that is not already under its jurisdiction. The MCMHB may achieve a transfer by an affirmative vote of eight of its voting members of the MCMHB, if the DHS Secretary approves the transfer.

After the MCMHB becomes a county entity a transfer of jurisdiction may not occur unless a majority of the members of the MCMHB and a majority of the members of the county board approve the transfer. In addition, once the MCMHB becomes a county entity, DHS no longer has authority to resolve disputes between the county board and the MCMHB over whether a function, program, or service is a mental health function, program, or service under the jurisdiction of the MCMHB.

DUTIES AND AUTHORITY OF THE MCMHB BOARD

Responsibility for the Mentally Ill and Alcoholic and Drug Dependent Citizens; General Duties

The Act provides that the MCMHB has the primary responsibility for the well-being, treatment, and care of the mentally ill, alcoholic, and other drug dependent citizens residing within Milwaukee County and for ensuring that those receive immediate emergency services when needed.

Specifically, the Act requires the MCMHB to do all of the following:

- Oversee the provision of mental health programs and services in Milwaukee County.
- Cooperate and consult with DHS on recommendations for and establishing policy for inpatient mental health treatment facilities and related programs in Milwaukee County.
- Allocate money for mental health functions, programs, and services in Milwaukee County within the budget amount determined by the formula established in the Act, as described below.
- Make the final determination on mental health policy in Milwaukee County.
- Carry out all mental health functions in Milwaukee County that are typically performed by a county board of supervisors.
- Attempt to achieve cost savings in the provision of mental health programs and services in Milwaukee County.
- Adopt policies regarding mental health and mental health institutions, programs, and services.

Required Meetings and Public Hearing

The MCMHB must meet at least six times each year. At least one of those meetings must be a public hearing held in Milwaukee County. As discussed above, the meetings of the MCMHB are subject to the public notice and open meetings requirements of the Wisconsin Open Meetings Law.

Method of Service Delivery Required

The Act requires the MCMHB to facilitate delivery of mental health services in an efficient and effective manner by making a commitment to all of the following:

- Community-based, person-centered, recovery-oriented, mental health systems.
- Maximizing comprehensive community-based services.
- Prioritizing access to community-based services and reducing reliance on institutional and inpatient care.
- 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.
- Providing early intervention to minimize the length and depth of psychotic and other mental health episodes.
- Diverting people experiencing mental illness from the corrections system when appropriate.
- Maximizing use of mobile crisis units and crisis intervention training.

Contract Approval Authority

The Act specifies that all contracts related to mental health with a value of at least $100,000, to which Milwaukee County is a party must be approved by the MCMHB. Specifically, these contracts may take effect only if the MCMHB votes to approve, or does not vote to reject the contract, within 28 days after the contract is signed or countersigned by the county executive.

Authority to Request Information; Other Agencies Required to Cooperate

The Act authorizes the MCMHB to request information from the Milwaukee Mental Health Complex, the county department of human services, the county community programs department under s. 51.42, Stats., and any other Milwaukee County governmental unit that possesses mental health information in order to fulfill its duties of overseeing mental health functions, programs, and services in Milwaukee County.

The Act prohibits a county department under s. 46.21 or 51.42, Stats., in Milwaukee County from impeding the MCMHB in performing its duties or exercising its powers and requires them to respond to any requests for information from the MCMHB.

Authority to Transfer Jurisdiction to Itself with DHS Approval

The Act authorizes the state MCMHB, with approval of the DHS Secretary, to transfer to itself jurisdiction over any Milwaukee County function, service, or program that pertains to mental health or is highly integrated with mental health services and that is not already under its jurisdiction. The MCMHB may achieve a transfer by an affirmative vote of eight of its voting members of the MCMHB, if the DHS Secretary approves the transfer. (As discussed

below, after the MCMHB becomes a county entity, DHS approval is not needed for transfer of functions, but approval of the county board is required.)

If the MCMHB transfer jurisdiction to itself in this manner, the county tax levy for mental health may be increased accordingly.

Authority to Establish and Operate an Entity to Provide Mental Health Services

The Act authorizes the MCMHB, together with a private or public organization or affiliation, to organize, establish, and participate in the governance and operation of an entity to operate, wholly or in part, any mental health-related service. The MCMHB is also authorized to participate in the financing of the entity, and to provide administrative and financial services or resources for its operation.

Payroll and Human Resources Procedures

The Act specifies that the MCMHB may change payroll and human resource procedures only for the divisions, branches, and functions of the Milwaukee County Department of Health and Human Services that relate to mental health, and only as specifically authorized in the Act.

MILWAUKEE COUNTY MENTAL HEALTH BUDGET

The MCMHB is authorized to allocate money for mental health functions, programs, and services in Milwaukee County within the budget amount as described below.

MCMHB Proposal

The Act provides that the MCMHB must annually propose a mental health budget to the county executive. The proposal must specify how much of the total proposed mental health budget consists of: (a) community aids funding; (b) the county tax levy; and (c) patient revenues, and all other sources, which may include grants, private contributions, gifts, and bequests. The MCMHB may not propose a tax levy amount that is less than $53 million or more than $65 million, except as provided below.

County Executive Budget

The county executive is not required to include the tax levy amount recommended by the MCMHB in his or her proposed budget, but must include a tax levy amount of at least $53 million and not more than $65 million for the mental health budget.

County Board Budget

The county board must incorporate all of the following amounts into the budget for Milwaukee County for mental health every fiscal year:

- The tax levy amount proposed by the county executive, which must be at least $53 million and not more than $65 million unless one of the following applies: (a) a majority of the MCMHB, a majority of the county board and the county executive all

agree to a different amount; or (b) the MCMHB assumes responsibility for a function, service, or program, as described below.

- Community aids funding that is the same or more than the amount allocated to mental health functions, programs, and services in the previous fiscal year (subject to the availability of community aids funds from the state).
- All amounts proposed by the MCMHB that are not tax levy funds or community aids funds.

Transfer of Function, Service, or Program to the MCMHB

If the MCMHB transfers to itself jurisdiction of a function, service, or program over which it did not previously have jurisdiction, the tax levy amount in the county budget for mental health is increased by an amount equal to the amount derived from the tax levy that was expended by Milwaukee County on that function, service, or program in the fiscal year before the fiscal year in which it is transferred. The $65 million tax levy limit may be exceeded by this amount in any year that the MCMHB has jurisdiction over the transferred function, service, or program.

Reserve Fund

The Act requires the Milwaukee County treasurer to hold any funds budgeted for mental health functions, programs, and services that are not encumbered or expended at the end of a fiscal year in a mental health reserve fund. Money in the reserve fund may be used at any time to cover deficits in the Milwaukee County mental health budget. If the amount in the reserve fund exceeds $10,000,000, the amount exceeding $10,000,000 may be used at any time for any mental health function, program, or service in Milwaukee County.

Transition Liaison Position

The Act requires the county executive to nominate an individual to be a transition liaison to assist the MCMHB in the transition of oversight functions and to ensure there is no interruption of mental health services. The individual must have knowledge of the mental health systems of Milwaukee County and the services they provide. The nomination is subject to the approval of the MCMHB.

The transition liaison may be assigned to that position for no longer than 12 months, unless the county executive grants an extension.

The county executive determines the salary, benefits and the job duties of the transition liaison and may remove him or her and nominate another transition liaison.

The county board may not hire, remove, or discipline, set the salary or benefits of, or assign or remove any job duties of the transition liaison.

COUNTY BOARD ACTIONS PROHIBITED

The Act prohibits the county board from forming policies regarding mental health or mental health institutions, programs, or services.

The Act eliminates the county board's authority to adopt policies for the management, operation, maintenance and improvement of the mental health complex or any mental health institution.

The Act prohibits the county board from exercising jurisdiction over any mental health policy, functions, programs, or services. The county board is prohibited from creating any new mental health functions, programs, or services and placing them under its jurisdiction. If any dispute arises between the county board and the MCMHB over whether a function, program, or service should be under the jurisdiction of the MCMHB, the Secretary of DHS must resolve the dispute.

The Act prohibits the county board from selling the Milwaukee County Mental Health Complex without approval of the MCMHB.

The Act eliminates the authority of the county board to exercise approval or disapproval over any contract relating to mental health or mental health institutions, programs, or services.

The Act eliminates the authority of the county board to set the salary of the superintendent of any mental health institution and the salaries of any visiting physicians and other officers and employees whose duties are related to mental health. The Act provides instead that these salaries are to be set by the county executive.

ADMINISTRATOR OF THE BEHAVIORAL HEALTH DIVISION

Appointment

The Act directs the county executive to nominate an individual to be the administrator of the Behavioral Health Division of the Milwaukee County Department of Human Services. The individual may be hired as the administrator only upon approval of the MCMHB. If the county executive does not nominate an individual by June 1, 2015, the MCMHB may hire an individual to be the administrator. If the position becomes vacant and the county executive does not nominate an individual within 12 months of the date the position becomes vacant, the MCMHB may hire an individual to be the administrator.

Salary and Benefits; Job Duties

The Act directs the county executive to determine the salary, benefits, and the job duties of the administrator of the behavioral health division. The county executive may not assign the administrator any duties that are not related to mental health functions, programs, and services in Milwaukee County.

The county board is specifically prohibited from hiring, removing, disciplining, or setting the salary or benefits of the administrator of the behavioral health division. The county board is also prohibited from assigning him or her any job duties or removing any of his or her duties.

Removal

The administrator of the behavioral health division may be removed by the MCMHB by a vote of eight members. However, if the county executive recommends removal of the administrator to the MCMHB, the MCMHB may remove the administrator upon a vote of six members.

AUDIT AND REPORT BY DEPARTMENT OF HEALTH SERVICES

The Act requires DHS to perform or arrange for an operational and programmatic audit of the behavioral health division of the Milwaukee County department of health and human services, the psychiatric hospital of the Milwaukee County mental health complex, and the related behavioral health programs. DHS may enter into a contract for the performance of the audit.

By December 1, 2014, DHS or the person with whom DHS has entered into a contract for the audit must submit a report of the findings of the audit, including recommendations for inpatient mental health treatment in Milwaukee County, to the DHS secretary, who must in turn submit a copy of the report to the MCMHB, the county board, the county executive, and the legislature.

The Act requires the MCMHB, the behavioral health division and the community services branch of the Milwaukee County department of health and human services, and any other Milwaukee County governmental unit that has information necessary for the performance of the audit, to cooperate with DHS or the contractor for the performance of the audit.

The county board must arrange for payment of expenses of the performance of the audit and the completion of the report from the Milwaukee County mental health budget under an agreement between the county board and DHS.

MCMHB REPORTING AND STUDY REQUIREMENTS

Annual Report

The Act requires the MCMHB to submit a report to the county executive, the county board, and DHS By March 1, 2015, and annually by March 1 thereafter. The report must include the following:

- A description of the funding allocations for Milwaukee County's mental health functions, services, and programs.
- A description of any improvements and efficiencies in those mental health functions, programs, and services.
- DHS must provide public access to the report by posting it on the DHS website.

