

**2003-04 SESSION
COMMITTEE HEARING
RECORDS**

Committee Name:

Senate Committee on
Health, Children,
Families, Aging and
Long Term Care
(SC-HCFALTC)

Sample:

Record of Comm. Proceedings ... RCP

- 03hrAC-EdR_RCP_pt01a
- 03hrAC-EdR_RCP_pt01b
- 03hrAC-EdR_RCP_pt02

➤ Appointments ... Appt

➤ **

➤ Clearinghouse Rules ... CRule

➤ **

➤ Committee Hearings ... CH

➤ **

➤ Committee Reports ... CR

➤ **

➤ Executive Sessions ... ES

➤ **

➤ Hearing Records ... HR

➤ 03hr_sb0057_pt01

➤ Miscellaneous ... Misc

➤ **

➤ Record of Comm. Proceedings ... RCP

➤ **

Informational Paper
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Services for Persons with #50
Developmental Disabilities

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State of Wisconsin, Legislative Fiscal Bureau
January, 2001

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Services for Persons with Developmental Disabilities

*Prepared by:
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Central Center, which provides specialized health and educational services available to children and young adults.

Within 30 days after a person is admitted for extended care, DHFS and the county must identify the support services that would be necessary for an individual to successfully live in the community.

The population at the Centers has steadily declined since 1970, when nearly 3,700 persons resided in the Centers, to 839 on December 31, 2000. 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. The resident population for each Center, as of December 31, 2000, is shown in Table 5.

Table 5
State Centers Resident Population as of December 31, 2000

Northern Center	189
Central Center	377
Southern Center	273
Total	839

The Centers are certified as intermediate care facilities for the mentally retarded (ICFs-MR) by the U.S. Department of Health and Human Services, Health Care Financing Administration. 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 6 identifies the total budget and the number of full-time equivalent (FTE) staff positions for each Center for the 2000-01 fiscal year and identifies funding and position reductions resulting from CIP IA placements from the Centers in the 1999-01 biennium. As a matter of practice, these funding and position reductions are made as part of the succeeding biennial budget.

The total amount of MA funds that will be claimed for the Centers is greater than the MA amount budgeted for operation of the Centers in that year. This is because DHFS can claim MA reimbursement for certain departmental administrative overhead costs, such as services provided by the Department's Bureau of Fiscal Services and the costs of interest paid on capital projects at the Center, that are funded from state GPR. Further, MA provides reimbursement for capital expenses on a depreciated basis, rather than based on the full value of capital expenditures incurred in a given year. For this reason, DHFS may claim MA reimbursement, on a depreciated basis, for capital expenditures incurred in previous years. MA moneys claimed that exceed the MA funding budgeted for operating the Centers is deposited to the state's general fund.

Other Institutional Services

Other facilities, besides the three state Centers, 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, Health Care Financing Administration (HCFA) and must meet federal MA care and treatment standards. Excluding the three state Centers, there are currently 37 ICFs-MR that operate in Wisconsin. The 37 ICFs-MR range in size from 14 to 260 staffed



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*Promoting Quality of Life for People with
Developmental and Related Disabilities*

**Over
53
Years of Service**

TO: Members, Senate Committee on Health, Children, Families, Aging and Long
Term Care

FROM: Jayn Wittenmyer, President
Jim Hoegemeier, Executive Director
The Arc-Wisconsin Disability Association

RE: Opposition to Senate Bill 57

DATE: March 11, 2002

The Arc-Wisconsin Disability Association, directly representing nearly 10,000 members through 35 chapters statewide, urges you to oppose Senate Bill 57.

We applaud the authors and sponsors of Senate Bill 57 for supporting placing greater emphasis on providing community-based services, rather than institutional-based services, to people with developmental and related disabilities. For nearly 54 years, The Arc network in Wisconsin has actively promoted the value of the increased opportunities and benefits community-based care offers everyone in Wisconsin, not just the people who directly receive community-based care. Community-based care offers more opportunities for people to become fully integrated into their respective communities through job skill development and placement and social interaction with an increased circle of friends and family members.

