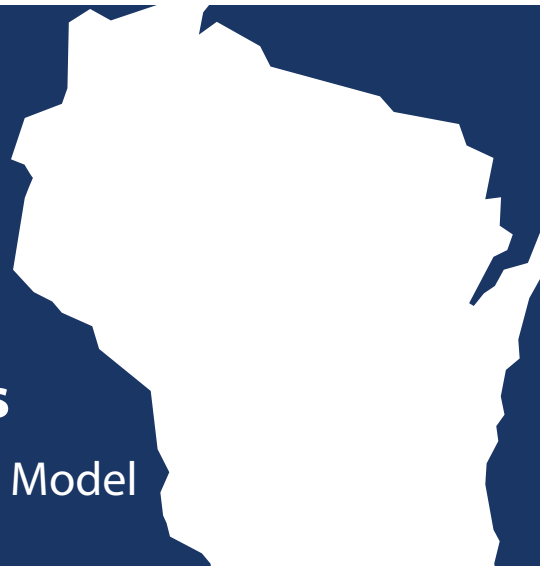
Comprehensive Community Services

Statewide Implementation of Regional Services Model



Wisconsin Department of Health Services

Comprehensive Community Services

Statewide Implementation of Regional Services Model

Department of Health Services

February 28, 2014

Pursuant to s. 49.45(30e)(e), this report addresses the Department of Health Services' (DHS) implementation of Comprehensive Community Services (CCS) statewide. Specifically, the Department is required to submit to the Joint Committee on Finance no later than March 1, 2014 a report on the Department's plan for implementation of CCS through a regional model. The Department must include in the report:

1. A description of the criteria the Department will apply to CCS regions.
2. A description of how CCS regions will be established and the role of counties and tribes in that process.
3. A list of counties and tribes that have indicated the intent to provide CCS on a regional basis.
4. An evaluation of the estimated long-term costs of the proposed regional model.

CCS Background

CCS are community-based psychosocial rehabilitation services. CCS are medical assistance (MA) reimbursable benefits that qualify under federal law as other 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. CCS are available to adults and children to address the consumer's needs across their lifespan, and are effective at improving consumer outcomes and reducing utilization of more costly and intensive inpatient and institutional services.

To be eligible for CCS under Wisconsin's MA program, an individual must be determined, as a result of a DHS-approved functional screen, to require more intensive services than typically offered in outpatient counseling. They must also 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. Attachment A provides a description of the fourteen service titles in the CCS array of services.

CCS is a county administered Medicaid benefit. Counties choose whether to become certified CCS providers and participate in the program. Currently, these counties pay the non-federal share (approximately 40%) of MA-allowable CCS costs. The counties also submit CCS cost reports to the Department, which are used as the basis for establishing the MA reimbursement rate. DHS then pays the county the federal share (approximately 60%) of the MA rate.

2013 Wisconsin Act 20 adopted the Governor's plan to begin funding both the non-federal and federal share of MA-allowable CCS beginning July 1, 2014 in counties that elect to deliver CCS on a regional basis, as approved by the Department. The goal of the Governor's plan is to significantly strengthen county resources to provide early intervention and treatment services to people with mental illness through programming that promotes recovery and reduces costly inpatient services. The budget provides $10,202,000 GPR to the Joint Finance Committee's appropriation under s. 20.865(4)(a) in SFY 15 to fund the non-federal share of CCS costs.

Development of Regional Criteria

The Department has involved a wide range of stakeholders to develop an implementation plan for the expansion of CCS. The Department recognizes that needs vary among communities across the state, so efforts were made to maximize the flexibility available to counties and tribes in forming CCS regions.

The Division of Mental Health and Substance Abuse Services (DMHSAS) solicited county and tribal input into the development of regional models for CCS through several mechanisms. Some of the forums included:

- Quarterly meetings of county human service agency directors coordinated by DHS Area Administration.
- Wisconsin County Human Services Association (WCHSA) Fall 2013 conference.
- November 2013 Great Lakes Intertribal Council meeting.