Study on Alternate Funding Sources

The Act directs the MCMHB to arrange for a study to be conducted on alternate funding sources for mental health services and programs including fee-for-service models, managed care models that integrate mental health services into the contracts with an increased offset through basic county allocation reduction, and other funding models.

The MCMHB must submit a report of the results of the study to the county board, the county executive, and DHS by March 1, 2016.

AUDIT BY LEGISLATIVE AUDIT BUREAU

The Act directs the Legislative Audit Bureau (LAB) to perform a financial and performance evaluation audit of the MCMHB and of mental health functions, programs, and services in Milwaukee County. The audit must include a review of all of the following:

- The effectiveness of the MCMHB and new policies it implements in providing mental health services.
- The expenditures of the MCMHB.
- Milwaukee County's expenditures for mental health functions, programs, and services.
- The outcomes of Milwaukee County's mental health programs and services in the period after the formation of the MCMHB.

The LAB must complete the audit by January 1, 2017, and perform a similar audit every two years thereafter. The LAB must file a copy of the audit report with all of the following:

- The MCMHB.
- The county executive.
- The county board of supervisors.
- The chief clerk of each house of the Legislature.
- The Governor.
- The Department of Administration.
- The Legislative Reference Bureau.
- The Joint Committee on Finance.
- The Legislative Fiscal Bureau.

RECOMMENDATIONS RELATING TO CLOSING THE MILWAUKEE MENTAL HEALTH COMPLEX

The Act requires DHS to perform or arrange for an operational and programmatic audit of the behavioral health division of the Milwaukee County Department of Health and Human Services, the psychiatric hospital of the Milwaukee County Mental Health Complex, and the

related behavioral health programs. DHS may enter into a contract for the performance of the audit. The audit and a report of the findings of the audit must be completed by December 1, 2014.

The audit must include recommendations for all of the following:

- The state assuming oversight responsibility for emergency detention services and the psychiatric hospital of the Milwaukee County Mental Health Complex.
- Developing a plan for closing the Milwaukee County Mental Health Complex.
- Developing a plan for state oversight of a regional facility for the delivery of institutional, inpatient, crisis services, and behavioral health services using similar state-operated regional facilities as a model.

The audit must provide details and specifications on how, after the transitioning of the county-run institutional model to a state-based regionalized model, the state-based MCMHB will transition to a county-based board, the positions on the MCMHB will transition to a community-based focus, the funding for inpatient services and community-based services will continue, and mental health services will be delivered in a manner that reflects all of the following principles:

- Community-based, person-centered, recovery-oriented mental health systems.
- Maximizing comprehensive community-based services.
- Prioritizing access to community-based services and reducing reliance on institutional and inpatient care.
- 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.
- Providing early intervention to minimize the length and depth of psychotic and other mental health episodes.
- Diverting people experiencing mental illness from the corrections system when appropriate.
- Maximizing use of mobile crisis units and crisis intervention training.

Effective date: April 10, 2014.

Prepared by: Mary Matthias, Principal Attorney May 7, 2014

MM:jb;ty

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May 16, 2014

Initial Report on 2013 Act 203,

Establishing the Milwaukee County Mental Health Board

This report includes information and Opinions of this Office on initial questions and issues that have arisen from 2013 Wisconsin Act 203, which created the Milwaukee County Mental Health Board ("MHB"). The Act made a number of substantial changes in the way mental health services are governed, administered and funded in Milwaukee County.

Neither the list of issues addressed nor the analysis provided is intended to be exhaustive. This report is intended as a practical guide for officials, administrators and employees during the early stages of the transition to MHB governance. Some of the information in this report addresses specific questions that have been posed to this Office. As additional questions arise, they can be addressed in detail by this Office or by others.[1]

At this early stage, there are no court rulings, administrative decisions or other precedents to guide interpretation of the new statutes. The language of the Act is clear in most places but potentially ambiguous or contradictory in others. Some of the observations in this report are sure to change over time. Unions or others are likely to raise legal challenges that could affect interpretations. And MHB may have differing interpretations once seated.

[1] MHB appointments and related matters have been addressed elsewhere. In summary, 9 of MHB's initial 11 members are to be appointed by the Governor by June 9, 2014, based on suggestions from the County Executive and the County Board, with two *ex officio* members. MHB will be attached to state DHS until January 1, 2015, when it becomes a County entity.

In the meantime, mental health services – as a matter both of statutory directive and moral obligation – must be provided with "no interruption." Wis. Stat. § 51.41(12)(a). This report is intended to assist in doing so.

I. Background

The Act was passed by both houses of the Legislature in Spring 2014. It was signed by Governor Walker on April 8 and published on April 9, 2014. It became effective April 10, 2014.

The Act contains 52 sections that amend dozens of state statutes, primarily in chapters 15, 46, and 51. Some of the provisions are automatically repealed as of January 1, 2015, and replaced by other provisions of the Act. Section 53 of the Act contains non-statutory provisions that aid in interpretation, set dates, etc.

The text can be found at https://docs.legis.wisconsin.gov/2013/related/acts/203

II. As of April 10, 2014, mental health policy and function lies with MHB; the County Board has no jurisdiction over mental health.

The Act removes all mental health jurisdiction from the County Board; mental health in Milwaukee County is now under the jurisdiction of the Mental Health Board. This is stated numerous times in the Act's statutory changes:

- MHB "shall adopt the policies … regarding mental health and mental health institutions, programs, and services" in Milwaukee County. § 46.21(2)(a).
- MHB shall "[m]ake the final determination on mental health policy in Milwaukee County." § 51.41(1s)(c).
- MHB shall "[r]eplace the Milwaukee County board of supervisors in all mental health functions that are typically performed by a county board of supervisors." § 51.41(1s)(d).
- "The county board of supervisors may not form policies regarding mental health or mental health institutions, programs or services." § 46.21(2)(a).
- "The Milwaukee County board of supervisors has no jurisdiction over any mental health policy, functions, programs or services." § 51.41(5)(a).
- "The Milwaukee County board of supervisors may not create new mental health functions, programs, or services that are under the jurisdiction of the board of supervisors." § 51.41.(5)(a).

• "The Milwaukee County board has no jurisdiction and may not take any actions, including under s. 59.52(6) and (31), 66.0301, and 66.0607(2), related to mental health functions, programs and services." § 59.53(25).[2]

The County Board retains responsibility for the developmentally disabled, except where explicitly delegated to MHB. § 51.41(1)(b).

Because the Act took effect and removed County Board jurisdiction April 10, 2014, but the MHB is not likely to be seated until about July 1, 2014, there is a gap in policy governance over BHD.

BHD, under the control of the County Executive, will continue to operate its day-to-day operations in the interim (which were outside County Board purview in any event, *see* § 59.794(3)(a)("the Board may not exercise day-to-day control of any county department or subunit of a department. Such control may be exercised only by the county executive as described in s. 59.17")). Governance delegated to MHB over broader issues will be assumed by MHB when it convenes.

III. MHB jurisdiction applies to two County operational areas: Behavioral Health Division and Community Programs/Services

MHB has jurisdiction over the "functions, programs, and services that Milwaukee County included in its 2014 budget under the behavioral health division unit 6300 and under the behavioral health community services branch of unit 8700." 2013 Act 203 §53(3) (non-statutory provisions).

BHD (6300) includes:

-Management and support services
-Adult Crisis Services
-Inpatient Services (Adult & Children)
-Inpatient (Rehab Central)
-Inpatient (Hilltop)

The 2014 Adopted Budget has $78.4 million in expenditures, a tax levy of $47.2 million, revenues of $31.2 million, and 525 FTE.

Behavioral Health Community Services Branch (8700) includes:

-Adult Day Treatment
-AODA (detox, outpatient, medication assisted treatment)
-Family Intervention Support Services
-CATC Wraparound and non-court-ordered Wraparound
-Mobile Urgent Treatment

[2] As to the statutes referenced in § 59.53(25), § 59.52(6) deals with acquisition of property, § 59.52(31) deals with contract review and approvals post-Act 14, § 66.0301 deals with intergovernmental agreements, and § 66.067(2) deals with disbursements from the treasury.

The 2014 Budget has $101.4 million expenditures, a tax levy of $10.3 million, revenues of $91.1 million, and100 FTE.

Totals for the two units as shown in the adopted 2014 budget:

- **$179.8 million expenditures**
- **$57.5 million tax levy**
- **$122.3 million revenues**
- **625 FTE, including 753 individuals**

Until January 1, 2015, with the approval of the state DHS Secretary, MHB may transfer to itself jurisdiction over any other Milwaukee County function, service, or program that pertains to mental health or is highly integrated with mental health services and that is not already under its jurisdiction. § 51.41(5)(b). Starting January 1, 2015, such new jurisdiction may be claimed by MHB with the concurrence of the County Board. § 51.41(5)(b).

IV. MHB has substantial duties and powers

MHB shall "oversee the provision of mental health programs and services in Milwaukee County," budget and allocate monies for them, and attempt to achieve cost savings. § 51.41(1s). MHB must commit to certain treatment concepts, such as community-based services and early intervention. *Id.*

MHB "has the primary responsibility for the well-being, treatment and care of the mentally ill, alcoholic, and other drug dependent citizens residing within Milwaukee County, including emergency services they need. § 51.42(1)(b).

MHB (rather than County Board) is now responsible for an annual cash reserve contribution of 2% of original cost or appraised value of buildings of "existing mental health infirmary structures and equipment." § 46.18(13).

MHB is to meet six times a year and may also meet at the call of its chair or a majority of its members. § 51.41(3). MHB must hold an annual public hearing. § 51.41(3).

As a unit of local government, *see* § 19.42(7w)(e), MHB is subject to public records and open meetings laws.

V. Directors, appointments, duties.

The County Executive appoints the county DHS director as Community Programs director. § 51.42(6m). "Community Programs" in this context is broader than budget unit 8700 and includes essentially all of BHD (unit 6300) as well.

The County Executive nominates the BHD administrator, and sets the salary, benefits and job duties. § 54.41(9). *But see* § 46.21(3) (MHB determines the mental

health administrative and executive powers to be placed under the jurisdiction of the BHD administrator). The nomination is subject to MHB confirmation. *Id.*

The Executive also appoints, subject to MHB confirmation, a transition liaison to serve up to 12 months. § 54.41(11). The County Board cannot hire or remove the transition liaison or change salary or duties. *Id.*

The County DHS director, in his or her role as Community Programs director, has substantial oversight over federally or state funded inpatient and outpatient care and treatment, residential facilities, partial hospitalization, emergency care and supportive transitional services. *See* § 51.42(ar)4.

MHB may also (but is not required to) delegate mental health functions to the county DHS director. § 46.21(3).[3]

VI. Mental health personnel now are now under the control of MHB, the County Executive and mental health administrators, and are not governed by general County ordinance.

