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May 6, 2014

TO: Members
Joint Committee on Finance

FROM: Bob Lang, Director

SUBJECT: Health Services: Comprehensive Community Services -- Agenda Item VIII

On February 28, 2014, the Department of Health Services (DHS) requested the release and transfer of $10,202,000 GPR in 2014-15 from the Joint Committee on Finance program supplements appropriation to the GPR appropriation that supports medical assistance (MA) benefits. This transfer would enable DHS to begin implementing provisions contained in 2013 Wisconsin Act 20 (the 2013-15 biennial budget act) to fund the non-federal share of comprehensive community services (CCS) provided by counties on a regional basis, beginning July 1, 2014. On March 19, the Co-Chairs notified the Department that the Committee wished to meet on the matter.

Act 20 placed this funding in the Committee's supplemental appropriation for release by the Committee under a 14-day passive review process and directed DHS to submit to the Committee by March 1, 2014, a request for the release of funds and a report that includes all of the following: (a) a description of the criteria that DHS will apply in the regionalization model; (b) a description of how the regions will be established and the degree of county participation in that process; (c) an updated list of counties that intend to offer MA-funded CCS services on a regional basis; and (d) an estimate of the long-term costs of the proposed regional model.

BACKGROUND

Comprehensive Community Services and Act 20

Comprehensive community services are community-based psychosocial rehabilitation services. Under federal law, CCS is an optional MA benefit that falls under the definition of diagnostic, screening, preventive and rehabilitative services recommended by a physician or other licensed practitioner "for the maximum reduction of physical or mental disability and restoration of an individual to the best possible functional level." DHS describes the program as a "wraparound"

program -- providing maximum flexibility that is participant directed, recovery oriented, and outcome based.

In order to qualify for these services, an MA recipient must, as determined by a DHS-approved functional screen, require more intense services than outpatient counseling services. Further, the individual must have a diagnosis of a mental disorder or a substance-use disorder and a functional impairment that interferes with, or limits one or more major life activities, and results in need for services that are ongoing and comprehensive. These services may be provided to adults and children.

Fifteen service categories are provided under this benefit: (a) assessments; (b) recovery planning; (c) service facilitation; (d) communication and interpersonal skills training; (e) community skills development and enhancement; (f) diagnostic evaluations and assessments; (g) employment-related skills training; (h) medication management; (i) physical health and monitoring; (j) psycheducation; (k) psychotherapy; (l) recovery education and illness management; (m) substance abuse treatment; (n) non-traditional or other approved services; and (o) psychosocial rehabilitative residential supports. Participating counties are not required to provide all 15 services under the CCS benefit.

DHS Administrative Rule 36 specifies CCS program requirements relating to county and tribal certification, services, program personnel, eligibility, assessments, consumer records and consumer rights. Only counties and tribes that meet specified certification standards may provide CCS.

Currently, counties may elect to provide MA-funded CCS to qualifying county residents and pay the non-federal share of the costs of providing these services (currently, approximately 41% of eligible costs). As previously indicated, Act 20 included a provision that required DHS, beginning July 1, 2014, to reimburse CCS providers for both the federal and non-federal costs of these services if the services are provided on a regional basis and if the Joint Committee on Finance authorizes DHS to implement this provision. The non-federal share of these costs would be funded from the DHS GPR MA benefits appropriation.

Act 20 provided $10,202,000 GPR in 2014-15 in the Committee's supplemental appropriation to support the estimated state's share of MA costs that would be incurred in 2014-15. This funding amount was based on several assumptions, including that: (a) 26 counties that currently provide CCS services would switch to the DHS-certified regional model over a six-month period, beginning July 1, 2014; and (b) all remaining counties would establish certified CCS programs under the DHS regional model over a twelve-month period, beginning July 1, 2014, and that individuals in those counties would participate in CCS at the same average rate as in the current CCS counties.

Based on the Act 20 assumptions, the annualized costs of providing the state's share of these benefits were estimated to be approximately $19.2 million GPR, compared to the $10.2 million budgeted during the "phase in" of the regional model. For this reason, this office identified $9.0

million per year in additional general fund commitments relating to these services, beginning in 2015-16.

Other MA Community-Based Mental Health Services

Under state law, counties have the primary responsibility for the well-being, treatment, and care of residents with mental illness, developmental disabilities, and alcohol or other drug dependency. However, counties are only responsible for the programs, services, and resources that the county can reasonably provide within the limits of state, federal and county matching funds. For this reason, counties have some discretion in what programs and services they offer to their residents and have a fiscal incentive to provide these services in the most cost-effective manner.

The state's MA program funds several community-based mental health services for MA recipients, most of which are administered by counties, either directly or through contracts with agencies. The scope and limitations of these services are described in administrative rules.

Case Management Services. Counties may choose to provide case management services to certain groups, including adults with mental illness. Case management services include: (a) a comprehensive, written assessment of the individual's abilities, deficits, and needs; (b) development of a written plan of care to address the needs of a client; and (c) ongoing monitoring and service coordination. Several limitations apply to these services, such as limits on annual reimbursement for assessment and case plan development to no more than one per client in a calendar year unless the recipient's county of residence has changed. Further, counties cannot claim reimbursement for case management services provided to individuals who are enrolled in health maintenance organizations or MA-supported home- and community-based waiver programs, as case management services are provided and funded as part of these services.