Senate Bill 57 will not lead to our shared goal. Due to the decreasing number of residents at all three of the state centers for the developmentally disabled, staff from the Department of Health and Family Services, county human service agencies and all three of the state centers for the developmentally disabled have been developing plans to address the declining census for the past several years. Numerous alternatives and scenarios have been considered. For various and numerous reasons, those developing these plans have identified that Northern Wisconsin Center is the most logical facility with which to begin the planned downsizing.

If implemented, Senate Bill 57 would undermine the efforts and extensive planning that have gone into the development of plans to promote the deinstitutionalization of people with disabilities. Senate Bill 57 would put an end to the progress that has been made in Wisconsin to place greater value on providing community-base care to people with disabilities.

We urge you to oppose Senate Bill 57.

Jayn Wittenmyer, President Kay Hurkmans, Vice-President Leigh Roberts, Past President
Perry Mueller, Secretary Gene Kreienbrink, Treasurer Jim Hoegemeier, Executive Director

 **Community
Health Charities**
of Wisconsin
YOUR RESOURCE FOR HEALTH IN WORKPLACE-GIVING CAMPAIGNS

Institutional and Community-Based Systems For People With Mental Retardation: A Review Of The Cost Comparison Literature

Kevin K. Walsh, Ph.D., Regina Gentlesk Green, R.N.,
and Theodore A. Kastner, MD, MS

Developmental Disabilities Health Alliance, Inc.

with the support of
Voice of the Retarded

May, 2002

EXECUTIVE SUMMARY¹

A historical literature review of studies comparing costs of institutional and community services was carried out and found that, when all relevant costs are properly included and differences in the settings are taken into account, cost differences between community and institutional settings are minimal. *From the studies reviewed here, it is clear that large savings are not possible within the field of developmental disabilities by shifting from institutional to community placements.*

The view of many in the mental retardation and developmental disabilities (MR/DD) service field that community services are inherently less expensive than institutions is not warranted for the following reasons: (1) the lack of comparability between community and institutional settings; (2) the possibility for the shifting of some costs in community settings to other federal and state program funds; (3) certain methodological problems in the research literature, and (4) the reduced staffing costs due to various factors (e.g., state-owned vs. private, rural vs. urban, etc.). In this study, over 200 published studies and documents of various types were identified, and a careful selection of a subset of peer-reviewed and often-cited studies were reviewed from both cost and methodological perspectives.

The scope of the present literature review did not allow for the simultaneous review of research on the many clinical and quality of life outcomes, but noted the importance of including

¹ This Executive Summary derives from a report submitted to VOR in September, 2001. A slightly modified manuscript has been submitted for publication.

in policymaking consideration of a full range of individual outcomes. The issues that affect the interpretation of cost comparisons and their implications for public policy include elements of both the costs to the service systems as well as the quality of care received by the individuals being served.

Findings. Clear-cut evidence was *not* found in the studies reviewed to support the unambiguous conclusion that community services are inherently less expensive than institutional settings. From the studies reviewed here, it is clear that large savings are not possible within the field of developmental disabilities by shifting from institutional to community placements. That is, the costs of residential care for people with mental retardation and related developmental disabilities, regardless of setting, involve a specific amount of resources that vary, somewhat predictably, with staffing levels, characteristics of those served, and other variables. The studies reviewed here that employed the most sophisticated and complex analyses and statistical comparisons generally tended to show the smallest differences across settings.

With notable exceptions, few studies have been able to clearly aggregate costs in community settings while assuring comparability with cost aggregation in institutional settings. In fact, the shifting cost structures across settings, system changes occurring over time, and the heterogeneity of the populations served suggests that the more appropriate questions underlying public policy should not be generalized statements about cost-efficiency, rather, they should revolve around the individual and his/her needs: "What does this person need?" "Where best to provide for these needs?" and "At what cost?"

