1999 DRAFTING REQUEST

Bill

Received: **09/24/98**

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For: **Administration-Budget 6-2288**

By/Representing: **Fossum**

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May Contact: **Richard Chao (DHFS)**

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LRB-0326

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LRB-0326

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DHFS

Department of Health and Family Services
1999-2001 Biennial Budget Statutory Language Request
September 11, 1998

The Blue Ribbon Commission on Mental Health
Drafting Instructions for 1999-01 Budget Bill

Current Language

State and county responsibilities for providing mental health services for providing mental health services are specified in Wis. Stat. 51.42.

Proposed Changes

A. Amend existing statutes to:

1. Include philosophy of BRC recommendations in Wis. Stat. 51.001, 51.42(1)(a) 2., and 51.45(1).

   Amend Sec. 51.001 as follows:
   (1) It is the policy of the state that within the funding limits provided in this section, all persons in need of services, including children and their families, adults and older persons, have access to resources that strengthen self-determination and self-sufficiency by promoting health and wellness, improvement and recovery, and quality of life and dignity. The state shall assure the provision of a full range of treatment, ~~and~~ rehabilitation and habilitation services in the state for all mental disorders and developmental disabilities and for mental illness, and substance abuse. There shall be a unified system of prevention of such conditions and provision of services which will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs, and movement through all treatment components to assure continuity of care, within the limits of available state and federal funds and of county funds required to be appropriated to match state funds.
   (2) To protect personal liberties, no person who can be treated adequately outside of a hospital, institution or other inpatient facility may be involuntarily treated in such a facility.

   DN - no def ? Subst abuse

2. Add definitions of *consumer outcomes*, *system outcomes*, *organizational outcomes*, *prevention*, *early intervention*, *crisis intervention*, *treatment*, *habilitation* and *recovery* and *stigma of mental illness and substance abuse* and *individualized service planning* to Wis. Stat. 51.01.

   A workgroup has been formed to work with DHFS staff and LRB to define these terms.

3. Include *prevention, early intervention,* and *community education services* in Wis. Stat. 51.42(3)(aw), 51.45(5) and create 51.45 (5) (aw) to include these services.

4. Include in Department duties the responsibilities of promoting each of the guiding principles of the BRC in Wis. Stat. 51.03 and 51.45(4).

   Create 51.03(1); renumbering existing sections:

   51.03(1) The department shall:
   a. Promote the creation of partnerships between the state, the counties, providers of mental health and substance abuse services, consumers of these services and their families and advocates to develop, coordinate and provide a full range of resources to address prevention, early intervention, treatment, recovery, safe and affordable housing, opportunities for education, employment, and recreation, family and peer support, self-help, and safety and well-being of the community.
   b. In cooperation with counties, service providers, consumers, advocates and other community partners develop and implement a comprehensive strategy to eradicate stigma and discrimination against persons with mental illness and/or substance abuse.
   c. Develop and implement a comprehensive strategy to involve consumers of mental health or substance abuse services and their families along with counties, service providers, advocates and other community partners as equal stakeholders in service system governance, planning and delivery.
   d. Promote responsible stewardship of human and fiscal resources in the provision of mental health and/or substance abuse services.
   e. Develop and implement methods to identify and measure outcomes for persons who are recipients of mental health and/or substance abuse services.
   f. Promote the provision of mental health and substance abuse treatment services that are individualized, culturally relevant, flexible, cost effective, clinically appropriate, and based on consumer choice and participation in treatment and service planning.
   g. Promote access to high quality mental health and substance abuse services for persons throughout the state regardless of geographic location, age, degree of disability, or availability of personal financial resources.
   h. Promote mental health and substance abuse services that focus on successful living in communities by providing access to jobs, housing, and transportation as well as health, education, vocational, social, spiritual and recreational resources, including the full use of natural supports.
   i. Promote consumer empowerment to enable persons with mental illness or substance abuse to take more control of their lives.
   j. Promote provider practices for an individualized service planning process to develop a written individualized service plan in partnership with the individual, families of children, and chosen advocates, that promotes the process of treatment and recovery. The plan should establish meaningful and measurable goals, be based on a comprehensive assessment of the individual's strengths and abilities, stated needs and preferences, and is to be kept current and be modified when needed.

B. Create non-statutory session law or statutory provisions to Chapters 51 or 46 to:

1. Establish the number of demonstration projects up to three, to commence during the first year (1999/2000) and not more than five additional demonstration projects in the following year.

2. Waive Wisconsin Administrative Code provisions necessary for implementation of demonstration projects, so long as such waivers are cost effective and do not impair consumer health and safety.

3. Establish an advisory committee of all stakeholders to ensure demonstration projects meet the objectives of the BRC recommendations.

4. Authorize Department to enter into performance based contracts using outcomes indicators and to add necessary terms to State/County contract under Wis. Stat. 46.031. *

5. Authorize Department to pool funds for demonstration projects and to define and identify funding sources, which will be part of demonstration projects and develop capitated rates, if necessary. *

6. Provide authority in Department to establish target groups for services within the demonstration projects providing services beyond the list of services in 51.42.

* To be coordinated with Family Care.

Effect and Rationale for Change

The proposed statutory language change will permit the Department of Health and Family Services to implement the recommendations made in 1997 by the Governor's Blue Ribbon Commission (BRC) on Mental Health. One of the major initiatives is to develop specifications and program features for mental health and alcohol and other drug abuse (MH/AODA) managed care demonstration programs. These programs will provide flexible, customer centered MH/AODA treatment services to Medicaid recipients with mental illness and substance abuse disorders in addition to individuals now served through the public mental health system under the authority of s. 51.42 Wis. Stats.

Desired Effective Date:	Upon Passage
Agency:	DHFS
Agency Contact:	Richard T. Chao
Phone:	267-0356

Kennedy, Debora

From: Fossum, Gretchen [gretchen.fossum@doa.state.wi.us]
Sent: Monday, November 02, 1998 2:31 PM
To: Kennedy, Debora
Subject: FW: Definitions for BRC Mental Health Draft


definitions51.01.doc

> Debora:
>
> Attached are the definitions the department is proposing for the BRC
> Mental Health Draft.
>
> <<definitions51.01.doc>>

1. Add to definitions section of Chapter 51.

551.01 Definitions

(__) "Consumer Outcomes" means the identification, realization, and measurement of positive outcomes that matter to individuals who are receiving care for mental illness and/or substance abuse (e.g., clinical outcomes, quality of life outcomes, recovery outcomes).

(__) " Crisis Intervention" means the immediate response to a crisis situation that is caused by an individual's apparent mental disorder and/or substance abuse and that is beyond the available coping mechanisms of the individual, of persons providing care to the individual, and/or of the public; such interventions may include but not be limited to, pre-planned crisis protocols for individuals, system response plans, stabilization services, medication administration, telephone services, and walk-in services.