If a county chooses to offer case management services to one or more groups of MA recipients, it receives the federal share of the statewide MA-reimbursement rate plus an additional payment under the Wisconsin Medicaid cost reporting (WIMCR) program, which is based on actual costs documented in county reports.

Community Support Program (CSP). Wisconsin's MA program funds CSP services that are prescribed by a physician. These non-institutional services provide medical treatment and related services to enable clients to better manage the symptoms of their illnesses, to increase the likelihood of their independent, effective functioning in the community and to reduce the incidence and duration of institutional treatment otherwise brought about by mental illness.

DHS Administrative Rule 63 specifies requirements relating to county and tribal certification, services, program personnel, eligibility, assessments, consumer records and consumer rights. Covered services include: (a) initial assessment; (b) in-depth assessment; (c) development of treatment plans; (d) treatment services, which may include family, individual and group psychotherapy, symptom management or supportive psychotherapy, medication prescription, administration and monitoring, crisis intervention, including short-term emergency care at home or elsewhere in the community, and psychiatric and psychological evaluations; (e) psychological

rehabilitation services; and (f) case management in the form of ongoing monitoring and service coordination activities.

Community Recovery Services (CRS). Adult MA recipients in families with income up to 150% of the federal poverty level (FPL), who do not live in an institution and who have severe and persistent mental illness may receive community recovery services (CRS). To qualify for CRS, a consumer must have a diagnosis of mood disorder, schizophrenia or another psychotic disorder in combination with a functional need for community assistance. For each CCS client, an individualized service plan is developed through a person-centered planning process. There are three types of services provided under the CRS benefit -- community living supportive services, supported employment and peer support.

Community living supportive services allow individuals to live with maximum independence in community-integrated housing and can include meal planning and preparation, household cleaning, assistance with personal hygiene, medication management and monitoring, parenting skills, community resource access and utilization, emotional regulation skills, crisis coping skills, shopping, transportation, recovery management skills and education, financial management, social and recreational activities, and developing and enhancing interpersonal skills.

Supported employment services assist individuals in obtaining and maintaining competitive employment. These services can include intake, assessment, job development, job placement, work-related symptom management, employment crisis support, and follow-along supports by an employment specialist.

Peer specialists serve as advocates, provide information and peer support for individuals in emergency, outpatient, community and inpatient settings and demonstrate techniques in recovery and ongoing coping skills.

As with CCS, a county or tribal agency that wishes to provide CRS must meet certain service standards and be certified by DHS. Under CRS, counties and tribes provide the non-federal share of CRS expenditures and MA reimburses counties and tribes the federal share based on the federal medical assistance percentage (FMAP) applicable at the time of the service.

Outpatient Mental Health Services. Outpatient psychotherapy services may be provided to an MA recipient if the services are prescribed by a physician, provided by a certified provider and if other conditions are met, such as the completion of a patient assessment. The services must be rendered by certain types of providers at certain types of facilities. Certain limitations apply, including prior authorization for services beyond 15 hours or $825, whichever is attained first. Unlike the mental health services previously described, these services are not provided by counties, either directly or through contracts.

DHS 35 establishes minimum standards for certification of outpatient mental health clinics that receive reimbursement for services under the state's MA program, from private insurance regulated under the state's insurance statutes, and other federal and state programs. The rule defines outpatient mental health services as services that include intake, assessment, evaluation,

diagnosis, treatment planning, psychotherapy and medication management.

Psychotherapy is a general term for treating mental health problems by talking with a psychiatrist, psychologist, or other mental health provider. During psychotherapy, the client learns about his or her conditions, moods, feelings, thoughts, and behaviors. Psychotherapy is intended to help the client learn how to respond to challenging situations with healthy coping skills. Psychotherapy is also known as talk therapy, counseling, psychosocial therapy or simply therapy.

CSP, CCS and CRS provide community-based psychosocial rehabilitation services through counties and tribes that have met DHS certification standards. DHS has summarized some of the most significant differences between these programs, which are shown in Table 1.

TABLE 1

Primary Differences Between CSP, CCS, and CRS

	CSP	CCS	CRS
Participants	Adults with mental illness and high degree of functional impairment and on-going high needs.	Adults and children with mental illness and/or substance abuse. They may have low intensity on-going needs or cyclical on-going high intensity needs.	Adults and children over 14 who are enrolled in MA in families with countable income at or below 150 percent of the federal poverty level (FPL). Meet CRS functional eligibility criteria.
Type of Program	Complete wrap-around model in which all services are provided by the treatment team.	Looser wrap-around model with a greater amount of coordination and services are provided by a variety of people.	Medicaid waiver program that focuses on three supportive services for those living in group homes and in the community.
Focus of the Program	Provide a wide variety of services to enable the individual to live independently in the community.	Based on recovery principals and consumer's input.	Provide three services to enable the individual to mitigate the mental illness and live independently in the community and to reduce the incidence and duration of institutional treatment for mental illness.
Services Provided	Multitude of psychosocial rehabilitation services, based on consumers functioning.	A number of psychosocial rehabilitation services that are mutually determined by the consumer and professionals.	Three services: CLSS: Community Living Support Services Peer Specialists Independent Placement and Support - employment services.