Summary: Either specifically or as part of the overall authority and structure of Act 203, control over personnel who work in MHB programs is exercised by MHB or by mental health administrators including the county DHS director, the BHD administrator and the County Executive or their delegates. This includes setting salaries and work conditions. The lone collective bargaining agreement, with the nurses' union, continues in force until it expires at the end of 2014. Under Act 10, it deals only with wages. Any replacement contract will go to MHB, not the County Board, for approval.

General County ordinances such as "status quo," minimum wage provisions, and wage and salary scales will not apply to mental health employees unless MHB or Mental Health Administrators choose to adopt them or to apply them in the interim.

The Civil Service Commission, rather than the Commission's Personnel Review Board, will hear appeals of terminations and disciplines directly.

A. Wages, working conditions

The Community Programs director (DHS director) is required by statute to "Establish salaries and personnel policies of the programs of the county department of community programs," subject only to County Executive and MHB approval. § 51.42(6m)(i).

This appears to cover most mental health employees. Any remaining employees would be covered by § 46.19(4), which specifies that "the salaries of any visiting

[3] Much of the statutory language in Ch. 46, dealing with county hospitals and other institutions, lay dormant in Milwaukee County, apparently for decades. Nonetheless, Act 203 amended many Ch. 46 provisions, stating that MHB shall now perform such functions as naming "trustees" who shall name a "superintendent" for an "institution" that, at least under a plain reading of the statute, includes the BHD residential, acute and emergency treatment units. *See* §§ 4.18(1), 46.19, 51.08. On the one hand, this could be seen a source of additional authority for MHB and the mental health administrators. On the other hand, this assumes meaning for language that has been ignored for decades.

physician and necessary additional officers and employees whose duties are related to mental health shall be fixed by the county executive."[4]

Given the definitions included in § 53(3) of Act 203 (non-statutory provisions), these personnel provisions apply to employees in the 6300 and 8700 budget units, not to employees elsewhere in the County who may be peripherally related to mental health, e.g., an employee in the Comptroller's office who handles mental health accounts.

As noted, the County Board "has no jurisdiction and may not take any actions … related to mental health functions, programs and services." § 59.53(25). In addition, the mental health budget is now under the control of MHB and the County Executive, with no control or approval of the County Board. *See* Sec. VII, *below*. In the face of these statutory directives, the County Board has no means to impose the provisions of general personnel ordinances on mental health employees, including the numerous Ch. 17 ordinances that concern matters ranging from position classification and advancement to salary structures and benefits. Likewise, no jurisdiction exists for the County Board to apply the "status quo" ordinances in sections 17.015 to 17.018 to mental health workers, nor to apply the minimum wage ordinances in Ch. 111.

Admittedly, questions here remain under study, for example application of existing County benefit and pension programs to mental health workers absent any direction to the contrary by MHB. Additional information on labor relations issues also could be required if the courts modify the implementation of Act 10.

B. No change was made in the indemnification requirements of § 895.46

§ 895.46 provides that a judgment entered against a public official or government employee because of acts committed while acting within the scope of his or her employment must be paid by the official's or employee's employer, i.e., Milwaukee County. This provision was not amended by Act 203 to account for MHB. Thus any such judgments will remain a general obligation of the County, as now.

C. Mental health employees remain subject to the Civil Service System, administered for MHB by the County Human Resources department.

General employment provisions found in the state civil service and public employee statutes will continue to apply to MHB and the mental health employees. *See , e.g.,* § 46.19(3), applying the civil service system explicitly to employees who are "remove[d]"from a BHD or other institution; *see also* § 63.03(1), establishing civil service for "all office and positions in the public service in the county;" *see also generally* §§ 63.01-63.17, Stats., establishing Civil Service Commission for Milwaukee County.

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[4] Some potential ambiguities can be identified. For example, §§ 59.60(10) and 63.11 of the statutes provide general position-creation and salary setting powers to the County Board under its "organizational" and civil service powers. However, under standard rules of statutory construction, the newer, specific MHB provisions most likely would be interpreted by a court as trumping those older, general provisions. And the BHD director is authorized to "appoint" necessary employees, signifying also the ability to appoint employees to new positions.

The civil service procedures require the appointing authority to fill vacancies through an eligible list process (§§ 63.05, 63.08) and observe temporary appointment limits (§ 63.07), as assisted by the county personnel director. Given the County Board's lack of jurisdiction over mental health, § 51.45(5)(a), and MHB's authority to replace the County Board in all mental health functions, § 51.41(1s)(d), and MHB's budget authority, *see below*, MHB becomes the appointing authority.

D. Appeals of terminations, demotions and appealable suspensions will be heard by the Civil Service Commission, not the Personnel Review Board.

The County Board created the Personnel Review Board in 1978 to assist the Civil Service Commission by hearing civil service appeals. The Board relied on an interpretation of home rule and similar powers contained in § 59.03 (originally enacted as § 59.025) and under the powers granted to the County Board in § 59.15(2)(a) "as to any … commission, position or employee in county service…." *See* MCO 33.01, invoking provisions of Ch. 118, Laws of 1973. However, Act 203 expressly precludes County Board jurisdiction over any mental health function, § 51.45(5)(a), and expressly grants MHB the authority to replace the County Board in all mental health functions, § 51.41(1s)(d). The County Board's creation of PRB to hear employment appeals no longer applies to mental health workers in budget units 6300 and 8700.

Instead, appeals will be heard by the Civil Service Commission under the procedures set out in § 63.10, Stats. These will include appeals of: demotion, discharge, suspensions of more than 10 days, or more than two suspensions of any length within 6 months. § 63.10(a). Neither the appointing authority nor the employee has a right to counsel, although the commission has the discretion to allow counsel.

An administrative appeal process can provide a grievance procedure consistent with § 66.0509(1m) for other matters.

The Civil Service Commission has five members. It appears nothing in the statutes technically would prevent the commission from deciding to meet in panels of three (still a quorum) to hear appeals, if that proved an expedient way to hear more appeals. However, only a unanimous vote of a panel of three (majority of the commission) could grant an employee's appeal, raising certain due process issues.

As to pending appeals arising from incidents on April 10 or later that have not been heard by the Civil Service Commission within the 21-day statutory limit, § 63.10(2), it may be that jurisdiction to challenge those appeals has been lost.

E. Mental health workers could unionize.

Mental health workers would have the ability to form and certify a union to exercise the limited collective bargaining powers available to public employees under Act 10, mainly wage negotiation. Negotiations would be conducted with the Executive Office. § 59.17(2)b.1. As a mental health contract, the collective bargaining agreement would be approved by MHB, not by the County Board. Funds required for higher salaries under a collective bargaining agreement would need to be found by MHB within the mental health budget.

VII. The Milwaukee County mental health budget is set by the Executive and MHB, with the budgeted tax revenue levied by the County Board. § 51.41(4).

A. Budget process

1. MHB proposes the total mental health budget, the proposed tax levy and the community aids amount. The proposed levy must be $53 million to $65 million, unless an allotment is added for new programs. § 51.41(4)(b).

2. The Executive may include in his/her proposed County budget a different levy amount, but still from $53 million to $65 million. *Id.* It is unclear how MHB would make its budget if the Executive reduced MHB's requested levy.

3. The County Board "shall incorporate into the budget for Milwaukee County" the tax levy amount proposed by the County Executive and the mental health community aids amount determined based on previous years, along with the overall mental health budget amount first proposed by MHB. *Id.*

4. MHB, the County Board and the Executive may jointly agree to a levy greater than $65 million or less than $53 million. Otherwise the levy proposed by the Executive shall be adopted.

5. The mental health levy becomes part of the overall county levy that is subject to the state-imposed levy rate limits of § 59.605(2).

The mental health levy now resembles the levy on County residents for non-elected boards including MATC, MMSD, the Wisconsin Center and SEWRPC, although those levies are not subject to the § 59.605(2) levy limit.

B. Deficits, funds

There is no provision for the County to make good a deficit if MHB falls short. MHB will need to make its own arrangements. This could include seeking a fund transfer from other County entities, which would require approval by two-thirds of the County Board and the Executive. MHB could also possibly carry a small deficit into its following year's budget, although details need to be examined further. The Comptroller has stated he may be statutorily prevented from releasing disbursements for MHB obligations if deficits are too high too early in the year.[5]

MHB is to use surpluses to finance a reserve of up to $10 million under § 51.41(4)(d).

MHB (rather than County Board) is now responsible for an annual cash reserve contribution of 2% of original cost or appraised value of buildings of "existing mental health infirmary structures and equipment." § 46.18(13).

In 2014 only, the County Board is required to provide funds for MHB's board expenses. § 51.41(6) ("payment of expenses of the [MHB] and for the performance of the audit and the completion of the report" required by Act § 53(4).)

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[5] Statutory obligations imposed on the Comptroller are complex and, as they may relate to MHB, are beyond the scope of this report.

C. Bonding

MHB does not have any direct bonding authority, and, from a lender's perspective may not have any guaranteed future source from which to repay bonds other than its annual operating levy. Capital projects could be paid from current operating revenues. Only if the County Board offered to make its authority available could MHB projects be bonded through the County.

D. MHB determines the "manner" of mental health disbursements.

Under § 46.21(6), "Disbursements shall be made in the manner that the … Milwaukee County mental health Board… adopts." The methods of disbursements adopted by MHB must be "consistent with sound accounting and auditing procedure and with applicable federal statutes and regulations, state statutes and rules and requirements of the county auditor and county department of administration," but need not necessarily be controlled by those entities. § 46.21(6).

MHB may place "administrative and executive powers and duties of managing, operating, maintaining and improving institutions and departments," including "functions related to the central service departments," under the jurisdiction of other county entities. § 46.21(3r).

This allows but does not require MHB to use other county services or departments if desired (facilities, IMSD, HR, financial and purchasing services, comptroller, etc.). While MHB can seek services from County departments, the intent of the legislation should be seen as preventing MHB from requiring County departments to make changes in operations at MHB's request. A provision to that effect was introduced but then eliminated by amendment. See Sen. Am. 1 to Sen. Sub. Am. 1, § 15.

County departments will cross-charge MHB for services, as they do now. MHB is not required to use these County "vendors" (unless there are statutory requirements, such as using the Comptroller for certain funds or HR for civil service processing). MHB could seek outside services if it felt cross-charges were too high. There do not appear to be limitations on MHB's ability to outsource services or personnel.

MHB's budget and spending authority extends to creating or eliminating positions as it sees fit, consistent with civil service rules.

Since MHB has control over mental health issues, MHB would be empowered to receive additional funds through grants, etc., that could be applied to expenditures over which MHB has control.

"The County Board may not sell the county mental health complex … without approval of the Milwaukee County mental health board." § 51.08.

