



Services for Persons With Developmental Disabilities

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Services for Persons with Developmental Disabilities

Wisconsin provides a wide range of treatment and rehabilitation services for persons with developmental disabilities, mental illnesses, and alcohol and other drug abuse problems. State law aims to maintain a unified system of prevention of these conditions, and the provision of services to ensure access to minimally restrictive treatment alternatives, while providing continuity of care.

This paper describes state programs that provide services to individuals with developmental disabilities and their families.

Provision of Public Services

Chapter 51 of the Wisconsin statutes defines a developmental disability as:

"a disability attributable to brain injury, cerebral palsy, epilepsy, autism, Prader-Willi syndrome, intellectual disability, or another neurological condition closely related to an intellectual disability or requiring treatment similar to that required for individuals with an intellectual disability, which has continued or can be expected to continue indefinitely and constitutes a substantial handicap to the afflicted individual."

The federal Developmental Disabilities Assistance and Bill of Rights Act of 2000 defines "developmental disability" as a severe, chronic disability that is attributable to a mental or physical impairment or combination of impairments, is manifested before age 22, is likely to continue indefinitely, and requires a combination of individually planned and coordinated services, supports, or other forms of assistance of lifelong or

extended duration. In addition, the disability must result in substantial functional limitations in three or more of the following areas of major life activity: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; or (g) economic self-sufficiency.

The Department of Health Services. The Division of Long Term Care (DLTC) in the Department of Health Services (DHS) is generally responsible for the state's programs for persons with developmental disabilities, including Family Care, the community options program, the Birth-to-3 program, several medical assistance (MA) waiver programs, and the State Centers for the Developmentally Disabled. The DLTC consists of the Bureau of Long Term Support, the Bureau of Aging and Disability Resources, the Bureau of Center Operations, and the Bureau of Financial Services.

Nine councils and committees advise DLTC: the Autism Council, the Council for Children with Long Term Support Needs, the Council for the Deaf and Hard of Hearing, the Governor's Birth-to-3 Interagency Coordinating Council, the Governor's Committee for People with Disabilities, the Council on Blindness, the Wisconsin Long Term Care Advisory Council, the IRIS Advisory Council, and the Wisconsin Council on Physical Disabilities. These councils and committees each have different membership structures and missions, as designated by statute or established by the Governor.

The Board for People with Developmental Disabilities. The Board for People with Developmental Disabilities is a state agency charged with advocacy, capacity building, and systems change to benefit individuals with developmental

disabilities. While the Board is responsible for its own rule-making and policy positions, the Department of Administration performs human resource, payroll, contracting, purchasing, and budgeting functions for the Board.

The Board's mission is to promote a consumer- and family-directed system of services and informal supports that enable people with developmental disabilities to exercise self-determination, and be independent, productive, and integrated in the community. The main responsibilities of the Board include reviewing and analyzing available services, developing a state plan for advocacy and systems change, advising DHS, the Governor, and the Legislature, administering programs funded by the Board, advocating for persons with developmental disabilities, strengthening a statewide self-advocacy organization, and supporting opportunities for people with developmental disabilities to participate in coalitions and develop leadership skills.

The agency's governing Board is comprised of 20 members, each appointed by the Governor to a four-year term. At least sixty percent of the Board must consist of persons with developmental disabilities, their parents or guardians, or of immediate relatives or guardians of persons with developmental disabilities who cannot advocate for themselves. The remaining Board members include representatives from the following agencies or organizations:

- The agency that administers vocational rehabilitation services (the Department of Workforce Development);
- The agency that administers MA (DHS);
- The agency that administers the Older Americans Act (DHS);
- The agency that administers the state's maternal and child health program (DHS);

- The Department of Public Instruction;
- The Waisman Center at the University of Wisconsin-Madison;
- Disability Rights Wisconsin, the state's designated protection and advocacy agency;
- A public (county) provider;
- A private, not-for-profit developmental disability service provider; and
- A non-governmental advocacy group.

In 2012-13, the Board is budgeted \$1,301,700 to support its operations (\$732,200 FED and 7.75 FED positions and \$25,900 GPR) and grants (\$543,600 FED). The Board receives federal funds from the U.S. Department of Health and Human Services, Administration on Developmental Disabilities.

County Service Provision. In Wisconsin, counties are responsible for the well-being, treatment, and care of residents with developmental disabilities, and must ensure that persons in need of immediate emergency services receive these services. Each county establishes its own policy and budget for these services.

State statutes assign counties the responsibility for the program needs of persons with developmental disabilities only within the limits of available state and federal funds, and required county matching funds. Counties may limit service levels and establish waiting lists to ensure that expenditures for services do not exceed available resources. State policy also emphasizes individualized services for the needs of each client.

For these reasons, the type and amount of community-based services available to persons with developmental disabilities varies between counties. However, rules promulgated by DHS

require that all counties meet certain minimum service standards to receive state financial assistance for community-based services. These rules (DHS 61) apply to sixteen service areas, including information and referral, diagnosis, evaluation, and counseling. Counties may offer services that are not specified in rule, such as supported employment services.

To ensure that a minimum array of services is available in all counties, the state distributes funding for a variety of programs and services that complement and support these basic services. Most of this funding is provided under the state's MA program.

Total County Expenditures. Appendix I shows county expenditures for programs that serve persons with developmental disabilities for calendar years 2007 through 2011. This appendix includes expenditures from various local, state and federal sources at the county level, but does not include Family Care expenditures.

Medical Assistance Community-Based Services

Medical assistance (MA) is a state and federally-funded entitlement program that provides primary, acute, and long term care services to certain low-income individuals. Under the MA program, recipients are entitled to receive MA card services, such as physician services, dental services, home health and case management services, as long as the services are medically necessary and provided within the limitations set by state and federal law and policy. Some children with long term disabilities and complex medical needs may also qualify for MA coverage under the Katie Beckett provision.

In addition, the MA program offers several comprehensive program options to persons in need of long term care for a developmental disa-

bility. These programs include the MA home- and community-based waiver programs, the state-funded community options program, and Family Care. Children with developmental disabilities may also receive services under the children's long term support waiver program. These programs are summarized in this section and described in more detail in the Legislative Fiscal Bureau Informational Paper entitled "Medical Assistance and Related Programs."

For the purposes of MA eligibility, state statutes define disability as "the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months." The determination of disability and blindness are made by the Disability Determination Bureau (DDB) in DHS. Individuals meeting the definition of disabled are said to have met the non-financial eligibility criteria for MA. These individuals must also meet the financial eligibility criteria for MA.

Individuals found not disabled by the DDB can send a reconsideration request to the DDB within 45 days to have the decision reviewed. If denied a second time, the applicant would be given another determination hearing whose finding would be final.

Some low-income individuals with disabilities are 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 and for any other personal expenses common to community life. Eligibility for SSI provides categorical eligibility for MA.

Individuals with developmental disabilities whose income and resources exceed the SSI lim-

its may also qualify for MA by "spending down" to the medically needy income and asset levels. In addition, due to the high cost of long term care, individuals enrolled in home- and community-based waiver programs and Family Care have a special income limit that allows them to have a higher maximum monthly income than participants receiving standard MA services.