The Department also formed the CCS Advisory Committee in September 2013 to guide implementation and gather stakeholder feedback in implementing CCS on a regional basis. The Committee consisted of various community stakeholders who are interested in the expansion of CCS and increasing access to community mental health services statewide. Categories of members included counties, tribes, consumers, providers, state councils and provider associations. The committee met monthly September 2013 through December 2013. The meeting agendas, meeting summaries, and other project documents can be found on the Department's website at the following location:

http://www.dhs.wisconsin.gov/MH_BCMH/ccs/expansion/meetings.htm

The CCS Advisory Committee provided feedback to the Department on five general approaches for regional CCS delivery. The Department utilized the feedback to refine and finalize approaches which were presented to the CCS Advisory Committee at the November 2013 meeting. The five approaches describe the various regional models available to counties and tribes partnering to form regions to provide CCS. The five regional approaches available to counties and tribes include:

Regional Model/Option	Description
Population-based Model	Individual counties with a population over 350,000.
Shared Services Model	Counties providing CCS services within a region maintain separate certification and share services and resources to serve the region.
Multi-County Model	Counties provide CCS through one certified regional program with a lead county.
Existing Regional Model	Two or more counties join as a legal entity to provide a number of human service programs, one of which is CCS.
Tribal Nations Options	Tribes can provide CCS independently or in partnership with a county under the 4 regional models.

Attachment B provides detailed information on eligibility, certification, service delivery and legal authority requirements for the regional approaches available to counties and tribes intending to provide CCS on a regional basis.

County Intent to Provide Regional CCS

In November 2013, the Department provided counties and tribes with a CCS Regional Intent Form through which they informed the Department of their intention to implement a regional model. This form was developed under the consultation and review of the CCS Advisory Committee. Counties and tribes were free to work with any other counties and tribes to develop partnerships to form regions based on the needs of that county or tribe and the resources available through their regional partners. The form required that counties and tribes intending to provide CCS on a regional basis provide certain information, including:

- the counties and tribes within the regional partnership
- the type of regional approach selected
- the number of individuals the CCS region projected to serve by county within the region in CY 14, CY 15, CY 16 and CY 17
- a description of the service delivery system structure in the proposed region
- the array of services the CCS region would provide
- administrative structure of the proposed region
- total program cost and the average cost per CCS recipient
- an estimate of individuals currently served in other locally administered programs that would transition to CCS

CCS Regional Intent Forms were requested to be returned to the Department by December 31, 2013. To date, the Department has received CCS regional intent forms from twenty-one proposed regions covering sixty-one Wisconsin counties, as well as intent from two regions to partner with two tribes to

provide CCS to tribal members. These sixty-one counties include approximately 94% of the state's population, which will more than double the portion of the state population that has access to CCS.

Counties reported on the regional intent forms the number of people they project to serve within their region through 2017. Counties report increasing numbers of individuals served annually through 2017. Statewide totals of county estimates are:

Projected CCS Recipients by Calendar Year				
Actual	Projected			
CY 13	CY 14	CY 15	CY 16	CY 17
1,731	3,027	4,230	4,888	5,385

CCS enrollment estimates reflect six months or less of operation in CY 14 which explains the significant increase in the number of individuals served between CY 14 and CY 15.

Attachment C lists the counties and tribes that submitted CCS regional intent forms and the regions proposed by counties in those forms, attachment D is a map that shows counties currently certified to bill MA for CCS and the regions counties proposed in the CCS regional intent forms.

The degree of service delivery and administration coordination between counties will vary by region. In some regions, all services will be provided by a single county. In other regions, counties may share a limited set of services or administrative functions. Regions that report sharing only certain services and resources frequently identified intent to share the following functions:

- Clinical Supervision
- Training
- Providers
- Coordinating Committees
- Child Psychiatrist/telemedicine
- Quality Assurance
- Policies & Procedures
- Electronic Health Record Information Technology
- Administrative Functions

CCS Regional Approval

Counties must undergo a three step approval process to receive the non-federal share of CCS costs.