VIII. MHB has the approval authority for mental health contracts and disbursements in Milwaukee County. § 51.41(10).

Contracts of more than $100,000 related to mental health to which Milwaukee County is a party take effect only if approved by MHB or if MHB does not vote to reject the contract within 28 days after it is signed and presented. § 51.41(10). The county executive is to countersign mental health contracts. *Id.*

Because these are, by statutory definition, "Contracts … to which Milwaukee County is a party," § 51.41.(10), comptroller and corporation counsel signatures are statutorily required. See § 59.42(2)(b); 59.255(2)(e).

The County Board is specifically barred from considering mental health contracts. "The county board of supervisors may not exercise approval or disapproval power over any contract relating to mental health or mental health institutions, programs, or services." § 46.21(2)(j). Moreover, Milwaukee County cannot use central its central purchasing department for "matters that are related to mental health." § 46.21(2)(j). The Milwaukee County Board may not take any mental health-related actions under the general contract review provisions of § 59.52(31) or the intergovernmental agreements provisions of § 66.0301. *See* § 59.53(25).

Because the County Board has no authority over mental health contracts, the bid, RFP, purchasing and appeal procedures found in MCO Chs. 32, 44, 56 and 110 will not apply to mental health contracts.

MHB approves the annual state DHS contract. The state submits the contract to MHB, and MHB "shall approve the contract before January 1 of the year in which it takes effect unless the [state] department grants an extension." § 46.031(2g)(a). MHB "may appropriate funds not used to match state funds under ss. 46.495(1)(d) and 51.423." § 46.031(2g)(b).

The Community Programs director, with the approval of MHB, provides or contracts for the Community Programs services relating to mental health. § 51.42(6m)(c).

IX. Reporting.

The state is to perform an audit by December 1, 2014, that includes recommendations for the state assuming oversight responsibility for emergency detention services and the psychiatric hospital of the Milwaukee County Mental Health Complex, developing a plan for closing the Milwaukee County Mental Health Complex, and developing a plan for state oversight of a regional facility for institutional, impatient, crisis and behavioral health services, among other things. Act 203 § 53(4).

MHB reports annually by March 1 to the State, the Executive, the County Board and the public on its programs, improvements and efficiencies. § 51.48(8)(a).

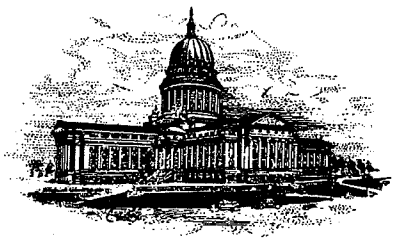
By March 1, 2016, MHB is to report to the state, the Executive and the County Board on alternate funding sources for mental health services and programs. § 51.41.(8)(b).

The county DHS and BHD directors report annually on matters of mental health to MHB. § 46.21(6).

The County Board may request informational reports on mental health matters from the DHS director or the County Executive. § 59.794(3)(b).

Respectfully submitted,

Paul Bargren
Corporation Counsel



Wisconsin State Assembly

P.O. BOX 8952 • MADISON, WI 53708

TO: SPEAKER ROBIN VOS

FROM: The Speaker's Task Force on Mental Health

RE: Report of the Speaker's Task Force on Mental Health

DATE: October 9, 2013

This report contains the recommendations of the Speaker's Task Force on Mental Health. The Task Force was established on February 6, 2013 by Speaker Vos and charged with:

- Eliminating barriers to treatment, and promoting early and voluntary intervention for juveniles and adults in need of mental health services.
- Improving coordination of care among those who treat people with mental illness.
- Increasing awareness and reducing the stigma that often accompanies mental health diagnoses.
- Identifying and promoting best practices for addressing the link between mental illness and substance dependence and abuse.
- Addressing mental illness in the prison population.

Appendix 1 lists the members of the Task Force. The recommendations in this report are based on testimony received by the Task Force at meetings and public hearings that it held throughout the state. The Task Force met and held hearings on the following dates, at the locations indicated:

February 27, 2013: Madison

March 27, 2013: Neenah

April 18, 2013: Milwaukee

May 9, 2013: Balsam Lake

July 23, 2013: Madison

Several of the recommendations contained in this report were initially developed by the Legislative Council's Special Committee on Review of Emergency Detention and Admission of Minors Under Chapter 51, hereafter referred to as the Special Committee, which was

comprised of both legislators and public members. The Special Committee held eight meetings between August 2010 and October 2012, and developed the following four bills which were introduced by the Joint Legislative Council on April 3, 2013:

- 2013 Senate Bill 125, relating to disabled offender recidivism reduction pilot programs.
- 2013 Senate Bill 126, relating to admission of minors for inpatient treatment.
- 2013 Senate Bill 127, relating to emergency detention, involuntary commitment, and privileged communications and information.
- 2013 Senate Bill 128, relating to requiring county community programs board appointees to include consumers and their family members, law enforcement personnel, and hospital employees or representatives, and increasing the size of county community programs boards.

These bills have been referred to the Senate Health and Human Services Committee. Additional information on these bills may be found in Joint Legislative Council Report 2013-04, "Joint Legislative Council's Report of the Special Committee on Review of Emergency Detention and Admission of Minors Under Chapter 51", dated April 5, 2013. The report is available online at: http://www.legis.wisconsin.gov/lc.

This report is organized by the following topics:

2013 SENATE BILLS 125, 126, 127, AND 128

Background

As described above, four drafts relating to various mental health topics were developed by the Joint Legislative Council's Special Committee on Review of Emergency Detention and Admission of Minors Under Chapter 51. Following Joint Legislative Council custom, these drafts were introduced by the Joint Legislative Council as Senate bills because the chair of the Special Committee was a member of the Senate.

Recommendation

Introduce Assembly versions of Senate Bills 125, 126, 127, and 128.

HOSPITAL DIVERSION, EMERGENCY DETENTION, AND CIVIL COMMITMENT

Establish and Train Crisis Intervention and Mobile Crisis Teams

Background

Several individuals provided testimony to the Task Force in support of expanded crisis intervention teams and mobile crisis teams. Crisis intervention teams (CIT's) are comprised of law enforcement officers who are specially trained in responding to individuals with mental health issues who are acting out in the community. Mobile crisis teams typically include mental health professionals such as nurses, social workers, psychologists, peer counselors, and addiction specialists. One CIT model, the Memphis Model, provides a 40-hour course for law enforcement officers to inform officers about mental illness, recognize symptoms, and utilize nonviolent de-escalation techniques to reduce the possibility for harm to the individual, the officer, and the community. Wisconsin counties that have implemented CIT include Milwaukee, Brown, Winnebago, and Racine.

Recommendations

- Provide grants for CIT trainings throughout the state and within the Department of Corrections (DOC).
- Provide matching funds to counties to establish mobile crisis teams to serve individuals in mental health crisis in rural areas.

Provide Funding and Support for Peer-Run Respite Centers

The Task Force heard testimony that peer-run respite centers are an effective alternative to detention or hospitalization for certain individuals experiencing a mental health crisis. In other states that have implemented this alternative, peer-run respite centers are usually community-based residential facilities (CBRFs) with beds available to people in a mental health or substance abuse crisis situation, with services provided by staff who have

successfully participated in mental health or substance abuse recovery or treatment programs. There is no requirement that peer-run respite centers be licensed as CBRFs.

2013 Wisconsin Act 20 (the 2013-14 Biennial Budget Act), provides $64,600 in 2013-14 and $1,282,700 in 2014-15 and 1.0 position, beginning in 2013-14, to distribute grants to regional peer-run respite centers for people with mental health or substance abuse concerns, with the goal of improving crisis treatment and reducing inpatient hospitalizations. The funding will support: (1) three regional peer-run centers, beginning in 2014-15, each with an annual allocation of $400,000; and (2) 1.0 position to administer the program ($64,600 in 2013-14 and $82,700 in 2014-15).

Recommendation

Provide matching funds, in addition to the funds provided in Act 20, to counties to enter into contracts with peer-run organizations to pilot peer-run respite services.

Study on Utilization of Certified Peer Specialists

Background

A certified peer specialist is an individual who has lived with mental illness and has also had formal training in the peer specialist model of providing support to individuals with mental illness. To become certified as a peer specialist in Wisconsin, an individual must attend a week-long training session and pass an exam. The training is offered through the University of Wisconsin-Milwaukee School of Continuing Education. A peer specialist must also complete specified continuing education requirements to maintain their certification. Currently, Wisconsin has 253 certified peer specialists, and there will be an estimated 100 additional individuals who will become certified peer specialists in Wisconsin.

According to testimony provided to the Task Force, national statistics show that individuals working with a certified peer specialist show an average of a 40% reduction in hospital stays and crisis events within one year, and remain in recovery longer.

Recommendation

Commission a study to determine how health care providers and systems can best utilize and collaborate with certified peer specialists in various settings.

Modify the "24-Hour Rule" for Emergency Detentions in Milwaukee County

Background

Current law provides different procedures for emergency detention in counties with a population of 500,000 or more (currently, only Milwaukee County) and those with a population of less than 500,000. In counties with a population of 500,000 or more, the treatment director of the facility in which the person is detained, or his or her designee, must determine within 24 hours whether the person is to be detained. If the individual is detained,

the treatment director or designee may supplement in writing the statement filed by the law enforcement officer or other person undertaking the emergency detention. This requirement does not apply in other counties.

Concerns have been raised with the 24-hour requirement and the difficulty in complying with this requirement when it is not possible to evaluate an individual within that time period due to physical incapacities of the individual.

Recommendation

Support the provision in Senate Bill 127 to modify the 24-hour emergency detention rule, described above, for individuals in need of nonpsychiatric stabilization before psychiatric evaluation.

This provision specifies that any time delay that is directly attributable to evaluating or stabilizing any nonpsychiatric medical conditions of the individual is excluded from the calculation of the 24-hour time period.

Request an Attorney General Opinion Regarding Several Issues Pertaining to Emergency Detention

Background

In testimony provided to the Task Force, it was stated that health care providers often perceive that they could be viewed as responsible for decisions made by law enforcement or county crisis agencies to not initiate and approve a psychiatric emergency detention for an individual who the health care provider believes is a danger to himself or herself or others.

Testimony also indicated that under the federal Emergency Medical Treatment and Active Labor Act (EMTALA), hospital emergency departments have certain obligations regarding the evaluation, stabilization, and transfer of patients, though the extent of obligation may depend on the wishes of the patient or an agent of the patient making decisions on behalf of the patient. The WHA asserted that, there has been some confusion, including among federal regulators, as to whether Wisconsin's emergency detention law is compatible with the federal EMTALA law.

Recommendation

Request an Attorney General's opinion to clarify two areas of confusion regarding psychiatric emergency detentions:

- Whether a health care provider has fulfilled his or her duty to warn regarding an individual's dangerousness, if the provider requests law enforcement to initiate an emergency detention.
- Whether a law enforcement officer with custody of an individual under an emergency detention is an agent entitled to make decisions on behalf of the

individual under Wisconsin law. If so, clarify which decisions about the individual's evaluation, stabilization, or transfer in or from the emergency department must be made by the individual rather than the law enforcement officer with custody.