(__) " Early Intervention" means entering into a situation as early as possible so as to hinder or alter an individual's mental disorder or substance abuse that has already begun with the goals of reducing the occurrence of new cases, delaying the onset of the disorder, illness and/or abuse, reducing the length of time the early symptoms continue, and reducing the duration and/or severity of diagnosable mental illness and/or substance abuse.

(__) "Habilitation" means the education, training, and/or support services provided to individuals to assist them in acquiring skills not yet gained or learned, which will enable them to learn, practice, and refine skills needed for independent living, productive and meaningful employment, and community participation.

(__) " Individualized Services Planning" means the process of providing children and their families, adults, and older individuals, with mental illness and/or substance abuse, with the information, education, and skills, to mutually and creatively participate with their clinicians and providers in the development of their assessment, identification of personal goals, crisis protocol, treatment, and plan; this planning is tailored to each individual and is based upon he individual's strengths, abilities, and needs

1. "Individualized Services Planning", "Treatment" (as defined by s. 510.01 (__)), and "Recovery" (as defined by s. 51.01(__)), are intended to be read and interpreted together.

(__) "Organizational Outcomes" means the identification and measurement of performance outcomes of an organization serving individuals with mental illness and/or substance abuse, on the following levels:

1. the performance of the processes put into place by the organization, as well as the performance of the organization as a whole, (e.g., staff turnover, whether or not individuals are appropriately being brought into and served by the organization, accreditation), and

2. how the members of the organization feel about such things as the organization the performance of the organization, and their participation in the organization, (e.g., staff satisfaction whether they are helping to meet the purposes and goals of the organization).

(__) "Prevention" means intervention that occurs before there is a diagnosable mental illness with the goals of reducing the number of individuals with mental disorders, delay in onset of mental disorders, and/or lessened severity by reducing risk factors, enhancement of protective factors, and prompt treatment of early warning signs.

(__) "Recovery" means the process of growth over time in improving the individual's attitudes, feelings, values, goals, skills and roles, and is measured by a decrease in dysfunctional symptoms and an increase in the maintenance of the individual's highest level of health and wellness, stability, self-determination and self-sufficiency, and in leading as productive and fulfilling a life as is possible. "Recovery" means the development of hope, dignity, a new and valued sense of self, meaning and purpose, and quality of life, despite the mental illness and/or history of substance abuse.

(__) "Self-stigma" means that an individual with mental illness and/or substance abuse internalized societal stigma, which results in feelings of disempowerment, worthlessness, and loss of hope and dignity, which are often compounded by poverty and/or minority status.

(__) "Stigma" means that individuals with mental illness and/or substance abuse are disqualified from social acceptance, discredited, marginalized, and ostracized, by society's negative attitudes, feelings, perceptions, representations, and acts of discrimination, including but not limited to the areas of, housing and community acceptance, employment, education, health care systems, insurance, media coverage, laws, personal and social relationships, and research.

(__) "System Outcomes" means the identification and measurements of performance outcomes of aggregate populations functioning within a specific system for individuals with mental illness and/or substance abuse, such as a county's system of mental health and substance abuse services, (e.g., whether all providers met the system's standards, whether system met the purposes and goals established for all individuals served by the system, the preferences and needs of interested groups of persons); the information gathered from aggregate populations is then used to make individual decision sand to take individual actions, (e.g., whether to renew a contract with a specific provider, whether the needs of an individual have been appropriately met by the system).

(__) "Treatment" means use of the most currently accepted methods of care, practices, and services, within the mental health and substance abuse files, including but not limited to psychiatric, psychological, social, chemical, medical, somatic techniques, natural supports, peer support, self-help, community supportive services, and in-residence services, designed to bring about the process of individualized services planning, "Treatment" and recovery.

2. Include *prevention, early intervention,* and *community education services,* in Wisconsin Statutes 51.42(3)(aw), 51.45(5) and create 51.45(5)(aw) to include these services.

(__) "Community Education Services" means education about mental disorders and/or substance abuse, and about the negative affects of stigma and self-stigma as well as, prevention, early intervention, individualized services planning, treatment, and recovery which is provided for consumers, their families, the general public, and key service sectors, including but not limited to, primary health care professionals, teachers and schools, law enforcement personal, mental health care professionals, employers, and landlords.

9/30/98 Draft Chapter 51 Definitions. Submitted by Ruth Roschke, J.D., Consumer.

ch\51.01definitions

STATE OF WISCONSIN
DEPARTMENT OF ADMINISTRATION
DIVISION OF EXECUTIVE BUDGET AND FINANCE
DOA-3167 N(R08/95)

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Gretchen A. Fossum	4	(608) 267-0372
Location		**Telephone Number**
101 East Wilson Street, 10th Floor; Madison, WI 53702		6-2288

COMMENTS / INSTRUCTIONS

DHFS

Department of Health and Family Services
1999-2001 Biennial Budget Issue Paper
September 15, 1998

Implementation Costs for Mental Health/Alcohol and Other Drug Abuse Managed Care Pilots

DIN 8102 (Chao)

Summary of Program

The Department is currently in the process of implementing the recommendations made in 1997 by the Governor's Blue Ribbon Commission (BRC) on Mental Health. One of the major initiatives is to develop specifications and program features for mental health and alcohol and other drug abuse (MH/AODA) managed care demonstration programs. These programs will provide flexible, customer centered MH/AODA treatment services to Medicaid recipients with mental illness and substance abuse disorders in addition to individuals now served through the public mental health system under the authority of s. 51.42 Wis. Stats. Some programs may also incorporate primary and acute medical care for the Medicaid population. The Department intends to issue a request for proposals (RFP) for entities interested in piloting these managed care programs and plans to phase in up to 3 demonstration programs by January 2000 and up to 5 more by January 2001.

Problem Definition

The MH/AODA managed care demonstration pilots require one time funding for initial costs and start-up program support.

Background

1. The Department began development of MH/AODA managed care in November of 1995 and subsequently released a concept paper in April of 1996. The Governor's Blue Ribbon Commission (BRC), which met during 1996 and 1997, recommended the use of managed care to pool MH/AODA funding to create a more flexible and responsive system of mental health services. The 1997-99 biennial budget allocated funding for three positions (two located in the Bureau of Health Care Financing, one shared between the Bureau of Substance Abuse and Services and the Bureau of Community Mental Health) to develop and implement these programs. In addition, the Department receives funds through the Center for Health Care Strategies from the Robert Wood Johnson Foundation (RJW) to support the planning process for the demonstrations. The Department also intends to apply for additional funding for an evaluation grant from RJW.

2. The MH/AODA managed care demonstrations will enroll persons with mental illness and substance abuse disorders into managed care programs. The Bureaus plan to implement two models: 1.) A carve-out model, that will provide the MH/AODA services only through

managed care; and 2.) An integrated model which will provide MH/AODA as well as primary and acute care to the target population. The goals of these demonstrations include:

- Reducing the long-term rate of growth in the cost of care for this population.
- Integrating the major sources of funding for this population. The managed care organization would have combined Medicaid, community aids and county tax levy dollars now serving this population.
- Removing fiscal incentives leading to inappropriate care such as individuals being placed in hospitals or nursing facilities, when Medicaid reimburses care, rather than in less restrictive settings that may be more appropriate but are funded solely by local dollars.
- Increasing the flexibility of the use of Medicaid dollars through managed care capitation.
- Implementing the guiding principles of the Governor's Blue Ribbon Commission on Mental Health, which includes person-centered planning, a focus on recovery as the goal of the MH/AODA system and increased consumer and family involvement at all levels.
- Increasing the accountability of the delivery system through performance-based contracts.