First, counties must provide services through a regional model approved by the Department. The Division of Mental Health and Substance Abuse (DMHSAS) will approve regional approaches using a request for approval process. The Request for Approval CCS Regional Service Model form can be found on the DHS website at:

http://www.dhs.wisconsin.gov/forms/F0/F00944.docx

The specific requirements for regional approval will vary based on the regional approach selected. However, regions will need to provide, demonstrate or assure the Department of the following to receive regional approval:

- Regional approach being utilized
- Assessments and reassessments are being completed annually and as appropriate
- Legal authority to operate regional CCS
- The full array of CCS are available across consumers' lifespans based on individual needs
- Outcome measurement/Quality assurance is performed and reported
- Required training and technical assistance is completed
- CCS financial and service data reporting will be timely and complete

Second, as under current law, counties must be certified by the Division of Quality Assurance (DQA) in accordance with administrative code DHS 36 in order to provide CCS services. Finally, counties must also be a Medicaid certified CCS provider. Medicaid certification requires DQA certification.

The necessary DQA certification and Medicaid certification as required by the regional approach selected will also be required prior to reimbursement for the non- federal share of any CCS costs. Counties must submit comprehensive and detailed information to DQA on the structure of their CCS program to receive certification for their CCS program. For existing CCS programs, materials on file with DQA must be updated with CCS program information as proposed for the region. Medicaid certification can only be obtained once DQA certifies a CCS.

CCS Financial Impact

The Department has updated its projection of CCS expenditures based on enrollment, service, and cost information received on CCS regional intent forms.

Seventeen regions indicated that they would begin to provide CCS on a regional basis beginning July 1, 2014. Three regions indicated an October 1, 2014 start date. The Department is providing technical assistance to counties and regions working towards a July 1 implementation date. However, it is unlikely all regions and counties will have met all approvals and certification requirements prior to July 1, 2014. It is also probable that regions that have been fully approved and certified by July 1 will experience a gradual enrollment increase as regions expand capacity to meet demand for services.

For purposes of estimating FY 15 CCS costs, the Department assumes counties that have expressed intent to provide CCS and currently operate a certified CCS program will transition existing CCS enrollment to an approved regional model on July 1 and gradually increase to projected CCS enrollment levels through SFY 15. The Department also assumes that counties that have expressed intent to provide CCS but do not currently operate a CCS will increase to projected CCS enrollment levels through SFY 15. Based on these assumptions, the Department estimates CCS costs of $10,539,300 GPR ($25,377,500 AF) in FY 15. This reflects a $337,300 GPR increase over Act 20 assumptions. The following table compares Act 20 estimates to current estimates for FY 15, and estimates CCS costs for the 2015-17 biennium.

Projected CCS costs by Fiscal Year				
Fund Source	FY 15		2015-17 Biennium	
	Act 20	Current Estimate	FY 16	FY 17
GPR	$ 10,202,200	$ 10,539,300	$ 21,517,200	$ 26,536,300
AF	$ 24,882,900	$ 25,377,500	$ 51,811,200	$ 63,896,800

If CCS enrollment increases at the same rate of annual increase as counties projected between CY 16 and CY 17 on regional intent forms, the Department estimates that CCS recipients would increase by 497 in FY 18 and each subsequent fiscal year. The cost of serving 497 additional CCS recipients is estimated to be $2,287,800 GPR ($5,508,900 AF) annually.

The projection relies on the estimated enrollments reported on regional intent forms, with the exception of Milwaukee County for FY 16 and FY 17. In its intent form, Milwaukee indicated that its enrollment projection (92 in CY 14, 245 in CY 15, and 286 in CY 16 & CY 17) was preliminary pending further guidance from DHS on program eligibility and design.