Expand Authority to Initiate Emergency Detention to Additional Parties

Background

Under current law, in counties with a population under 500,000, a law enforcement officer must sign the statement of emergency detention, which must provide detailed specific information concerning the recent overt act, attempt, or threat to act or omission which forms the basis for the detention, and the names of persons observing or reporting the recent overt act, attempt, or threat to act or omission. [s. 51.15 (5), Stats.] In addition, in Milwaukee County, the facility treatment director (or designee) must determine, within 24 hours of the subject being taken in to custody, that the individual must be detained. [s. 51.15 (4), Stats.]

In addition, in all counties, the county department of community programs in the county in which the individual was taken into custody must approve the need for detention. [s. 51.15 (2) (intro.), Stats.]

Recommendation

- Create a way for interested parties to formally request that a county initiate an emergency detention or to petition a judge to order an emergency detention if a county will not proceed.
- Establish a pilot program in Milwaukee County to expand the authority to initiate emergency detentions to designated mental health professionals. Sunset the pilot program after two years and require an evaluation of the program to be conducted including a recommendation as to whether this authority should be expanded statewide.

MENTAL HEALTH CARE AND TREATMENT FOR MINORS

Establish a Pediatric Telephone Consultation Line

Background

Pediatric primary care physicians are the main providers of health care, including mental health care, to children in Wisconsin. Testimony provided to the Task Force indicated that, according to the American Academy of Pediatrics, 13% of school aged children and 10% of preschool children in the United States have parents expressing concerns about their children's behavior or mental health. Wisconsin primary care clinicians have expressed the desire for additional support from child psychiatrists. According to testimony provided to the Task Force, this support is difficult to provide in person, since in 2009, most counties had

fewer than four child and adolescent psychiatrists, and many counties had none. Massachusetts and Minnesota have provided $3 million and $1 million per year, respectively, to fund pediatric telephone consultation lines to facilitate consultation between primary care physicians and psychiatrists.

Recommendation

Support a program that provides a pediatric telephone consultation line to allow primary care physicians to have access to consultation with child and adolescent psychiatrists and an access coordinator to facilitate referrals to community resources.

Facilitate the Provision of Mental Health Services in Schools

Background

Testimony received by the Task Force indicated that DHS currently requires mental health outpatient clinics to obtain branch office certification in order for clinic staff to provide therapy to children in a school setting. This requirement creates extra work and licensing fees that are unnecessary to protect consumers.

Testimony also indicated that due to the shortage of mental health professionals in most of the state, it is difficult to find licensed therapists willing to travel to multiple schools to work with children. Masters-degreed therapists who are gathering hours towards licensure (referred to as qualified treatment trainees) are willing to take these positions, but MA HMOs and private insurers nearly always refuse to pay for the services of these individuals.

The Task Force also heard testimony that some providers have a consultation meeting with parents to discuss treatment needs and options before therapy with a child is started. Providers using this approach have no mechanism to bill Medicaid for this meeting. While the meeting is clearly related to the child's treatment and in the child's best interest, it does not fit neatly into a diagnosis code. A non-diagnostic "V" code would create a mechanism to bill for this time that allows for parent engagement in the process and sound planning for the treatment to follow.

Recommendations

- Modify s. DHS 35.07, Wis. Adm. Code, to allow mental health services to children in a school setting without requiring clinic branch office certification for the school setting.
- Require MA HMOs to pay for the services of qualified treatment trainees.
- Require DHS to develop a MA payment mechanism to support mental health consultation.

Modify Statutes Governing Inpatient Mental Health Treatment of Minors

Background

Under current law, s. 51.13, Stats., governs inpatient mental health treatment of minors. Testimony provided to the Special Committee indicated that, in some areas of the state, there is little awareness of the ability of a parent of a minor age 14 or older to obtain treatment for the minor even if the minor does not want treatment. In some cases, this lack of awareness has resulted in the failure to provide treatment that could have prevented harm to a minor.

Recommendation

Support the passage of 2013 Senate Bill 126, relating to mental health treatment of minors, which was created by the Special Committee. The bill, which streamlines some of the procedures in s. 51.13, Stats., does all of the following:

- Eliminates the need to file a petition for review of an admission of a minor under age 14 for treatment of mental illness, alcoholism or drug abuse, or developmental disability. Because under current law, parents have the authority to consent to inpatient admission for minors under age 14 without the minor joining in the petition, the committee determined that the petition and hearing requirements in current law for minors under age 14 are unnecessary and should be eliminated. A petition would still be required if the minor wanted treatment but the parent refuses; if a parent with legal custody or guardian cannot be found; or if there is no parent or guardian.

- Eliminates the need to file a petition for a minor age 14 or older who voluntarily participates in inpatient treatment for mental illness. A petition would still have to be filed if the minor age 14 to 17 refused to join in the application, or if the parent with legal custody or guardian cannot be found, or there is no parent with legal custody or guardian. A petition would also still be required if the minor wanted treatment but the parent refused. It should be noted that a minor age 14 or older may request discharge from the inpatient facility at any time. If the request is denied, current law sets forth a procedure for determining the continued appropriateness of the admission. This procedure is retained, and provides protection of the minor's rights if the minor withdraws his or her consent to the treatment.

- Eliminates the petition requirement at the expiration of the 12-day time period if the admission was voluntary on the part of the minor and the parent.

- Eliminates the provision that allows for no more than one short-term (up to 12 days) voluntary admission of a minor every 120 days.

The bill also creates subsection and paragraph titles within s. 51.13, Stats., to provide guidance to the reader regarding the subject matter of the subsections and paragraphs, and also eliminates some redundant language in s. 51.13, Stats.

JAILS AND THE CORRECTIONS SYSTEM

Expand the Treatment Alternatives and Diversion (TAD) Program

Background

Under current law, the Department of Justice (DOJ) administers a grant program which provides funds to counties to establish and operate programs that provide alternatives to prosecution and incarceration for criminal offenders who abuse alcohol or other drugs. These include suspended and deferred prosecution programs and programs based on principles of restorative justice. [s. 165.95, Stats.]

There are currently nine counties receiving funding under the program: Ashland, Bayfield, Burnett, Dane, Milwaukee, Rock, Washburn, Washington, and Wood. In addition to the ongoing funding for the current projects, the 2013-14 Biennial Budget Act provided $1 million for grants for new projects in counties that do not currently have a TAD program. Applications for new projects are due in October 2013. Projects will be funded for the 2014 calendar year, and projects that continue to meet program requirements may reapply for funding through December 31, 2016.

A county receiving grant funds must provide matching funds that are equal to 25% of the amount of the grant.

A county is eligible for a grant if all of the following apply:

- The program is designed to meet the needs of a person who abuses alcohol or other drugs and who may be or has been charged with or who has been convicted of a crime related to the person's use or abuse of alcohol or other drugs.
- The program is designed to promote public safety, reduce prison and jail populations, reduce prosecution and incarceration costs, reduce recidivism, and improve the welfare of participants' families by meeting the comprehensive needs of participants.
- The program establishes eligibility criteria for participation and specifies that a violent offender is not eligible to participate.
- Services provided are consistent with evidence-based practices in substance abuse and mental health treatment, as determined by DHS, and the program provides intensive case management.
- The program uses graduated sanctions and incentives to promote successful substance abuse treatment.

- The program provides holistic treatment to its participants and provides them services that may be needed, to eliminate or reduce their use of alcohol or other drugs, improve their mental health, facilitate their gainful employment or enhanced education or training, provide them stable housing, facilitate family reunification, ensure payment of child support, and increase the payment of other court-ordered obligations.

- The program is designed to integrate all mental health services provided to program participants by state and local government agencies and other organizations. The program must require regular communication among a participant's substance abuse treatment providers, other service providers, the case manager, and any person designated under the program to monitor the person's compliance with his or her obligations under the program and any probation, extended supervision, and parole agent assigned to the participant.

- The program provides substance abuse and mental health treatment services through providers that are certified by DHS.

- The program requires participants to pay a reasonable amount for their treatment, based on their income and available assets, and pursues and uses all possible resources available through insurance and federal, state, and local aid programs, including cash, vouchers, and direct services.

- The program is developed with input from, and implemented in collaboration with, one or more circuit court judges, the district attorney, the state public defender, local law enforcement officials, county agencies responsible for providing social services, including services relating to alcohol and other drug addiction, child welfare, mental health, and the Wisconsin Works program, DOC, Children and Families, and DHS, private social services agencies, and substance abuse treatment providers.

- The county complies with other eligibility requirements established by DOJ.

On December 22, 2011, the Office of Justice Assistance (OJA), in collaboration with DOC and DHS, submitted a report to the Legislature identifying savings generated through implementation of the TAD program. The Executive Director of OJA summarized the report as finding that "TAD projects effectively divert non-violent offenders with substance abuse treatment needs from incarceration thereby avoiding costs associated with incarceration." Specifically, the report concluded, based on five years of program data, that the seven funded TAD projects generated $1.93 of savings in the form of reduced incarceration and reduced future crime for every $1.00 spent.

Recommendation

Provide funding to expand the TAD program to include offenders with mental health and co-occuring disorders. The funding should be used to support the development of new

county or regional TAD diversion and treatment court programs designed to work with this population.

Establish a Pilot Program to Assist Former Jail Inmates to Obtain Benefits

Background

Among the population of incarcerated individuals in Wisconsin, offenders who, upon release from incarceration, are eligible for but who fail to obtain certain benefits such as SSDI, SSI, or MA are particularly at risk of recidivism. There is often a gap between an offender's date of release and the date that he or she begins to receive benefits for which he or she is eligible. During this period, an offender may be at higher risk of recidivism.

DOC has taken significant steps to address this issue among Wisconsin's prison population. In the last several years, DOC has secured funding for a program to provide individualized assistance to prisoners in 14 Wisconsin prisons in obtaining benefits for which they are eligible as of release. The program is known as the Disabled Offender Economic Security (DOES) project. It is administered through DOC, via a contract with Legal Action of Wisconsin, in collaboration with DHS. DOC considers the program a success and has expressed an interest in continuing the program and eventually expanding it to prisoners across the state.

Thus far, efforts to address this issue in Wisconsin have been limited to offenders housed in prisons. No similar form of individualized assistance is currently available to offenders housed in county correctional facilities (i.e., county jails, houses of correction, and rehabilitation facilities). The committee concluded that replicating DOES at a county level would help reduce recidivism and potentially save county funding.

Recommendation

Streamline the MA application process for released offenders, such as proposed in the pilot program in 2013 Senate Bill 125, developed by the Special Committee. That bill creates a pilot program at a small number of county correctional facilities to provide individualized assistance to eligible offenders in obtaining SSDI, SSI, or MA, including any applicable MA-related program, upon release.