3. Because of the historical role of the counties and tribes in providing and funding services to this population, the Bureaus envision that demonstrations will be built on the current county-based system of care. The managed care organizations (MCOs) will either be counties/tribes or be under contract to these entities. The Bureaus have selected six planning partners (county or multi-county/tribal groups representing 11 counties and 1 tribe) to assist in the demonstration planning. County/tribal staff, key providers, consumers and families from each site are committing two full days per month to planning meetings, plus additional office time to assist in developing policy and budget estimates.

4. While initially conceived as being a part of the Department's FamilyCare effort, the MH/AODA managed care project is now on a separate, but parallel track. Program staff for these programs are collaborating to share information, reduce duplication of effort and ensure program integration at the local level. Key management staff are involved in overseeing both efforts and discussions with the Health Care Financing Administration (HCFA) are being held jointly. Potential cost savings exist if MH/AODA demonstration projects are implemented in the same counties as FamilyCare. For example, combining resource center functions could lead to cost efficiencies.

5. The Department intends to release a RFP for demonstration sites. A federal waiver may be needed to waive freedom of choice if it is decided to pursue mandatory enrollment. The Bureaus are also exploring eligibility waivers to allow the state to claim federal match for individuals now funded solely by local dollars. A waiver request will likely be submitted to HCFA during the first quarter of 1999. It is expected that initial contracts will be signed with demonstration sites in January 2000. However actual enrollment would begin Spring 2000.

6. The Bureaus estimate that the demonstration program will require an average funding of $160,000 AF ($120,000 GPR) per demonstration site, and intends to fund up to 8 sites during the biennium. The Bureaus plan to fund three sites in SFY 2000. Each site will receive two payments in a six-month interval. In addition, the program requires $50,000 ($25,000 GPR) to support the development, collection and analysis of necessary baseline system performance

measurements prior to implementation of the demonstrations. This funding would be contracted through the University of Wisconsin (UW). The Department is currently working with the UW to develop outcome measurement instruments using funding through the RWJ Foundation. Table 1 shows the projected phase in schedule and costs of the project.

Table 1. Cost of MH/AODA Managed Care Demonstration Project

Date	Description	Cost per Site	Total Cost (AF)	
			SFY 2000	SFY 2001
July 1999	Baseline Measurement	$50,000	50,000	
January 2000	First 3 demonstrations (first payment	$80,000	$240,000	
July 2000	First 3 demonstrations (second payment)	$80,000		$240,000
July 2000	Second 3 demonstrations (first payment)	$80,000		$240,000
January 2001	Second 3 demonstrations (second payment)	$80,000		$240,000
January 2001	Final 2 demonstrations (first payment)	$80,000		$160,000
Totals			**$290,000 AF ($205,000 GPR)**	**$880,000 AF ($660,000GPR)**

7. Applicants for the CMOs will be required to identify how these funds would be used in their response to the State's request for proposals. The managed care projects will use these one-time funds to develop and support:
   - Costs of staff person needed to develop CMO policies and procedures, develop provider network and contracts and other functions necessary to prepare for enrollment.
   - Costs of the purchase and development of management information systems.
   - Specialized programming for co-occuring mental illness and substance abuse.
   - Costs of a consumer affairs coordinator or other activities to develop or enhance consumer operated programs.
   - Costs related to quality assurance activities for the demonstration project.
   - Costs relating to increasing consumer and family involvement in decision making and evaluation of local
   - Costs related to increasing consumer and family involvement at planning, decision making and evaluation of local demonstrations.

8. These administrative and program support funds are necessary to ensure sufficient resources are available for program development because:
   - These projects will serve a broad population, from individuals with severe and persistent illnesses or chronic substance abuse problems to those with little or no disability who are in need of information, referral, early intervention or preventive activities. Costs associated with the single entry point concept are incorporated into this project.

- The population with severe illnesses presents unique challenges because of the fluctuations in the severity of the mental illness over time. This differs from fragile FamilyCare recipients where the level of need may be high, but is relatively stable.
- The MH/AODA demonstrations may include children and adolescents. This group requires extensive coordination activities with schools, child protective services, juvenile justice and other child-serving systems.
- Some of the MH/AODA demonstrations will also integrate primary and acute care services, requiring negotiation with HMOs or other provider organizations.

9. There are components or services that are critical for the successful implementation of the MH/AODA managed care demonstrations. Two of these identified in the Blue Ribbon Commission (BRC) Report as needing improvement or strengthening are 1.) Consumer-operated self-help and peer support activity, and 2.) Dual diagnosis services for persons with co-occurring mental disorders and substance abuse. Due to the nature of Medicaid funding, both of these areas have been historically underfunded.

10. Costly professionals in high cost settings currently provide many mental health services. Many of these services could be provided by less costly and more effective consumer-operated alternative services. Examples of services, which could be provided in these consumer-operated alternative settings, include vocational, social and recreational services, activities of daily living training and support, early crisis intervention and crisis prevention. In addition, successful services for dual diagnosis recipients can achieve cost effectiveness. Over the past five years, it has been learned that the most effective treatment for people with dual diagnosis is through an integrated wraparound treatment system, which simultaneously addresses the mental and substance abuse illness components. Start up funding is needed to provide adequate staff training and develop program guidelines and best practices in order for dual diagnosis recipients to be treated in a cost effective integrated manner. In addition, start-up funds in these areas will allow MCOs to achieve savings, which can be reinvested for future program support. The Bureaus envision that MCOs will be able to use their newly flexible Medicaid funds to support these programs in the future, when capitation payments are at an adequate level to begin self-funding these programs.

Recommendation

Provide one time funding of $290,000 AF ($205,000 GPR) in SFY 2000 and $880,000 AF ($660,000 GPR) in SFY 2001 to support up to eight MH/AODA managed care demonstration sites.

From Gretchen Fossum 11/6/98:

Use "alcohol and other drug abuse" in draft where "substance abuse" is mentioned – want to avoid inference that "substance" includes tobacco

Sheldon Gross (DHFS) can be a contact.

SOON ltr 11/23/98

State of Wisconsin
1999 – 2000 LEGISLATURE

D-NOTE

LRB–0326/P1
DAK.....:.....:.....
cmy
*
jlg

DOA:.....Fossum – Blue Ribbon Commission on Mental Health recommendations

FOR 1999–01 BUDGET — NOT READY FOR INTRODUCTION

WPD - check auto refs

does not scan

AN ACT ...; **relating to:** the budget.