Alternatively, disabled individuals who are working or enrolled in a certified job counseling program or involved in competitive, supported or sheltered employment may also qualify for MA by meeting the MA purchase plan (MAPP) criteria.

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 institutions, including intermediate care facilities for persons with intellectual disabilities (ICF-ID). In Wisconsin, there are six such programs: (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); and (6) the children's long term support waivers (CLTS), which include the intensive autism services waiver. Four of these programs, CIP IA, CIP IB, BIW, and CLTS, provide services to persons with developmental disabilities. CIP IA and CIP IB only serve persons with developmental disabilities, BIW only serves persons with brain injuries, and CLTS has three separate waivers for persons with developmental disabilities, persons with physical disabilities, and persons with mental illness.

The Family Care program provides a similar package of community-based services for people who are elderly, physically disabled, or developmentally disabled. It also provides certain

standard MA long term care services, such as personal care and home health care, through managed care organizations (MCOs). This broader range of services allows the MCO to manage all long term care services and avoids creating a fiscal incentive for the MCO to use less efficient services in order to shift costs to standard MA services. Family Care operates under four federal waivers. For counties that choose to participate, Family Care replaces many of the other waiver programs. Finally, the state has a federal waiver to offer a self-directed care program, called IRIS (Include, Respect, I Self-Direct), which covers waiver services and operates in Family Care counties as an alternative to managed care.

Funding

DHS allocates the funding budgeted for each waiver program to participating counties on a calendar year basis. Counties in which the Family Care benefit is available do not receive funding allocations for CIP IA and IB, COP-Regular, BIW, or for waiver services provided to individuals over age 18 in the CLTS program. Funding for the Family Care and IRIS programs is discussed in their respective program descriptions.

Funding allocations for the waiver programs were based on a waiver reimbursement rate per individual, number of allocated slots, and total number of days in the contract year. Currently, slots in the various programs are based on a combination of the historical budget allocations, the addition of the care plan costs for new program enrollees, and in some cases the rate DHS associates with a new slot. DHS makes some adjustments when an individual moves between counties.

For most of the waivers' existence, counties could only serve one person for every waiver slot they were allocated. Beginning with CIP IB and BIW in 2008 and CLTS in 2009, DHS allowed counties to treat their state waiver funding as an

allocation and use the total available funding to serve as many individuals as possible. For CIP IA and the BIW, while funding may be treated as an allocation, a county may not serve more people than the number of slots awarded. Counties may serve fewer people in order to adjust for increased costs for participants. Counties are reimbursed fully by the state for allowable expenses for each program up to the county's funding allocation.

The state contributions are supplemented with federal matching funds. In 2011-12, the state and federal responsibility for MA funding allocations was approximately 40 percent and 60 percent, respectively. Counties may also obtain additional federal MA matching funds for waiver-covered services supported by county funds.

State Relocation Initiatives

DHS operates four separate MA waiver programs that offer community-based services to individuals who previously received services in institutions. Two of these programs -- the community integration program IA (CIP IA) and the ICF-ID restructuring initiative -- specifically serve individuals with developmental disabilities. The ICF-ID restructuring initiative is operated under the same authority as the CIP IB waiver program. These program distinctions are all established at the state level. Federally, all of these waivers for people with developmental disabilities are operated under a single federal waiver.

Community Integration Programs (CIP IA and CIP IB). CIP IA and CIP IB provide MA-funded, community-based services to individuals with developmental disabilities. CIP IA supports services for persons who are relocated from the State Centers for the Developmentally Disabled (Centers), while CIP IB supports services for other qualified persons. 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 available to other MA recipients.

Community placements using CIP funding can be initiated by county staff, parents or guardians, the courts, or, if a client lives at one of the Centers, by staff at the Center. Placements can also be initiated as part of facility closing plans for private ICFs-ID. Once a person is identified for community placement, county officials work with the person's parents or guardian to plan for the individual's community-based services. Courts are often involved in ordering placements so the individual can live in the most integrated and least restrictive setting available.

County and facility staff completes a comprehensive assessment of each individual's needs, preferences and desired outcomes to determine the services and supports the individual requires for a successful community placement. An individualized service plan (ISP) is also developed for each applicant. This plan details the supports and services that will be made available to the individual, how and when they will be delivered, the cost of these services, and how the services will be funded.

Staff in the DHS Bureau of Long Term Support reviews and approves all initial ISPs. The review process determines whether the individual's needs can be effectively met with the services and supports proposed in the plan and whether the costs are appropriate and all the necessary community resources are in place. The state and counties are jointly responsible for assuring that clients receive all necessary services identified in the ISP. Since not all of the costs of community living identified in a person's plan are eligible for MA reimbursement, counties may have to fund 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 community

options and community aids programs.

For CIP IA recipients, the county in which the person relocates receives the CIP IA funding to finance the services in the community. If the CIP IA participant dies, the county retains the CIP IA funding to support community services to other individuals with developmental disabilities. When an individual is relocated, funding for the state centers is reduced by the cost of the individual's community care plan under CIP IA and is reallocated to fund the CIP IA slot.

Prior to 2009-10, DHS provided counties a maximum average per day allowance for CIP IA recipients. Since fiscal year 2009-10, the state provides the funding needed to meet the individual's care plan in the community.

In 2011-12, the maximum average per day allowance for state reimbursement under CIP IB was \$49.67, although DHS pays a higher rate for placements from facilities that close or have on file a Department-approved plan for significant downsizing. The state claims federal matching funds for county costs that exceed the state payment rates up to a maximum of the average cost of care in an ICF-ID (approximately \$215 per day in 2012). In addition to these state funds, Wisconsin also claims federal matching funds for individuals for whom counties provide the state match.

In calendar year 2011, 265 individuals received services under CIP IA and 3,127 individuals received services under CIP IB.

ICF-ID Restructuring Initiative. 2003 Wisconsin Act 33 included statutory changes that were intended to reduce the number of individuals with developmental disabilities admitted to, and living in, ICFs-ID. With limited exceptions, the act prohibits a person from placing an individual with a developmental disability in an ICF-ID, and prohibits an ICF-ID from admitting an individual, unless, before the placement or admission and after considering a plan developed

by the county, a court finds that the placement is the most integrated setting appropriate to the needs of the individual.

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-ID and nursing homes, other than the state centers for people with developmental disabilities. 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 noninstitutional services for these individuals, 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-ID that agreed to reduce their number of licensed beds.

Individuals at a developmental disability level of care are the target population for the restructuring initiative. From January 1, 2005 to June 30, 2011, 744 individuals at a developmental disability level of care had been successfully relocated from ICFs-ID and nursing homes, other than state centers, to alternative community-based residential settings.

Under the relocation initiative, DHS establishes a global budget to provide services to all individuals eligible for the program, including individuals located in either an institutional or community setting. Counties are then responsible for managing the cost of providing services to these individuals within the approved budget amounts established by the state. If actual costs exceed the budgeted allotment, counties are then responsible for making up the difference. Care provided by institutional facilities is still billed to the state, however, DHS then reduces the amount of funding available for providing community-

based services by a corresponding amount.