The bill directs the OJA to seek funding for the pilot program and, after at least $300,000 in funding has been obtained, to make grants to up to four counties to administer the pilot program. Participating counties must operate the pilot program for at least two years and include performance outcome measurements and data collection to allow for program evaluation. The counties must create an oversight committee to advise the county in administering and evaluating the pilot program. The bill provides that DOC and DHS may participate in the activities of the oversight committee and must provide consultation services to the oversight committee.

In addition to the basic program requirements set forth in the statutes, the bill allows OJA to establish additional eligibility requirements, criteria, and procedures that a county must meet in order to be eligible for the program. The bill expressly provides that OJA is not required to promulgate administrative rules in establishing criteria for the grant program.

MEDICAL ASSISTANCE (MA)

Simplify MA Prior Authorization Requirements for Mental Health Therapy

Background

Under current DHS policy, prior authorization is required before mental health therapy may be provided under MA.

Recommendation

Implement changes to MA's prior authorization process to increase access to mental health therapy as follows:

- Allow children with severe emotional disturbance (SED) to access in-home therapy without requiring them to first fail at outpatient therapy.
- Allow qualifying families to participate in in-home therapy even if their child is enrolled in day treatment programs. In-home therapy with families can complement the gains that children make during the day in mental health day treatment.
- Reduce the MA outpatient prior authorization form to these elements: diagnostic criteria and symptoms, patient and provider identification, modality and frequency of treatment, goals, and discharge criteria for treatment.

Provide MA Reimbursement For Tele-Healthcare Provided by Out-Of-State Physicians

Background

Mental Health and Substance Abuse TeleHealth is generally described as the use of telecommunication equipment to link mental health and/or substance abuse providers and consumers in different locations. TeleHealth is sometimes referred to as telepsychiatry, however treatment professionals other than psychiatrists may use telehealth.

According to the DHS Community Mental Health and Substance Abuse Prevention and Treatment Block Grant Application for fiscal year 2014-15, the use of TeleHealth for mental health and substance abuse services in Wisconsin has been increasing since 2007. TeleHealth is used approximately twice as much for mental health services compared to substance abuse services. TeleHealth seems to be currently used more often for regular outpatient services and less for emergency/crisis services and psychosocial rehabilitation programs.

There were 113 TeleHealth certifications in Wisconsin in 2012 for an array of MH/AODA services. The number of providers offering TeleHealth is less than the 113 certifications as some providers are certified to provide multiple TeleHealth services.

Under current DHS policy, MA reimbursement for TeleHealth is provided only for services provided by professional staff who are affiliated with a program that is certified under one of the following chapters: DHS 34, Emergency Mental Health Service Programs; DHS 36, Comprehensive Community Services Programs; DHS 40, Mental Health Day Treatment Services For Children; DHS 61, Community Mental Health and Developmental Disabilities; DHS 63, Community Support Programs for Chronically Mentally Ill Persons; or DHS 75, Community Substance Abuse Services, Wis. Adm. Code.

Recommendation

Allow MA reimbursement of Wisconsin-licensed physicians providing services to MA patients via telehealthcare from an out-of-state location.

HIPAA AND ELECTRONIC MEDICAL RECORDS

Background

The federal Health Insurance Portability and Accountability Act (HIPAA) law allows for broader disclosure of medical records among treatment providers than does the Wisconsin law. HIPAA law provides that if the state law provides greater privacy protections to patients than HIPAA does, the state law provisions, rather than the HIPAA provisions, apply. Therefore, Wisconsin's provisions supersede HIPAA law. Wisconsin law on the confidentiality of mental health treatment records generally provides that all treatment records must remain confidential and are privileged to the subject individual. Generally, these records may be released only to designated persons with the informed written consent of the subject individual. [s. 51.30, Stats.] In addition, the Wisconsin definition of "treatment records" does not include notes or records maintained for personal use by an individual providing treatment services for DHS, a county department, or a treatment facility, if the notes or records are not available to others. [s. 51.30 (1) (b), Stats.]

Wisconsin law permits the release of records to a health care provider, or to any person acting under the supervision of the health care provider who is involved with an individual's care, if necessary for the current treatment of the individual. However, as stated above, the information that may be released under this provision is limited to the following:

- The individual's name, address, and date of birth.
- The name of the individual's provider of services for mental illness, developmental disability, alcoholism, or drug dependence.
- The date of any of those services provided.

- The individual's medications, allergies, diagnosis, diagnostic test results, and symptoms.
- Other relevant demographic information necessary for the current treatment of the individual.

Under federal HIPAA regulation [45 C.F.R. s. 164.506], a covered entity may use or disclose protected health information for its own treatment, payment, or health care operations. In addition, a covered entity may disclose protected health information for treatment activities of a health care provider. A covered entity must obtain an authorization for any use or disclosure of psychotherapy notes. Psychotherapy notes may only be released in the following circumstances:

- Use by the originator of the psychotherapy notes for treatment.
- Use or disclosure by the covered entity for its own training programs in which students, trainees, or practitioners in mental health learn under supervision to practice or improve their skills in group, joint, family, or individual counseling.
- Use or disclosure by the covered entity to defend itself in a legal action or other proceeding brought by the individual.

Several persons testifying before the Task Force indicated that the restriction in state law on release of treatment notes or records for personal use inhibits the provision of appropriate care for someone who may enter the emergency room for emergency mental health treatment.

A memorandum to the Task Force members on this issue was prepared and distributed on April 17, 2013.

Recommendation

Enact legislation to harmonize Wisconsin law with HIPAA as needed to remove barriers to mental health care coordination. Explicitly cross-reference in state statute the federal HIPAA law rights to request privacy protection for health information. The legislation would allow health care providers and others subject to HIPAA to communicate mental health information about a patient with other health care providers and entities subject to HIPAA, if the communication is made for treatment purposes, payment purposes, or health care operations purposes, and the communication is made in compliance with HIPAA.

Direct the DHS to develop a comprehensive, accessible, and comprehendible document explaining patient privacy rights. Make the document easily accessible online and at health care facilities across the state.

PRIMARY CARE AND PSYCHIATRY SHORTAGE GRANT PROGRAM

Background

Testimony received by the Task Force proposed the establishment of a grant program to encourage primary care physicians and psychiatrists to locate in medically underserved areas of the state. Under the proposal, service-based financial assistance would be provided to a physician who graduates from a Wisconsin medical school, completes a medical residency training program in Wisconsin with a primary care or psychiatry emphasis, and practices primary care medicine or psychiatry in a medically underserved area of the state.

Enrollment in Program

Participants must sign up for the program prior to accepting an employment offer within a designated health shortage area in Wisconsin and may enroll (but may not receive grant payments) while still participating in an eligible graduate medical education (GME) training program. These GME programs include: Family Medicine; Internal Medicine; Pediatrics; Psychiatry; and General Surgery. Qualifying GME programs may be located anywhere in the state.

Practice Requirements

Following completion of a qualifying GME program, participants must begin practicing primary care medicine or psychiatry within a medically underserved area of the state. Primary care practice is defined as the following Medical Examining Board licensure codes: Family Medicine; Pediatrics; Internal Medicine; and General Surgery. The practice of psychiatry includes the following codes: Psychiatry and Child Psychiatry. Medically underserved areas are defined as Health Professional Shortage Areas (HPSA's); Medically Underserved Areas/Populations (MUA/MUP); and Governor's Designation of Shortage Areas for Rural Health Clinics.

Annual Grant Payments

Annual grant payments would be made directly to participants and would be unrestricted (i.e., they would not have to be used toward loan repayment). Eligibility would be lost if a participant leaves the shortage area or begins practicing within a nonqualifying subspecialty. There would be no repayment penalty for leaving the program early, as payments are based on previously completed service. The program would be administered by the Wisconsin Higher Educational Aids Board (HEAB). Rule-making authority would be provided to administer, track, and enforce the program.

Funding

The program would be funded with a one time, $2 million appropriation; $1 million would be used for grants directed to primary care physicians and $1 million would be directed

to psychiatrists. The number of participants would be limited to 17 primary care physicians and 17 psychiatrists that may receive annual grant payments over a three-year period.

The program would begin providing assistance to participants who complete GME training programs in calendar years 2014 and beyond. Grant assistance would be exempt from Wisconsin income tax.

Recommendation

Implement the Primary Care and Psychiatry Shortage Grant Program, a service-based, tuition assistance program designed to increase the number of medical students who enter primary care medicine and practice and stay in medically underserved areas of the state.

CERTIFICATION OF OUTPATIENT MENTAL HEALTH CLINICS

Background

Under current law, outpatient mental health clinics must be certified under ch. DHS 35, Wis, Adm. Code. Testimony received by the Task Force indicated that some of these clinics are also required to meet standards for accreditation by the Accreditation Association for Ambulatory Health Care in order to be eligible to participate in the MA or Medicare programs.

Recommendations

- Determine whether ch. DHS 35, Wis. Adm. Code, certification should be required for an organization that is accredited by the Accreditation Association for Ambulatory Health Care.
- Review ch. DHS 35, Wis. Adm. Code, which regulates outpatient mental health clinics, as part of the Assembly's "Right the Rules" project.

MENTAL HEALTH SERVICES PROVIDED BY COUNTIES

Require Consumer Members on Community Programs Boards

Background

Under current law, county departments of community programs are run by "county community programs boards", which are governing and policy-making boards comprised of members of the county board of supervisors and citizen members. [s. 51.42 (4) (b), Stats.]

In a single-county department, the community programs board must be composed of nine to 15 members. Members must have a recognized ability and demonstrated interest in the problems of mentally ill, developmentally disabled, alcoholic, or drug dependent persons and must have representation from interest groups of all of the following: the mentally ill, the developmentally disabled, alcoholics, and the drug dependent. At least one member must be either a consumer of services or a family member of a consumer. No more than five members may be members of a county board of supervisor.

In a multi-county department, the board is composed of 11 members, with three additional members for each county in excess of two counties that are in a multi-county department of community programs. A multi-county department board must have representation from the same interest groups as a single-county department board and at least one member must be a consumer of services or a family member of a consumer. Each of the counties in the multi-county department of community programs may appoint not more than three members from its county board of supervisors.

Recommendation

Support the adoption of 2013 Senate Bill 128, developed by the Special Committee, which requires county community programs boards to include consumers, family members of consumers, law enforcement personnel, and hospital employees or representatives, and increases the size of county community programs boards.

The bill retains the interest group representation requirements and the family member of a consumer requirement, and, in addition, requires at least one of the members appointed to a single- or multi-county community programs board to be each of the following:

- A person who has received services for mental illness, developmental disability, alcoholism, or drug dependence.
- A law enforcement officer.
- A hospital employee or representative.

The maximum number of members for a single-county department is accordingly increased to 17. The number of members for a multi-county department is increased to 13, with three additional members for each county in the multi-county department in excess of two.

The bill also revises the references to interest group representatives who must serve on the boards.