Analysis by the Legislative Reference Bureau

HEALTH AND HUMAN SERVICES

MENTAL ILLNESS AND DEVELOPMENTAL DISABILITIES

This is a preliminary draft. An analysis will be provided on a later version.

The people of the state of Wisconsin, represented in senate and assembly, do enact as follows:

SECTION 1. 51.001 (1) of the statutes is amended to read:

51.001 **(1)** It is the policy of the state ~~to~~ that, within the limits of available state and federal funds and of county funds required to be appropriated to match state funds, all persons in need of services for mental disorders, developmental disabilities, mental illness and alcohol and other drug abuse shall have access to resources that strengthen self–determination and self–sufficiency by promoting

health, wellness, improvement, recovery, quality of life and dignity. The state shall assure the provision of a full range of treatment ~~and~~ , rehabilitation services and habilitation services in the state for all mental disorders and developmental disabilities ~~and~~ , for mental illness, and for alcoholism and other drug abuse. There shall be a unified system of prevention of such conditions and provision of services which will assure all people in need of care access to the least restrictive treatment alternative appropriate to their needs, and movement through all treatment components to assure continuity of care, within the limits of available state and federal funds and of county funds required to be appropriated to match state funds.

History: 1975 c. 430; 1995 a. 92.

SECTION 2. 51.01 (8m) of the statutes is created to read:

51.01 **(8m)** "Habilitation" means education, training or other service provided to persons to assist them in acquiring skills that will, in turn, enable the persons to learn, practice and refine skills necessary for independent living, productive and meaningful employment and community participation.

SECTION 3. 51.03 (1) of the statutes is renumbered 51.03 (1r).

SECTION 4. 51.03 (1g) of the statutes is created to read:

51.03 **(1g)** In this section:

(a) "Early intervention" means action to hinder or alter a person's mental disorder or abuse of alcohol or other drugs in order to reduce the duration of early symptoms or to reduce the duration or severity of mental illness or alcohol or other drug abuse that may result.

(b) "Individualized service planning" means a process under which a person with mental illness or who abuses alcohol or other drugs and, if a child, his or her family, receives information, education and skills to enable the person to participate mutually

and creatively ~~participate~~ with his or her mental health or alcohol or other drug abuse service provider in identifying his or her personal goals and developing his or her assessment, crisis protocol, treatment and treatment plan. "Individualized service planning" is tailored to the person and is based on his or her strengths, abilities and needs.

(c) "Prevention" means action to reduce the instance, delay the onset or lessen the severity of mental disorder, before the disorders may progress to mental illness, by reducing risk factors for, enhancing protections against and promptly treating early warning signs of mental disorder.

(d) "Recovery" means the process of a person's growth and improvement, despite a history of mental illness or alcohol or other drug abuse, in attitudes, feelings, values, goals, skills and behavior and is measured by a decrease in dysfunctional symptoms and an increase in ~~maintaining~~ the person's highest level of health, wellness, stability, self–determination and self–sufficiency.

(e) "Stigma" means disqualification from social acceptance, ~~discrediting~~, marginali~~zing~~ation and ostracism encountered by persons with mental illness or persons who abuse alcohol or other drugs as the result of societal negative attitudes, feelings, perceptions, representations and acts of discrimination.

SECTION 5. 51.03 (4) of the statutes is created to read:

51.03 **(4)** The department shall do all of the following:

(a) Promote the creation of coalitions among the state, counties, providers of mental health and alcohol and other drug abuse services, consumers of the services and their families and advocates for persons with mental illness and alcoholic and drug dependent persons to develop, coordinate and provide a full range of resources to advance prevention; early intervention; treatment; recovery; safe and affordable

housing; opportunities for education, employment and recreation; family and peer support; self–help; and the safety and well–being of communities.

(b) In cooperation with counties, providers of mental health and alcohol and other drug abuse services, consumers of the services, interested community members and advocates for persons with mental illness and alcoholic and drug dependent persons, develop and implement a comprehensive strategy to eradicate stigma of and discrimination against persons with mental illness, alcoholics and drug dependent persons.

(c) Develop and implement a comprehensive strategy to involve counties, providers of mental health and alcohol and other drug abuse services, consumers of the services and their families, interested community members and advocates for persons with mental illness and alcoholic and drug dependent persons as equal participants in service system planning and delivery.

(d) Promote responsible stewardship of human and fiscal resources in the provision of mental and alcohol and other drug abuse services.

(e) Develop and implement methods to identify and measure outcomes for consumers of mental health and alcohol and other drug abuse services.

(f) Promote the provision of mental health and alcohol and other drug abuse treatment services that are individualized, culturally relevant, flexible, cost effective, clinically appropriate and based on consumer choice and participation in treatment and service planning.

(g) Promote access to high quality mental health and alcohol and other drug abuse services for persons regardless of the persons' geographic location, age, degree of mental illness, alcoholism or drug dependency or availability of personal financial resources.

(h) Promote consumer empowerment to enable persons with mental illness and alcoholic or drug dependent persons to take more control of their lives.

(i) Promote use by providers of mental health and alcohol and other drug abuse services of individualized service planning, under which the providers develop written individualized service plans that promote treatment and recovery, together with service consumers, families of service consumers who are children and advocates chosen by consumers. Each individualized service plan should establish meaningful and measurable goals; be based on a comprehensive assessment of the service consumer's strengths, abilities, stated needs and preferences; be kept current; and be modified as necessary.

SECTION 6. 51.45 (5) (a) of the statutes is renumbered 51.45 (5) (a) (intro.) and amended to read:

51.45 **(5)** (a) (intro.) In this section~~, "primary :~~

2. "Primary prevention" means a process which promotes health by providing individuals with the resources that are necessary for them to confront complex, stressful life conditions and by enabling individuals to lead personally satisfying and enriching lives.

History: 1973 c. 198; 1975 c. 200, 428; 1975 c. 430 s. 80; 1977 c. 29; 1977 c. 187 ss. 44, 134, 135; 1977 c. 203 s. 106; 1977 c. 428; 1977 c. 449 s. 497; Sup. Ct. Order, 83 W (2d) xiii (1987); 1979 c. 32 s. 92 (11); Sup. Ct. Order, eff. 1–1–80; 1979 c. 221 ss. 417, 2200 (20); 1979 c. 300, 331, 356; 1981 c. 20; 1981 c. 79 s. 17; 1981 c. 289, 314; 1983 a. 27 ss. 1116 to 1121, 2202 (20); 1985 a. 29 s. 3202 (56); 1985 a. 139; 1985 a. 176 ss. 533 to 556, 615; 1985 a. 265; 1985 a. 332 s. 251 (1); 1987 a. 339, 366; 1989 a. 31, 336, 359; 1991 a. 39; 1993 a. 16, 27, 213, 451, 490; 1995 a. 27 ss. 3268, 3269, 9145 (1); 1995 a. 77, 225; 1997 a. 27, 35, 237.

