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Services for Persons with Developmental Disabilities

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Prepared by

Katie Maguire and Rebecca Hotynski

Wisconsin Legislative Fiscal Bureau
One East Main, Suite 301
Madison, WI 53703

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Wisconsin policy assures the provision of a full range of treatment and rehabilitation services for persons with developmental disabilities, mental disorders, alcoholism, and other drug abuse problems. Further, state law expresses the Legislature's intent to implement a unified system of prevention of these conditions and provision of services that 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 county funds required to match state funds.

This paper describes the types of services that are available to persons with developmental disabilities in Wisconsin. The first section presents a brief discussion of the most common types of developmental disabilities and the factors that are believed to cause these disorders. The second section describes the counties' primary role in providing community-based services to persons with developmental disabilities and institutional services available to these persons, including services provided by the state centers for the developmentally disabled.

The Nature of Developmental Disabilities

Wisconsin statutes define a "developmental disability" as "a disability attributable to brain injury, cerebral palsy, epilepsy, Prader-Willi syndrome, autism, mental retardation, or another neurological condition closely related to mental retardation or requiring treatment similar to that required for mental retardation, which has

continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual." This definition is used in determining eligibility for services provided under Chapter 51 of the Wisconsin statutes.

The federal definition, used with respect to federally-supported programs, is somewhat different from the state definition. It defines a developmental disability as a severe, chronic disability of an individual five years of age or older, that:

- Is attributable to a mental or physical impairment or combination of mental and physical impairments;
- Is manifested before the person attains the age of 22;
- Is likely to continue indefinitely;
- Results in substantial functional limitations in three or more of the following areas of life activity: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; and (g) economic self-sufficiency; and
- Reflects the person's need for a combination and sequence of special, interdisciplinary, or generic services, supports, or other assistance that is of a lifelong or extended duration and is individually planned and coordinated.

When applied to infants and young children up to age five, the term describes a substantial developmental delay or specific congenital or acquired conditions with a high probability of resulting in developmental disabilities if services

are not provided.

Using either definition, the Wisconsin Council on Developmental Disabilities estimates that there are approximately 100,000 persons in Wisconsin with developmental disabilities who require one or more publicly-funded services, representing approximately 1.8% of the state's population.

[The Council on Developmental Disabilities is a federally-funded systems advocacy and planning council for individuals with developmental disabilities and is attached to the Department of Health and Family Services (DHFS) for administrative purposes. The Council develops and monitors implementation of the state plan on the provision of services for individuals with developmental disabilities and reviews and advises DHFS on local budgets and plans relating to these services. The Council was established in response to a federal requirement that states establish such a council as a condition of receiving federal funds for advocacy services.]

The most common type of developmental disability is mental retardation, which is becoming more commonly referred to as cognitive disability. The American Association on Intellectual and Developmental Disabilities characterizes cognitive disability by significant limitations in intellectual functioning and in adaptive behavior as expressed in conceptual, social, and practical adaptive skills. In addition, the Association states that cognitive disability refers to a particular state of functioning that begins in childhood, has many dimensions, and is affected positively by individualized supports.

Cognitive disability can be caused by any condition that impairs development of the brain before birth, during birth, or in the childhood years. Several hundred causes of cognitive disability have been discovered, but in one-third of those affected, the cause remains unknown. The three major known causes of mental retardation are Down syndrome, fetal alcohol syndrome, and

Fragile X syndrome.

Developmental disabilities often result from damage to the brain structure or functioning. These types of disabilities include epilepsy, cerebral palsy, and autism.

Epilepsy is a neurological condition in which the normal pattern of brain activity becomes disturbed, causing strange sensations, emotions, and behavior and sometimes convulsions, muscle spasms, and loss of consciousness. These physical changes are epileptic seizures that may occur in one part of the brain (partial seizures) or affect nerve cells throughout the brain (generalized seizures). For most people with epilepsy, the cause of the condition is not known. However, things that interfere with the way the brain works, such as head injuries, a lack of oxygen during birth, brain tumors, genetic conditions, and infections such as meningitis or encephalitis, may cause epilepsy.

Cerebral palsy is a group of chronic disorders of movement or posture that appear early in life and generally is non-progressive irritation or injury to an immature brain. The causes of cerebral palsy, which are known in approximately 80% of cases, include prenatal maternal diseases and infections, prolonged or abnormal deliveries, birth trauma and prematurity, and several post-natal causes, such as respiratory distress and infections.

Autism is a developmental disorder of the brain that typically appears before a child is three years old and is characterized by three types of symptoms: (a) impaired social interaction; (b) problems with verbal and nonverbal communication; and (c) unusual or severely limited activities and interests. In addition, autistic behavior frequently includes abnormal responses to sounds, touch, or other sensory stimulation. Autism is a spectrum disorder affecting each individual differently, and at varying degrees. In most cases, the causes of autism are unknown, although it appears to be a physiological, rather than a psychological disorder.

Evidence suggests that many developmental disabilities can be prevented, primarily through proper perinatal care. Developmental disabilities are commonly associated with low-birthweight and premature babies. In addition, developmental disabilities may occur due to exposure and ingestion of lead, head injuries resulting from accidents and child abuse, use of alcohol and other drugs during pregnancy, and periodontal disease.

The Role of Counties in Providing Services

In Wisconsin, counties are assigned primary responsibility for the well-being, treatment, and care of persons with mental disabilities (persons with developmental disabilities, persons with mental illness, and alcohol- and other drug-dependent persons) who reside in the county and for ensuring that persons in need of emergency services who are in the county receive immediate emergency services.

Each county establishes its own policy and budget for these services. Because the statutes specify that counties are responsible for the program needs of persons with developmental disabilities only within the limits of available state and federal funds and county funds required to match these funds, counties limit service levels and establish waiting lists to ensure that expenditures for services do not exceed available resources. For this reason, the type and amount of community-based services that are available to persons with developmental disabilities varies among counties in the state.

DHFS rules require each county to meet certain minimum service standards to be eligible for state financial assistance for community-based services for persons with developmental disabilities. These rules define and provide minimum standards for the following 16 different services:

- Information and referral;
- Follow-along;
- Diagnostic;
- Evaluation;
- Counseling;
- Education;
- Recreation;
- Training;
- Treatment;
- Sheltered employment and work activities;
- Day care;
- Personal care;
- Domiciliary care;
- Special living arrangements;
- Transportation; and
- Protective services.

As previously indicated, each county's responsibility to meet the minimum service standards, as specified by rule, is limited by the availability of state, federal, and county matching funds. Further, some counties may offer services to persons with developmental disabilities that are not defined in the rules, such as supported employment services. Finally, state policy has increasingly placed emphasis on tailoring individualized services to the needs of each client. For these reasons, the availability and scope of services in the state varies by county. However, in an effort to ensure that a minimum array of services is available in all counties, the state distributes funding to counties for a variety of programs and services that are intended to complement and support these basic county services.

Programs Funded Under Community Aids

Under the state's community aids program, DHFS distributes state and federal funds to counties for community-based social, mental health, developmental disabilities, and substance abuse services. Community aids funding is allocated to counties on a calendar year basis and is distributed in a single amount that includes federal and state revenue sources. Counties receive both a basic

county allocation, which may be expended for any of these eligible services, and categorical allocations, which are funds that are earmarked for specific services and programs. For 2006, the estimated basic county allocation totals \$242,151,800 (all funds), representing 92.4% of all funds to be allocated to counties under the community aids program in that year (\$260,680,600). From the remaining portion, counties receive funding earmarked for selected programs, including the family support program.

Services Supported by the Basic County Allocation. Counties may use funding they receive under the community aids basic county allocation for a wide range of services for specified populations, including persons with developmental disabilities. Annually, counties report the amount of community aids funds, including required county matching funds and local funds contributed that are in excess of the required matching funds ("overmatch funds"), to the Wisconsin Council on Developmental Disabilities. Appendix I identifies county expenditures for programs that serve persons with developmental disabilities for calendar year 2005.