Milwaukee does not currently operate a CCS program. The administrative work required to implement CCS and obtain the required approvals and certifications to receive Medicaid reimbursement is significant. Additionally, from a clinical perspective, creating and expanding a treatment model, and acquiring and building the infrastructure and resources to support it can only be accomplished over time. As a result, Milwaukee enrollment projections for CY 14 and CY 15 are reasonable as Milwaukee implements CCS and expands capacity to meet demand for community-based psychosocial services.

To account for the uncertainty of Milwaukee's CCS enrollment estimates in future years, the Department's cost estimate conservatively assumes that Milwaukee CCS enrollment will increase to 800 in CY 16 and 1,100 in CY 17. The 2009-11 biennial budget created a new mental health benefit, Community Recovery Services (CRS) to provide rehabilitative mental health services to individuals below the institutional level of care at home or in the community. Milwaukee estimated serving about 1,100 individuals annually in CRS during the 2009-11 budget development (Milwaukee did not implement CRS due to federal program changes). CRS and CCS serve a similar clientele. The Department does not assume that enrollment will increase above Milwaukee estimates in CY 14 and CY 15.

Long Term Fiscal Effect of a Regional CCS System

The goal behind expanding CCS statewide is to enable people with mental illness to access evidence-based treatment services to address their illness and achieve recovery. In many parts of the state, individuals are too often not receiving the services they need, and expanding access will improve not only their lives but those of their families and communities as well.

Untreated mental illness can have wide ranging consequences, including poorer employment and educational outcomes and higher demands on the criminal justice, correctional, juvenile justice, child welfare, and primary and acute health care system. An expanded CCS will ameliorate these negative

outcomes and reduce costs, although the time needed to fully realize the positive effects will vary from system to system.

It is best to think of CCS as both a net new investment in service capacity and a strategy to reduce costs elsewhere. These savings will partly, but likely not completely, offset the new investment the state is making in community-based mental health services.

Expenditures for CCS itself will depend largely on how many individuals seek those services in coming years, which is difficult to project with certainty. On the regional intent forms, counties project enrollment through the calendar year 2017. It is unknown whether CCS participation will plateau at those levels, or if additional growth should be expected. At a minimum, enrollment will likely grow along with the overall state population in future years. However, CCS expansion to individuals currently in need of community-based mental health services should have financial benefits for counties and the state.

The Department's estimate for CCS expansion costs through FY 17 uses enrollment growth as projected by counties on regional intent forms. The estimate assumes an average cost for each county within a region based on one of three scenarios: 1) the average cost per individual for counties currently providing CCS, 2) the highest average cost per individual of any county within the region currently providing CCS, or 3) the current statewide average cost per individual in regions with no counties currently providing CCS. It also assumes that the average participant will use 10% more services as enrollment is broadened to a larger population, with further 2% annual utilization increases in subsequent years. To be conservative, the estimate does not factor in potential offsets to CCS costs. It is reasonable to assume that savings should result from:

- Increased program efficiencies by regional delivery models.
- Decreased utilization of other, more costly Medicaid or county funded services such as crisis, inpatient hospital, and institutional care.
- Savings across the other publicly funded systems described above.

The Department expects counties to realize administrative and service delivery efficiencies by providing CCS through regional models. Counties will achieve these efficiencies over time as regions expand services to additional recipients utilizing existing CCS program infrastructure, and as new regions serving large geographic regions implement shared administrative structures. These efficiencies could result in lower overall costs if they result in a lower average cost per CCS recipient. Before actual implementation, the Department lacks the data necessary to estimate with precision the savings resulting from these efficiencies, and therefore did not include them in the estimate.

CCS expansion should lower utilization of other Medicaid services. CCS is a recovery-focused rehabilitative program that provides person-centered services based on the individual's needs. As a CCS recipient's recovery progresses, the individual can be expected to transition into less intensive services such as mental health care on an outpatient basis. In absence of CCS, the needs of individuals with mental illness often go unmet. Consequently, they may need more costly intensive crisis and crisis stabilization services, inpatient hospitalization, or care at the state mental health institutes and other

facilities. To illustrate, the average annual cost of serving an individual through CCS is approximately $10,700, whereas the average cost of institutionalization at a state mental health institute is approximately $16,000 for 16 days, the average length of stay in FY12.