Factors Affecting Cost Comparisons. The literature review outlined several factors that underlie variability in service costs in institutional and community settings: sources of funds, cost shifting, cost variability, staffing, and consumer characteristics. These factors were examined in selected peer-reviewed studies that have appeared in the published literature over the past quarter century.

The first major influence identified was related to differences in the *sources of funds* that support institutional and community facilities. Institutions are often paid for by a combination of state funds and federal Medicaid funding obtained through the ICF/MR program (Intermediate Care Facilities for Persons with Mental Retardation). However, community services are often funded solely by state funds, or by state funds augmented by federal Medicaid funds from the Home and Community Based Services (HCBS) waiver program. The differences in the two

federal programs (ICF/MR and HCBS waiver) lead to the potential for the second identified influence, *cost shifting*. Costs structures in institutional placements typically encompass more services within the funding model than do community services. Thus, for example, health care services are included in institutional models (i.e., there are staff physicians and nurses) that are not included in community settings (i.e., health care services are accessed through Medicaid fee-for-service or Medicaid managed care systems).

The literature reviewed in this study clearly supported the view that one of the most salient characteristics of nationwide cost comparisons is the *extreme variability both within and between agencies and service systems across states*. A great many factors, some local, contribute to service cost differences. For example, in one of the studies reviewed here institutional costs were, on average, \$40,000 more per individual in New Hampshire than in Nebraska and there was nearly a \$19,000 difference in community costs between regions of Michigan and Nebraska. In a study conducted in the United Kingdom, researchers reported differences of as much as \$20,000 between regular and specialized units *within* institutional settings. Such cost variability must be considered when cost comparisons are made.

Staffing effects have come to be understood as one of the major factors underlying the costs in service settings, often accounting for differences when they are found. Staffing variation in terms of number assigned, union vs. non-union, private vs. public employee and so on account for a great deal of variability in cost comparisons. The literature shows that a substantial portion of differences in costs are associated with differences in staffing costs. In short, differences arise in the fact that many institutions are publicly-funded and many community settings have been privatized.

Finally, a factor that has been included only sporadically in the literature or, in some cases, not at all, has to do with the variability in the characteristics of those being served (referred to here as *case mix*). Individuals with mental retardation and related developmental disabilities are quite heterogeneous with some individuals being nearly indistinguishable from people without disabilities to those who are quite disabled and dependent. Over the period reviewed, it has been typical for a higher proportion of individuals with mild disabilities to live in community settings while people with more complex needs requiring extensive care remained in institutional facilities. However, few studies adequately included these effects, or made

appropriate statistical corrections when comparing costs. More recent research has begun to recognize the importance of these factors and to include corrections for case mix.

Methodological Problems Found. The complexity in the cost comparisons between setting types give rise to several recurring methodological problems in the studies reviewed. These problems include (1) the lack of comparability between groups based on biased, non-random or convenience samples, (2) the lack of adequate case-mix controls to control variability across samples, (3) differences in data collection and cost aggregation methods across groups, (4) the exclusion of critical categories of costs such as medical expenses, case management, start-up and capital costs, and (5) extreme variability in costs, cost shifting, and difficulties in applying statistical models to the data. The studies reviewed here document that the facilities, services, and populations between institutions and community placements vary to such an extent that comparisons between them as to costs need to take into account various factors and be conducted with great care using complex statistical models. Only a few of these studies, most notably those conducted in the United Kingdom, meet these criteria and they often show that community settings are not less expensive than institutional settings. As noted above, underlying any differences that are found are typically cost differences related to various staffing factors.

Conclusion. Historical claims that cost savings will be realized by shifting costs from institutional to community settings are not borne out by this review. This study showed that a variety of factors including staffing, consumer characteristics, sources of funds, cost shifting, and regional differences influence the actual costs of care. As indicated, the quality of care may also impact costs, although outcomes were not specifically considered in the present literature review.