Other MA-Supported Programs for Individuals with Disabilities

Brain Injury Waiver (BIW). Individuals who are substantially disabled by a brain injury and receive, or are eligible for, post-acute rehabilitation institutional care may receive community services under this special waiver program. In calendar year 2012, the maximum reimbursement rate was \$180 per day. BIW slots are reserved for MA enrollees who receive care in certified units for brain injury rehabilitation and who will be relocating to the community. In addition, counties may not retain a BIW slot if an enrollee dies.

Before DHS implemented this program, brain-injured individuals would typically have to be institutionalized because the other MA waiver programs for which these individuals are eligible, did not provide sufficient funding to meet the needs of this group. People who suffer a brain injury after they are 21 years old are not considered developmentally disabled and therefore are not eligible for services provided under CIP IA or CIP IB. In calendar year 2011, 96 individuals received services under the program.

Children's Long Term Support (CLTS) Waivers. 2003 Wisconsin Act 33 provided funding to support a MA waiver program, operating under three MA home- and community-based waivers, that provides MA services to children with long-term care needs and a single entry point for eligibility determinations in each county.

The CLTS waiver 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. In order to be eligible to participate in the CLTS waiver, children must meet functional and finan-

cial 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. The impairment must be characterized by the need for individually planned and coordinated care, treatment, vocational rehabilitation or other services that result in eligibility for MA if the child (1) is in a hospital or nursing facility, (2) requires a level of care typically provided in a hospital nursing facility, (3) can appropriately receive care outside of the facility, and (4) can receive care outside of an institution that costs not more than the estimated cost of institutional care.

The financial eligibility criteria require that in 2013, the child's income not exceed \$2,130 per month and, for those aged 18 and over, countable assets not exceed \$2,000. Children with greater income or assets 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 based on annual income and family size. 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 plan costs and increasing up to a maximum of 41% of service costs for families with incomes over 1,580% 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 significant 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, whichever is greater.

The services provided under the CLTS waiver are similar to those available under other MA home- and community-based waivers. However, 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 (RCACs), and community-based residential facilities (CBRFs), are not available to children under the waivers. The CLTS waiver also supports services that are not available under other waivers, including specialized medical and therapeutic supplies. In addition to receiving waiver services, CLTS participants have access to all MA-covered card services.

DHS provides each county with a funding allocation to provide CLTS services. Counties must serve children on a first-come, first-served basis, so long as funds are available, and may serve as many children as their allocation allows.

Counties may serve additional children by supplying the local match to obtain the federal financial participation on these services. Children applying for state-matched funding must meet the functional level of care requirement and be determined disabled by the DDB. Children applying for county-matched funding need only meet the functional level of care requirements. Once funding has been allocated, counties then have the authority to serve as many individuals as available funds will allow. As of June 30, 2012, 5,096 children were receiving services under the CLTS waiver.

Similar to other MA waiver programs, counties may establish waiting lists for services when the funding provided by the state is not sufficient to provide services to all eligible individuals. As of June 30, 2012, 2,653 children were on the CLTS waiting list, including 424 waiting for autism treatment services. Children may continue receiving services under the waiver until they reach the age of 22 (as long they continue to be

eligible for MA), after which they would need to receive some services under an adult waiver program. This could result in some individuals being placed on waiting lists for MA services once they reach 22 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.

As shown in Table 1, as of June 30, 2012, 5,096 children were enrolled in the CLTS waiver program. An additional 2,653 children were on the CLTS waiting list, including 424 waiting for intensive treatment and on-going services.

Table 1: CLTS Waiver Enrollment as of June 30, 2012

	Enrollment	Waiting List
Autism Services	2,300	424
Other CLTS Services	<u>2,796</u>	<u>2,229</u>
Total	5,096	2,653

Autism Treatment Services. 2003 Wisconsin Act 33 created the intensive in-home treatment services benefit for children with autism spectrum disorders. In 2011, the Department began to phase out the intensive in-home treatment program and created two distinct levels of intensive service -- the Early Intensive Behavioral Intervention (EIBI) service and the Consultative Behavioral Intervention (CBI) service -- to reflect the most recent research into the benefits of early intervention. The services remain fundamentally the same in the two programs, but children in the EIBI service receive 30 to 40 hours of face-to-face treatment and children in the CBI service receive 10 to 20 hours of face-to-face treatment.

Autism treatment services are intended to teach children with autism spectrum disorders the skills that developing children would usually learn by imitating others around them, such as social interaction and language skills. These services are designed to improve a child's social, behavioral, and communicative skills in order to

demonstrate measurable outcomes in these areas and overall developmental benefits in both home and community settings. The intent is for the child to make clinically significant improvements and have fewer needs in the future as a result of the service.

The state began providing autism treatment services under the CLTS waivers on January 1, 2004. When this benefit became available under the waivers, responsibility for administering it was transferred from the state to counties. Counties conduct assessments, establish individual service plans (ISPs), and perform quality assurance activities for each participant.

In order to qualify for autism treatment services, a child must have a verified diagnosis of autism, Asperger's Disorder or Pervasive Developmental Disorder, Not Otherwise Specified (PDD-NOS). This requirement is in addition to all other CLTS Waiver eligibility criteria.

An ISP is developed for each participant to identify the type of care and number of hours of service that each individual requires. A child is eligible for autism treatment services at the EIBI or CBI levels for up to three years as long as the child is placed on the state waitlist for these services before the time he or she is eight years old. Weekly services received prior to the CLTS waiver are figured into this total regardless of whether private insurance or public funding provided the service. Each week children receive their weekly hours of treatment and case management services.

Children who have received intensive autism treatment services, EIBI or CBI, for at least 12 of the past 18 months are eligible to receive ongoing CLTS Waiver services. Ongoing services must be identified in the ISP, and may include any services allowable under the waiver in which the child is enrolled, including respite and adaptive aids, but do not focus on direct treatment. As of June 30, 2012, 738 children were receiving intensive autism services, while 1,562 children were

receiving ongoing autism services.

The waitlist for intensive autism services is managed at the state level and functions on a slot-based system. When a slot becomes available the slot goes to the next child on the state-wide waitlist. The child's county and provider meet with the child to determine the number of hours of treatment the child will need each week. The county receives the corresponding rate for that level of treatment. The annual amount for the intensive services is added to the county's contract at the end of the year. Once the child leaves the program, the funding for the slot is returned to the state and is used to fund autism services for other children.

Counties are permitted to claim up to 7% of direct service and case management costs to support administrative expenses in both the CLTS waiver and the autism treatment program.

Counties are allocated \$30.60 per day to serve children receiving ongoing services. Counties have the choice to limit services for each child to \$30.60 per day or, based on the children's service plans, to provide some children with more or less than \$30.60 per day as long as the total average cost per child is no more than \$30.60 per day. When a child ages out of ongoing autism services, the county retains the funding to serve other children in need of those services.

Community Options Program. The non-waiver community options program is a 100% GPR-supported program. Counties can use COP-Regular funds as the non-federal share for additional MA eligible services provided to individuals in other home and community-based waiver programs or to pay the full costs of services not eligible for federal MA matching funds. Counties also use this funding as the local match to fund services for additional waiver enrollees or to draw down federal matching funds on MA allowable costs that exceed the waiver daily rate. This funding may also be used to support non-

MA allowable expenditures, such as room and board costs or certain medical supplies and care provided by a spouse or parent of a minor.

