Legislative Fiscal Bureau
One East Main, Suite 301 • Madison, WI 53703 • (608) 266-3847 • Fax: (608) 267-6873
Email: fiscal.bureau@legis.wisconsin.gov • Website: http://legis.wisconsin.gov/lfb

June, 2023 Joint Committee on Finance Paper #408

Community Support Program
(Health Services -- Medical Assistance -- Eligibility and Benefits)

[LFB 2023-25 Budget Summary: Page 246, #15]

CURRENT LAW

The Community Support Program (CSP) is a set of psychosocial rehabilitation services covered under the Medical Assistance program (MA) and administered by counties, multi-county partnerships, and Native American tribes and bands. Under current law, the state does not provide GPR funding for these services; the Department of Health Services (DHS) claims federal Medicaid matching funds (61% of costs in 2024-25) for county and tribal expenditures and provides the majority of this revenue to counties and tribes, but the remaining costs are borne by the counties and tribes.

CSP is intended to serve people with severe mental health conditions that affect day-to-day functioning, and typically serves people with schizophrenia, bipolar disorder, schizoaffective disorder, or recurrent major depression. Approximately 4,000 people receive CSP services per year. Specific treatment services include individual, family, and group psychotherapy, medications, and crisis intervention. Services are delivered using a treatment team approach, with each individual having a case manager who maintains a clinical treatment relationship with the client on a continuing basis.

To be eligible for CSP services, a patient must be likely to require repeated acute treatment or prolonged periods of institutional care. CSP provides non-institutional services that can prevent the need for admissions into a more restrictive setting.

Comprehensive Community Services (CCS) is a similar county-administered psychosocial rehabilitation MA benefit that is intended to serve patients with lower-intensity or shorter-term needs than are addressed by CSP, but greater needs than can be met by counseling and

psychotherapy alone. CCS can provide medication management, peer support, skills development and employment-related training, mental health education, psychotherapy, and substance use disorder treatment. Unlike for CSP, the state reimburses counties for the full allowable cost of CCS services, including both the federal matching funds and state funds for the nonfederal share.

DISCUSSION POINTS

1. Assembly Bill 43 and Senate Bill 70 would provide $19,239,100 GPR in 2023-24 and $21,516,500 GPR in 2024-25 to provide reimbursement payments to counties for CSP services for both the federal and nonfederal share of the payment, instead of only the federal share.

2. Counties report that CSP services are effective at reducing the need for extended hospitalizations or other institutional care, and provide support to county residents with acute needs. CSP interventions are based on the assertive community treatment model, which has demonstrated positive outcomes in numerous evaluations since it was developed by Wisconsin researchers in the 1970s and is now endorsed by national mental health provider organizations, nonprofits, and government agencies.

3. Based on expenditures in recent years, DHS estimates that CSP expenditures statewide will total $49.6 million in 2022-23, consisting of $19.2 million in county funding and $30.4 million in federal funds.

4. CSP services are currently offered in 66 counties, all except Florence, Fond du Lac, Portage, Richland, Taylor, and Wood. The Wisconsin County Human Service Association indicates that smaller rural counties face financial constraints that make it difficult for them to make the initial investment necessary to establish CSPs, although not all of the counties without a CSP are rural. Aside from financial constraints, some counties may also choose not to prioritize providing these services.

5. Transferring responsibility for the nonfederal share of CSP costs from counties to the state would remove the financial barrier to counties providing these services. This would increase the likelihood that these services would be available in the remaining counties, achieving consistency across the state in the care provided to residents with severe mental health needs.

6. Reducing or eliminating the county share of costs could also support the expansion of CSP services in counties where they are currently available, but limited due to constraints placed on the program by the county. For example, counties may be able to reduce waitlists, expand the range of services offered, or expand the geographic reach of services to improve access in under-served areas of a county.

7. In other cases, increased funding may improve the quality of CSP services. Counties may be able to better adhere to evidence-based methods and the assertive community treatment model. Such program modifications have the potential to improve outcomes for people already receiving CSP services and new participants.

8. More broadly, transferring the nonfederal share of expenditures from counties to the

state would provide financial support to counties, many of which face difficulty meeting costs within existing revenues. CSP funding could support human services and mental health budgets in particular, by making revenue sources currently dedicated to CSP available to support other costs. The state allocates funding to each county under the Community Aids program to support health and human services, including an allocation designated specifically for community mental health services. These allocations generally remain fixed from year to year, while many counties report significant growth in costs and challenges in recruiting staff. Providing state funding for CSP could enable counties to redirect community aids funding to meet rising costs in other areas.

9. In addition to changing caseloads, expansions in CSP services are expected to increase program expenditures. The cost estimates described in this paper assume 5% growth from 2022-23 to 2023-24 and a further 10% growth from 2023-24 to 2024-25, as counties respond to the new funding available. There is potential for continued growth beyond this biennium, as occurred when the state assumed the nonfederal share of costs for the CCS program in 2014-15.