Decreases in utilization of state mental health institutes and crisis services result in savings to counties and decreases in utilization of inpatient and other acute health services result in GPR savings to the Medicaid program. As discussed above, serving individuals in CCS expansion should reduce costs to state and local governments by avoiding involvement in the justice and correctional systems.

The Department will require DHS-approved regions providing CCS to adhere to a number of service array, data reporting, quality assurance, and individual assessment standards. These standards will ensure that services provided to CCS recipients are both necessary and appropriate, that CCS consumers are satisfied with their experience in CCS, and that the Department captures information necessary to monitor CCS services for efficiency, quality, and effectiveness. The Department's implementation of CCS will be a transparent effort, and the Department intends to make information about the efficiency, quality and effectiveness of CCS service available to legislators and stakeholders.

While the Department does not assume other Medicaid savings by expanding CCS recipients through FY 17, the benefits of providing person-centered rehabilitative mental health services to individuals before they are in need of more intensive treatment and services will lead to better overall health outcomes for Medicaid consumers. The Department plans to monitor CCS utilization and its relationship to utilization of more costly Medicaid mental health services as CCS expands statewide through regional models.

Attachment A

CCS SERVICE ARRAY
(Updated April 1, 2013)

County's DHS 36 - CCS Psychosocial Rehabilitation Service Array

*Assessment Domains 36.16 (4). Identify all domains applicable to each service described in the array:
(a) life satisfaction, (b) basic needs, (c) social network, family involvement, (d) community living skills, (e) housing issues, (f) employment (g) Education. (h) finances and benefits, (i) mental health, (j) physical health, (k) substance use, (l) trauma / life stressors, (m) medications. (n) crisis prevention management, (o) legal status, (p) other identified domains

ASSESSMENT DOMAINS*	SERVICE TITLE	DESCRIPTION AND EXAMPLES OF ACTIVITIES
all domains	1. Assessment	Initial assessment, functional screen and assessment summary; completion of annual review of strengths, attributes and needs. Includes: • Activities involved in the process used to identify the strengths, needs and desired outcomes of a consumer, and • Activities involved in evaluating progress toward desired outcomes.
all domains	2. Recovery Planning	Services are determined through the development of an individualized recovery/service plan designed to provide for the highest level of independent functioning and quality of life possible and desired by the consumer.
all domains	3. Service Facilitation	All coordination, follow-up and monitoring activities that ensure the consumer receives assessment services, service planning, service delivery and supportive activities in an appropriate and timely manner. Includes: • Assisting the consumer in self-advocacy. • Helping the consumer obtain necessary medical, dental, legal and financial services and living accommodations. Progress will be tracked toward goals and consumer satisfaction with the services rendered. Coordinating the provision of emergency services during crisis periods. This may be coordinating the actual provision or coordinating with the HFS 34 designated crisis intervention program.
c, d, e, f, l, n	4. Communication and Interpersonal Skills Training	Specific skill training in communication, interpersonal skills, problem solving, conflict resolution, assertiveness, and other specific needs identified within the consumer's functional assessment.