TABLE 1

Primary Differences Between CSP, CCS, and CRS

	CSP	CCS	CRS
Duration of Services	Expected to be in program a significant number of years: can be life long.	Recovery is anticipated and expected so shorter duration than CSP, not life long.	Can be lengthy service but consumer has to continue to have deficits in functioning and financial level to qualify for program; recovery is anticipated.
Level of Services	Very intense in number of services provided and frequency and duration of services.	Intensity varies on consumer's need. Less intense in number, frequency and duration of services than CSP.	Limited number of services to provide and case management is not a covered service.
Model	Medical model - very prescriptive model - least flexible.	Recovery model - least prescriptive model - most flexible.	Supportive services model
Limits on Services	Limited to the scope of the Administrative Rule 63 and those that are needed.	Limited to the scope of the Administrative Rule 36 and those that are needed and desired by the consumer.	Daily and monthly service limits for the services.

Emergency Mental Health Services (Crisis Services). Emergency mental health services, or crisis services, are a coordinated system of mental health services that provide an immediate response to assist an individual who is experiencing a mental health crisis. A "crisis" is a situation caused by an individual's apparent mental disorder, which results in a high level of stress or anxiety for the individual, persons providing care for the individual, or the public and which cannot be resolved by the individual or others who provide ordinary care or support for the individual. In addition to providing services to individuals in crisis, services may be provided if a situation is likely to develop into a crisis if supports are not immediately provided.

Counties may be reimbursed for crisis services they provide, either from the MA program or other third-party payers, by meeting certification standards established in rule. The rule identifies six required services for certified programs: (a) telephone services; (b) a mobile crisis team; (c) walk-in services; (d) short-term voluntary or involuntary hospital care; (e) linkage and coordination services to support cooperation in the delivery of emergency mental health care in the county in which the program operates; and (f) specialized services to meet the unique needs of children, adolescents, and their families.

As with CCS, CPS, and mental health outpatient services, certified agencies that provide emergency mental health services are reimbursed for that portion of allowable costs for which federal MA matching funds are available.

Crisis services are somewhat different from CCS, CPS and CRS because they are provided to address the immediate needs of individuals in crisis, rather than as part of an ongoing plan of

care for an individual. However, they are an important component of every county's mental health services. Moreover, county-administered CCS, CPS and CRS programs are intended to reduce the need and costs of emergency mental health services.

Information on Mental Health Services Provided by Dane County

The following information is presented as an example of one county's adult mental health services. to describe how mental health services for adults are currently provided in one county.

The county's mental health system currently offers a broad set of services for adults with mental illness, including:

- Community support services;
- Day center services;
- Case management;
- Work services;
- Supervised living arrangements through community-based residential facilities (CBRFs), adult family homes and other community living options;
- Crisis intervention and stabilization;
- Inpatient hospital services;
- Counseling and therapeutic resources (including psychotropic medications);
- Intake assessments;
- Psychosocial rehabilitation; and
- Outreach.

The Dane County Department of Human Services contracts with 21 different agencies to provide these services. In 2013, the county budgeted approximately $24.0 million to support adult mental health services, of which approximately $5.3 million (22%) was budgeted to fund CSP program services. Approximately 73% of the total cost of adult mental health services was funded from MA funds (37%), state grants (18%), state and federal grants, client fees and other revenues (18%), and 27% of the total cost of these services was funded from county property tax revenues.

Dane County does not currently offer CCS, but indicated that it would begin providing the MA CCS benefit, as a single populous county, beginning July 1, 2014, if the Committee approved the DHS request to implement the Act 20 provisions. County staff projected that the average number of individuals who would receive services would increase to an average of 265 individuals in 2015, 315 in 2016, and 350 in 2017.

ANALYSIS

This section discusses: (a) the method DHS used to estimate program costs in fiscal years 2014-15 through 2016-17; and (b) several factors that may affect the state's costs of providing these services in future years; and (c) options for the Committee's consideration.

Cost Estimates for Fiscal Years 2014-15 through 2016-17

In its report to the Committee, DHS estimated that the GPR costs of CCS regionalization would total $10,539,300 in 2014-15 (a $337,100 increase from the amount budgeted in that year), $21,517,200 in 2015-16 and $26,536,300 in 2016-17. The estimated cost increase in 2014-15, compared to the Act 20 budgeted amount, would be funded from the current MA benefits budget. It should be noted that in its most recent quarterly report (March, 2014) on the status of the MA benefits appropriation, DHS identified a potential shortfall of approximately $20.3 million GPR in the 2013-15 biennium.

Based on the DHS cost estimates for the 2015-17 biennium, the additional estimated 2015-17 general fund commitments, originally estimated at $9.0 million annually, would increase by approximately $2.3 million, to $11.3 million in 2015-16 and by approximately $7.3 million, to $16.3 million, in 2016-17.