Require a Report on the Department of Health Services (DHS) Regional Mental Health Services Pilot Projects

Background

In September 2009, DHS issued the "Wisconsin Public Mental Health and Substance Abuse Infrastructure Study," which reviewed the funding and delivery of public mental health and substance abuse services in Wisconsin and other states. The study also identified models and pathways for system reform.

From this study, a shared-services regionalization pilot grant program was developed and awarded in the Summer of 2012. The Request for Proposals stated that the pilot programs

are expected to serve as models for the future administration and delivery of mental health and substance abuse services.

Grants were awarded to two multi-county consortia which are each piloting three-year demonstration projects that use shared public services across organizations or in multi-county regional networks. The two consortia are the Western Region Recovery and Wellness Consortium (WRRWC) and the Western Region Integrated Care (WRIC) Consortium. These consortia, both located in the western part of Wisconsin, encompass both urban and rural populations. Each plans to carry out extensive needs assessments and involve multiple stakeholders in program redesign. The redesign seeks to increase "core benefit" access for consumers, and increase administrative efficiencies, including moving toward shared information technology infrastructure in the regions.

Recommendation

Request DHS to report to the Legislature its interim findings of the regional pilots for mental health and substance abuse services and, by January 1, 2015, make recommendations to the Legislature for expanding the pilot statewide.

Require a Legislative Council Study on the Iowa Regional Public Health System

Background

In July, 2011 legislation was enacted in Iowa which initiated a redesign of the Iowa mental health system. Previously, the mental health system was county-based, with each county responsible for providing mental health services. The legislation directed the state department of health services to appoint and lead workgroups to recommend steps to transition to a regional system.

Since that time, workgroups have met to analyze numerous issues relating to the transition and develop recommendations for the implementation of the reorganization. Several pieces of legislation have been enacted to facilitate the transition, including legislation that identifies required core services, provides for the establishment of service regions, and revises property tax provisions.

Special Committees are established by the Joint Legislative Council to examine major issues and problems identified by the Legislature. During the summer and fall interim of each even-numbered year, the Legislative Council selects a number of subjects for study from suggestions submitted by members of the Legislature. Often these topics are issues that are difficult to resolve in the regular course of legislative business or that legislators feel require further consideration prior to the introduction of legislation.

Special Committees are chaired by legislators and are comprised of legislative and public members with expertise or interest in the issue under study by the committee. Each committee is charged by the Legislative Council to study their issue and recommend legislative solutions as needed. Special Committees generally meet from three to six times

during the interim and ultimately report their recommendations, in the form of bill drafts, to the full Joint Legislative Council for approval and introduction in the next legislative session.

Recommendation

- Request the Legislative Council to study Iowa's recent transition from a county-based to a regional public mental health system.

Require Counties to Report Which Mental Health Services They Provide

Background

Current law specifies the services that county departments of community programs must provide, within the limits of available state and federal funds and of county funds required to be appropriated to match state funds, for the program needs of persons suffering from mental disabilities, including mental illness, developmental disabilities, and alcoholism or drug abuse. Those services are:

- Prevention programs.
- Comprehensive diagnostic and evaluation services, including certain statutorily required assessments.
- Inpatient and outpatient care and treatment, residential facilities, partial hospitalization, emergency care, and supportive transitional services.
- Related research and staff in-service training.
- Continuous planning, development, and evaluation of programs and services for all population groups. [s. 51.42 (3) (ar) 4., Stats.]

Some counties provide mental health services and programs in addition to those which are required by statute.

Recommendation

Require DHS, by January 1, 2016, to enact rules that create a mechanism for counties to report to DHS which mental health services and programs they each provide.

INDIVIDUAL PLACEMENT AND SUPPORT

Background

IPS is a type of supported employment for individuals with mental illness. It was developed at Dartmouth College Psychiatric Research Center, which conducts interdisciplinary research on services for individuals who have mental illness. According to the Dartmouth IPS website, IPS is three times more effective than other vocational approaches in helping people with mental illness to work competitively.

The eight practice principles of IPS are as follows:

1. Every person with severe mental illness who wants to work is eligible for IPS supported employment.
2. Employment services are integrated with mental health treatment services.
3. Competitive employment is the goal.
4. Personalized benefits counseling is provided.
5. The job search starts soon after a person expresses interest in working.
6. Employment specialists systematically develop relationships with employers based upon their client's work preferences.
7. Job supports are continuous.
8. Client preferences are honored.

According to the materials provided by the WCMH, there are currently nine counties in Wisconsin with an IPS site: Washington, La Crosse, Marathon, Barron, Dunn, Chippewa, Dane, Jefferson, and Lincoln.

Recommendation

Support the rollout of the IPS program by providing funding for regional technical assistance and training positions.

REDUCTION OF STIGMA

Background

Wisconsin's Initiative for Stigma Elimination (WISE) is a statewide collaboration of organizations and individuals seeking to reduce the stigma of mental illness in the state by promoting the use of evidence-based practices and outcome evaluation. Research on addressing the discrimination and stigma has shown that individuals' attitudes improve when they have direct contact with persons with mental illnesses, when they can get to know people beyond labels and myths.

Recommendation

Provide funding for an evidence-based stigma reduction plan throughout Wisconsin through WISE.

\ksm

Attachment

APPENDIX

Members of the Speaker's Task Force on Mental Health

Representative Erik Severson, Chair

Representative Sandy Pasch, Vice Chair

Representative Joan Ballweg

Representative Jim Steineke

Representative John Jagler

Representative Kevin Petersen

Representative Joe Sanfelippo

Representative Paul Tittl

Representative Chris Danou

Representative Josh Zepnick

Representative Debra Kolste

John Nygren
WISCONSIN STATE REPRESENTATIVE ★ 89TH ASSEMBLY DISTRICT

HOPE Agenda

Heroin, Opiate Prevention and Education

Assembly Bill 445: Requires individuals to show proper identification when picking up schedule II or III narcotic/opiate prescription medication in order to address prescription fraud and diversion.

Assembly Bill 446: Provides all levels of EMTs, first responders, police and fire the ability to be trained to administer Naloxone Narcan, a drug used to counter the effects of opiate overdose, such as a heroin overdose. Any person who administers the drug is immune from civil or criminal liability provided their actions are consistent with Wisconsin's Good Samaritan law.

Assembly Bill 447: Provides limited immunity from certain criminal prosecutions for a person who seeks assistance from the police or medical professionals for another individual who has overdosed on controlled substances.

Assembly Bill 448: Encourages communities to set up drug disposal programs and regulates these programs so unwanted prescription drugs do not fall into the wrong hands.

Assembly Bill 668: Expands Treatment Alternatives and Diversion (TAD) programs by increasing funding by $1.5 million annually. Administered by the county, TAD has proven to be an effective and efficient means of combatting drug and alcohol abuse in our state.

Assembly Bill 701: Creates regional pilot programs to address opiate addiction in underserved areas. The treatment programs will assess individuals to determine treatment needs, provide counseling, and medical or abstinence-based treatment. After individuals successfully complete the program, they will be transitioned into county-based or private post-treatment care.

Capitol: P.O. Box 8953 ★ Madison, Wisconsin 53708-8953 ★ (608) 266-2343 ★ Toll-Free: (888) 534-0089 ★ Fax: (608) 282-3689
Rep.Nygren@legis.wi.gov

John Nygren

WISCONSIN STATE REPRESENTATIVE ★ 89TH ASSEMBLY DISTRICT

Assembly Bill 702: Creates a system of immediate punishments for individuals who violate their parole or probation parolees based on so-called "swift and certain" laws in other states. The model is based on research that shows that it's the swiftness and the certainty of the sanction, not the length of the confinement, which has the greatest impact on influencing an offender's behavior.

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FIREARMS LEGISLATION AS DEFINED BY THE LRB

LEGISLATION PROPOSED – 41 bills (companions included)

Firearms and dangerous weapons

- Assault weapons: ban on transportation, purchase, possession, or transfer of created; exceptions and penalty provisions; JRCCP report - AB222
- Bird hunting preserve licensed by DNR considered a sport shooting range re liability, nuisance, and zoning provisions - AB7
- Carrying a firearm in certain public buildings: ambiguity resolved (remedial legislation) - AB558
- Carrying a firearm in certain public buildings: ambiguity resolved (remedial legislation) - SB422
- Carrying firearms in the capitol building prohibited, exceptions specified and penalty provision - SB102
- Certification cards for concealed weapons: DOJ may issue to former out-of-state law enforcement officers who are Wisconsin residents - AB165
- Concealed weapon license: applicant who is stationed in Wisconsin in active service of the U.S. armed forces is eligible - AB740
- Concealed weapon prohibition on school grounds and certain posted private property: exemption for law enforcement officers acting in their official capacity and qualified law enforcement and former law enforcement officers - AB9
- Crossbow hunting license established; resident, nonresident, and archer hunting license provisions [A.Sub.Amdt.1: further revisions, hunting season for bow and arrow but not firearms established for specified animals must include a crossbow season, DNR required to record weapon used to kill animals registered by hunters with DNR; S.Sub.Amdt.1: further revisions, rule to specify the open seasons special deer hunting permits may be used and types of weapons authorized for use] - AB194
- DNR authorized to lease state forest land in the Town of Boulder Junction to the Boulder Junction Shooting Range for terms not to exceed 30 years - AB359
- DNR authorized to lease state forest land in the Town of Boulder Junction to the Boulder Junction Shooting Range for terms not to exceed 30 years - SB277
- False information provided to firearms dealer re intent to knowingly transfer firearm to person prohibited from possessing one: penalty increased and DOJ authorized to prosecute; JRCCP report - SB69
- False report of active shooter made intentionally: penalty created; JRCCP report - AB884
- Fees collected for handgun purchase background checks and issuing concealed carry certification cards and licenses to one appropriation to provide these services [Sec. 383-385, 1971] - AB40
- Firearm possession by habitual criminal prohibition created re multiple misdemeanors, penalty provision - AB885