Family Support Program. Funding for the family support program is budgeted as a categorical allocation within the community aids appropriation. DHFS distributed \$4,986,200 in CY 2005 and \$4,913,300 in CY 2006 to counties to pay for services that enable parents to keep children who have severe disabilities at home. In order to be eligible for program services, a child must have a severe physical, emotional, or mental impairment which is diagnosed medically, behaviorally or psychologically and which is characterized by the need for individually planned and coordinated care, treatment, vocational rehabilitation or other services and which has resulted, or is likely to result in, a substantial functional limitation on at least three of the following seven functions of daily living:

- Self-care;
- Receptive and expressive language;
- Learning;
- Mobility;
- Self-direction;
- Capacity for independent living; and
- Economic self-sufficiency.

For the purposes of this program, a child is defined as a person under the age of 24. However, a county must receive approval from DHFS to provide services for families of children ages 21 through 23. Although family income is not a basis for eligibility, cost-sharing may be required, which is based on a sliding fee scale.

Under the family support program, families receive an assessment to determine which services are needed to enable a child with a disability to live at home. Counties are required to ensure that the family participates in the assessment and that the assessment process involves people who are knowledgeable about the child's condition. The assessment also includes a review of available services and sources of funding, such as the family's health insurance or medical assistance. A written service plan is then developed with family support program funds used to provide services for which other funding sources are not available. Up to 10% of the funds allocated to a county may be used to pay for staff and other administrative costs. Local advisory committees determine who receives funding and how much funding is spent.

In 2005, 86.6% of the 2,687 children who received services under the program had developmental disabilities. Approximately 18.2% of the children who received services were age six or under, 34.9% were age seven through 12, 34.5% were age 13 through 20, and 2.3% were age 21 or over. Of the children that received services in 2005: (a) 36.4% required personal care services because they were unable to help with their personal care; (b) 74.1% required assistance with some personal care activities; (c) 10.4% could not walk; (d) 15.5% required assistance with walking; (e) 35.4% had a severe developmental delay; and (f) 55% had a

moderate or mild developmental delay.

Although the program provides up to \$3,000 in services and goods annually to eligible families (along with additional amounts that may be provided with the Department's approval), the average per child allocation for the 2,423 children served in 2005 was \$1,730. Of these children, 843 were served on a one-time basis or considered underserved.

Table 1 identifies expenditures for the family support program, by service category, for calendar year 2005.

Table 1: Family Support Program Expenditures, by Service Category -- Calendar Year 2005

	Program Expenditures	% of Total
Architectural modifications of home	\$327,341	7.8%
Child care	242,932	5.8
Counseling and therapeutic resources	246,401	5.8
Dental and medical care	152,619	3.6
Diagnosis and evaluation	22,484	0.5
Diet, nutrition, and clothing	167,121	3.9
Equipment and supplies	1,153,993	27.5
Homemaker services	44,358	1.0
In-home nursing services-- attendant care	33,742	0.8
Home training/parent courses	65,962	1.5
Recreation/alternative activities	478,416	11.4
Respite care	927,596	22.1
Transportation	98,100	2.3
Utility costs	42,011	1.0
Vehicle modification	67,677	1.6
Other	<u>112,632</u>	<u>2.6</u>
Total	\$4,183,391	100.0%

The difference between the amount allocated for the family support program and the total expenditure amount in Table 1 are counties' administration costs.

As of March, 2006, 2,586 children were on waiting lists to receive services under the family support program.

Other Community-Based Service Programs Administered by DHFS

Early Intervention Services for Infants and Toddlers with Disabilities (Birth-to-Three). The early intervention entitlement program for infants and toddlers up to three years of age with developmental delays or disabilities, commonly referred to as the Birth-to-Three program, is a federal program authorized under Part C of the Individuals with Disabilities Education Act (IDEA). Under the program, Wisconsin supplements federal grant funds with state funds to develop and implement a statewide, comprehensive, coordinated, multidisciplinary, interagency program of early intervention services for infants and toddlers with disabilities and their families. Counties also provide a significant amount of funding for the program.

The goals of the Birth-to-Three program, as expressed in the federal legislation, are to: (a) enhance the development of infants and toddlers with developmental delays or disabilities and to minimize their potential for developmental delay; (b) reduce the educational costs to society and schools by minimizing the need for special education and related services; (c) minimize the likelihood of institutionalization of individuals with disabilities and maximize their potential for independent living in society; (d) enhance the capacity of families to meet the special needs of their infants and toddlers with disabilities; and (e) enhance the capacity of state and local agencies and providers to identify, evaluate, and meet the needs of historically underrepresented populations, particularly minority, low-income, inner-city, and rural populations.

Counties are responsible for administering the program, based on state and federal guidelines, and have the following primary responsibilities:

- Establishing a comprehensive child find system to identify, locate, and evaluate children

who may be eligible for the Birth-to-Three program;

- Designating a service coordinator for every child referred to the program for evaluation;
- Ensuring that core services, such as evaluation, service coordination, and the development of an individual family service plan (IFSP) are provided to families at no cost; and
- Determining parental liability for services received in accordance with the IFSP.

An evaluation of a child is conducted to determine eligibility for the Birth-to-Three program. This evaluation is conducted by an early intervention team, which includes the service coordinator and at least two professionals from different disciplines of suspected areas of need. Evaluations must be done in consultation with the child's parents. A child is considered eligible if he or she is under three years of age and has a significant developmental delay or determined to have a physician-diagnosed and documented physical or mental condition which has a high probability of resulting in a developmental delay.

Once eligibility is determined, an assessment is conducted by the early intervention team in order to further identify the unique needs of the child and his or her family. The results of the assessment are used by a team of professionals, the service coordinator, the parents, other family members, and an advocate, if requested by the parent, to develop the individual family service plan (IFSP). The IFSP must include a statement of the outcomes expected to be achieved for the child and family, how those outcomes will be achieved, a timeline for the provision of services, the manner in which services will be provided, and how the services will be paid.

While children are eligible for the Birth-to-Three program beginning after they are born until they reach the age of three, in 2005, almost 44% of

program participants were enrolled in the program for one year or less. Table 2 provides the number and percent of children, by age of referral, for program participants for calendar year 2005.

Table 2: Birth-to-Three Program: Age at Referral for 2005 Participants

Age	Number	Percent
Under six months	2,418	20.3%
Six to 12 months	1,573	13.2
12 to 18 months	1,448	12.2
18 to 24 months	2,624	22.1
24 to 30 months	2,853	24.0
30 months or older	<u>974</u>	<u>8.2</u>
Total	11,890	100.0%

In 2005, the most frequently used services by participants in the Birth-to-Three program, other than service coordination (which is mandatory for all participants), included communication services, special instruction, occupational therapy, physical therapy, and family education. In addition to these services, the following services may also be provided: (a) assistive technology services and devices; (b) audiology services; (c) certain health care services; (d) medical services provided only for diagnostic or evaluation purposes; (e) nursing services; (f) nutrition services; (g) psychological services; (h) social work services; (i) transportation; and (j) vision services. In December, 2005, 97% of these services were provided in either the child's home or usual childcare location and 3% of services were provided in a clinic, classroom, or other setting.

In 2006-07, \$6,878,700 general purpose revenue (GPR) and \$6,931,600 FED is budgeted for Birth-to-Three allocations to counties and state administrative costs. Appendix II identifies the county-by-county allocation of state, federal, and local Birth-to-Three funds for calendar year 2005. In addition, Table 3 identifies all of the revenues received by counties in calendar year 2005 for the Birth-to-Three program.

Table 3: Total Revenue for Birth-to-Three Program -- Calendar Year 2005

State and federal funds	\$13,288,800
County funds	13,100,000
Medical assistance	1,939,700
MA enhanced reimbursement	1,692,800
Private insurance	5,044,000
Collections for family cost-sharing	513,000
Other revenue	<u>690,800</u>
 Total	 \$36,269,100

On January 1, 2002, DHFS began paying an enhanced medical assistance (MA) reimbursement rate for MA- covered services provided to children enrolled in the Birth-to-Three program that are provided in the child's natural environment. This enhancement reflects the additional costs of providing services to youth in the Birth-to-Three program in the child's natural environment.

Supported Employment Opportunities. DHFS provides \$60,000 GPR annually to fund supported employment opportunities for individuals with developmental disabilities. These funds, which are used to match federal funds received by the Department of Workforce Development, Division of Vocational Rehabilitation under Title I-B of the federal Rehabilitation Act, are awarded to counties or other entities under a competitive process. These funds are then used to contract with private agencies to provide assessment, job development, job coaching, and/or other necessary supports/ services, such as transportation or adaptations to an individual's work environment that will promote integrated employment.