The state-only COP funds (within the limits of the portion of COP state funds allocated specifically for this purpose) are used to provide the cost of an individualized assessment and care plan for any person who is seeking admission to or is diverted from admission to a nursing home. In addition COP-regular funds may be used to provide the non-federal portion of MA-eligible waiver services to serve more waiver eligible people, for the non-federal match portion of MA-eligible services when costs exceed the state reimbursement rate for a waiver program, and to support "wrap around" services for individuals that are not covered under MA, such as room and board costs. In calendar year 2011, 26.4% of the individuals receiving services under the GPR-funded COP program were persons with developmental disabilities.

An individual who meets the financial eligibility criteria for MA nursing home care or one of the MA waiver programs also meets the financial eligibility criteria under COP. In addition, COP provides an alternative financial eligibility test that allows a person who is likely to become medically indigent within six months by spending excess assets for medical or remedial care to be financially eligible under COP. Before becoming eligible for COP services, an individual must be a resident of Wisconsin for at least six months and have a long-term care need that is defined as lasting a year or more.

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 state waiver requirement that the average cost of care statewide under the COP-waiver program may not exceed the average cost of care in nurs-

ing homes. Statewide, per person COP spending cannot exceed the average per person GPR cost of nursing home care. In calendar year 2011, per person per month COP spending could not exceed \$1,649.68.

Family Care. The Family Care program is a comprehensive long term care program that was created to improve the quality of long term care services individuals receive, provide individuals with more choices and greater access to services, and be 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, managed care organizations (MCOs) 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-service basis.

While MCOs provide comprehensive case management services, Family Care enrollees may also choose to participate in the "self-directed supports" option, which is available through each of the MCOs. Under the self-directed supports option, participants have greater control over how most 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 January, 2012, 28 counties and tribes were independently operating resource centers, while 50 counties and tribes operated 13 additional regional ADRCs collaboratively. At the same time, MCOs operated in 58 counties. All of the MCOs provide services to individuals who are elderly, developmentally disabled, and physically disabled. As of June 1, 2012, 12,690 of the 34,119 persons (37.2%) enrolled in Family Care were people with developmental disabilities.

In order to be eligible for the Family Care benefit, enrollees must meet both functional and financial 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 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 if one of the following applies: (a) the person's functional capacity is at the nursing home level, meaning they require ongoing care, assistance, or supervision; or (b) the person's functional capacity is at the non-nursing home level meaning that the person is at risk of losing his or her independence or functional capacity unless he or she receives assistance from others.

2011 Wisconsin Act 32, the 2011-13 biennial budget act, established an enrollment cap for the Family Care, PACE, Family Care Partnership, and IRIS programs for the period July 1, 2011, through June 30, 2013. During this period, the total enrollment in each ADRC service region for these long-term care programs could not exceed the number of individuals enrolled in these programs on June 30, 2011.

Act 32 provided a limited exception to the

enrollment cap for certain individuals who relocated from institutions if any of the following applied: (a) the individual resided at the facility for at least 90 days; (b) the facility closed or relocated residents; (c) the facility was no longer licensed to operate in the state; or (d) the individual relocated due to an emergency, as determined by DHS.

Act 32 reduced MA benefits funding by approximately \$265.5 million (\$105.9 million GPR and \$159.6 million FED) in the 2011-13 biennium to reflect: (a) an estimate of savings that would result from implementing the general enrollment cap (-\$115.9 million GPR and -\$174.9 million FED); and (b) additional one-time funding to support long-term care services for individuals who were on waiting lists for these programs and who were in urgent need of long-term care services, as determined by DHS (\$10 million GPR and \$15.2 million FED).

In addition, Act 32 prohibited DHS from expanding these long-term care programs to any new county unless DHS determined that these programs were more cost-effective than the county's current long-term care service system. DHS implemented the enrollment cap on July 1, 2011.

Notwithstanding the Act 32 enrollment cap, some individuals were enrolled in these programs after July 1, 2011. This was due, in part, to an increase in the number of applications DHS received in the months immediately prior to the effective date of the enrollment cap and a subsequent lag in applicant processing times. Within guidelines described above, 614 individuals that previously lived in institutions were permitted to enroll in these long-term care programs. In addition, approximately 102 individuals were enrolled in these programs and received services funded from the "urgent needs" funding provided in Act 32, for total expenditures of approximately \$765,000. In addition, 3,055 individuals were

able to enroll as other individuals left these programs.

On December 13, 2011, CMS notified DHS that states could not implement changes to state waiver programs without first receiving approval from CMS. CMS directed the Department to enroll into the Family Care, PACE, Partnership and IRIS programs any individuals that would have been entitled to services under these programs if the enrollment cap had not been put in place.

2011 Wisconsin Act 127 repealed the Act 32 provisions relating to the enrollment cap, effective April 3, 2012.

IRIS (Include, Respect, I Self-Direct). CMS requires the state to offer a fee-for-service alternative to managed care in order to provide individuals with sufficient choice in obtaining long-term care services. The IRIS program is a self-directed support waiver under the MA home- and community-based services waiver authority where individuals may self-direct their care and manage a designated budget amount. Under the self-directed supports option, participants have greater control over how services are received and who provides these services. IRIS is only available in counties where Family Care services are also available.

DHS contracts with two agencies to administer the IRIS program. First, DHS contracts with The Management Group to serve as the IRIS program's independent consulting agency (ICA). The ICA is responsible for assisting individuals in selecting a consultant that will work with the individual to develop a support plan. The services included in the plan must remain within the individual's approved budget, must be allowable under the federal Medicaid waiver, and must ensure the individual will be healthy and safe. The ICA also maintains a 24-hour call center that provides immediate access to IRIS participants who may need assistance in resolving any unanticipated

and urgent issues.

Second, DHS contracts with the Milwaukee Center for Independence to serve as the IRIS program's statewide financial services agency (FSA). The FSA assures that all services are paid according to an individual's plan and assists enrollees in managing all fiscal requirements, such as paying providers and assuring that employment and tax regulations are met. The FSA also provides training and support to help individuals with financial accountability and processes all payments to service providers.

To be eligible for IRIS services, an individual must reside in a Family Care county and meet the same financial and non-financial eligibility requirements as Family Care participants. This includes meeting a nursing home level of care as determined by the long-term care functional screen. Eligible individuals then have the option to enroll in either a managed care option or IRIS. DHS permits individuals to switch between these different options.

The services available under the IRIS program are limited to the home and community-based services not available through MA card services. This differs from Family Care, which covers all long-term care services, including those otherwise available through MA card services. IRIS does not cover MA long-term card services, such as therapies, personal care, and nursing home care. Instead, IRIS recipients continue to receive these services through their MA card. Although provided as an MA card service, IRIS enrollees have the option of self-directing their personal care services with the help of the ICA.

IRIS allows enrollees to receive customized goods and services, which are services, supports or goods that address a long-term support need and enhance the individual's opportunity to achieve outcomes related to living arrangements, relationships, community inclusion, work and

functional or medical status with respect to a long-term support need. To qualify as a customized good and service, the service, support or good must be: (a) designed to meet the participant's assessed long-term support need related to functional, vocational, medical or social needs and also advances the desired outcomes specified in the individual service plan; (b) documented in the individual service plan; (c) not prohibited by federal and state statutes or guidance; and (d) not available through another source and is not experimental in nature.