- Firearm possession prohibited for persons subject to an individuals-at-risk injunction; court and law enforcement may request information from DOJ re person's eligibility to possess a firearm [A.Amdts.1 and 2: further revisions] - AB727
- Firearm possession prohibited for persons subject to an individuals-at-risk injunction; court and law enforcement may request information from DOJ re person's eligibility to possess a firearm - SB580
- Firearm prohibition notice required when serving notice for injunction hearings re domestic abuse, child abuse, or harassment; procedure for surrendering firearms after the court grants an injunction established [A.Sub.Amdt.1: further revisions, extending a TRO, notification to local law enforcement, and penalty provisions added; A.Amdt.1: provisions re 2013 AB727] - AB464
- Firearm prohibition notice required when serving notice for injunction hearings re domestic abuse, child abuse, or harassment; procedure for surrendering firearms after the court grants an injunction established - SB605
- Firearm sale or transfer prohibited unless through a federally licensed firearms dealer and background check on transferee is conducted; exceptions and penalty provisions - AB138
- Firearm sale or transfer prohibited unless through a federally licensed firearms dealer and background check on transferee is conducted; exceptions and penalty provisions - SB124
- Firearms buy-back program: DOJ to award City of Milwaukee a one-time grant - AB571
- Firearms restriction background check fee [A.Sub.Amdt.1: Sec. 1970q, 9226 (2L)] - AB40
- Firearms restrictions record search before transferring a handgun: alternate means for firearms dealer to transmit information to DOJ - SB295
- Gun safes: sales and use tax exemption created; JSCTE appendix report - AB631
- Hollowpoint bullets and certain other bullets: selling, transporting, manufacturing, or possessing prohibited; exception and penalty enhancement provisions; JRCCP report - AB221
- Hunting with a bow and arrow or crossbow: local government may not restrict within its jurisdiction; prohibition on hunting within specified distance of a hospital, sanatorium, or school grounds only applies to firearms [A.Amdt.1: hospital, sanatorium, and school ground provisions deleted; A.Amdt.3: modifies restriction allowed by local governments - AB8
- Pardoned criminal offense: removing records from CCAP, determination of habitual criminal modified, and possession of firearms provisions - SB620
- Penalty enhancer for certain crimes committed on the premises of a gas station while armed with a handgun; JRCCP report - AB357
- Rifle or shotgun purchased in another state and transferred to this state: ``contiguous state'' provision removed - AB368
- Rifle or shotgun purchased in another state and transferred to this state: ``contiguous state'' provision removed - SB285

- School zone firearm prohibition: exceptions enumerated in statutes versus references to federal law; school board may contract with person, or person's employer, that allows possession of firearm in school zone - AB118
- Seized firearm: provisions for returning to the owner re no charges filed, dismissal of charges, and final disposition of charges if owner is not adjudged guilty - AB853
- Sexual assault of a child statues of limitations cross-reference corrections and other revisions; suspension of concealed carry license if person is prohibited from possessing a dangerous weapon as a condition of release with a felony or misdemeanor charge (remedial legislation) - AB563
- Sexual assault of a child statues of limitations cross-reference corrections and other revisions; suspension of concealed carry license if person is prohibited from possessing a dangerous weapon as a condition of release with a felony or misdemeanor charge (remedial legislation) - SB429
- Shot Spotter Program in the City of Milwaukee appropriation; Sheboygan County tuberculosis response funding decreased - AB693
- Shot Spotter Program in the City of Milwaukee appropriation; Sheboygan County tuberculosis response funding decreased - SB521
- Sport shooting range: civil liability immunity and zoning conditions exceptions under certain conditions - AB691
- Sport shooting range: civil liability immunity and zoning conditions exceptions under certain conditions - SB527
- Sport shooting range: date of existence modified re continuing operation notwithstanding a local zoning ordinance - AB178
- Sport shooting range: date of existence modified re continuing operation notwithstanding a local zoning ordinance - SB162

ACTS CREATED – 14 new acts

Firearms and dangerous weapons

- Carrying a firearm in certain public buildings: ambiguity resolved (remedial legislation) - Act 162
- Crossbow hunting license established; crossbow season established and to run concurrently with bow and arrow season for first two years; specifying seasons special deer hunting permits may be used; information required to be recorded at time of carcass registration; emergency rule provision - Act 61
- DNR authorized to lease state forest land in the Town of Boulder Junction to the Boulder Junction Shooting Range for terms not to exceed 30 years - Act 82
- Fees collected for handgun purchase background checks and issuing concealed carry certification cards and licenses to one appropriation to provide these services [Sec. 383-385, 1971] - Act 20
- Firearm possession prohibited for persons subject to an individuals-at-risk injunction; court and law enforcement may request information from DOJ re person's eligibility to possess a firearm - Act 223
- Firearm prohibition notice required when serving notice for injunction hearings re domestic abuse, child abuse, or harassment; procedure for surrendering firearms after the court grants an injunction established; extending a TRO, notifying local law enforcement, and penalty provisions - Act 321
- Firearms restriction background check fee [Sec. 1970q, 9226 (2L)] - Act 20
- Firearms restrictions record search before transferring a handgun: alternate means for firearms dealer to transmit information to DOJ - Act 109
- Gun safes: sales and use tax exemption created; JSCTE appendix report - AB631
- Rifle or shotgun purchased in another state and transferred to this state: ``contiguous state" provision removed - Act 232
- Sexual assault of a child statues of limitations cross-reference corrections and other revisions; suspension of concealed carry license if person is prohibited from possessing a dangerous weapon as a condition of release with a felony or misdemeanor charge (remedial legislation) - Act 167
- Shot Spotter Program in the City of Milwaukee appropriation; Sheboygan County tuberculosis response funding decreased - Act 263
- Sport shooting range: civil liability immunity and zoning conditions exceptions under certain conditions - Act 202
- Sport shooting range: date of existence modified re continuing operation notwithstanding a local zoning ordinance - Act 35

Legislative Fiscal Bureau

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May 22, 2014

TO: Members
Wisconsin Legislature

FROM: Bob Lang, Director

SUBJECT: 2013-15 and 2015-17 General Fund Budget

At the request of numerous legislators, this memorandum provides information on the condition of the state's general fund for 2013-15 and 2015-17. The following tables (in millions) incorporate all legislation enacted in the current legislative session (through 2013 Act 380) and decisions of the Joint Committee on Finance.

TABLE 1

2013-15 General Fund Condition Statement

	2013-14	2014-15
Revenues		
Opening Balance, July 1	$759	$724
Taxes	14,229	14,725
Departmental Revenues		
Tribal Gaming Revenues	24	24
Other	577	535
Total Available	$15,589	$16,008
Appropriations, Transfers, and Reserves		
Gross Appropriations	$15,014	$15,883
Transfers to:		
Transportation Fund	61	144
Veterans Trust Fund	5	0
Compensation Reserves	79	133
Less Lapses	-294	-317
Net Appropriations	$14,865	$15,843
Balances		
Gross Balance	$724	$165
Less Required Statutory Balance	-65	-65
Net Balance, June 30	$659	$100

Table 2 focuses only on the 2014-15 fiscal year. 2014-15 is the "base year" for construction of the 2015-17 budget.

TABLE 2

2014-15 General Fund Condition Statement

	2014-15
Opening Balance, July 1	$724
Revenues (Taxes and Departmental Revenues)	15,284
Total Available	$16,008
Net Appropriations	$15,843
Gross Balance	$165

Table 3 addresses the structure of the general fund budget. To do so, only the revenues, net appropriations, and the difference between the two is shown. Thus, Table 3 ignores the opening balance and focuses only on the revenues and net appropriations for the 12 months of the fiscal year.

TABLE 3

2014-15 Balance of Revenues and Expenditures

	2014-15
2014-15 Revenues	$15,284
Net Appropriations	15,843
Difference	-$559

Table 3 indicates that net appropriations exceed revenues by $559 million. Thus, the structure of the general fund shows an imbalance of -$559 million. The -$559 million becomes $165 million when the $724 million opening balance is considered. However, Table 3 focuses only on the revenues and net appropriations for the 12-month period (July, 2014, through June, 2015).

Table 4 shows estimated 2015-17 general fund commitments. This table reflects estimated increases or decreases of various items for each year of the 2015-17 biennium as a change to base year (2014-15) revenues and net appropriations.

TABLE 4

2015-17 General Fund Commitments

	2015-16	2016-17
Revenues (Taxes and Department Revenues)		
2014-15 Base Revenues (from Table 3)	$15,284	$15,284
Modifications to Base		
Withholding table changes	$166	$166
Manufacturing and agriculture credit	-42	-73
Capital gains for Wisconsin-based assets	0	-6
Collections from federal audit reports	0	-10
Increase cap for economic development credits	2	8
Phase-out medical records credit	3	5
Program revenue lapses	0	-38
HIRSP assessment credit	1	1
Sales tax bad debt	-8	-8
College savings plans	0	-1
Subtotal-- Modifications	$122	$44
Total	$15,406	$15,328
Net Appropriations		
2014-15 Base (from Table 3)	$15,843	$15,843
Modifications to Base		
Transfer to DOT	-$108	-$108
Depletion of TANF balance	6	48
Zoo Interchange bonding debt service	11	14
Debt service (excluding Zoo interchange)	-28	-83
Parental choice program	16	33
FoodShare work requirements	8	8
Disaster damage aids	-9	-9
Disproportionate share hospital payments	-15	-15
Mental health services	11	16
TB response	-2	-2
Attorney pay progression	5	9
Covenant	0	-4
Health care data grants	-2	-3
Kenosha County human services	-1	-1
MA fiscal agent	0	-1
Courts lapse	5	5
Legislative lapse	5	5
UI interest payment	-7	-7
Technical excellence scholarships	1	2
WEDC Marketing	-4	-4
DWD training grants	-3	-3
Extended out-of-home care	1	2
One-time mental health funding	-1	-1
Subtotal -- Modifications	-$111	-$99
Total	$15,732	$15,744

Table 5 places the figures from Table 4 into condition statement format for the 2015-17 biennium. No assumptions are made about changes (increases or decreases) in caseload and population estimates or for such items as state employee compensation in the 2015-17 biennium. Also, the figures in Table 5 are displayed for the purpose of examining base revenues and appropriations, adjusted for 2015-17 commitments. The table does not reflect any potential revenue growth or other appropriation changes.

TABLE 5

2015-17 General Fund Condition Statement
(Before Revenue Growth and Program Expansion)

	2015-16	2016-17
Opening Balance, July 1	$165	$65
Revenues (from Table 4)	15,406	15,328
Total Available	$15,571	$15,393
Net Appropriations (from Table 4)	$15,732	$15,744
Required Balance	65	65
Total	$15,797	$15,809
Amount Needed	$226	$416
Biennial Amount	$642	

Table 5 shows that, for 2015-16, the general fund would need $226 million to meet commitments under current law, maintain the required statutory balance, and balance the budget for that year. In 2016-17, $416 million would be needed ($190 million above the 2015-16 amount).

Table 6 lists the estimated general fund amounts necessary to produce a balanced budget for 2015-17 and the nine preceding biennia.

TABLE 6

General Fund Amounts Necessary for a Balanced Budget*

	1st Year	2nd Year	Total
For the 2015-17 Biennium	$226	$416	$642
For the 2013-15 Biennium	-140	-6	-146
For the 2011-13 Biennium	1,232	1,279	2,511
For the 2009-11 Biennium	800	882	1,682
For the 2007-09 Biennium	653	846	1,499
For the 2005-07 Biennium	701	845	1,546
For the 2003-05 Biennium	1,340	1,527	2,867
For the 2001-03 Biennium	693	1,026	1,719
For the 1999-01 Biennium	589	914	1,503
For the 1997-99 Biennium	624	908	1,532

*Except for 2013-15, all figures indicate amounts necessary to produce a balanced budget. A surplus of $146 million is shown for 2013-15.

In addition to the amounts shown above for 2015-17, it should be noted that the budget stabilization fund currently has a balance of $279.5 million.

BL/sas