Beginning July 1, 2004, through June 30, 2007, funding was provided to support seven projects in Chippewa, Clark, Rock, Sheboygan, Taylor, Wau-paca, and Washburn Counties. Projects were supported through this grant money for up to a three-year period, if annual outcomes were achieved, that is., promoting consistency and sustainability in program development.

Epilepsy Service Grants. In the 2005-07 bien-nium, DHFS provided \$150,000 GPR annually to

private, nonprofit organizations or county agencies that provide direct or indirect services to or on behalf of persons with epilepsy. "Direct services" include services provided to a person with epilepsy or a member of the family of a person with epi- lepsy, including counseling, referral to other ser- vices, case management, daily living skills training, providing information, parent helper services, em- ployment services, and support group services. "Indirect services" include services provided to a person working with or on behalf of a person with epilepsy and including service provider training, community education, prevention programs and advocacy.

In reviewing applications for epilepsy grants, DHFS is required to review the need for direct and indirect services to persons with epilepsy and their families in the area in which the applicant provides services or proposes to provide services and ways to ensure that both urban and rural areas receive services under the program.

Agencies that receive grant funding are required to report to DHFS annually: (a) the estimated number of persons with epilepsy that reside within the area served by the agency; and (b) the number of persons with epilepsy and other persons and organizations who received services within the area served by the agency.

In 2005, \$30,000 grants were distributed to five affiliates of the Epilepsy Foundation. In that year, these associations provided direct services to approximately 9,362 individuals and indirect services to 23,335 individuals with state and local funds.

**Medical Assistance
Community-Based Services**

Low-income individuals with disabilities can be eligible for federal and state supplemental security

income (SSI) benefits. For many individuals with developmental disabilities, SSI payments are the only income they receive. Recipients often use these benefits to pay room and board in community-based settings. Eligibility for SSI provides categorical eligibility for medical assistance (MA), a state and federally-funded entitlement program that provides primary, acute, and long-term care services to certain low-income individuals.

Individuals with developmental disabilities whose income and resources exceed the SSI limits may also qualify for MA by spending down to the medically needy income and asset criteria. Disabled individuals who are working or enrolled in a certified job counseling program may also qualify for MA by meeting the qualified working and disabled individuals (QWDI) or the MA purchase plan (MAPP) criteria.

Under the MA program, recipients are entitled to receive MA card services, such as home health and case management services, as long as the services are medically necessary and are provided within the limitations set by state and federal law and policy.

In addition to MA card services, the MA program offers persons who are developmentally disabled and in need of long-term care several comprehensive program options. These programs include the MA home- and community-based waiver programs, the state-funded community options program, and Family Care. Certain children may also be eligible for MA under the Katie Beckett provision, while working disabled adults may qualify under the MAPP or QWDI criteria. These programs are summarized below and described in more detail in Legislative Fiscal Bureau Informational Paper, "Medical Assistance, BadgerCare, SeniorCare, and Related Programs."

Medical Assistance Community-Based Waiver Programs

Federal law authorizes the U.S. Department of Health and Human Services, Centers for Medicare

and Medicaid Services, to waive certain MA requirements to enable states to provide home- and community-based services to persons who would otherwise require care in an institution. In Wisconsin, there are seven such programs that operate under six MA waivers: (1) the community integration program IA (CIP IA); (2) the community integration program IB (CIP IB); (3) the community integration program II (CIP II); (4) the community options waiver program (COP-W); (5) the brain injury waiver (BIW); (6) the children's long-term support waivers (CLTS); and (7) the intensive in-home autism waiver. The Department is also working with CMS to secure a seventh waiver to implement a community opportunities recovery (COR) program, targeting services to adults who have co-occurring mental and physical health conditions. Five of the existing programs, CIP IA, CIP IB, BIW, CLTS, and the intensive in-home autism waiver, provide services to persons with developmental disabilities.

The Family Care program, which provides comprehensive services to elderly, physically disabled and developmentally disabled individuals through care management organizations, also operates under four federal waivers.

CIP IA and CIP IB. The distinction between CIP IA and CIP IB is that CIP IA supports services for persons who are relocated from the state centers for the developmentally disabled, whereas CIP IB supports services for persons who are diverted or relocated from nursing homes and ICFs-MR other than the centers to community-based programs. However, CIP IA and CIP IB are administered under a single federal waiver of MA rules. Further, CIP IA and CIP IB participants are eligible to receive the same array of community-based support services, such as supported employment services and prevocational services, which are not otherwise reimbursed under the state's MA program.

CIP IA and CIP IB participants also have the option of participating in the self-determination project. The project was created in 1998 under a

three-year Robert Wood Johnson Foundation grant to expand consumer choice and control for individuals with developmental disabilities in three Wisconsin counties (La Crosse, Winnebago, and Dane). Under the initiative, participants are part of a person-centered team that is responsible for identifying the care needs of the individual and how those needs will be met by: (a) identifying the enrollee's goals and establishing a method to attain those goals; (b) adhering to the constraints of a care budget established for the individual; (c) strengthening social supports and using community resources; and (d) establishing processes and supports to meet the needs identified in a consumer-directed service plan. The project allows participants to have greater choice in determining what services will be provided and who will provide those services, while technical functions, such as payroll-related duties are designated to fiscal intermediaries.

Community placements using CIP funding are usually initiated by county staff, parents or guardians, the courts, or, if a client lives at one of the centers, by staff at the center. Once a person is identified as having needs that can be met in a community setting, county staff seek permission from the person's parents or guardian to allow the individual to participate in a community-based program.

Relocation Initiative. 2003 Wisconsin Act 33 (the 2003-05 biennial budget act) included statutory changes that were intended to reduce the number of individuals with developmental disabilities admitted to, and living in, ICFs-MR. In addition, the act transferred from the state to counties the responsibility for the non-federal costs of care for individuals with developmental disabilities who were receiving services in ICFs-MR and nursing homes, other than the state centers for the developmentally disabled. The change was intended to increase access to community-based, long-term care services for individuals with developmental disabilities by allowing counties access to funding which had been previously designated solely for

institutional care, and to instead use those funds to support non-institutional services for these individuals (referred to as "the money follows the person"), as long as total program costs for institutional and community services could be managed within the same allowable funding limit. Act 33 also provided funding for phase-down payments to ICFs-MR that agreed to reduce the number of their licensed beds.

As of January 1, 2005, 1,412 individuals in Wisconsin resided in ICFs-MR and nursing homes, other than the state centers. This population is considered to be the target population for the community relocation initiative. As of September, 2006, 434 of these individuals had relocated from institutions to alternative community-based residential settings.

County and center staff are responsible for completing an assessment of each individual's functional and comprehensive needs to determine the individual's abilities, disabilities, and need for social and medical long-term care services, taking into account the interests and preferences of the person. Appendix III to this paper describes some of the criteria DHFS uses in assigning individuals to various levels of care. An individual service plan (ISP) is also developed for each waiver applicant that indicates what supports and services will be available to an applicant, how and when they will be delivered, the cost of these services, and how the services will be funded.

Staff in the DHFS Bureau of Developmental Disabilities determine whether the individual's needs can be effectively met under the proposed ISP and whether the care costs are within the limits of available CIP funding. The person is transitioned to the community only after DHFS approves the care plan and all the necessary community resources are in place. Counties are responsible for assuring that clients receive all necessary services identified in the ISP. Since not all of the costs identified in an ISP are eligible for MA reimbursement, counties may have to support

certain costs, such as room and board services, with funding from other sources. These costs are frequently supported by funding made available to counties under the state-funded COP program and the community aids programs.

DHFS reimburses counties for the actual costs of eligible services based on monthly cost reports submitted by counties. For the 2006, under CIP IA, eligible services are funded up to a maximum average per day allowance of \$125 for each person relocated from the centers before July 1, 1995, \$153 for relocations that occurred between July 1, 1995 and June 30, 1997, \$225 for persons placed between July 1, 2002 and June 30, 2003, and \$325 for persons placed on or after July 1, 2003. For CIP IA clients whose service costs exceed the fully funded rate, counties can be reimbursed with federal matching funds for approximately 58% of the excess costs, as long as overall expenditures for these services are below the maximum permitted under the waiver. This additional funding is available as a result of the county, rather than the state, providing match for federal MA dollars.