The DHS report described the method and assumptions the agency used to estimate these costs for fiscal years 2014-15 through 2016-17. First, DHS solicited county and tribal input into the regional models for CCS, and formed a CCS Advisory Committee. Second, DHS asked counties and tribes to complete a "CCS regional intent form," which required counties that intended to provide CCS on a regional basis to provide certain information, including: (a) the counties and tribes within the regional partnership; (b) the type of region the county would join; (c) the number of individuals the CCS region expected to serve, by county, within the region in each calendar year, from 2014 through 2017; (d) a description of the service delivery system structure in the proposed region; (e) the array of services the CCS region would provide; (f) the administrative structure of the proposed region; (g) total program costs and the average cost per CCS recipient; and (h) an estimate of the number of individuals currently served in other locally-administered programs that would transition to CCS.

Based on the information provided by counties, and the assumption that all counties that expressed interest would transition to a regional model on July 1, 2014, and gradually increase CCS enrollment through state fiscal year 2014-15, DHS estimated program costs through fiscal year 2016-17. DHS used actual 2011-12 program costs, but assumed that the average per recipient service costs would increase by approximately 10% in 2014-15 and by 2% per year thereafter to reflect anticipated growth in the use of services.

For Milwaukee County, DHS used the enrollment estimates submitted by the county for calendar year 2014 and 2015 (92 and 245, respectively), but did not use the county's enrollment estimates for calendar years 2016 and 2017 (286 in each year). Instead, DHS assumed that enrollment would increase to 800 in calendar year 2016 and to 1,100 in calendar year 2017, based on the number of individuals that Milwaukee County had estimated would be initially served under the CRS mental health benefit, at the time DHS was developing its 2009-11 biennial budget request. (Milwaukee County later decided not to offer the CRS benefit in response to changes enacted in the federal Affordable Care Act that would have reduced the county's ability to limit service costs.)

Attachment 1 summarizes the program status and enrollment estimates DHS used to project program costs, by county. DHS converted these calendar year projections to state fiscal years, resulting in the state fiscal year cost and enrollment estimates shown in Table 2. The administration's enrollment and cost estimates appear reasonable, as they are largely based on responses each county provided.

TABLE 2

Implementation of Regional Comprehensive Community Services
Estimates of Total MA Benefits Costs and Average Caseload

	Estimates		
	2014-15	2015-16	2016-17
Funding			
GPR	$10,539,300	$21,517,200	$26,536,300
FED	14,838,200	30,294,000	37,360,500
All Funds	$25,377,500	$51,811,200	$63,896,800
Change from Previous Year			
GPR		$10,977,900	$5,019,100
All Funds		26,433,700	12,085,600
Average No. of Individuals Enrolled	2,594	4,752	5,737

Long-Term Effect on State and Mental Health Systems Costs

As previously indicated, while there is substantial uncertainty regarding potential CCS enrollment after the expansion, the administration's cost estimates for the three-year period appear reasonable. However, the state's costs of this initiative are likely to continue to increase in the future for several reasons. Although state costs may increase, there are potential savings to counties and to the mental health system as a whole that are not captured in an analysis of the state costs alone. The reasons for potential cost changes are discussed below.

Shift in Services from Other Programs. CCS offers several similar services that counties currently provide for adults and children from other funding sources, including community aids and county tax levy. For individuals who can receive the appropriate level of care in CCS, counties would have a fiscal incentive to shift those individuals away from county-funded programs to the state-funded CCS benefit. For instance, some individuals who are currently enrolled in CSP may be disenrolled from that program and instead begin to receive less intensive services under the CCS benefit. This may enable counties to serve some individuals who are currently on county CSP waitlists.

Similarly, some services that are currently funded under one county-funded program would instead be billed under the CCS benefit. For instance, some services provided to children with

mental illness who are eligible for services under the children's long-term services (CLTS) waiver could instead be funded from the CCS benefit if a child qualifies for CCS services. Since CCS is considered a "state plan service," any eligible CCS service, such as a functional screen provided for a child enrolled in the CLTS waiver program, would be claimed under the CCS benefit, rather than under an MA waiver program which, for these purposes, is a payer of last resort.

This shift from county-funded programs to CCS is captured in the county enrollment estimates, and it is assumed that a substantial number of new CCS participants will have previously been receiving other county-funded services (either at a similar, lower, or higher level of care). However, if these projections understate the degree to which clients are reassigned to receive CCS services, long-term costs may exceed the DHS estimates.

Ten counties (Burnett, Clark, Douglas, Grant, Iowa, Menomonee, Price, Sawyer, Trempealeau, and Washburn Counties) have indicated to DHS that they do not intend to offer CCS at this time. While the Department's cost estimates shown in Table 1 do not assume that these counties will begin offering these services during the next three years, it is possible that these counties will begin offering these services in the future. Similarly, counties that currently offer CCS may choose to increase the types of services they offer, as some counties do not currently offer all 15 CCS services.

Due to changes in the BadgerCare Plus eligibility standards, effective April 1, 2014, more adults without dependent children will qualify for MA and potentially be eligible for county-supported mental health services, although a comparable number of adults with dependent children in families with income greater than 100% of the FPL will no longer be eligible for coverage under BadgerCare Plus. It is not known whether this will affect the state costs of the CCS regionalization initiative, or if counties considered this eligibility change in submitting CCS caseload projections on their regional intent forms.