		Individual or group interventions, including supportive activities, to increase social connections and meaning, and to improve communication skills and comfort in interpersonal relationships.
a, b, c, d, h	5. Community Skills Development and Enhancement	Problem solving, support, training, assistance, and cuing related to functional living skills living to assist the consumer to gain and utilize skills related to personal hygiene, shopping, laundry, benefit education, household tasks, money management, how to access transportation, medication adherence, parenting, independent living problem solving, self-management, connection to community resources, social skill development, and other day to day requirements of living. • May be provided in a one-to-one or group intervention, including supportive activities. • May include one-to-one therapeutic support to ensure that a consumer acquires the skills needed to attain independence.
j, k, l, m	6. Diagnostic Evaluations and Assessments	Diagnostic evaluations and assessments including the assessment process and summary to determine appropriate treatment and behavioral interventions, and the level of community support needed for an individual consumer. • Diagnostic Evaluations determine diagnosis, medication to be prescribed, as well as how to address clinical symptomatology, and should be performed by a person who holds a Safety and Professional Services license as a physician, a psychiatrist, psychologist, a Licensed Marriage and Family Therapist, a Licensed Professional Counselor or a Licensed Clinical Social worker. An Advanced Practice Nurse Practitioner with certification in behavioral health may also assess medication-related symptoms and needs. • Diagnostic Evaluations and Assessments are conducted by mh/sa providers with specific credentials and training in the administration of these assessments/tests. • Assessments performed by a provider with a Bachelor Degree, or less training, or other non-behavioral health specialists including, for example, Occupational and Physical Therapists should be recorded under Service Array #1 “Assessment”.

CCS SERVICE ARRAY
(Updated April 1, 2013)

a, b, d, f, g, i, m	7. Employment Related Skill Training	Services that address the person's illness or symptom-related problems in order to secure and keep a job. Services to assist in gaining and utilizing skills necessary to undertake employment. May include: • Initial employment and education assessment, • Ongoing, on-site employment assessment/evaluation/feedback sessions to identify symptoms or behaviors and to develop interventions with the recipient and employer that affect work, • Focus on work-related symptom management, anxiety reduction, and education about appropriate job-related behaviors, • On-the-job or work-related crises. (Does not include specific job seeking and placement activities.), • One-to-one therapeutic support, including peer support, • Activities related to preparation for seeking employment including assistance in appropriate personal hygiene and grooming, clothing choices, anxiety reduction, arranging transportation, and other issues related to symptoms or behaviors that hinder securing employment, and • Assistance in accessing or participating in educational and employment related services, and coaching/cuing in order to minimize the effects of the consumer's disabilities for a limited amount of time, to reach a higher level of independence.

Attachment A

CCS SERVICE ARRAY

(Updated April 1, 2013)

i, j, k, m, n,	8. Medication Management	Major activities may include: • *Medication evaluation* – making an acute diagnosis and specifying target symptoms and initial severity, medication, • *Prescription* – prescribing the type and does of medication(s) designed to alleviate the symptoms identified above, • *Medication monitoring* – monitoring changes in symptoms, occurrence and tolerability of side effects as well as reviewing data used in making medication decisions, and • *Individual client education* – increasing consumer knowledge and understanding of the symptoms being treated, medication being prescribed, the expected benefits, impact on symptoms, and identification of side effects. Assistance in helping the consumer develop his/her own compliance in adhering to scheduled medications.
j, m	9. Physical Health and Monitoring	All activities related to the consumer's physical health conditions, management of side effects and symptoms related to the consumer's mental illness or prescribed medications and assistance in helping the consumer to develop his/her own monitoring abilities, including supportive activities. Monitoring of weight and vitals.
i, k, l, m	10. Psychoeducation	A method of working in partnership to impart current information about mental illness and substance abuse, to assist with coping skills for supporting recovery, and to encourage problem solving strategies for managing issue posed by mental illness and substance abuse disorders. Family intervention geared toward coping strategies, support and problem solving skills to assist in fostering consumer's recovery. Activities must be performed for the direct benefit of the CCS consumer. Consultation to family members for treatment of their problems not related to the CCS consumer's is not part of this service. May include one-to-one therapeutic support, including supportive activities.
i, k, l, m	11. Psychotherapy	Individual or group psychotherapy. Performed by a psychiatrist, psychologist, or master's level psychotherapist only (In HFS 36, it is staff listed #1 through #8.).