These findings should be taken into account by state and federal officials, other policymakers, advocates, and taxpayers. Further, accurate determination of actual costs should have implications on the appropriations necessary to ensure high quality care and supports, regardless of setting (institution or community). This review suggests that little or no cost savings are realized when costs of institutions and community settings are properly aggregated and compared. This finding implies that all involved should consider individual needs, preferences and choices as the primary considerations for placement decisions.



Central Wisconsin Center
Ted Bunck, Ph.D., Center Director
Madison, Wisconsin
FACT SHEET (Updated September 15, 2002)

FY 03 Appropriation: \$57,131,893
Total Employees: 967 full and part-time employees (871 full time equivalents)

Medical Short Term Care

10 bed medical unit

175 admissions for medical services ranging from 5 to 90 days

Residential Care

- 355 people (9 short-term)
- Eight residential buildings on 105 acre campus.

- 285 individuals are totally dependent on others for bathing.
- 216 individuals are totally dependent for dressing.
- 314 individuals are totally dependent on others to use the toilet.
- 258 individuals are totally dependent on others for eating their meals.
- 288 individuals are non-ambulatory.
- 180 individuals are fed by tube, and this occurs 570 times in a 24-hour period.
- All individuals have medically prescribed diets; 160 of those diets are mechanically altered or textured based on individual needs, 123 individuals are on therapeutic diets. These specialized diets are prepared three times a day, every day of the year.
- 106 individuals have limited or no vision.
- 265 individuals have limited or no hearing.
- An average of 16 doses of medication are prescribed, dispensed, and administered per resident every 24 hours. There are approximately 5480 medications administered every 24 hours.
- Additionally, there is a Centerwide total of 742 other prescribed nursing treatments or interventions given across the Center during every 24-hour period.
- 91 individuals have a history of fractures or very fragile bones due to medical conditions. These individuals require extremely careful lifting and transfer protocols.
- 246 individuals receive physical therapy, and 280 receive occupational therapy services.
- 63 individuals receive regular respiratory therapy 3-4 times per day.
- 25 individuals have tracheostomies. An average of 37 tracheostomy changes are performed each month.
- 75 individuals have psychiatric needs requiring medication.
- 264 individuals are being treated for seizures.
- There are no instances of skin breakdowns or decubitus ulcers even though this is a group of individuals particularly susceptible to this condition.
- 54 individuals have problems with regulating body temperatures.

Partnerships

- University of Wisconsin Hospital
- Waisman Center
- Department of Rehabilitation Medicine at UWH
- Internships programs with Mayo Clinic, Columbia University Medical School, Florida State University
- Madison Public Schools
- WI Chapter of American Association on Mental Retardation
- Northside Planning Council
- Wisconsin State Employees Union Best Practices Program
- Malcolm Baldrige National Quality Award Program (WI Forward)
- University of Wisconsin School of Business



DIVISION OF CARE AND TREATMENT FACILITIES

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December 5, 2002

Rebecca Underwood
669 McCarthy Drive
Hartford, WI 53027

Dear Ms. Underwood:

In your letter of October 18th, you raised concerns about rate-setting for the state Centers for the Developmentally Disabled. Specifically, you voiced concerns about the "extra 5%" you noticed on the FY 03 rate calculation spreadsheet we shared with you earlier. You assumed that DCTF was reimbursed at this "extra 5%" rate, therefore, you concluded that there must be \$6.4 million (\$2.5 million state funds) of extra revenue that is being collected "above and beyond anticipated expenses." You asked what the rationale for this "extra 5%" charge is, and what the extra \$6.4 million is used for.

The "extra 5%", as you call it, is actually a factor added to the estimated expenses for each Center in order to derive a "private pay rate." The private pay rate is the amount that DCTF is reimbursed for private pay residents whose care is not eligible for Medical Assistance reimbursement, e.g., persons with significant personal wealth, out-of-state residents, etc. The private pay rate is the rate we publish and provide to the counties, since this is the rate counties will be charged for any non-MA eligible clients.