In addition to meeting all of these criteria, the service, support or good must also meet at least one of the following: (a) maintain or increase the participant's safety in the home or community environment; (b) decrease or prevent increased dependence on other MA-funded services; (c) maintain or increase the participant's functioning related to the disability; or (d) address a long-term support need and maintain or increase the participant's access to or presence in the community.

Individuals participating in the IRIS program are given an annual budget, based on their functional needs and a comparison to people with similar needs in the managed care programs. The individual then develops an individual support plan. Once the plan is reviewed and approved by the ICA, the person may use funds from his or her individual budget to obtain the services needed on a fee-for-service basis.

Individuals receiving IRIS services may reside, on a short-term basis, in any living arrangement, such as a CBRF, adult family home or a RCAC, as long as it is not a nursing home or other institutional facility. Individuals are not permitted to use any of their individual budget amount to pay for room and board. Further, IRIS enrollees may use their individual budget to pay caregivers, including family members, friends and members of their community, to provide services. Enrollees work with an ICA consultant to

develop an appropriate care plan that fits their individual budget. The budget amount determined by DHS is based on results from the individual's long-term care functional screen.

The estimated costs for the services included in the plan are based on the average Family Care capitation rates. Once the care plan and budget have been determined, the FSA then assists enrollees in managing the payments for services received. Annually, excess funds not used by an individual revert back into the program and are reallocated to other enrollees as needed.

As of July 1, 2012, there were 6,192 individuals in IRIS, including the elderly and those with physical or developmental disabilities.

MA Purchase Plan. 1999 Act 9 created an option provided under federal MA law to extend MA coverage to certain working persons with disabilities. 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 (\$2,327 per month for an individual and \$3,152 per month for a two-person family in 2012); (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 en-

gaged in gainful employment or is participating in a training program that is certified by DHS; and (e) the individual is at least 18 years old. As of July 1, 2012, approximately 20,700 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 (\$1,396 for an individual in 2012).

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. As a result, some 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," named after Katie Beckett, a child who was dependent upon a ventilator and was unable to return to her home, not for 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: (a) would be eligible for MA if they were in a hospital, nursing facility or ICF-ID; (b) require a level of care typically provided in a hospital, skilled nursing facility, or ICF-ID; (c) are determined to be appropriate for receiving care outside of a facility; and (d) 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 June 3, 2012, 5,095 children in Wisconsin were enrolled in the Katie Beckett program.

Institutional Services

Several facilities offer institutional care for Wisconsin residents with developmental disabilities. All of these facilities, including the State Centers, are certified by the U.S. Department of Health and Human Services Centers for Medicare and Medicaid Services (CMS) as institutional care facilities for the mentally retarded (ICFs-MR), and must meet federal MA care and treatment standards. 2011 Wisconsin Act 126 replaced "mentally retarded" and "mental retardation" with "intellectual disability" in state statutes. Act 126 retitled ICFs-MR as ICFs-ID. However, federal law continues to refer to these facilities as ICFs-MR

An ICF-ID provides care and active treatment to residents with an intellectual disability and who need medical, nursing and/or psychiatric supports to acquire skills for personal independence. This certification makes these facilities eligible for federal cost sharing under the state's MA program.

As noted above, DHS encourages counties to provide care to persons with developmental disabilities in the community rather than institutions. Policies intended to promote community care include: (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 meet the needs of the individual, taking into account information presented by all affected parties; (b) transferring responsibility for the non-federal share of ICF-ID costs for persons with developmental disabilities

from the state to counties; and (c) providing funding to ICFs-ID 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 MA waiver programs, under the "Relocation Initiatives" heading.

As a result, the number of these facilities has continued to decline over time, as an increasing number of individuals receive services in a community-based setting. For example, excluding the three State Centers, at the end of calendar year 2005 there were 26 facilities, with 990 total licensed beds, serving individuals with developmental disabilities operating in Wisconsin. As of July 1, 2012, there were 10 facilities with 341 licensed beds. Current facilities range in size from nine to 80 staffed beds. Counties operated seven of the 10 ICFs-ID (70%), which accounted for 80% of the licensed ICF-ID beds (274 of 341). Nearly all ICF-ID residents in the state are supported by MA.

Table 2 provides information on the various types of institutional settings for persons with developmental disabilities in Wisconsin at the end of 2008, 2009, 2010, and 2011. As shown in this table, the number of developmentally disabled persons in institutions decreased by 208 (21.6%) over this four-year period, from 964 on December 31, 2008, to 756 on December 31, 2011.

Table 2: People with Developmental Disabilities in Institutions as of December 31

Institution Type	2008	2009	2010	2011
State Centers	461	440	452	426
Other ICFs-ID	439	348	317	282
Nursing Homes	<u>63</u>	<u>56</u>	<u>51</u>	<u>48</u>
Total	964	845	820	756

State Centers. The DHS Division of Long Term Care (DLTC) currently operates three residential facilities for the care of persons with developmental disabilities: Northern Wisconsin Center (NWC) in Chippewa Falls; Central Wisconsin Center (CWC) in Madison; and Southern Wisconsin Center (SWC) in Union Grove (Racine County).

As counties' capacity to support individuals in the community has increased, there has been a shift from long term extended care admissions to short-term admissions at the Centers. In 1995, CWC and SWC entered into an agreement with the United States Department of Justice under the Civil Rights of Institutionalized Persons Act (CRIPA). Under the agreement, CWC and SWC were not permitted to 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. Although this agreement terminated as of February, 2006, state law still mandates that all requests for longer-term admissions 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. Short-term programs are the Intensive Treatment Programs (ITPs) at all three Centers and the Medical Short Term Care Program at CWC. These types of admissions require the approval of the local community board or appropriate managed care organization, the director of the Center and the parent or 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 with mutual agreement of the referring entity and the Center Director. Short-term admissions are typically voluntary admissions.

In recent years there have been no admissions

for long term care to the Centers. However, if there were, the statutes require that within 30 days after a person is admitted for long term care, DHS and the county or appropriate MCO 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 for long term care if he or she is determined to be in need of protective placement under Chapter 55 of the statutes. Community support plans are reviewed annually in the Watts review for all long term admissions to the Centers. The Watts review determines whether each person is in the least restrictive environment appropriate for their needs and abilities.

The Centers provide residents with services that may not otherwise be available to them and assist them in returning to the community. 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 Centers provide the following services: (a) education, training, habilitative and rehabilitative 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 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.

Currently, two of the three state-operated facilities, Central and Southern Centers, serve individuals with developmental disabilities on a long term basis. These individuals have lived at the Centers many years. The 2003-05 biennial budget (2003 Wisconsin Act 33) required DHS to re-

locate Northern Center's residents to either a community-based setting or to another ICF-ID, but authorized the facility to continue to provide short-term ITP services and certain alternative services.

The 2009-11 biennial budget (2009 Wisconsin Act 28) directed DHS to accelerate relocations of individuals who were receiving long term care services at SWC to alternative community-based settings on a voluntary basis. Funding for SWC was reduced to reflect an estimated 70 voluntary relocations. However, only 10 relocations occurred in the 2009-11 biennium. 2011 Wisconsin Act 32 restored funding for SWC to reflect the higher resident population.