c, i, l, n	12. Recovery Education and Illness Management	Recovery education and Illness management are a broad set of strategies that promote hope, healing and empowerment. These strategies are designed to help individuals manage their illness, reduce their susceptibility to the illness, cope effectively with symptoms, identify supports that are effective, and advocate for receiving those supports. Major activities may include: • *Individual skills/illness self-management training* – focus on recovery training where outcome is to give the consumer self-assessment skills, and includes interventions such as modeling, role-playing, practice, homework, shaping and reinforcement. Community activities which focus on decreasing the symptoms of mental illness through various wellness activities. May include one-to-one therapeutic support, including supportive activities. • *Counseling* – Oriented toward problem solving and supportive activities provided in individually and in groups for consumers and their families to engage in recovery-based activities at home and in the community. Teaching individuals how their thinking styles and beliefs influence their feelings, and helping them to evaluate and change thoughts the lead to depression, anxiety, and anger. Includes cognitive-behavioral strategies to reduce severity and distress of persistent symptoms and promote personal insight within a group dynamic. • *Support to develop a crisis plan* – includes identification of early warning signs of crisis and details about preferred supports.
	13. Substance Abuse Treatment	Gender-based, strength based, and integrated treatment, including substance abuse assessments.

variable	14. Non-Traditional or Other Approved Services	Non-traditional services are identified for specific individuals, and are expected to accomplish treatment ends that traditional behavioral health services have not. • Non-traditional services billed to CCS must have a psychosocial rehabilitative purpose, are not merely recreational activities, and are not otherwise available to the individual. • Documentation: medical necessity of non-traditional services must be documented in the individual's record and through assessed needs in the treatment plan, including documenting the psychosocial rehabilitative benefits. The treatment plan must document the corresponding measurable objectives and goals of the non-traditional service. • These services will have specified, reasonable time limits (e.g. 3 months) and successful outcomes that are reviewed regularly by the service facilitator. Non-traditional services will be discontinued if measurable objectives and goals are not met in reasonable timeframe.
d, e, j, m	15. Psychosocial Rehabilitative Residential Supports	For services of residential staff only. Alternative licensed community living situations only include adult family homes; community based residential facilities (CBRFs), child foster homes, and child group homes. Includes psychosocial rehabilitation services only, no room, board, and other staff services. May include the following services: • communication and interpersonal skills training, • community skills development and enhancement, • diagnostic evaluations and specialized assessments, • employment related skill training, • medication management, • physical health and monitoring, • psycho education, psychotherapy, • recovery education and illness management, and • substance abuse treatment.

Attachment B

COMPREHENSIVE COMMUNITY SERVICES (CCS) REGIONAL SERVICE MODELS

	Population-Based Model	Shared Services Model	Multi-County Model	Existing Regional Models (§46.23 or §51.42)		Tribal Nations: Options
ELIGIBILITY	A single county with a population exceeding 350,000.	A group of counties each with individual CCS certifications, agree to share resources and/or expenses with each other.	Two or more counties partner under a single certification and create a shared CCS program	Regional Departments of Community Programs (three in WI) and/or Regional Departments of Human Services.		Sovereign Tribal Nations
MODEL DESCRIPTION **Note**: Counties in a region do not need to be contiguous. However, DHS reserves the right to determine feasibility.	Individual counties with a population over 350,000 could be certified to provide CCS. This would be considered a "region". They would not be required to collaborate with other counties or tribes.	Counties in this model would maintain their own CCS certifications, while agreeing to share some significant resources, expenses and/or components of CCS programming such as providers, supervision, training, administrative operations, etc. DHS will review and approve these models.	Counties would collaborate to create a CCS service area. A region of counties would be certified as a program, with a lead county identified. This would create a fully regionalized CCS program.	Two or more counties join as a legal entity to provide a number of human service programs, one of which is CCS.		Tribes can provide CCS using one of two models: • be a tribal provider (as a single entity similar to a population-based model) • collaborate with one or more counties/tribes to provide regional CCS programming (in either a shared-services or multi-county format).