MA regulations require that the MA reimbursement rate be lower than the rate paid by private pay patients. Also, MA regulations require that the rate we charge to all Center residents must be uniform. Therefore, the private pay rate is charged to all residents. However, almost all residents at the Centers are MA eligible. (In FY 02, only 30 out of 133,058 (.02%) resident care days at CWC were private pay.) When DCTF is reimbursed by MA for the vast majority of our resident care days, we are reimbursed at the MA rate (the line entitled "Estimated Expenses per Day" on the enclosed spreadsheet) not the private pay rate.

Because almost all Center residents are MA eligible, not private pay, and because the interim rate at which MA reimburses DCTF equates to our projected costs, your assertion that there must be \$6.4 million of extra revenue collected that is unaccounted for is incorrect.

Enclosed are copies of the FY 01 and FY 02 rate spreadsheets, per your request.

Sincerely,

Michael R. Hughes
Program Support Director

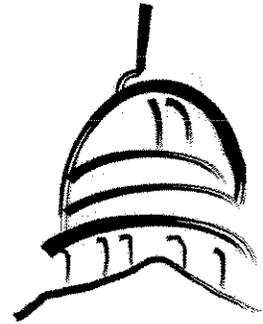
*Services for Persons with Developmental
Disabilities*



*Informational
Paper 49*

*Wisconsin Legislative Fiscal Bureau
January, 2003*

Services for Persons with Developmental Disabilities



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Services for Persons with Developmental Disabilities

It is the state's policy to assure 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 of this paper 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's 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 combin-

ation 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, representing approximately 2.0% of the state's population.

[The Council on Developmental Disabilities is an institutional advocacy and advisory 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. The American Association on Mental Retardation defines mental retardation as a disability characterized 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 mental retardation refers to a particular state of functioning that begins in childhood, has many dimensions, and is affected positively by individualized supports.

Mental retardation 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 mental retardation 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 pervasive 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 fre-

quently includes abnormal responses to sounds, touch, or other sensory stimulation. 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 and use of alcohol and other drugs and tobacco during pregnancy. In addition, developmental disabilities may occur due to exposure and ingestion of lead or head injuries resulting from accidents and child abuse.

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 alcoholic 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 compliment 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 2003, the estimated basic county allocation totals \$242,174,000 (all funds), representing 93% of all funds to be allocated to counties under the community aids program in that year (\$261,720,500). 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 the budgeted amounts of community aids funds, including county match and overmatch, reported by counties for programs that serve persons with developmental disabilities for calendar year 2001.

Family Support Program. Funding for the family support program is budgeted as a categorical allocation within the community aids appropriation. 2001 Wisconsin Act 16 (the 2001-03 biennial budget act) increased funding for the family support program by \$250,000 in 2001-02 to \$750,000 in 2002-03. Therefore, under the family support program, DHFS may distribute \$4,589,800 in 2001-02 and \$5,089,800 in 2002-03 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.

In 2001, 92.6% of the 2,675 children who received services under the program had developmental disabilities. Approximately 20% of the children who received services were age six or under, 37.9% were age seven through 12, 41.9%

were age 13 through 20, and 0.3% were age 21 or over. Of the children that received services in 2001: (a) 39.3% required personal care services because they were unable to help with their personal care; (b) 56.8% required assistance with some personal care activities; (c) 32.6% could not walk; (d) 15.8% required assistance with walking; (e) 38.1% had a severe developmental delay; and (f) 52.0% 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 cost for 2,675 children served in 2001 was \$1,467. Of these children, 570 were served on a one-time basis or considered underserved.

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

Table 1: Family Support Program Expenditures, by Service Category -- Calendar Year 2001

	Program Expenditures	% of Total
Architectural modifications of home	\$292,800	7.5%
Child care	304,183	7.8
Counseling and therapeutic resources	171,045	4.4
Dental and medical care	132,339	3.4
Diagnosis and evaluation	13,812	0.4
Diet, nutrition and clothing	144,748	3.6
Equipment and supplies	1,263,678	32.1
Homemaker services	27,955	0.7
In-home nursing services-- attendant care	28,558	0.7
Home training/parent courses	49,710	1.3
Recreation activities	418,809	10.7
Respite care	768,837	19.6
Transportation	152,111	3.8
Utility costs	53,149	1.4
Vehicle modification	69,807	1.8
Other	<u>32,979</u>	<u>0.8</u>
Total	\$3,924,520	100.0%

year 2001.