SECTION 7. 51.45 (5) (a) 1. of the statutes is created to read:

51.45 **(5)** (a) 1. "Early intervention" means action to hinder or alter a person's abuse of alcohol or other drugs in order to reduce the duration of early symptoms or to reduce the duration or severity of alcohol or other drug abuse that may result.

SECTION 8. 51.45 (5) (b) 2. of the statutes is amended to read:

51.45 **(5)** (b) 2. Develop and implement community–wide alcohol and other drug abuse programs relating to early intervention and to primary prevention.

History: 1973 c. 198; 1975 c. 200, 428; 1975 c. 430 s. 80; 1977 c. 29; 1977 c. 187 ss. 44, 134, 135; 1977 c. 203 s. 106; 1977 c. 428; 1977 c. 449 s. 497; Sup. Ct. Order, 83 W (2d) xiii (1987); 1979 c. 32 s. 92 (11); Sup. Ct. Order, eff. 1–1–80; 1979 c. 221 ss. 417, 2200 (20); 1979 c. 300, 331, 356; 1981 c. 20; 1981 c. 79 s. 17; 1981 c. 289, 314; 1983 a. 27 ss. 1116 to 1121, 2202 (20); 1985 a. 29 s. 3202 (56); 1985 a. 139; 1985 a. 176 ss. 533 to 556, 615; 1985 a. 265; 1985 a. 332 s. 251 (1); 1987 a. 339, 366; 1989 a. 31, 336, 359; 1991 a. 39; 1993 a. 16, 27, 213, 451, 490; 1995 a. 27 ss. 3268, 3269, 9145 (1); 1995 a. 77, 225; 1997 a. 27, 35, 237.

(END)

WPO: I goofed; please move to the end.

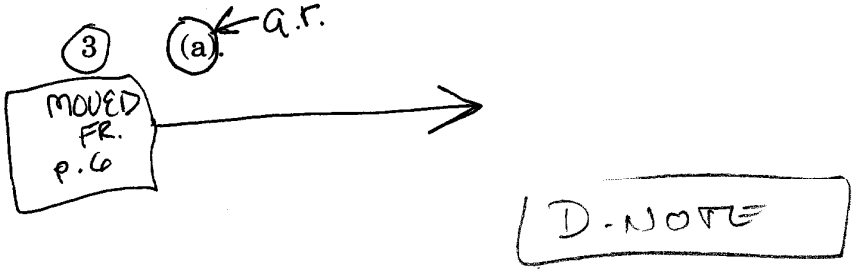
SECTION 9123. Nonstatutory provisions; health and family services.

(1) MENTAL HEALTH AND ALCOHOL OR OTHER DRUG ABUSE MANAGED CARE DEMONSTRATION PROJECTS. (a) From the appropriation under section 20.435 (5) (b) and (o) of the statutes, the department of health and family services shall contract with counties or tribes to provide up to 3 demonstration projects in state fiscal year 1999–2000 and up to 5 additional such projects in state fiscal year 2000–01. The demonstration projects shall be to provide mental health and alcohol or other drug abuse services under managed care programs to persons who suffer from both mental illness and alcohol or other drug dependency and who are eligible for medical assistance under sections 49.46 or 49.47 of the statutes.

(b) The department of health and family services shall submit for approval by the secretary of the federal department of health and human services any requests for waiver of federal medical assistance laws that are necessary to effectuate the managed care demonstration projects under this subsection.

(c) The department of health and family services shall establish an advisory committee for each demonstration project under this subsection. Each advisory committee shall be comprised of representatives of the county or tribe with which the department of health and family has contracted under paragraph (a), providers of mental health and alcohol or other drug abuse services and persons who suffer from both mental illness and alcohol or other drug dependency and their families. Each

advisory committee shall participate in developing policy and planning for delivery of services under the relevant managed care demonstration project under paragraph (a).



DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB–0326/P1dn
DAK...:...:...
cmy + jlg

To Gretchen Fossum:

1. Item A. 1. of the drafting instructions appears to request the language proposed for s. 51.001 (1), stats., also for ss. 51.42 (1) (a) 2. and 51.45 (1), stats. I have only drafted the language proposed for s. 51.001 (1); ordinarily, we no longer draft statements of legislative intent, findings or policy, except if constitutional issues are involved, but I have done so because s. 51.001 (1) is current law. I am, however, concerned about the implications of the language drafted, because it is possible that a court may interpret it to provide rights or benefits that may not have been intended. To also draft the language for the other statutes would be redundant. Moreover, if anything, the declaration of policy in s. 51.45 (1), stats., should probably be repealed; it is an example of a statement of intent that includes provisions that may be interpreted to be substantive in nature, having unforeseen effects on other, seemingly unrelated laws. See *State ex rel. Jacobus v. State*, 198 Wis.2d 783 (Ct. App. 1995), in which the court used s. 51.45 (1), stats., (which states that alcoholics and intoxicated persons should not be subjected to criminal prosecution because of their consumption of alcohol beverages) to hold that a person may not be convicted of bail jumping for consuming alcohol in violation of the terms of release bonds. This case was reversed at 208 Wis.2d 39 (1997), but the provisions remain an example of how these generalized statements may pose problems.

2. Item A. 2. of the drafting instructions requests the creation of numerous definitions in s. 51.01, stats., the statutory section that provides definitions for use in all of chapter 51, stats. The following is an explanation of what I have done, or have not done, with respect to this request, together with questions:

a. "Consumer outcomes", "system outcomes", "organizational outcomes" and "self–stigma"—These terms are used neither in the statutes nor in requested language. I did not include these definitions.

b. "Prevention"—I have defined this term for use in s. 51.03, stats; the language requested for this definition is applicable only to mental illness. The term is used in ss. 51.001 (1), 51.02 (1) (a), 51.42 (2) and (3) (ar) 4.a., 51.437 (1), 51.45 (throughout) and 51.91 (2) (f), stats. If the intent is to have the term defined for all of these statutes (including those dealing with alcoholism and developmental disability), please read all of them within the context of the defined language and advise me on how to change the language of the definition appropriately. The definition uses the term "mental

disorder"; it is not defined. What is the difference between a mental disorder and mental illness? This needs clarification.

c. "Early intervention"—This term is used in s. 51.44, stats., and in language requested for s. 51.03, stats. The definition proposed appears to be inapplicable for s. 51.44; do you agree? At this point, I have defined the term for use in s. 51.03 only. In drafting the term, I eliminated "with the goals of reducing the occurrence of new cases" and "delaying the onset of the disorder, illness and/or abuse", because the rest of the definition makes clear that the disorder or abuse has begun. Shouldn't "mental illness" be added to this definition? The same comment about the meaning of "mental disorder" as above (Drafter's Note 2. b.) applies.

d. "Crisis intervention"—This term is not used in requested language. I did not draft it. Notably, it is used in ss. 46.54, 49.45 (41), 49.46 (2) (b) 15. and 51.421 (2), stats. Is the language proposed applicable to all those statutes?

e. "Treatment"—This term is already defined for purposes of the chapter, in s. 51.01 (17), stats.; I did not include this definition, because it's unclear to me whether or not the intent is that the requested language replace the current definition. What is your intent?