For CIP IB, services are funded, up to an average of \$49.67 per person per day. In addition, an enhanced rate is available for placements made from facilities that close or have approved plans for significant downsizing. The enhanced rate is determined by a formula that is related to the facility's MA reimbursement rate. Similar to CIP IA, additional federal funds are available to support approximately 58% of the costs that exceed the applicable CIP IB rate (if below the federal maximum). In calendar year 2005, counties and tribes contributed \$83.1 million as the local match for federal MA funds under CIP IB and \$6.6 million as the local match for federal MA funds under CIP IA.

The CIP reimbursement rates represent an average amount that may be reimbursed by the state for services provided to all participants within a county. Consequently, the state permits more funds to be spent on behalf of one individual and less on another as long as the average per diem

expenditure for participants does not exceed the overall allowable per diems. If expenditures exceed the allowable per diems, counties use their own funds (combined with available federal matching funds) to support the excess costs. This mechanism provides counties flexibility in managing resources to maximize program participation.

Table 4 illustrates the growth in CIP IA and CIP IB expenditures and participants between calendar years 1993 and 2005. Through December 31, 2005, there were 1,314 active CIP IA cases and 10,566 CIP IB cases for the calendar year. The CIP IB slots can be either state-supported (the state pays the 42% match under MA) or locally-supported from county COP or community aids funds or county

Table 4: CIP IA and IB Expenditures and Participants (Calendar Years 1993 thru 2005)

		Funding*	Participants**
CIP IA	1993	\$23,033,600	621
	1994	29,346,300	693
	1995	34,595,700	795
	1996	42,309,000	846
	1997	45,716,300	938
	1998	55,619,900	1,068
	1999	63,407,100	1,115
	2000	67,125,200	1,115
	2001	70,464,000	1,130
	2002	72,797,100	1,145
	2003	74,601,400	1,165
	2004	80,149,000	1,188
	2005	89,997,200	1,248
CIP IB	1993	\$32,724,100	1,483
	1994	48,722,500	2,270
	1995	73,878,600	3,848
	1996	109,520,600	4,806
	1997	139,695,900	6,098
	1998	172,738,900	7,424
	1999	198,498,200	7,849
	2000	212,463,400	8,849
	2001	227,372,100	9,299
	2002	254,507,000	8,961
	2003	283,297,500	9,444
	2004	302,968,100	9,668
	2005	329,300,100	10,166

*Includes local expenditures.

**Number of participants as of December 31 of each year.

property taxes. Table 4 includes both locally- and state-supported expenditures and participants.

DHFS estimates that, in calendar year 2005, the average cost of providing care for persons with developmental disabilities in institutions was \$526.50 per day for the three state centers and \$185.00 per day in other ICFs-MR, when including MA card costs. By comparison, the average cost to serve a person under CIP IA and CIP IB was estimated to be \$259.73 per day and \$121.20 per day, respectively, when expenditures for MA card services are included. These cost differences may be due to several factors, including differences in the care needs for individuals who currently live in institutions versus in community-based settings, increasing costs of care per individual in institutions as resident populations decrease, and differences between wage rates of caregivers in institutions and in community-based settings.

Brain Injury Waiver (BIW). Individuals who are substantially handicapped by a brain injury and receive or are eligible for post acute rehabilitation institutional care may receive community-based support services under this waiver program, which began on January 1, 1995. Before the waiver was implemented, individuals who had a brain injury were most frequently institutionalized, since: (a) the other MA waiver programs for which these individuals are eligible do not provide sufficient funding to meet the needs of this group; and (b) people who suffer a brain injury after they are 21 years old are not considered developmentally disabled and thus are not eligible for the CIP IA or CIP IB programs. For calendar year 2006, the budgeted reimbursement rate is \$180 per day. In calendar year 2005, program expenditures totaled approximately \$19.9 million when including local expenditures (approximately \$2.2 million). In calendar year 2005, 334 individuals were enrolled in this waiver program.

Children's Long-Term Support (CLTS) Waiver. 2003 Wisconsin Act 33 provided funding to support a new MA waiver program, operating

under three MA home- and community-based waivers, that provides children with long-term care needs MA services and a single entry point for eligibility determinations in each county. These waivers include: (a) the children's developmental disability waiver for children who meet the ICF-MR level of care; (b) the children's mental health waiver for children who meet the psychiatric hospital or severe emotional disturbance level of care; and (c) the children with physical disabilities waiver for children with hospital, intensive skilled nursing, skilled nursing, and intermediate care facility levels of care.

The CLTS program seeks to improve access to services, choice, coordination of care, quality, and financing of long-term care services for children with physical, sensory, and developmental disabilities, and severe emotional disturbance.

2003 Wisconsin Act 33 provided \$821,800 in 2004-05 to support MA benefits to individuals participating in the CLTS program. DHFS allocated these waiver slots to various counties around the state. Counties may also create waiver slots by supplying the local match to obtain the federal financial participation on these services. Under 2005 Act 25, an additional \$794,200 was provided to support more slots. As of July 1, 2006, there were 95 children in state-funded slots and 515 children in locally-matched CLTC slots.

In order to be eligible to participate in the CLTS waiver, children must meet functional and financial eligibility criteria that are similar to the family support program and the Katie Beckett eligibility criteria. The functional criteria require a child to have a severe physical, emotional or mental impairment which is diagnosed medically, behaviorally or psychologically and which is characterized by the need for individually planned and coordinated care, treatment, vocational rehabilitation or other services and which has resulted, or is likely to result in, a substantial functional limitation in at least two of the five following functions of daily living: (a) learning; (b) mobility; (c) receptive and

expressive language skills; (d) self-direction; and (e) self-care.

The financial eligibility criteria require that, in 2006, the child's income may not exceed \$1,809 per month and countable assets may not exceed \$2,000. Children who have income and/or assets that exceed these limits may become eligible for MA by "spending down" to the CLTS income and asset criteria.

Although the income of the parents of the child is not considered for determining eligibility for MA, families may be required to contribute to the cost of services. Fees are assessed for families with income equal to or greater than 330% of the federal poverty level (FPL), beginning at one percent of the service costs and increasing up to a maximum of 41% of service costs for families with incomes over 2000% of the FPL. County support, service coordination, and administrative costs are excluded for purposes of calculating the fee. Families may request a fee recalculation if they experience a dramatic change in income, and may either deduct a disability allowance of either the standard \$3,300 from their adjusted gross income or their actual allowable medical deduction reported on their income taxes from the previous calendar year.

The services provided under the CLTS waiver are similar to those available under other MA home- and community-based waivers. Some of the services that are necessary for adults, such as home-delivered meals, housing counseling, adult day care, and services provided by adult family homes, residential care apartment complexes, and community-based residential facilities, are not available to children under the waivers. Similarly, the CLTS waiver supports services that are not available under the other waivers, including intensive in-home autism services and specialized medical and therapeutic supplies. The average daily rate that was paid to counties to provide services under the waiver is \$48.42 in 2006. In addition to receiving waiver services, CLTS participants have access to all MA-covered card services. As with other MA

waiver programs, a calendar year allocation is identified for each county and program, based on estimated expenditures.

Similar to other MA waiver programs, counties may establish waiting lists for services when the funding provided is not sufficient to provide services to all eligible individuals. As of November, 2006, 250 children were on the CLTS waiting list. Children may continue receiving services under the waiver until they reach the age of 21 (as long they continue to be eligible for MA), after which they would need to receive some services under another waiver program. This could result in some individuals being placed on waiting lists for MA services once they reach 21 years of age, although counties can prevent a disruption in services by placing children already receiving services under CLTS on waiting lists for adult waiver slots.

Intensive In-Home Autism Services. 2003 Wisconsin Act 33 also created an intensive in-home autism benefit operating under two of the three children's long-term care waivers (the children's developmental disability waiver and the children's mental health waiver). Intensive, in-home autism services are defined as one-on-one behavioral modification therapy services for children with autism disorder, Asperger's disorder, or pervasive developmental disorder. These services are intended to teach autistic children the skills that children would typically learn by imitating others around them, such as social interaction and language skills.