Benefit of Regionalization. Providing CCS on a regional basis may result in economies of scale in delivering mental health services, particularly in less populous, rural counties. This may result in lower costs per CCS enrollee than assumed in the DHS estimate. As indicated in the DHS report, counties have identified a willingness to share the following functions on a regional basis: (a) clinical supervision; (b) training; (c) providers; (d) coordinating committees; (e) child psychiatrist and telemedicine services; (f) quality assurance; (g) policies and procedures; (h) electronic health record information technology; and (i) administrative functions.

Improved Access to Community-Based Services. The Act 20 provisions are intended to expand CCS statewide and to increase consumer access to community mental health services. The administration cites potential cost savings of providing CCS, including increased program efficiencies by regional delivery models, and decreased use of more costly services, such as inpatient hospital and institutional care. For example, the current inpatient rate counties pay for adult psychiatric services provided at the state's mental health institutes is $999 per day, while DHS estimates that the statewide average annual cost of providing CCS services to an individual would be approximately $10,700, or $29.31 per day, in 2014-15. In addition, counties may use savings generated by this proposal to provide services to individuals who are currently on waitlists

for services, or are otherwise unable to receive mental health services due to county budget constraints.

Future Option to Increase State Support for Certified County Mental Health Programs

The DHS Division of Mental Health and Substance Abuse Services is budgeted $3,757,500 GPR in 2013-14 and 2014-15 to provide to counties to support the following statutory purposes: (a) community support program services; (b) community-based psychosocial services; (c) community recovery services; and (d) mental health crisis intervention services. Of this amount, DHS allocates $2,818,100 GPR to support the nonfederal share of the costs of the services listed above and $939,400 annually to fund CSP services for counties with waitlists for CSP services. Attachment 2 lists the GPR allocations each county received to support the nonfederal share of the costs of county-certified services in calendar years 2011, 2012, and 2013. Attachment 3 lists the GPR allocations DHS provided to counties with CSP waitlists for those years.

In light of concerns over potential future increases in state costs of providing county-administered MA-supported mental health services, the Committee could deny the Department's request and instead consider increasing GPR funding for the DHS sum certain appropriation to support MA-eligible, certified community-based mental health programs as part of the 2015-17 budget. This would permit the Committee to consider statutory changes, such as establishing county maintenance-of-effort requirements, as a condition of receiving additional state funding for community-based mental health services. In addition, the state would retain its ability to budget sum certain GPR funding to support county administered mental health services.

However, by denying the DHS request, the state would not achieve the objectives the administration sought in proposing the expansion and regionalization of services. It is unlikely that counties that currently do not offer CCS would begin to provide these services without the state's commitment to support the state's share of these MA-eligible these services. Further, counties would be less likely to begin providing additional CCS services or to deliver these services on a regional basis without the commitment of additional state funds.

Finally, it could be argued that community-based mental health services should not be treated differently than other MA-eligible services for which the state, rather than counties, pays the non-federal share of costs, as there may be a statewide interest in ensuring that all state residents have access to the CCS benefit.

SUMMARY

In summary, approval of the request would result in savings to counties and increased access to community-based mental health services, while increasing state-funded mental health services. If the Committee determines that increasing support for community mental health services is a priority use of state funds, it could approve the DHS request (Alternative 1). Alternatively, if the Committee determines that counties should continue to offer the CCS benefit and fund the nonfederal share of program costs, at their option, it could deny the request and direct DOA to lapse $10,202,000 in 2014-15 from the Committee's GPR program supplements appropriation to

the general fund in 2014-15 (Alternative 2).

This paper includes two additional attachments not previously referenced. Attachment 4 shows potential regional areas for the provision of CCS, which are based on county responses to the DHS regional intent forms. Attachment 5 provides information on the state's current 72 community support programs.

ALTERNATIVES

1. Approve the DHS request to transfer $10,202,000 GPR in 2014-15 from the Joint Committee on Finance program supplements appropriation under s. 20.865(4)(a) of the statutes to the GPR appropriation that supports medical assistance (MA) benefits [20.435(4)(b)]. Approve the DHS request to begin implementing the Act 20 provision to fund the non-federal share of comprehensive community services (CCS) provided by counties on a regional basis, beginning July 1, 2014.

2. Deny the request. In addition, direct the Department of Administration to lapse $10,202,000 in 2014-15 from the Committee's GPR program supplements appropriation to the general fund by September 1, 2014.