f. "Habilitation"—This term occurs in ss. 51.42 (3) (aw) 1. a., 51.437 (1) and 51.62 (2) (a) 3., stats., and is requested for use in s. 51.001 (1), stats. I have drafted it for s. 51.01, stats., but an appropriate person from DHFS should read the statutes in which it is currently used to ensure that the definition, as drafted, is appropriate for inclusion in those statutes.

g. "Recovery"—This term is used in ss. 51.42 (1) (b) and 51.437 (4) (c), stats., and is requested for use in s. 51.03, stats. I have drafted it for use in s. 51.03, stats., only, because the other statutes use the term only in the context of recovery of liability. Please review my definition; I have not included all of the language proposed.

h. "Stigma"—This term is not used in current statutes. I defined it for purposes of s. 51.03, stats., only. Please review my definition; I have not included all of the language proposed.

i. "Substance abuse"—No language was proposed for this requested term. In addition, it is my understanding that you prefer to use the term "alcohol and other drug abuse".

j. "Individualized service planning"—This term is not used in current statutes. I defined it for purposes of s. 51.03, stats., only.

3. I am baffled by the majority of the drafting instructions in Item A. 3. The following are my questions:

a. The term "prevention" is requested for inclusion in s. 51.42 (3) (aw), stats. (presumably, in s. 51.42 (3) (aw) 1. a., stats). However, as defined (see Drafter's Note No. 2. b., above), the term applies only to mental disorders prior to onset of mental illness; s. 51.42 (3) (aw), stats., deals with individuals suffering from mental disabilities (mental illness, developmental disability, alcoholism or drug abuse). The term seems inapplicable both as to type of illness and as to stage of progression, unless

you are also requesting a wholescale change of the paragraph; what is the intent? The term also is requested for inclusion in s. 51.45 (5), stats.; there, however, the term "primary prevention" is already defined and used. What is the intent? To replace the defined term? Lastly, the term is requested to be included as a service in (to be created) s. 51.45 (5) (aw); what does this instruction mean? It is not comprehensible.

b. The term "early intervention" is requested for inclusion in ss. 51.42 (3) (aw) and 51.45 (5), stats., and s. 51.42 (5) (aw). How does "early intervention" differ from "precare" in s. 51.42 (3) (aw) 1. a., stats.? Is my treatment of s. 51.45 (5) (a) and (b) 2., stats., what you want? Lastly, the term is requested for inclusion in s. 51.42 (5) (aw); as stated above (Drafter's Note 3. a.), I cannot tell what the instruction means.

c. The term "community education services" is requested for inclusion in s. 51.42 (3) (aw), stats. How does this differ from "public informational and educational services" in s. 51.42 (3) (aw) 1. c., stats.? The term is also requested for inclusion in s. 51.45 (5), stats. How does this differ from "Inform and educate the community about alcohol and other drug abuse issue" in s. 51.45 (5) (b) 1., stats.? Lastly, the term is requested for inclusion in s. 51.42 (5) (aw); as stated above (Drafter's Note 3. a. and b.), I cannot tell what the instruction means.

4. With respect to Item A. 4. of the instructions, the majority of items on the list of duties for DHFS that are drafted in this bill under s. 51.03 (4) require DHFS to "promote" certain things. It is unclear to me what the legal implications of this language are for DHFS; that is, how is DHFS expected to enforce these provisions? How would DHFS respond to, for instance, a consumer of mental health services who alleges that he or she has been unable to "take more control of (his or her) life" (see s. 51.03 (4) (j)) because DHFS has failed to "promote consumer empowerment" and, who, on that basis, sues DHFS for enforcement? These provisions are so sweeping and, at the same time, vague, that I question whether they are appropriate for inclusion in the statutes; if they are meant to serve only as aspirations, it seems to me that they are inappropriate. If, on the other hand, they are intended to act in a more forceful way as requirements for DHFS, they would seem to be unattainable. Moreover, not all of the duties require mere "promotion". Section 51.03 (4) (b) requires development and implementation of a "comprehensive strategy" to "eradicate" stigma and discrimination against persons with mental illness and drug and alcohol abusers. This language appears to function more as a requirement than as an aspiration. Again, how is DHFS expected to enforce this provision? How would DHFS respond to a mental health services consumer who alleges stigmatization? I am not sure that specifically attaching to these provisions a qualifier concerning action within the limits of available state and federal moneys would solve the problems created by them. The following are specific questions I had about, or an explanation of changes I made to, the provisions:

a. In s. 51.03 (4) (a), I did not use the term "partnerships" because it has legal implications that I believe were not intended; I also did not use "address" because I'm not sure how resources "address", for instance, opportunities for recreation.

b. In s. 51.03 (4) (b), I drafted the word "eradicate", but I would suggest "reduce" as a more attainable alternative.

c. In s. 51.03 (4) (c), I did not include participation in service system governance; this would appear to be a grant of authority that would intrude on local and state powers.

d. In s. 51.03 (4) (f), what do the terms "culturally relevant" and "clinically appropriate" mean? What if the characteristics under this paragraph conflict; that is, what if treatment services that are "flexible" or "based on consumer choice" are not "cost effective"?

e. In s. 51.03 (4) (g), what does "high quality" mean? How is it measured? What if it is not attained?

f. Please review the language proposed in the request as s. 51.03 (1) (h). I did not draft it, because I do not understand what is intended by the words "mental health and substance abuse treatment services that focus on successful living in communities by providing access to jobs, housing, and transportation as well as health, education, vocational, social, spiritual and recreational resources, including the full use of natural supports". How can the services "focus" by providing access? Does this require the provision of housing, health, transportation, etc. in providing the mental health and alcohol and other drug abuse services? What are "spiritual" resources? What are "natural supports"?

g. In s. 51.03 (4) (h), what is "consumer empowerment"? How can "taking more control of their lives" be attained, or even measured?

h. In s. 51.03 (4) (i), the requirements of the service plan would appear to be exactly that—requirements. If this is the intent, they should be separately drafted as service provider requirements. Also, shouldn't the service plan be based on more than an assessment of the consumer's stated needs?

5. Please carefully review the nonstatutory provisions of this draft concerning the managed care demonstration projects. I have the following questions or explanations of drafting decisions I made:

a. I did not draft the request to waive Wisconsin Administrative Code provisions necessary for implementation of the demonstration projects. Rules are defined in s. 227.01 (13) (intro.) to ". . . implement, interpret or make specific legislation enforced or administered by the agency", not the other way around. Moreover, the instruction is so vague that I am unable to draft provisions in this proposed legislation that would be necessary to overrule any potentially conflicting rules provisions.

b. I am unable to comply with that part of Item B. 3. of the instructions that concerns the "objectives of the BRC recommendations". Please provide me with a specific listing of these objectives if it is necessary to be drafted.

c. I am unable to comply with Item B. 4. of the instructions. What, specifically, are "outcomes indicators"? How are they to be used? Why is it necessary to amend s. 46.031? What is meant by "necessary terms"?

d. I am unable to comply with Item B. 5. of the instructions. Which funds? From what appropriations?

e. I do not understand the request in Item B. 6. of the instructions. The nonstatutory language I have drafted is quite broad; it does not appear to me to be constrained by s. 51.42. What "services beyond the list of services in 51.42" are referred to?