Until January 1, 2004, in-home autism services were provided as a fee-for-service benefit under the early and periodic screening, diagnosis, and treatment (EPSDT) benefit. However, in June of 2000, the U.S. Department of Health and Human Services (HHS) notified the state that in-home autism services offered under the EPSDT benefit would no longer be eligible for federal MA matching funds. HHS later indicated that the appropriate method for claiming federal financial participation for intensive in-home autism services is through a

section 1915 (c) home- and community-based waiver. As a result, the administration developed a proposal to recreate the benefit as a service available under the CLTS waivers.

The state began providing intensive in-home autism services under the CLTS waivers on January 1, 2004. When the in-home autism benefit became available under the waivers, responsibility for administering the in-home autism benefit was transferred from the state to counties. As a result, counties began conducting assessments, establishing individual service plans (ISPs), and performing quality assurance activities for each participant.

In order to qualify for intensive in-home autism services, a child must have a verified diagnosis of an autism spectrum disorder. The vast majority of children eligible to receive autism services are eligible for MA under the Katie Beckett provision, while a small number of eligible individuals qualify for MA as supplemental security income (SSI) recipients.

Services may be provided at either the intensive or ongoing level. Children are eligible for in-home autism services at the intensive level for up to three years as long as the individual begins receiving services by eight years of age. Services are available on an ongoing basis until the individual reaches 16 years of age. As of November, 2006, 697 children were receiving intensive in-home autism services, while 880 children were receiving ongoing autism services.

Participants at the intensive level may receive 20 to 35 hours per week of intensive in-home autism services plus one hour per week of case management services, while participants at the ongoing level are limited by the services identified in the ISP and the funding that is available. An ISP is developed for each participant to identify the type of care and number of hours of service that each individual requires.

Funding is provided to counties to support intensive in-home autism services based on an estab-

lished weekly rate and the number of hours specified in each participant's individual service plan. In addition, counties receive funding to support approximately one hour per week of case management services per recipient and are permitted to claim up to 7% of direct service and case management costs to support administrative expenses. At the ongoing level, counties receive \$30.60 per enrollee per day to support all benefit and administrative costs. The calendar year 2006 weekly rates for the intensive in-home autism services are listed in Table 5. In 2005-06, approximately \$38.2 million was expended for autism services for children participating in the CLTS waiver.

Table 5: Intensive In-Home Autism Services Weekly Rates

Number of Hours	Weekly Rate
20	\$450
21	465
22	485
23	510
24	535
25	555
26	575
27	600
28	620
29	645
30	665
31	685
32	710
33	730
34	755
35	780

Community Options Program

Under the community options program (COP), individuals who are at risk of entering a nursing home are screened to determine if they could continue to remain in the community if adequate support services are provided. COP includes services that are entirely funded from state general purpose revenues and services that are funded with state and federal MA funds for services provided under an MA waiver. Although the COP-waiver program only serves persons over the age of 65 and persons

who are physically disabled, the state-funded COP program serves the following groups: (a) persons with developmental disabilities; (b) elderly persons; (c) persons with chronic mental illness; (d) persons with physical disabilities; and (e) persons with Alzheimer's disease. The state-only COP funds are also used to support MA-eligible services when costs exceed the state reimbursement rate for a waiver program and to support services that are not covered under MA, such as room and board costs.

Funding for the state-only and COP-waiver program is provided to counties as a calendar year allocation that counties may then use to serve as many or as few participants as the funding allows. However, counties are subject to a federal waiver requirement that the average cost of care statewide under the COP-waiver program may not exceed the average cost of care in nursing homes. Currently, DHFS limits the average expenditure per COP-waiver participant to \$41.86 per day-the same limit that is applied to CIP II. In calendar year 2005, the average total cost of care for COP-waiver and CIP-II participants, including MA card costs, was \$73.33 per day, while the average cost for MA nursing home recipients was \$120.42 per day. These average cost differences may be due to several factors including differences in the care needs for individuals who currently live in institutions and community-based settings and differences in the wage rates of caregivers in institutions and community-based providers. Approximately \$151.8 million was expended for state-only and COP-waiver services in calendar year 2005.

In calendar year 2005, 48% of the individuals receiving services under the GPR-funded COP program were persons with developmental disabilities.

Family Care

The Family Care program is a comprehensive long-term care program that was created to: (a) increase flexibility and consumer choice; (b)

improve access to services; (c) improve the quality of long-term care services; and (d) develop a cost-effective system for delivering long-term care services.

The Family Care program consists of two major components. First, aging and disability resource centers (ADRCs) provide information, assessments, eligibility determinations and other preliminary services. Second, care management organizations (CMOs) manage and provide the Family Care benefit for every person enrolled in the program under a capitated, risk-based payment system. The Family Care benefit provides a comprehensive and flexible range of long-term care services, including the types of services currently available under COP, the MA community-based waiver programs, and the MA fee-for-service program. Acute care services, such as hospital care or physician care, are supported outside of the monthly capitation rate on a fee-for-services basis.

Family Care enrollees may participate in the "self-directed supports" option, which is available through each of the CMOs. Under the self-directed supports option, participants have greater control over how services are received and who provides such services. For instance, participants work with an interdisciplinary team to determine when and where work will be performed and are permitted to employ family members and friends to provide services. When an individual chooses to self-direct certain services, the associated funding is carved out of the capitation rate and managed by either a "fiscal intermediary" or "co-employment agency."

As of December, 2006, sixteen counties were independently operating resource centers (Fond du Lac, Jackson, Kenosha, La Crosse, Marathon, Milwaukee, Portage, Richland, Trempealeau, Brown, Barron, Green, Wood, Manitowoc, Sheboygan, and Forest), while six counties operated two additional ADRCs collaboratively (Calumet/ Outagamie/Waupaca and Green Lake/ Marquette/Waushara). At that time, five counties are operating CMOs (Fond du Lac, La Crosse, Milwaukee, Portage and Richland). Four of the

CMOs (Fond du Lac, La Crosse, Portage, and Richland) provide services to individuals who are elderly, developmentally disabled, and physically disabled. The Milwaukee County CMO serves only the elderly population. Additional counties engaged in the planning process anticipate operating CMOs beginning in early to mid-2007. As of November, 2006, 1,275 of the 10,102 persons (12.6%) enrolled in Family Care were developmentally disabled.

Under 2005 Act 386, the "pilot" status of the Family Care program was repealed, and the expansion of services to areas of the state that encompassed less than 50% of the state (up from 29% previously) was approved. The approval of the Joint Committee on Finance under a 14-day passive review process would be required before DHFS could approve any expansion of the Family Care program to areas where, in the aggregate, more than 29% but less than 50% of the population that is eligible for the Family Care benefit reside. In order to expand the program beyond where 50% of the population that is eligible reside, the approval of the full Legislature would be required. These same review provisions were extended to apply to any expansion of similar managed care programs for long term care services (such as PACE, WPP, and SSI managed care). The Department subsequently requested that the Joint Committee on Finance approve its intent to contract with Racine County to open an ADRC in October, 2006. No objections were raised, and the request was approved under the passive review process.

The act also expands requirements directing DHFS to conduct ongoing evaluations of the long-term care system, including the review of client access to services, client choice of living and service options, quality of care, and cost effectiveness. These provisions also apply to similar managed care programs for long term care services (such as PACE, WPP, and SSI managed care).

In order to be eligible for the Family Care benefit, enrollees must meet both functional and finan-

cial eligibility criteria. In general, enrollees must be at least 18 years of age and their primary disability must be something other than mental illness or substance abuse. An individual meets the functional eligibility criteria if one of the following applies: (a) the person's functional capacity is at the comprehensive level; (b) the person's functional capacity is at the intermediate level; or (c) the person has a condition that is expected to last at least 90 days or result in death within 12 months after the date of application, and the person was a resident in a nursing home or was receiving long-term care services when the Family Care benefit became available in the person's county of residence. Financial eligibility criteria are met if an individual either: (a) qualifies for MA; or (b) would qualify for MA except for financial criteria and the projected cost of the person's care plan, as calculated by DHFS or its designee, exceeds the person's gross monthly income, plus one-twelfth of his or her countable assets, less deductions and allowances permitted by DHFS rules (non-MA Family Care).