Table 3 shows the respective population and reimbursement rates as of July 1, 2012, for each of the Centers. The population at the centers has declined significantly over the years. For example, in 1970, nearly 3,700 persons resided in the Centers, compared to 415 as of July 1, 2012. This decrease is largely due to the state-initiated movement to relocate center residents into the community which 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 at Northern Center and restructuring efforts at Southern Center.

Table 3: State Centers Resident Population and Daily Inpatient Rates as of July 1, 2012

Facility	Rates	Population
CWC	\$875	245
NWC	1,673	17
SWC	958	<u>153</u>
Total		415

Table 4 shows the number of residents that have been relocated from the Centers into a

community-based setting as a result of the CIP IA program from 2009-10 through 2011-12.

Table 4: CIP IA Relocations

Facility	2009-10	2010-11	2011-12
CWC	1	1	1
NWC	0	0	0
SWC	<u>8</u>	<u>2</u>	<u>2</u>
Total	9	3	3

Finally, Table 5 identifies the total budget and the number of full-time equivalent (FTE) staff positions for each center for fiscal year 2011-12. As noted, most of the program revenue funding for the Centers is comprised of payments through the state's MA program. Unlike MA payments to other ICFs-ID, however, 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.

Non-MA Community-Based Services

While the MA program is the primary source of public funding for services to individuals with developmental disabilities, counties receive fund-

ing under other programs administered by DHS. Some of these programs are partially supported by MA funds.

Community Aids. DHS distributes state and federal funds to counties under the community aids program for community-based social, mental health, developmental disability, and substance abuse services. Counties receive both a basic county allocation (BCA), which they may expend for any of these eligible services, and categorical allocations designated for specific services and programs. Additional detail on community aids is available in the Legislative Fiscal Bureau Informational Paper entitled "Community Aids/ Children and Family Aids."

Basic County Allocation. Community aids includes the basic county allocation, and four categorical allocations that must be spent on specific areas (the family support program, mental health block grant, substance abuse block grant, and Alzheimer's family and caregiver support program). Counties use the BCA, in combination with funding from other sources, to support a wide range of human service programs, including the services they provide for individuals with developmental disabilities. Counties may use the basic county allocations for any allowable com-

Table 5: State Centers for the Developmentally Disabled -- Total Budget and Authorized Positions, State Fiscal Year 2011-12

	CWC	NWC	SWC	Total
Program Revenues – MA				
State operations	\$62,906,700	\$16,200	\$40,987,000	\$103,909,900
Utilities and fuel	2,160,900	1,346,300	2,032,600	5,539,800
Repair and maintenance	<u>269,700</u>	<u>0</u>	<u>350,400</u>	<u>620,100</u>
Subtotal	\$65,337,300	\$1,362,500	\$43,370,000	\$110,069,800
Program Revenues – Other				
Alternative services	\$478,500	\$8,004,200	\$274,100	\$8,756,800
Farm operations	0	0	50,000	50,000
Activity therapy	77,400	17,800	17,500	112,700
Gifts and grants	35,000	70,000	30,000	135,000
Interagency and intra-agency programs	<u>176,200</u>	<u>1,233,100</u>	<u>301,900</u>	<u>1,711,200</u>
Subtotal	\$767,100	\$9,325,100	\$637,500	\$10,765,700
Total Funding (All Sources)	\$66,104,400	\$10,687,600	\$44,043,500	\$120,835,500
Total Authorized Positions (All Sources)	811.40	122.30	529.75	1,463.45

munity aids service. In calendar year 2013, DHS will distribute \$171.7 million under the community aids BCA. In 2011, counties reported spending approximately \$32.4 million of the BCA on services for persons with developmental disabilities.

Family Support Program. The family support program is a categorical allocation within community aids that funds services that help children with severe disabilities remain in their homes. In calendar year 2011, 3,157 children received services under the program. Most of these children had developmental disabilities, although the program also provides services to children with physical disabilities and children with severe emotional disturbances. DHS will distribute \$4,909,300 to counties in CY 2013. Counties may spend up to 10% of these funds for staff and other administrative costs. Local advisory committees determine who receives funding, and how the funding is allocated. Table 6 identifies expenditures for the family support program for specific service categories in calendar year 2011.

Table 6: Family Support Program Expenditures by Service Category, Calendar Year 2011

Service Category	Amount	% of Total
Architectural Modification of Home	\$192,475	4.0%
Child Care	114,854	2.4
Children's Long Term Support		
Waiver Services	1,035,818	21.3
Counseling/Therapeutic Resources	184,604	3.8
Dental/Medical Care Not Otherwise Covered	53,274	1.1
Diagnosis and Evaluation	12,192	0.3
Diet, Nutrition and Clothing	118,855	2.4
Equipment and Supplies	1,609,050	33.1
Home Training/Parent Courses	54,583	1.1
Homemaker Services	17,966	0.4
In-Home Nursing Services - Attendant	15,819	0.3
Recreation/Alternative Activities	458,863	9.4
Respite Care	803,163	16.5
Transportation	98,548	2.0
Utility Costs	30,316	0.6
Vehicle Modification	41,775	0.9
Other	<u>15,489</u>	<u>0.3</u>
Total	\$4,857,643	100.0%

The program provides up to \$3,000 per year in services and goods to eligible families, along with additional amounts that may be provided with the Department's approval. To qualify for program services, a child must be diagnosed with a severe physical, emotional, or mental impairment which requires individually planned and coordinated care, treatment, vocational rehabilitation, or other services. The condition also must have resulted, or be likely to result, in a substantial limitation in at least three of seven functions of daily living (self-care, receptive and expressive language, learning mobility, self-direction, capacity for independent living, and economic self-sufficiency).

Families receive an assessment to determine what services a child requires to be able live at home. Counties ensure that the family participates in the assessment and that the assessment process involves people knowledgeable about the child's condition. The assessment also includes a review of other available services and funding sources, such as medical assistance or the family's private health insurance coverage. A written service plan is developed, with family support program funds allocated for services for which other funding sources are not available.

Although eligibility does not depend on income, some families are required to share in the cost of program services based on a sliding scale. Families with income under 330% of the FPL do not have any cost sharing requirement. (In 2012, 330% of the FPL was \$62,997 in annual income for a family of three.) For families with income at or above 330% of the FPL, families contribute to service costs on a sliding scale up to 41% of service costs.

Early Intervention Services for Infants and Toddlers with Disabilities (Birth-to-3). The Birth-to-3 program, au-

thorized under Part C of the federal Individuals with Disabilities Education Act, utilizes state, federal and local funds to support a statewide, comprehensive program of services for infants and toddlers with disabilities, and their families. Program goals established in federal law include enhancing the development of children with developmental disabilities, minimizing the need for special education, and decreasing institutionalization. In 2011, approximately 6,000 children in Wisconsin received Birth-to-3 services.

Counties are responsible for administering the program based on state and federal guidelines. Specific county responsibilities include establishing a comprehensive system to identify, locate, and evaluate eligible children, designating a service coordinator for every child referred to the program, ensuring the provision of core services at no cost (such as evaluation, service coordination, and the development of an individual family service plan (IFSP)), and determining parental cost-sharing for services.