Debora A. Kennedy
Assistant Chief Counsel
266–0137

DRAFTER'S NOTE
FROM THE
LEGISLATIVE REFERENCE BUREAU

LRB-0326/P1dn
DAK:cmh&jlg:jf

December 1, 1998

To Gretchen Fossum:

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a. The term "prevention" is requested for inclusion in s. 51.42 (3) (aw), stats. (presumably, in s. 51.42 (3) (aw) 1. a., stats). However, as defined (see Drafter's Note 2. b., above), the term applies only to mental disorders prior to onset of mental illness; s. 51.42 (3) (aw), stats., deals with individuals suffering from mental disabilities (mental illness, developmental disability, alcoholism or drug abuse). The term seems inapplicable both as to type of illness and as to stage of progression, unless you are also

requesting a whole scale change of the paragraph; what is the intent? The term also is requested for inclusion in s. 51.45 (5), stats.; there, however, the term "primary prevention" is already defined and used. What is the intent? To replace the defined term? Lastly, the term is requested to be included as a service in (to be created) s. 51.45 (5) (aw); what does this instruction mean? It is not comprehensible.

b. The term "early intervention" is requested for inclusion in ss. 51.42 (3) (aw) and 51.45 (5), stats. and s. 51.42 (5) (aw). How does "early intervention" differ from "precare" in s. 51.42 (3) (aw) 1. a., stats.? Is my treatment of s. 51.45 (5) (a) and (b) 2., stats., what you want? Lastly, the term is requested for inclusion in s. 51.42 (5) (aw); as stated above (Drafter's Note 3. a.), I cannot tell what the instruction means.

c. The term "community education services" is requested for inclusion in s. 51.42 (3) (aw), stats. How does this differ from "public informational and educational services" in s. 51.42 (3) (aw) 1. c., stats.? The term is also requested for inclusion in s. 51.45 (5), stats. How does this differ from "Inform and educate the community about alcohol and other drug abuse issue" in s. 51.45 (5) (b) 1., stats.? Lastly, the term is requested for inclusion in s. 51.42 (5) (aw); as stated above (Drafter's Note 3. a. and b.), I cannot tell what the instruction means.

4. With respect to Item A. 4. of the instructions, a majority of items on the list of duties for DHFS that are drafted in this bill under s. 51.03 (4) require DHFS to "promote" certain things. It is unclear to me what the legal implications of this language are for DHFS; that is, how is DHFS expected to enforce these provisions? How would DHFS respond to, for instance, a consumer of mental health services who alleges that he or she has been unable to "take more control of (his or her) life" (see s. 51.03 (4) (h) because DHFS has failed to "promote consumer empowerment" and, who, on that basis, sues DHFS for enforcement? These provisions are so sweeping and, at the same time, vague, that I question whether they are appropriate for inclusion in the statutes; if they are meant to serve only as aspirations, it seems to me that they are inappropriate. If, on the other hand, they are intended to act in a more forceful way as requirements for DHFS, they would seem to be unattainable. Moreover, not all of the duties require mere "promotion". Section 51.03 (4) (b) requires development and implementation of a "comprehensive strategy" to "eradicate" stigma and discrimination against persons with mental illness and drug and alcohol abusers. This language appears to function more as a requirement than as an aspiration. Again, how is DHFS expected to enforce this provision? How would DHFS respond to a mental health services consumer who alleges stigmatization? I am not sure that specifically attaching to these provisions a qualifier concerning action within the limits of available state and federal moneys would solve the problems created by them. The following are specific questions I had about, or an explanation of changes I made to, the provisions:

a. In s. 51.03 (4) (a), I did not use the term "partnerships" because it has legal implications that I believe were not intended; I also did not use "address" because I'm not sure how resources "address", for instance, opportunities for recreation.

b. In s. 51.03 (4) (b), I drafted the word "eradicate", but I would suggest "reduce" as a more attainable alternative.

c. In s. 51.03 (4) (c), I did not include participation in service system governance; this would appear to be a grant of authority that would intrude on local and state powers.

d. In s. 51.03 (4) (f), what do the terms "culturally relevant" and "clinically appropriate" mean? What if the characteristics under this paragraph conflict; that is, what if treatment services that are "flexible" or "based on consumer choice" are not "cost effective"?

e. In s. 51.03 (4) (g), what does "high quality" mean? How is it measured? What if it is not attained?

f. Please review the language proposed in the request as s. 51.03 (1) h. I did not draft it, because I do not understand what is intended by the words "mental health and substance abuse treatment services that focus on successful living in communities by providing access to jobs, housing, and transportation as well as health, education, vocational, social, spiritual and recreational resources, including the full use of natural supports". How can the services "focus" by providing access? Does this require the provision of housing, health, transportation, etc. in providing the mental health and alcohol and other drug abuse services? What are "spiritual" resources? What are "natural supports"?

g. In s. 51.03 (4) (h), what is "consumer empowerment"? How can "taking more control of their lives" be attained, or even measured?

h. In s. 51.03 (1) (i), the requirements of the service plan would appear to be exactly that—requirements. If this is the intent, they should be separately drafted as service provider requirements. Also, shouldn't the service plan be based on more than an assessment of the consumer's stated needs?

5. Please carefully review the nonstatutory provisions of this draft concerning the managed care demonstration projects. I have the following questions or explanations of drafting decisions I made:

a. I did not draft the request to waive Wisconsin Administrative Code provisions necessary for implementation of the demonstration projects. Rules are defined in s. 227.01 (13) (intro.) to ". . . implement, interpret or make specific legislation enforced or administered by the agency", not the other way around. Moreover, the instruction is so vague that I am unable to draft provisions in this proposed legislation that would be necessary to overrule any potentially conflicting rules provisions.

b. I am unable to comply with that part of Item B. 3. of the instructions that concerns the "objectives of the BRC recommendations". Please provide me with a specific listing of these objectives if it is necessary to be drafted.

c. I am unable to comply with Item B. 4. of the instructions. What, specifically, are "outcomes indicators"? How are they to be used? Why is it necessary to amend s. 46.031? What is meant by "necessary terms"?

d. I am unable to comply with Item B. 5. of the instructions. Which funds? From what appropriations?

e. I do not understand the request in Item B. 6. of the instructions. The nonstatutory language I have drafted is quite broad; it does not appear to me to be constrained by s. 51.42. What "services beyond the list of services in 51.42" are referred to?

Debora A. Kennedy
Assistant Chief Counsel
266–0137

Kennedy, Debora

From: Fossum, Gretchen [gretchen.fossum@doa.state.wi.us]
Sent: Monday, December 21, 1998 2:39 PM
To: Kennedy, Debora
Subject: Comments on LRB 0326/P1

Debora:

Attached are the departments comment on the Blue Ribbon Commission draft. You will find some DOA instruction or comments (signaled out in bold). If you have any questions, please contact me.