The Family Care benefit is not an entitlement for non-MA eligible persons and the provision of services is limited by program funding. As of May 1, 2003, DHFS instructed CMOs not to admit most non-MA eligible applicants until further notice. As of October, 2006, 123 (1.2%) of the 9,900 Family Care enrollees were not eligible for MA. In 2005-06, approximately \$233.8 million was expended on the Family Care program for capitated payments to care management organizations (CMOs). Funding provided to support aging and disability resource centers (ADRCs) is budgeted by calendar year, and is expected to total approximately \$9.7 million for 2006.

The Katie Beckett Provision

Before 1982, federal MA income and resource guidelines presented eligibility barriers for disabled children who could be provided needed care in their homes. If a child under the age of 21 was living at home, the income and resources of the child's parents were automatically considered

available for medical expenses for the child. However, if a child was institutionalized for longer than a month, the child was no longer considered to be a member of the parent's household and only the child's own financial resources were considered available for medical expenses. The child was then able to qualify for MA.

These restrictions created a situation where children would remain institutionalized even though their medical care could be provided at home. In 1982, federal MA law was modified to incorporate the "Katie Beckett provision" after Katie Beckett, a ventilator-dependent, institutionalized child, was unable to go home, not because of medical reasons but because she would have lost her MA coverage.

This provision permits states to extend MA coverage to disabled children under the age of 18 who: (1) would be eligible for MA if they were in a hospital, nursing facility or intermediate care facility for the mentally retarded (ICF-MR); (2) require a level of care typically provided in a hospital, skilled nursing facility, or ICF-MR; (3) are determined to be appropriate to receive care outside of a facility; and (4) have an estimated cost of care outside of an institution that is no more than the estimated cost of institutional care. Unlike certain other MA recipients, the families of the children eligible under the Katie Beckett provision are not subject to co-payment or deductible requirements.

As of July, 2006, 5,503 children in Wisconsin qualified for MA under the Katie Beckett provision. In the 2005-06 fiscal year, MA expenditures for these children totaled approximately \$41.3 million (\$17.4 million GPR and \$23.9 million FED).

MA Purchase Plan

1999 Act 9 created an option provided under federal MA law to extend MA coverage to certain working, disabled persons. The goal of this program, the "MA purchase plan" (MAPP), is to

remove financial disincentives for individuals with disabilities to work. For instance, a disabled person may want to work, but choose not to do so because the additional income the individual would receive may make him or her ineligible for health care coverage under MA or Medicare. The MA purchase plan provides the opportunity for an individual to earn more without losing his or her health care coverage. This plan also allows an individual to accumulate savings from earned income in an independence account to increase the rewards from working.

An individual is eligible to participate in the MA purchase plan if: (a) the individual's family income, excluding income that is excluded under federal SSI rules, is less than 250% of the FPL (\$2,041.67 per month for an individual and \$2,750 per month for a two-person family in 2006); (b) the individual's countable assets do not exceed \$15,000; (c) the individual is determined to have a disability under SSI standards (disregarding one's ability to work); (d) the individual is engaged in gainful employment or is participating in a training program that is certified by DHFS; and (e) the individual is at least 18 years old. As of September, 2006, 10,351 individuals were enrolled in MA under MAPP.

Individuals enrolled in MAPP pay a monthly premium if their gross monthly income, before deductions or exclusions, exceeds 150% of the FPL (\$1,225 for an individual in 2006).

Institutional Services

State Centers for the Developmentally Disabled

The DHFS Division of Disability and Elder Services (DDES) currently operates three residential facilities for the care of persons with developmental disabilities. Northern Center in Chippewa Falls, Central Center in Madison; and Southern Center in

Union Grove (Racine County).

As counties' capacity to serve individuals in the community has increased, there has been a movement from long-term extended care admissions to short-term admissions at the centers. In 1995, Central Center and Southern Center entered into an agreement with the United States Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA). Under the agreement, the facilities may not accept permanent placements unless services outside of the centers are not adequate to meet the needs of the individual, in which case an admission may only be made on a temporary basis. All requests for temporary admission must be approved by the appropriate court.

A short-term admission is typically made to provide evaluation, assessment, crisis intervention, or to allow the county and provider adequate time to redesign a community support plan. This type of admission requires the approval of the local community board, the director of the center and the guardian, unless the admission is ordered by a court. A short-term admission is typically for a 30- to 90-day period and may be extended to 180 days at the discretion of the Director. Within 30 days after a person is admitted for short-term care, DHFS and the county must identify the support services that would be necessary for an individual to successfully live in the community. In addition, a person over the age of 18 may only be admitted to a center if he or she is determined to be in need of protective placement under Chapter 55 of the statutes.

The purpose of the centers is to provide residents with services that may not otherwise be available to them and assist them in returning to the community when their needs can be met at the local level. Counties are responsible for the care and treatment of persons with developmental disabilities and, thus, play a significant role in determining where an individual will receive services.

The state centers provide the following services: (a) education, training, habilitative and rehabilita-

tive services for residents; (b) behavioral evaluation of individuals at the request of county community program boards and county developmental disabilities boards; (c) assistance to county boards to enable them to better meet the needs of developmentally disabled persons; and (d) short-term care to individuals, including intensive treatment program (ITP) services, to help prevent long-term institutionalization. In addition to these services, the centers may offer dental, mental health, therapy, psychiatric, psychological, general medical, pharmacy, and orthotics services.

The population at the centers has declined considerably over the years. In 1970, nearly 3,700 persons resided in the centers, compared to 578 on June 30, 2006. The state-initiated movement to relocate center residents into the community began in the early 1970's as the centers' mission shifted from primarily a residential to a treatment approach. This movement of residents into the community was further increased as a result of implementation of the community integration program (CIP IA) in 1983 and the recent phase-out of long-term care services of Northern Center. The resident population for each center, as of June 30, 2006, is shown in Table 6.

Table 6: State Centers Resident Population and Daily Inpatient Rates as of June 30, 2006

	Rates	Population
Northern Center	\$1,057	23
Central Center	604	324
Southern Center	541	<u>231</u>
Total		578

The centers are certified as ICFs-MR by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). An ICF-MR provides care and active treatment to residents with long-term disabilities or illnesses who need medical or nursing services to maintain stability. This certification makes the centers eligible for federal cost sharing under the

state's MA program. Unlike MA payments to other ICFs-MR, MA payments to the centers are based on the actual eligible costs of operating each center, as limited by the amount budgeted by the Legislature for this purpose.

Table 7 identifies the total budget and the number of full-time equivalent (FTE) staff positions for each center for the 2005-06 fiscal year.

Currently, only two state-operated facilities serve individuals with developmental disabilities on a long-term basis. The 2003-05 biennial budget (Act 33) required DHFS to relocate Northern Center's residents to either a community-based setting or to another ICF-MR, but authorized that facility to continue to provide short-term ITP services and certain alternative services.

Other Institutional Services

Other facilities offer institutional care for Wisconsin residents with developmental disabilities. Like the state centers, these ICFs-MR are certified by the U.S. Department of Health and Human Services, CMS and must meet federal MA care and treatment standards. Excluding the three state centers, on December 31, 2005, there were 26 facilities serving individuals with developmental disabilities operating in Wisconsin with 990 licensed beds. These facilities ranged in size from 8 to 374 staffed beds. Counties operated 15 of the 26 ICFs-MR (58%), which accounted for 52% of the licensed ICF-MR beds (517 of 990). Nearly all ICF-MR residents are supported by MA.