Prepared by: Charles Morgan
Attachments

ATTACHMENT 1

County Program Status and Estimates of CCS Program Enrollees

	Program Status			Enrollees				
					Estimates			
County	Current Program	Intends to provide CCS	No plans at this time	Actual 2012	2015	2016	2017	2018
Adams	x			32	40	45	48	51
Ashland		x			20	32	32	32
Barron		x			65	67	70	73
Bayfield		x			20	32	32	32
Brown	x			89	240	280	320	360
Buffalo		x			15	16	17	18
Burnett			x					
Calumet	x			38	60	62	65	68
Chippewa		x			61	64	66	68
Clark			x					
Columbia	x			11	35	45	55	65
Crawford		x			14	33	40	47
Dane		x			265	315	350	385
Dodge	x			28	40	45	50	55
Door		x			30	55	60	65
Douglas			x					
Dunn		x			28	29	30	31
Eau Claire		x			60	75	85	95
Florence		x			14	21	28	35
Fond du Lac	x			17				
Forest		x			19	23	26	29
Grant			x					
Green	x			31	50	55	65	75
Green Lake	x			5	15	25	34	43
Iowa			x					
Iron		x			20	30	40	50
Jackson		x			40	50	50	50
Jefferson	x			72	105	105	105	105
Juneau		x			30	45	62	79
Kenosha	x			57	215	255	295	335
Kewaunee	x			10	30	40	40	40
La Crosse	x			135	280	280	280	280
Lafayette		x			22	24	28	32
Langlade		x			45	50	55	60
Lincoln		x			45	55	60	65

	Program Status			Enrollees				
					Estimates			
County	Current Program	Intends to provide CCS	No plans at this time	Actual 2012	2015	2016	2017	2018
Manitowoc	x			17	70	90	110	130
Marathon	x			219	280	290	300	310
Marinette		x			105	125	150	175
Marquette		x			20	25	31	37
Menominee			x					
Milwaukee		x			245	673	800	1,100
Monroe		x			40	50	50	50
Oconto		x			12	24	48	72
Oneida	x			26	19	23	26	29
Outagamie	x			142	140	155	170	185
Ozaukee		x			30	40	40	40
Pepin		x			20	21	22	23
Pierce		x			44	46	48	50
Polk		x			70	72	76	80
Portage	x			42	50	55	60	65
Price			x					
Racine		x			140	160	180	200
Richland	x			70	85	87	90	93
Rock		x			45	45	45	45
Rusk		x			12	13	13	13
St. Croix		x			60	80	100	120
Sauk	x			52	115	120	125	130
Sawyer			x					
Shawano	x				30	45	60	75
Sheboygan	x			33	75	85	90	95
Taylor		x			20	30	40	50
Trempealeau			x					
Vernon		x			18	39	46	53
Vilas		x			19	23	26	29
Walworth	x			18	37	37	37	37
Washburn			x					
Washington	x			52	60	70	80	90
Waukesha	x			98	135	135	135	135
Waupaca		x			40	70	99	128
Waushara	x			33	40	45	46	47
Winnebago	x			94	120	130	140	150
Wood	x			86	110	120	128	136
Total	27	35	10	1,507	4,230	5,275	5,899	6,696

ATTACHMENT 2

GPR Funds to Support Certified County and Tribal Mental Health Programs
Calendar Year Contract Amounts

County	2012	2013	2014
Adams	$14,091	$14,355	$14,355
Ashland	14,091	14,355	14,355
Barron	23,938	24,386	24,386
Bayfield	14,091	14,355	14,355
Brown	118,603	120,824	120,824
Buffalo	10,568	0	0
Burnett	14,091	14,355	14,355
Calumet	22,704	23,129	23,129
Chippewa	31,120	31,703	31,703
Clark	19,555	19,921	19,921
Columbia	26,983	27,488	27,488
Crawford	14,091	14,355	14,355
Dane	216,167	220,215	220,215
Dodge	43,149	43,957	43,957
Door	14,779	15,056	15,056
Douglas	21,221	21,618	21,618
Dunn	22,427	22,847	22,847
Eau Claire	51,143	52,101	52,101
Florence	10,568	0	0
Fond du Lac	50,328	51,270	51,270
Forest-Oneida-Vilas	47,038	47,919	47,919
Grant	41,569	42,347	42,347
Green County	18,578	18,926	18,926
Green Lake	14,091	14,355	14,355
Iron	14,091	14,355	14,355
Jackson	14,091	14,355	14,355
Jefferson	39,496	40,236	40,236
Juneau	14,091	14,355	14,355
Kenosha	79,699	81,191	81,191
Kewaunee	14,091	14,355	14,355
La Crosse	57,621	58,700	58,700
Lafayette	14,091	14,355	14,355
Marathon	96,677	98,487	98,487
Manitowoc	42,720	43,520	43,520
Marinette	22,484	22,905	22,905

County	2012	2013	2014
Marquette	$14,091	$14,355	$14,355
Milwaukee	352,264	358,859	358,859
Monroe	22,749	23,175	23,175
Oconto	19,195	19,554	19,554
Outagamie	85,708	87,313	87,313
Ozaukee	43,530	44,345	44,345
Pepin	10,568	0	0
Pierce	20,096	0	0
Polk	23,084	23,516	23,516
Portage	35,486	36,150	36,150
Price	14,091	14,355	14,355
Racine	98,456	100,300	100,300
Richland	14,091	14,355	14,355
Rock	80,602	82,111	82,111
Rusk	14,091	14,355	14,355
St. Croix	38,563	39,285	39,285
Sauk	30,040	30,603	30,603
Sawyer	14,091	14,355	14,355
Shawano	22,135	22,549	22,549
Sheboygan	58,757	59,857	59,857
Taylor	10,568	10,766	10,766
Trempealeau	14,417	14,687	14,687
Vernon	16,279	16,584	16,584
Walworth	37,476	38,178	38,178
Washburn	14,091	14,355	14,355
Washington	62,877	64,054	64,054
Waukesha	190,857	194,431	194,431
Waupaca	27,699	28,218	28,218
Waushara	14,091	14,355	14,355
Winnebago	80,803	82,316	82,316
Wood	39,052	39,783	39,783
Menomonee	14,091	14,355	14,355
Total	$2,820,137	$2,820,138	$2,820,139