An early intervention team, comprised of a service coordinator and at least two professionals from different disciplines of suspected areas of need, evaluates children referred to the program to determine their eligibility for services. A child qualifies if he or she is less than three years old and has a significant developmental delay, or has a physician-diagnosed and documented condition likely to result in a developmental delay.

Once eligibility is determined, the early intervention team conducts an assessment to further identify the unique needs of the child and the 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. The plan must include a statement of the expected outcomes, how those outcomes will be achieved, a timeline for the provision of services, the manner in which services will be provided, and the sources of

payment for the services.

The most frequently used services by Birth-to-3 program participants include mandatory service coordination, communication services, special instruction, occupational therapy, physical therapy, and family education. Children in the program may also receive audiology services, certain medical services, nursing services, nutrition services, psychological services, social work services, transportation, and vision services.

The program is funded from several sources, including state and federal grants, county funds, community aids, Medicaid and private insurance reimbursement, and parental cost sharing. Table 7 shows the calendar year 2011 reported expenditures for the Birth-to-3 program from all sources. Appendix II provides federal, state and local expenditures reported by counties for Birth-to-3, as well as the number of children served, for calendar year 2011.

Table 7: County Reported Birth-to-3 Funding, Calendar Year 2011

Revenue Type	Amount
County Funds (includes Community Aids)	\$16,749,300
State and Federal Funds	11,316,500
Medicaid	2,633,700
Parental Cost Share	338,100
Private Insurance	440,000
Other	<u>331,400</u>
Total	\$31,809,000

Supplemental Security Income. The Supplemental Security Income program (SSI) provides benefits to approximately 115,000 low-income Wisconsin residents who are elderly, blind or disabled. Program participants receive monthly checks of up to \$781.78 in state and federal benefits, which they may use for any purpose. Participants also automatically qualify for coverage under the MA program. For additional information on SSI, including program policy

and funding information, see Legislative Fiscal Bureau Informational Paper #47 titled "Supplemental Security Income."

Disability Benefit Specialists. The disability benefit specialist (DBS) program provides assistance and information to people with disabilities between the ages of 18 and 59 (individuals 60 years of age or older can receive similar services from elderly benefit specialists). Benefit specialists work in 35 ADRCs in 59 counties, and provide services such as help with program applications, discussions regarding program choices to meet the individual's needs, and, at times, representation in appeals processes for certain programs. In 2011, a total of 10,344 cases were closed by these benefit specialists, with an additional 7,184 information only contacts. Seven percent of DBS clients had a developmental disability and no other diagnosis (the majority of clients served had either a physical disability or a mental illness). The three most common issues addressed by DBS are the disability determination process (34%), Medicare Part D (18%), and social security disability insurance (SSDI) (12%).

DHS allocated a total of \$8,305,200 all funds for DBS services in calendar year 2011. Costs are split between GPR and FED, and depend on federal cost reporting submitted by ADRCs to the Department (in 2012, that split was approximately 78% GPR and 22% FED). The majority of spending is for DBS services provided in ADRCs (\$7.0 million in 2011), with the remainder allocated for legal backup services, tribal DBS services, and training (\$1.3 million).

Epilepsy Service Grants. DHS allocates \$131,200 GPR annually to private, nonprofit organizations or county agencies that provide direct or indirect services to persons with epilepsy. Direct services include services provided to a person with epilepsy or a member of the family of a person with epilepsy, such as counseling, referral to other services, case management, and daily living skills training. Indirect services include services provided to a person working with or on behalf of a person with epilepsy, such as service provider training, community education, prevention programs, and advocacy. DHS issues grants to four regional affiliates of the Epilepsy Foundation.

Additional Resources

Additional information on these and other issues regarding services for persons with developmental disabilities can be found through the following resources:

Wisconsin Department of Health Services
www.dhs.wisconsin.gov/disabilities/DD

Wisconsin Board for People with Developmental Disabilities
www.wi-bpdd.org

National Center on Birth Defects and Developmental Disabilities
www.cdc.gov/ncbddd

APPENDIX I

Services for Individuals with Developmental Disabilities Reported County-Level Expenditures, All Funds Calendar Years 2007 through 2011

County	2007	2008	2009	2010	2011
Adams	\$1,973,785	\$1,881,648	\$1,980,882	\$2,037,811	\$2,099,322
Ashland	2,076,148	2,122,171	1,138,757	35,597	217,960
Barron	5,176,560	6,163,216	3,244,802	915,420	719,271
Bayfield	2,014,224	1,894,981	1,100,363	256,536	289,040
Brown	36,002,133	37,106,651	38,888,719	40,182,368	40,637,664
Buffalo	2,201,337	2,470,745	587,121	126,690	111,316
Burnett	1,896,717	2,085,708	963,108	341,170	243,579
Calumet	5,267,270	5,514,710	5,871,902	1,371,408	1,493,733
Chippewa	10,355,084	6,391,723	1,490,770	1,235,397	1,444,218
Clark	7,114,980	7,126,867	3,262,519	2,777,030	2,080,684
Columbia	9,957,657	4,837,510	1,342,949	1,265,554	1,049,897
Crawford	3,312,938	3,357,515	2,021,782	372,589	303,460
Dane	80,930,404	83,008,577	83,717,973	84,198,388	85,792,836
Dodge	9,444,040	7,882,550	1,767,629	1,751,584	1,626,945
Door	4,860,290	5,153,439	5,866,988	5,726,272	5,995,083
Douglas	6,747,704	6,515,175	2,689,375	1,260,888	1,316,893
Dunn	6,984,458	5,256,295	1,350,362	1,460,636	1,364,074
Eau Claire	14,552,945	14,692,439	3,838,672	2,694,911	2,561,393
Florence	381,298	341,223	461,795	381,459	502,105
Fond du Lac	3,054,442	3,348,983	3,735,920	3,528,738	3,215,712
Forest-Oneida-Vilas	11,556,512	11,454,290	11,939,559	11,498,566	11,569,463
Grant-Iowa	6,648,995	7,070,046	7,335,296	3,115,532	930,445
Green	3,035,761	3,272,922	538,296	560,438	536,610
Green Lake	3,613,179	3,184,426	1,462,448	1,501,002	1,534,944
Iron	875,742	669,611	465,559	61,304	70,240
Jackson	4,108,035	4,332,404	547,047	165,006	129,535
Jefferson	17,262,039	17,066,045	3,770,415	1,285,683	1,404,903
Juneau	2,899,390	3,019,505	2,182,402	875,284	529,187
Kenosha	11,395,539	1,278,549	1,645,070	1,720,978	1,377,788
Kewaunee	3,437,525	3,957,565	4,168,256	4,467,733	4,228,789
La Crosse	2,505,136	3,185,901	3,347,165	2,886,566	2,745,427
Lafayette	2,139,189	2,268,984	1,243,482	507,723	308,101
Langlade-Lincoln-Marathon	28,938,548	28,295,215	15,275,358	16,752,198	10,182,895
Manitowoc	14,139,212	15,793,049	16,100,917	7,976,367	2,192,376
Marinette	3,891,529	3,721,970	3,736,240	3,916,477	4,174,520
Marquette	1,412,435	1,095,156	308,272	301,258	339,744
Menominee	489,591	877,940	1,228,982	**	**
Milwaukee	87,323,875	88,178,161	89,988,449	40,670,414	11,076,897
Monroe	6,040,049	6,364,429	334,435	**	**
Oconto	8,207,649	8,594,857	8,720,597	8,490,651	8,973,422