Table 7: State Centers for the Developmentally Disabled –Budget and Authorized Positions – State Fiscal Year 2006-07

	Central Center	Northern Center	Southern Center	Total
I. Program Revenues—MA				
State Operations	\$60,365,600	\$2,600	\$38,386,700	\$98,754,900
Utilities and Fuel	1,595,800	801,800	1,200,700	3,598,300
Repair and Maintenance	<u>258,300</u>	<u>0</u>	<u>350,400</u>	<u>608,700</u>
Subtotal	\$62,219,700	\$804,400	\$39,937,800	\$102,961,900
II. Program Revenues—Other				
Alternative Services	\$219,000	\$7,785,200	\$28,100	\$8,032,300
Farm Operations	\$0	\$0	\$31,000	\$31,000
Activity Therapy	21,200	66,900	30,500	\$118,600
Gifts and Grants	35,000	70,000	30,000	\$135,000
Interagency and Intra-Agency Programs	<u>319,900</u>	<u>656,000</u>	<u>145,500</u>	<u>1,121,400</u>
Subtotal	\$595,100	\$8,578,100	\$265,100	\$9,438,300
III. GPR Funding				
General Program Operations	\$3,000	\$20,000	\$0	\$23,000
Total Funding (All Sources)*	\$62,817,800	\$9,402,500	\$40,202,900	\$112,423,200
Total Authorized Positions (All Sources)*	819.32	120.30	532.34	1,471.96

*Authorized positions and funding will be adjusted as part of the 2007-09 budget to reflect actual CIP IA placements that occurred in the 2005-07 biennium.

Act 33 included provisions that encourage counties to provide care to persons with developmental disabilities in the community. These changes included: (a) requiring counties to provide services to persons with developmental disabilities in the community unless it is determined that a community-based placement would not be the most integrated setting appropriate to the needs of the individual, taking into account information presented by all affected parties; (b) transferring responsibility for the non-federal share of ICF-MR costs for persons with developmental disabilities from the state to counties; and (c) providing funding to ICFs-MR entering into phase-down agreements and to counties to encourage community-based placements through additional CIP IB slots and one-time funding allotments. These provisions are described in greater detail under the prior section on CIP IB, under the heading "*Relocation Initiative*".

Table 8 provides information on these types of institutional settings for persons with developmental disabilities in Wisconsin at the end of 2003, 2004, and 2005. As shown in Table 8, the number of developmentally disabled persons in institutions decreased by 620 (36.9%) over this two-year period, from 2,300 on December 31, 2003, to 1,680 on December 31, 2005.

Table 8: People with Developmental Disabilities in Institutions on December 31, in 2003, 2004, and 2005

Setting	No. of Residents 12/31/03	No. of Residents 12/31/04	No. of Residents 12/31/05	Change Over Two Years
State Centers	772	671	583	-32.4%
Other ICFs-MR	1,415	1,412	990	-42.9
Nursing Homes	<u>113</u>	<u>141</u>	<u>107</u>	<u>-5.6</u>
Total	2,300	2,224	1,680	-36.9%

APPENDIX I

**2000-2005 County Expenditures for Services Provided
to Individuals With Developmental Disabilities
(All funds collected and spent at the county level)**

County	2000	2001	2002	2003	2004	2005
Adams	\$1,321,739	\$1,406,691	\$1,454,933	\$1,741,573	\$1,279,316	\$1,385,761
Ashland	1,653,649	1,662,598	1,738,002	1,582,476	1,831,811	1,836,958
Barron	3,166,731	4,256,699	4,378,010	4,837,792	6,050,830	5,587,788
Bayfield	1,054,734	1,146,734	1,391,663	1,685,218	1,976,167	2,095,892
Brown	15,351,723	16,131,859	17,536,434	19,495,666	22,529,768	26,958,707
Buffalo	1,039,154	1,158,905	1,179,937	1,186,988	1,735,508	1,860,067
Burnett	753,427	943,963	1,004,809	1,068,291	1,202,728	1,253,313
Calumet	3,174,497	3,320,083	3,529,611	3,573,803	4,036,424	4,482,321
Chippewa	3,551,046	3,862,943	4,509,403	5,315,763	6,243,110	7,282,954
Clark	5,174,187	5,500,367	5,789,295	6,018,698	6,684,994	6,807,819
Columbia	4,772,250	5,766,874	6,144,957	6,066,232	7,677,351	8,567,147
Crawford	2,624,403	2,693,187	2,908,469	2,923,674	2,959,756	2,962,825
Dane	62,384,761	67,672,417	67,837,046	73,857,484	76,775,600	78,889,136
Dodge	4,260,157	4,656,868	5,472,518	5,846,551	7,039,286	7,655,241
Door	2,641,991	2,975,385	2,965,481	2,880,386	3,828,683	3,512,613
Douglas	4,307,397	5,471,372	5,763,738	5,933,962	6,232,779	6,703,822
Dunn	4,147,813	4,052,359	4,030,124	4,560,812	4,932,619	5,409,055
Eau Claire	8,706,715	9,423,672	10,088,521	11,609,232	11,643,687	12,872,099
Florence	231,654	201,767	247,423	232,521	321,346	349,685
Forest-Oneida-Vilas	7,016,695	7,562,228	7,221,298	8,294,983	8,648,130	10,226,039
Grant-Iowa	4,592,000	4,829,187	5,075,912	5,423,031	5,796,635	6,484,135
Green	2,213,256	2,380,176	2,506,100	2,648,058	2,963,761	3,007,606
Green Lake	817,239	1,830,734	2,014,278	2,514,732	3,048,756	3,360,345
Iron	376,987	435,147	564,474	545,624	616,364	796,712
Jackson	2,978,313	3,143,513	3,230,707	2,982,752	3,330,843	3,379,455
Jefferson	5,598,914	6,355,836	8,101,116	10,155,065	11,534,827	13,899,921
Juneau	1,393,423	1,446,999	1,487,927	1,767,506	1,838,490	2,242,811
Kenosha	9,334,373	9,378,863	9,742,801	10,585,680	13,710,855	14,578,861
Kewaunee	2,009,052	2,338,931	2,535,457	2,762,766	3,258,572	3,350,892
Lafayette	1,304,855	1,430,382	1,619,155	1,804,476	1,807,743	2,031,981
Langlade-Marathon	12,867,416	14,347,952	16,940,767	18,282,353	18,083,380	21,125,067
Lincoln	2,451,053	2,743,370	2,734,871	3,291,545	3,314,211	4,188,217
Manitowoc	3,449,090	3,997,838	5,492,645	6,529,961	7,235,350	9,889,545
Marinette	2,632,439	2,690,360	2,837,232	3,437,723	3,404,661	3,193,998
Marquette	1,155,982	1,268,025	1,508,018	1,416,252	1,553,423	1,555,752
Menominee	280,007	324,792	416,667	462,388	525,180	382,545
Milwaukee	52,940,547	57,072,953	73,693,315	80,873,012	91,994,620	90,070,410
Monroe	3,388,112	3,739,973	4,125,772	4,620,193	4,581,912	5,068,056
Oconto	3,569,367	3,998,171	5,684,525	6,327,049	7,061,238	7,830,253
Outagamie	13,726,766	13,987,011	13,584,541	14,109,517	14,839,323	16,395,219

County	2000	2001	2002	2003	2004	2005
Ozaukee	\$5,213,489	\$5,792,129	\$6,726,458	\$7,528,623	\$8,201,025	\$9,012,186
Pepin	1,066,028	1,192,583	1,191,984	1,206,402	1,423,660	1,799,986
Pierce	3,423,013	3,865,913	4,031,580	4,155,662	4,820,016	4,734,038
Polk	1,769,269	2,290,314	2,393,339	2,602,525	3,053,106	3,407,889
Price	1,669,705	1,683,408	1,611,557	1,818,553	1,935,395	2,280,547
Racine	10,747,099	11,817,936	12,723,189	13,031,676	13,012,005	11,982,693
Rock	15,481,778	16,533,781	18,078,964	19,332,143	19,352,457	20,787,800
Rusk	1,263,343	1,153,889	941,543	1,351,703	2,197,358	2,627,032
St. Croix	8,504,566	9,145,184	10,133,649	11,244,630	12,837,269	2,532,199
Sauk	4,835,489	4,973,670	4,725,616	5,119,074	5,840,299	6,401,226
Sawyer	1,378,679	1,418,423	1,439,864	1,776,696	2,050,619	2,188,340
Shawano	2,795,106	2,716,076	2,820,675	3,075,112	3,719,861	4,414,040
Sheboygan	8,024,905	8,833,314	9,852,905	9,573,674	10,954,761	11,407,513
Taylor	2,285,424	2,432,612	2,569,228	2,688,470	2,755,712	3,074,434
Trempealeau	35,004	2,655,438	2,671,570	2,683,987	3,019,574	3,479,514
Vernon	2,136,650	2,492,548	2,658,188	2,759,554	3,071,204	3,146,918
Walworth	4,150,339	4,430,899	4,719,653	5,060,691	6,537,015	6,676,988
Washburn	1,549,880	1,049,456	1,280,250	1,591,721	2,114,002	2,438,532
Washington	8,321,767	9,972,911	10,775,188	11,271,767	11,716,010	13,550,552
Waukesha	16,486,881	16,437,222	16,639,906	19,260,527	24,043,241	25,298,511
Waupaca	4,453,232	4,758,630	5,453,369	5,654,831	7,046,465	7,859,958
Waushara	1,778,263	2,072,166	2,391,638	2,012,619	1,886,467	2,042,870
Winnebago	13,178,397	15,996,435	16,115,676	16,892,311	21,094,819	21,869,243
Wood	<u>5,720,422</u>	<u>5,353,225</u>	<u>7,482,172</u>	<u>7,697,897</u>	<u>8,212,142</u>	<u>9,226,744</u>
Total	\$390,682,642	\$453,867,649	\$472,367,204	\$514,298,416	\$571,909,175	\$598,573,952