ATTACHMENT 3

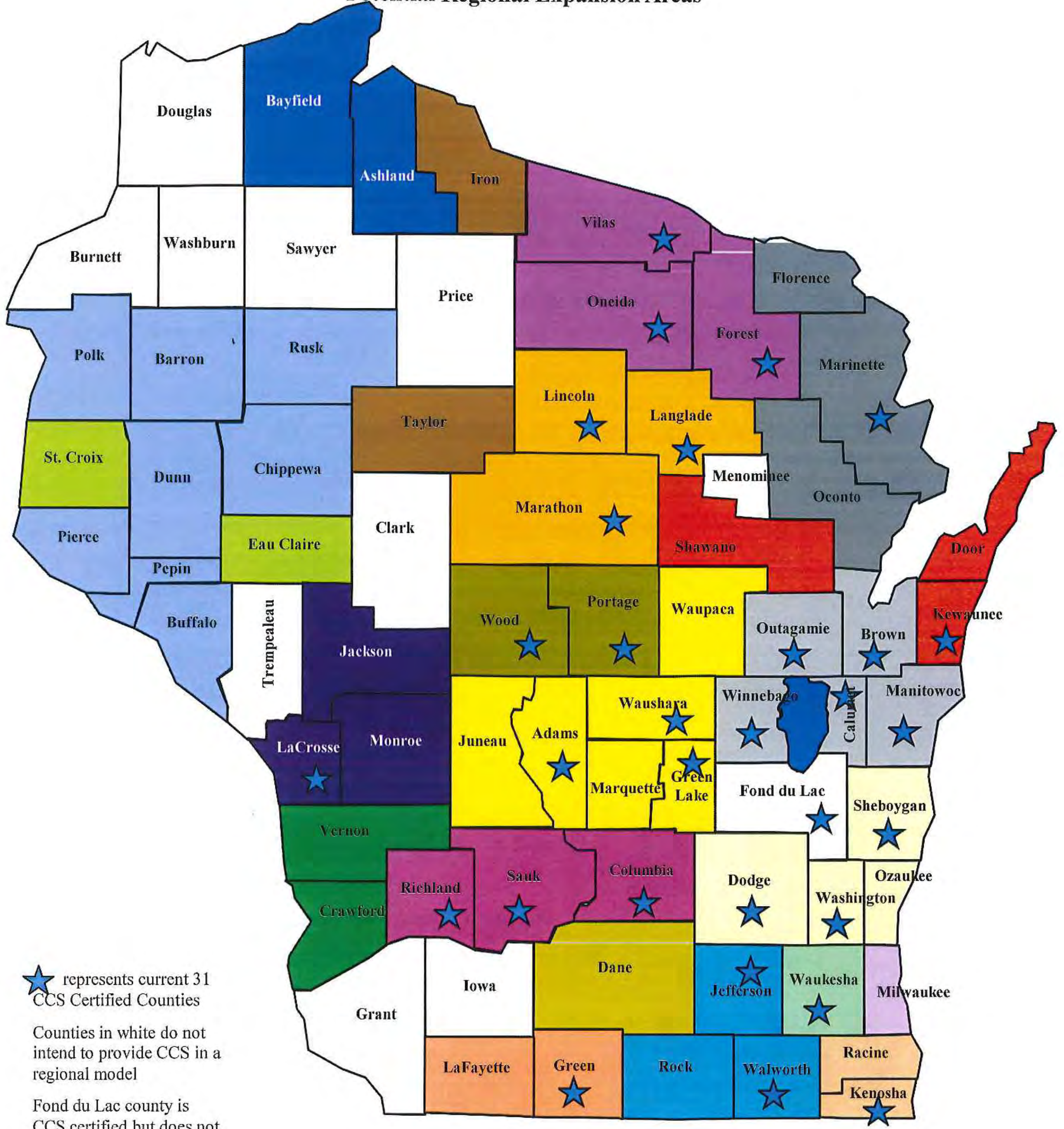
GPR Support for CSP Services for Counties with Waitlists
Calendar Year Contract Amounts

County	2012	2013	2014
Ashland	$14,897	$14,897	$14,897
Brown	83,618	83,618	83,618
Chippewa	54,014	54,014	54,014
Columbia	30,639	30,639	30,639
Dane	110,398	110,398	110,398
Eau Claire	10,714	10,714	10,714
Forest-Oneida-Vilas	57,772	57,772	57,772
Green	11,507	11,507	11,507
Jefferson	57,772	57,772	57,772
Kenosha	38,773	38,773	38,773
La Crosse	57,772	57,772	57,772
Manitowoc	32,549	32,549	32,549
Milwaukee	88,217	88,217	88,217
Monroe	21,133	21,133	21,133
Rock	57,772	57,772	57,772
St. Croix	45,288	45,288	45,288
Sheboygan	31,676	31,676	31,676
Vernon	5,054	5,054	5,054
Washington	46,371	46,371	46,371
Waukesha	60,617	60,617	60,617
Waushara	22,822	22,822	22,822
Total	$939,375	$939,375	$939,375