10. Some of the growth in CSP expenditures that would occur under the proposal may be attributable to a shift in services from one service category to another, rather than a net increase in overall program services. That is, individuals who could be eligible for CSP services, but who are not receiving them because of constraints on program access, are likely to need treatment in some form. So, for instance, a person in this situation may be receiving day treatment or require hospitalization, which are services for which the state is already responsible for the nonfederal share. In this case, a shift of services to CSP due to the state assuming the nonfederal share of the cost would not increase the state's cost. However, while some degree of shift in services is possible, the magnitude of this effect is unknown, and so is not included in the estimate.

11. The funding provided under AB 43/SB 70 reflects a two-year increase in federal matching rates the state would have qualified for by adopting full Medicaid expansion. The Committee removed full Medicaid expansion from further consideration under Motion #10. Hence, the nonfederal share of CSP expenses in this biennium would be higher.

12. To reduce the financial burden on counties and make CSP services available more consistently statewide, the Committee could provide $21,710,600 GPR in 2023-24 and $24,235,200 GPR in 2024-25 to assume the full nonfederal share of CSP costs. Under this alternative, counties would be reimbursed for 100% of the costs of CSP services; CSP services would no longer be included in the current cost reporting and partial reconciliation process used for other county-based services. This reflects the same policy as proposed under AB 43/SB 70, although the GPR funding amounts have been increased to reflect the removal of full Medicaid expansion. [Alternative A1]

13. The Committee could also determine that the nonfederal share of CSP services should remain a county responsibility. [Alternative A2]

14. If the Committee determines that the proposal to have the state assume the nonfederal share of the cost of CSP would have the benefit of establishing more uniform access to program services across the state, but has concerns about the overall cost, an alternative approach would be to adopt Alternative A1, but offset a portion of the cost by reducing GPR payments to counties under the mental health component of the community aids program.

15. Currently, DHS makes community aid payments to the counties under the community mental health component of the program totaling $24,348,700 GPR. The mental health component of the community aids grant was established by the 2015-17 budget, through the consolidation of several other grant programs used to support community-based mental health services. Among those grants were programs intended to support counties' costs for CSP and other psychosocial rehabilitation programs. However, the mental health component of the community aids program is a fixed payment to each county, and not tied to the level of service currently provided by the county. Consequently, unlike the CSP program change under Alternative A1, the program does not create incentives to attain a level of county service, or to serve specific policy goals.

16. The Committee could offset all or a portion of the estimated cost of Alternative A1 by eliminating the community mental health component of the community aids program or reducing the payment by some amount. For instance, the Committee could reduce the payment by $10,000,000, beginning in 2024 (community aids payments are made on a calendar year basis). While this would be a 41% reduction in this county aid payment, the counties in aggregate would still realize a net financial benefit from the combination of Alternatives A1 and B1 since their cost of CSP services would decrease by an estimated $21.7 million. [Alternative B1]

17. Eliminating the full community mental health component of the community aids program would reduce GPR costs by an amount that is approximately equal to the estimated cost of the CSP proposal in 2024-25. [Alternative B2]

18. The net cost of adopting Alternatives A1 and B1 together would be $30,945,800 GPR over the biennium ($16,710,600 GPR in 2023-24 and $14,235,200 GPR in 2024-25). Adopting Alternatives A1 and B2 together would have approximately no net cost in 2024-25. However, because the community aids reduction would take effect January 1, 2024, it only offsets a portion of the costs in fiscal year 2023-24. Therefore, the net cost of adopting Alternatives A1 and B2 together would be $9,422,800 GPR over the biennium ($9,536,300 GPR in 2023-24 and -$113,500 GPR in 2024-25).

ALTERNATIVES

A. Nonfederal Share of the Community Support Program

1. Provide $21,710,600 GPR in 2023-24 and $24,235,200 GPR in 2024-25 to assume the full nonfederal share of CSP costs. Require DHS to provide reimbursement payments to counties for CSP services for both the federal and nonfederal share of the payment, instead of, under current law, only the federal share. Delete CSP services from a list of county services for which counties may submit a cost report to DHS for a partial cost reconciliation payment.

ALT A1	Change to Base
GPR	$45,945,800

2. Take no action.

B. Community Mental Health Component of the Community Aids Program

1. Reduce the amount that DHS distributes under the community mental health component of the community aids program by $10,000,000, from $24,348,700 to $14,348,700, beginning in 2024. Reduce the community aids appropriation by $5,000,000 GPR in 2023-24 and $10,000,000 GPR in 2024-25 to reflect this reduction.

ALT B1	Change to Base
GPR	-$15,000,000

2. Eliminate the community mental health component of the community aids program, beginning in 2024. Reduce the community aids appropriation by $12,174,300 GPR in 2023-24 and 24,348,700 GPR in 2024-25 to reflect this reduction.

ALT B2	Change to Base
GPR	-$36,523,000

3. Take no action.

Prepared by: Carl Plant