Note: Counties that provide services to persons with developmental disabilities under Family Care (Fond du Lac, La Crosse, Portage, and Richland County) are not included in this table.

APPENDIX II

Birth-to-Three Allocations and County Expenditures Calendar Year 2005

County	Maintenance of Effort (1999 Actual Expenditures)	2005 County Expenditures	2005 State and Federal Allocation	2005 Total State/Federal and Local Funds	County	Maintenance of Effort (1999 Actual Expenditures)	2005 County Expenditures	2005 State and Federal Allocation	2005 Total State/Federal and Local Funds
Adams	\$29,297	\$29,297	\$35,071	\$64,368	Marathon	\$381,338	\$687,366	\$375,139	\$1,062,505
Ashland	22,283	22,283	34,984	57,267	Marinette	54,463	81,825	82,100	163,925
Barron	70,000	97,791	111,443	209,234	Marquette	27,018	27,019	32,695	59,714
Bayfield	39,294	39,294	41,848	81,142	Menominee	12,045	21,930	21,866	43,796
Brown	746,434	746,434	705,420	1,451,854	Milwaukee	2,190,392	2,338,889	3,034,838	5,373,727
Buffalo	10,800	36,171	30,187	66,358	Monroe	50,134	88,899	78,652	167,551
Burnett	25,592	30,708	37,995	68,703	Oconto	13,861	255,175	62,918	318,093
Calumet	136,044	228,899	127,436	356,335	Outagamie	157,066	417,600	368,664	786,264
Chippewa	45,686	151,653	111,226	262,879	Ozaukee	256,396	355,507	217,378	572,885
Clark	36,802	70,581	69,163	139,744	Pepin	5,447	31,427	45,584	77,011
Columbia	114,781	119,811	123,459	243,270	Pierce	23,860	29,802	70,540	100,342
Crawford	21,832	38,126	30,610	68,736	Polk	78,745	88,093	99,828	187,921
Dane	530,747	1,039,192	845,050	1,884,242	Portage	173,154	173,154	175,257	348,411
Dodge	148,178	189,467	179,928	369,395	Price	1,568	18,262	24,466	42,728
Door	93,818	101,425	91,549	192,974	Racine	299,898	269,974	503,100	773,074
Douglas	66,865	99,187	99,946	199,133	Richland	51,044	120,378	55,027	175,405
Dunn	153,855	248,168	145,775	393,943	Rock	142,984	360,800	390,699	751,499
Eau Claire	164,405	166,709	232,782	399,491	Rusk	26,110	27,072	36,280	63,352
Florence	500	16,534	16,358	32,892	St. Croix	117,392	165,879	137,928	303,807
Fond du Lac	211,284	254,880	235,630	490,510	Sauk	144,001	239,478	142,529	382,007
Forest/Oneida/Vilas	151,916	202,010	170,507	372,517	Sawyer	10,963	10,963	40,925	51,888
Grant/Iowa	108,817	111,813	141,297	253,110	Shawano	53,881	57,460	85,445	142,905
Green	22,338	22,338	60,262	82,600	Sheboygan	255,696	255,696	299,657	555,353
Green Lake	31,688	37,624	41,439	79,063	Taylor	4,863	12,422	36,306	48,728
Iron360	5,942	18,806	24,748		Trempealeau	9,186	93,793	56,834	150,627
Jackson	12,667	100,779	39,673	140,452	Vernon	33,815	141,296	51,591	192,887
Jefferson	148,415	382,804	187,112	569,916	Walworth	136,180	186,012	176,289	362,301
Juneau	29,124	77,815	53,094	130,909	Washburn	24,000	47,435	37,340	84,775
Kenosha	127,995	127,995	357,413	485,408	Washington	100,920	130,200	205,459	335,659
Kewaunee	35,429	47,119	50,211	97,330	Waukesha	277,602	277,602	619,189	896,791
La Crosse	115,671	203,204	205,509	408,713	Waupaca	151,886	190,803	155,158	345,961
Lafayette	2,446	15,535	30,470	46,005	Waushara	22,722	42,727	41,124	83,851
Langlade	150,854	150,854	100,951	251,805	Winnebago	270,287	290,170	340,019	630,189
Lincoln	70,611	117,071	72,175	189,246	Wood	<u>17,228</u>	<u>38,082</u>	<u>138,789</u>	<u>176,871</u>
Manitowoc	76,442	197,350	214,393	411,743					
					Total	\$9,329,415	\$13,100,054	\$13,288,785	\$26,388,839

APPENDIX III

Developmental Disabilities Levels of Care

Persons with developmental disabilities are evaluated to determine the severity of their functional, behavioral and health problems. Based on these evaluations, they are assigned one of four levels of care (DD-1a, DD-1b, DD-2 and DD-3), each with a different program emphasis and treatment goal. Generally, no single factor, such as level of retardation, determines an individual's classification. Instead, evaluations reflect a combination of factors that suggest which treatments may be appropriate for the individual.

Persons classified as DD-1a include developmentally disabled children and adults who require active treatment and whose health status is fragile, unstable or relatively unstable. The health care needs of these persons may be complex, requiring frequent professional assessments and monitoring. These individuals are often unable to communicate needs to caregivers verbally and may be totally dependent on staff for accomplishment of most activities of daily living. These persons are usually severely or profoundly retarded (IQ levels below 40). The program emphasis for these individuals is on the development of sensory and motor skills and environmental awareness.

Persons classified as DD-1b include developmentally disabled children and adults who require active treatment and considerable guidance and supervision. These persons frequently exhibit behaviors directed toward themselves and others which may be dangerous, including physical aggression or assaults to peers and staff, destruction of environment and hyperactivity. These persons may be unable to communicate needs to caregivers verbally and may have only limited understanding of the spoken word. Similar to DD-1a patients, DD-1b patients are usually severely or profoundly retarded. Persons classified as DD-1b have varying degrees of functional

abilities and require different amounts of assistance from staff to accomplish basic skills, such as feeding, dressing and bathing themselves. Health care assessments and monitoring is required at regular intervals for these individuals.

Persons classified as DD-2 generally include moderately retarded adults (IQs between 35 and 55) who require active treatment with an emphasis on skills training. These persons may only occasionally exhibit physically aggressive or undesirable social behaviors. They may have only limited understanding of the spoken word, but may know people by name and understand simple directions. These persons have varying degrees of functional abilities--most will be able to feed themselves with some degree of neatness, drink without assistance, and pull off clothing, but may require assistance with buttons, zippers and shoelaces. Persons in this category usually have stable health, but require assessment and monitoring of their health status at regular intervals.

Persons classified as DD-3 generally include mildly retarded adults (IQs between 55 and 70) who require active treatment with an emphasis on refinement of social skills and attainment of domestic and vocational skills. At this level, persons can usually participate in menu planning, shopping and food preparation. They are capable of daily participation in vocational training programs and sheltered workshops. Persons at this care level usually exhibit appropriate social behavior and have good language skills. They are capable of self-care for personal grooming, feeding, bathing and toileting, but may require assistance in other skills, such as managing money and selecting clothing. Since the health status of these persons is stable, health care focuses on prevention and health education.