APPENDIX I (continued)

**Services for Individuals with Developmental Disabilities
Reported County-Level Expenditures, All Funds
Calendar Years 2007 through 2011**

County	2007	2008	2009	2010	2011
Outagamie	\$20,525,504	\$21,203,498	\$21,657,105	\$21,840,695	\$2,221,802
Ozaukee	10,243,581	4,780,388	3,293,958	2,486,746	2,724,092
Pepin	1,874,952	1,799,592	347,005	107,640	69,106
Pierce	4,436,298	3,052,190	400,254	448,077	418,205
Polk	3,615,375	3,723,720	1,858,299	289,668	391,732
Portage	1,218,870	1,435,725	1,391,813	1,144,359	1,292,182
Price	2,960,079	2,960,545	2,002,788	316,459	483,308
Racine	5,019,013	2,581,108	3,219,027	3,346,792	2,728,517
Richland	364,507	468,118	247,993	269,605	289,970
Rock	24,961,084	25,364,097	27,253,078	27,650,581	25,712,818
Rusk	2,963,381	3,022,695	1,867,512	255,320	254,498
St. Croix	7,746,633	5,688,119	1,425,586	1,384,652	1,244,273
Sauk	2,519,693	1,994,923	1,264,506	354,302	375,887
Sawyer	5,218,421	6,213,600	6,540,519	6,279,619	6,219,010
Shawano	18,605,875	8,472,836	1,973,511	1,753,458	1,770,979
Sheboygan	2,646,396	3,048,391	1,621,298	1,601,890	**
Taylor	3,172,103	3,370,174	3,369,551	3,458,711	3,566,156
Trempealeau	3,811,033	4,216,132	577,655	537,568	518,744
Vernon	3,963,278	3,497,130	259,281	446,575	433,005
Walworth	6,909,952	7,437,534	6,660,114	1,784,484	444,004
Washburn	2,669,587	2,712,552	1,313,320	326,093	323,828
Washington	14,958,023	8,767,081	3,457,198	2,744,464	1,285,685
Waukesha	30,965,719	26,752,062	7,540,456	7,116,914	9,961,107
Waupaca	10,388,623	12,069,802	10,615,706	8,250,676	4,334,276
Waushara	2,310,583	1,677,033	594,125	506,294	425,325
Winnebago	24,291,294	25,054,517	25,937,859	16,353,201	6,228,034
Wood	<u>12,323,930</u>	<u>12,512,715</u>	<u>4,133,436</u>	<u>2,102,066</u>	<u>1,993,699</u>
Total	\$664,908,131	\$624,709,428	\$480,483,586	\$371,830,535	\$291,080,713

* Data obtained from the Human Services Revenue Reports (HSRR) collected by DHS. The decrease in reported county expenditures beginning in 2008 is mainly due to decreases in county spending on Community Integration Program waivers as the Family Care program expands. Family Care expenditures are not reported.

**No data reported (Menominee and Monroe Counties for 2010 and 2011, and St Croix County for 2011).

APPENDIX II

Birth-to-3 Expenditures and Number of Children Served, By County Calendar Year 2011

County	Expenditures*			Total Children Served**
	State/Federal	County	Total	
Adams	\$29,743	\$50,538	\$80,281	16
Ashland	31,132	67,257	98,389	20
Barron	94,202	119,866	214,068	48
Bayfield	36,171	43,626	79,797	10
Brown	368,008	746,434	1,114,442	178
Buffalo	26,863	50,723	77,586	8
Burnett	31,906	53,370	85,276	26
Calumet	113,404	290,344	403,748	64
Chippewa	78,828	383,055	461,883	67
Clark	61,548	112,963	174,511	45
Columbia	109,865	127,714	237,579	27
Crawford	27,240	42,995	70,235	24
Dane	707,479	1,905,545	2,613,024	442
Dodge	151,364	329,426	480,790	104
Door	78,856	196,253	275,109	21
Douglas	90,992	87,390	178,382	43
Dunn	129,724	253,881	383,605	58
Eau Claire	207,152	171,312	378,464	129
Florence	14,557	5,830	20,387	2
Fond Du Lac	209,686	266,552	476,238	92
Forest/Oneida/Vilas	143,803	187,993	331,796	40
Grant/Iowa	119,706	204,641	324,347	44
Green	53,627	49,478	103,105	41
Green Lake	35,141	58,290	93,431	15
Iron	16,736	6,453	23,189	8
Jackson	35,304	83,163	118,467	15
Jefferson	166,510	513,869	680,379	118
Juneau	45,138	120,450	165,588	27
Kenosha	299,107	176,137	475,244	182
Kewaunee	42,563	51,713	94,276	11
La Crosse	111,123	237,915	349,038	89
Lafayette	25,749	52,194	77,943	12
Langlade/Marathon	458,180	707,529	1,165,709	156
Lincoln	64,228	120,399	184,627	24
Manitowoc	190,787	356,797	547,584	154
Marinette	73,060	99,664	172,724	44
Marquette	27,853	47,501	75,354	12
Menominee	18,559	38,493	57,052	8
Milwaukee	2,700,671	2,266,296	4,966,967	1,427
Monroe	65,645	176,836	242,481	62

APPENDIX II (continued)

**Birth-to-3 Expenditures and Number of Children Served, By County
Calendar Year 2011**

County	Expenditures*			Total Children Served**
	State/Federal	County	Total	
Oconto	\$52,312	\$267,903	\$320,215	43
Outagamie	328,072	504,093	832,165	167
Ozaukee	193,443	256,902	450,345	94
Pepin	39,796	22,332	62,128	5
Pierce	62,774	79,683	142,457	34
Polk	88,837	123,321	212,158	50
Portage	155,960	166,452	322,412	51
Price	20,788	29,493	50,281	18
Racine	422,233	301,999	724,232	203
Richland	47,337	130,629	177,966	15
Rock	330,035	523,296	853,331	153
Rusk	32,285	41,685	73,970	14
St. Croix	122,741	183,986	306,727	96
Sauk	122,675	331,066	453,741	55
Sawyer	33,999	70,697	104,696	29
Shawano	66,840	132,627	199,467	47
Sheboygan	256,479	292,873	549,352	136
Taylor	32,308	68,599	100,907	29
Trempealeau	48,214	106,934	155,148	24
Vernon	45,910	107,005	152,915	31
Walworth	161,575	707,959	869,534	71
Washburn	33,229	64,935	98,164	18
Washington	182,837	258,347	441,184	128
Waukesha	551,013	277,602	828,615	311
Waupaca	138,074	256,298	394,372	59
Waushara	35,132	78,817	113,949	13
Winnebago	302,581	306,059	608,640	137
Wood	<u>116,839</u>	<u>196,797</u>	<u>313,636</u>	<u>67</u>
Total	\$11,316,528	\$16,749,275	\$28,065,803	6,011

* This appendix provides the state/federal and local allocations for the Birth-to-3 program. Other funding sources include Medicaid, private insurance, and parental cost-sharing requirements. The "County Funding" category includes state and federal community aids funding provided to counties.

**Child count is as of October, 2011.