BRC Drafting Instructions

The following are responses to the concerns raised by Debora Kennedy, LRB in LRB-0326/P1dn, regarding the BRC drafting instructions:

1. Item A. We concur that only s.51.001 be amended. This language has been reviewed by staff in the Department's OLC and they are comfortable this language would not be interpreted as to "provide a right or benefit". LRB also states that the declaration of policy contained in Section 51.45 should probably be repealed. The policy addresses the issue de-criminalization of intoxication and alcoholism. We oppose this recommendation to repeal the policy. Section 51.45 was included in statute in recognition of the fact that alcoholism is a disease. While the statement of policy may reflect what is referred to as a "generalized statement", Section 51.45 is the statutory foundation for the concept of treatment.

   DOA instruction: Repeal s. 51.45(1).

   DOA Comment: The amendment to s. 51.001 may not survive (LRB concerns and current policy are well founded) but I would like to leave this in the draft pending final decisions.

2. Item A.2.

   a. We agree that definitions for "consumer outcomes", "system outcomes", "organizational outcome", and "self-stigma" do not need to be included.

   b. Agree, this definition of Prevention is only applicable to mental illness as used in 51.001(1), 51.02(1)(a) and 51.91(2)(f). Regarding mental disorder, this is already used in statutes and not defined.

      DOA instruction: ~~Remove the reference to "mental disorder"~~. No. Do not remove. G. Fossum 12/28

   c. We agree early intervention is only applicable to 51.03 and not applicable to 51.44. The rewording of the definition is acceptable but agree "mental illness" should be added after mental disorder on line 19. We agree with the definition as drafted for "early intervention".

      DOA instruction: Remove the reference to "mental disorder" and substitute "mental illness".

   d. We would prefer the definition of "crisis intervention" be added in s. 51.01 to be applicable to all statutes mentioned by the drafter. If the drafter finds it problematic to include this definition, it does not need to be drafted.

DOA instruction: Do not include the definition of crisis intervention in the draft.

e. The intent here is to replace the current definition of "treatment".

DOA instruction: Do not change the definition of treatment in s. 51.01(17). The department has excluded the current law reference to the developmentally disabled in its new definition.

f. The definition for habilitation is acceptable for all statutes identified.

g. The definition for recovery is acceptable and only applicable to 51.03.

h. The definition for stigma is acceptable and only applicable to 51.03.

i. No language is needed at this time for "substance abuse".

j. The definition for individualized service planning is only necessary for 51.03

3. The purpose here is to add these three services as optional programs to be provided in s.51.42 (3) (aw).

a. In response to the drafter's questions, recommend adding, "Prevention services, where applicable" in s.51.42 (3) (aw).

DOA instruction: Do not include "prevention services" in s. 51.42(3)(aw).

b. Early intervention is a more prescribed term for a specific service as outlined in the definition. Precare could be a number of different services and is not defined in statute. Therefore we are requesting that early intervention be listed as a separate service in 51.42 (3) (aw). With regards to 51.45(5) (a) 1, we suggest the definition as indicated above. For 51.45 (5) (b) 2 we request that ""prevention" also be inserted on line 24.

DOA instruction: Do not include the requested drafting in part b. above. Delete sections 6, 7 and 8 from the draft. These sections and the request above go beyond the Blue Ribbon Commission.

c. There is no difference between "community" education services" and "public informational and educational services". Therefore there is no need to draft any statutory language related to community education services.

For item 3a, b and c it is not necessary to create and include these terms in 51.45 (5) (aw) at this time.

4. To address concerns of LRB we suggest at the beginning of this section the following language be inserted:

In s. 51.03(4) use the following: "Within the limits of available state and federal funds the Department may" With this addition the Department's OLC is supportive of this language.

DOA comment: this language is similar to s. 51.42(3)(aw)1..

In addition all of the suggested wording revisions, as drafted by LRB, are acceptable. We also agree with the suggestion to eliminate 51.03 (h) and propose the following revisions to other items:

a. We agree with your approach.

b. S. 51.03(4)(b) - We agree "reduce" rather than "eradicate" should be used.

c. S. 51.03 (4) (c), we agree that system governance can be omitted.

d. 51.03(4)(f) - "Culturally Relevant" means that services are provided in a manner appropriate to individual culture and/or ethnic background. "Clinically Appropriate" means the services that are provided are necessary to treat the symptoms of the individuals. If actual definitions are needed for statute, DHFS will draft them.

DOA instruction: Delete s. 51.03(4)(f) on page 4, lines 18 through 21.

e. 51.03(4)(g) - We agree that "high quality" is a difficult concept to define and measure. We suggest "high quality" be replaced with "appropriate".

f. We agree that our proposed provision for s. 51.03(1)h can be omitted.

g. 51.03(h) – Rather than using the terms "consumer empowerment" and "taking control of their lives", we suggest s.51.03 be revised to read, "Promote consumer decision making to enable persons with mental illness and alcohol or drug dependency to be more self-sufficient."

h. 51.03(4)(i) – On line 9 eliminate the words "service" and "stated" so that the penultimate clause reads "be based on a comprehensive assessment of the consumer's strengths, abilities, needs, and preferences;" That is, the service plan is based on all four factors.

12/28/98: From Gretchen Fossum: Draft as of 1/5. request

5. Non-statutory provisions:

a. Your recommended approach is acceptable.

b. Our intent in (c) was for DHFS to establish one advisory committee to oversee all the demos, not one for each as suggested in line 16. We will, through our contracts, establish requirements for local oversight committees, but DHFS will not establish these. We recommend that (c) be revised to read: "(c) The department of health and family services shall establish an advisory committee for the demonstration projects under this subsection.

c. We agree that we do not need to draft the provisions B.4

d. Upon further review we believe that we do not need to draft provision B.5 of our original request. We believe that the statutory language changes proposed for Family Care give the Department the authority to pool funds for MA, Community Aids, and COP and develop capitated rates.

e. No further drafting is necessary at this time on this issue

In addition we have the following requested revisions:

a. Under (a) we need to clarify that while the appropriation from 20.435 relates to Medicaid recipients only, the demos are not limited to Medicaid recipients, as is suggested in line 9.

DOA instruction: on page 6, line 3 change the chapter 20 references to s. 20.435(6)(a) and (n). On line 9 delete the material beginning "and who". Delete line 10.

12/28 From Gretchen Fossum: Do not draft

b. Since some demos may also cover primary and acute care, the language on lines 6 and 7 need to be changed to reflect this.

c. The demos are for persons with mental illness and/or AODA disorders. Line 8, and also line 20, makes it sound like they must have both.

DOA comment: I am not sure precisely what the department means here.

Thank you for the opportunity to comment. If you have questions please let me know.

GF: ok { MI AODA MI and AODA

GF: ok { Should change "tribes" to "federally recognized American Indian tribes or bands"