Attachment B

COMPREHENSIVE COMMUNITY SERVICES (CCS) REGIONAL SERVICE MODELS

	Population-Based Model	Shared Services Model	Multi-County Model	Existing Regional Models (§46.23 or §51.42)	Tribal Nations: Options
CERTIFICATION (**Note:** Both DQA and Medicaid CCS certificates are required.)	Each county/tribe would be required to maintain DQA and Medicaid certifications for CCS.	Each county/tribe in the region would be responsible for maintaining individual county CCS certifications for DQA and Medicaid.	A CCS certification would be required for service to the designated CCS region. A county or tribe would need to be identified as the lead administrative agency; this responsibility would include maintaining CCS certification.	The region is required to have a DQA and a Medicaid CCS certification.	A tribe can maintain CCS certifications as a tribal provider; or they could join with other counties and/or tribes under the shared-services or multi county model.
SERVICE DELIVERY	Counties with large populations could provide CCS as a single county and would be considered a regional service delivery system eligible for the state contribution to CCS program. These counties could join other consortia based on their interest, but the consortia's model would then apply.	This model allows counties with existing or new CCS certifications to develop a shared service approach. Sharing services and/or expenses creates efficiencies and would be considered a regional service delivery system eligible for the state contribution to CCS programs. DHS will review applications for shared services designs to determine factors such as: • acceptable number of counties/tribes participating • identified geographical service areas • the level or types of shared services involved	This model encourages the expansion of CCS programming from one certified county to a larger geographic area, or the creation of a new region of CCS services. This would be considered a regional service delivery system eligible for the state contribution to CCS program.	The multi county DCP designs are statutorily based and currently exist in WI. Multi county Departments of Human Services are statutorily based, however, there are no existing models in WI in 2013. These multi-county entities serve an area and provide regional programming including CCS, and are considered a regional service delivery system eligible for the state contribution to CCS program.	Tribes can evaluate the best options for tribal people. Tribes are eligible for the state contribution to CCS as a tribal provider or as a partner in a regional provider system.

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COMPREHENSIVE COMMUNITY SERVICES (CCS) REGIONAL SERVICE MODELS

	Population-Based Model	Shared Services Model	Multi-County Model	Existing Regional Models (§46.23 or §51.42)	Tribal Nations: Options
AUTHORITY OPTIONS	Existing governance and statutory models include: • Wis. stat §46.23 Single or Multi County Departments of Human Services • Wis. stat §51.42(3) Single or Multi County Departments of Community Programs	Services that are shared impact the formality of the relationship between counties/tribes. Counties may use contracts or memorandums of understanding as the authority for shared services. Wis. stat §66.0301 Intergovernmental Cooperation contractual agreements are applicable, Wis. Stat §46.23 and §51.42(3) statutory structures may be explored.	Wis. stat §66.0301 Intergovernmental Cooperation **Note**: Wis. stat §46.23 and §51.42(3) may be explored.	Existing governance and statutory models include: • Wis. stat §46.23 Single or Multi County Departments of Human Services • Wis. stat §51.42(3) Single or Multi County Departments of Community Programs	Tribal Sovereignty

Attachment C

Proposed CCS Regions

(Based on Regional Intent Forms)

Population-Based Models

Dane
Milwaukee
Waukesha

Shared Services Models

Adams
Green Lake
Juneau
Marquette
Waupaca
Waushara

Ashland
Bayfield

Brown
Calumet
Manitowoc
Outagamie
Winnebago

Columbia
Richland
Sauk

Dodge
Ozaukee
Sheboygan
Washington

Door
Kewaunee
Shawano

Eau Claire
Saint Croix

Jefferson
Rock
Walworth

Kenosha
Racine

Portage
Wood

Multi-County Models

Barron
Buffalo
Chippewa
Dunn
Pepin
Pierce
Polk
Rusk

Crawford
Vernon

Florence
Marinette
Oconto

Green
Lafayette

Iron
Taylor

Jackson
La Crosse
Monroe

Existing Regional Models

Forest
Oneida
Vilas

Langlade
Lincoln
Marathon

Attachment D

COMPREHENSIVE COMMUNITY SERVICES (CCS) PROGRAMS

Proposed Regional Expansion

(Based on Regional Intent Forms)