ATTACHMENT 4

Comprehensive Community Services (CCS) Programs

Potential Regional Expansion Areas



★ represents current 31 CCS Certified Counties

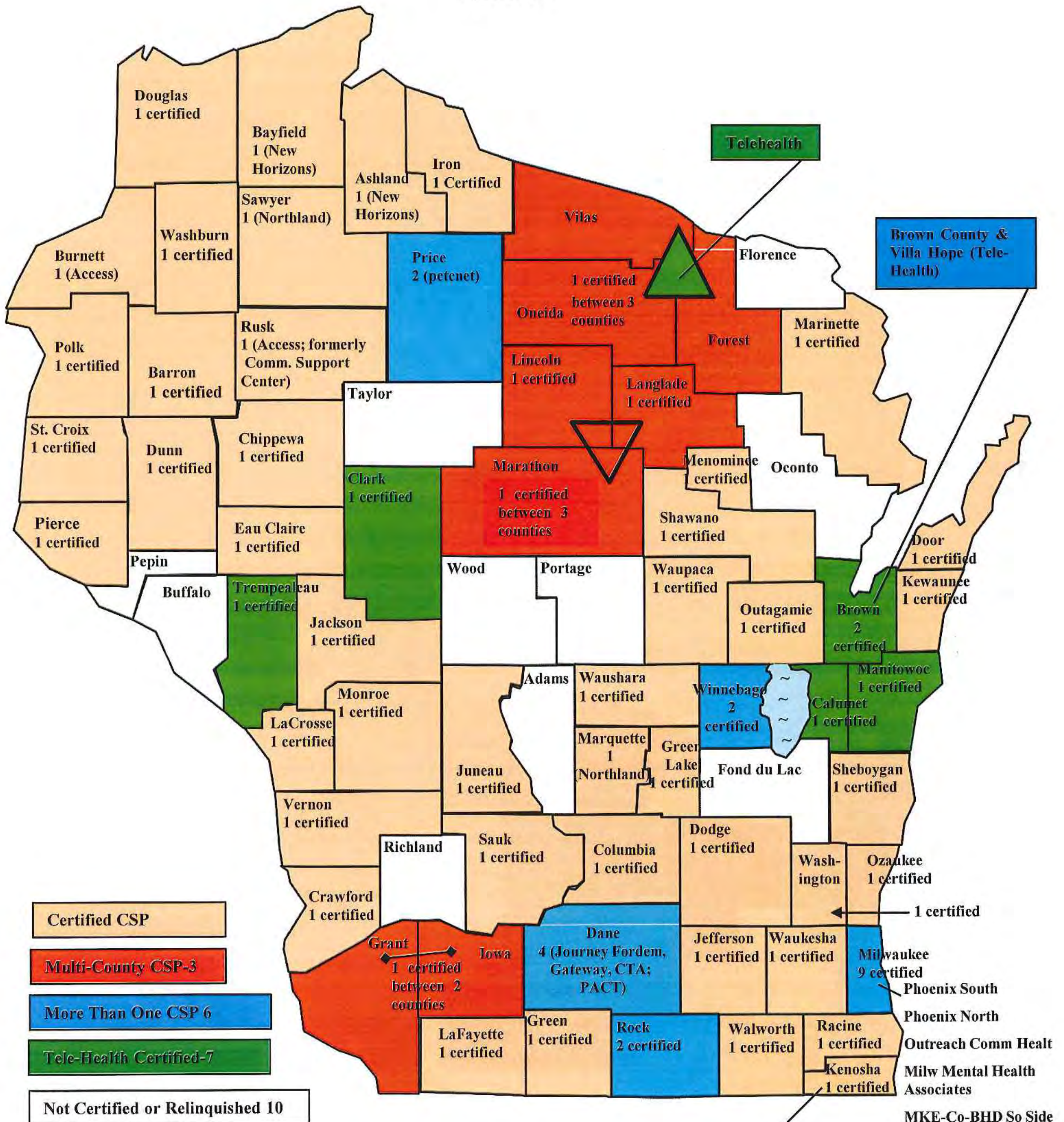
Counties in white do not intend to provide CCS in a regional model

Fond du Lac county is CCS certified but does not intend to participate in a regional model

ATTACHMENT 5

72 Community Support Programs (CSPs)

April 2014



There are 72 certified Community Support Programs in the State of Wisconsin. The following counties have a joint CSP: Forest, Oneida and Vilas; Marathon, Lincoln, Langlade; and Grant and Iowa. Six counties have more than one CSP: Brown (2); Dane (4); Milwaukee (9); Price (2); Rock (2); and Winnebago (2). Ten counties do not have a certified CSP.