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

As of December, 2001, 2,690 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 program for infants and toddlers up to three years of age with 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 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 individualized 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. Such an evaluation 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 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 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

Table 2: Birth-to-Three Program: Age at Referral for 2001 Participants

Age	Number	Percent
Under six months	266	21.9%
Six to 12 months	158	13.0
12 to 18 months	152	12.5
18 to 24 months	283	23.3
24 to 30 months	293	24.3
30 months or older	60	5.0
Total	1,212	100.0%

provided, and how the services will be paid.

While children are eligible for the birth-to-three program from birth to age three, in 2001, almost 58% of program participants were enrolled in the program for one year or less. Table 2 provides the percent of children by age of referral for program participants for calendar year 2001.

In 2001, 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, 2001, 92% of these services were provided in either the child's home or usual childcare location and 8% of services were provided in a clinic or classroom.

2001 Act 16 increased funding for the birth-to-three program by \$1,019,700 GPR in 2001-02 and by \$2,039,300 GPR in 2002-03 to increase state funding for services provided in 46 counties. This funding was intended to ensure that each county received an amount that represents at least 60% of the total

state, federal, and county calendar year 1999 costs. In addition, counties are required to maintain their calendar year 1999 level of funding for the birth-to-three program. In October, 2001, DHFS requested clarification from the Joint Committee on Finance on the legislative intent for birth-to-three funding for six counties: Manitowoc, Barron, Burnett, Polk, Rusk, and Washburn Counties. The Committee provided \$40,200 GPR in 2001-02 and \$80,200 GPR in 2002-03 to increase allocations for these six counties. With this increase, a total of \$6,878,700 GPR and \$6,589,800 FED is budgeted in 2002-03 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 2002. In addition, Table 3 identifies all of the revenues received by counties in calendar year 2001 for the birth-to-three program.

Table 3: Total Revenue for Birth-to-Three Program -- Calendar Year 2001

State and federal funds	\$9,998,610
County funds	12,121,734
Medical assistance	1,879,570
Private insurance	630,049
Collections for family cost-sharing	68,163
Other revenue	<u>259,495</u>
Total	\$24,957,621

Source: DHFS Bureau of Developmental Disabilities.

Act 16 also provided \$627,300 GPR and \$884,400 FED in 2002-03 to support an enhancement to the maximum medical assistance (MA) reimbursement rate available for MA-covered services provided to children enrolled in the birth-to-three program and provided in the child's natural environment. This enhancement was first available on January 1, 2002.

Services to Residents of the Christian League for the Handicapped. DHFS provided \$53,800 GPR in both 2001-02 and 2002-03 to counties that are

fiscally responsible for providing services to persons who resided in the Christian League for the Handicapped in Walworth County when that facility ended its participation in the medical assistance program. This funding has been provided to Walworth County annually since funds were made available for this purpose, beginning in 1987-88.

Supported Employment Opportunities. DHFS provided \$60,000 GPR in 2002-03 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 distributed to participating counties. Counties use these funds to contract with private agencies to provide job development, job coaching and necessary support services, such as transportation and adoptions to an individual's work environment. Beginning July 1, 2001, through June 1, 2002, funding was provided to support seven projects in Clark, Green Lake, Jackson, Kewaunee, Richland, Rusk, and Washburn Counties. Projects are supported for three years.

Epilepsy Service Grants. In the 2001-03 biennium, 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 epilepsy, including counseling, referral to other services, case management, daily living skills training, providing information, parent helper services, employment 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 calendar year 2001, these associations provided direct services to approximately 2,417 persons and indirect services to 21,037 persons 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 health program that provides primary, acute and long-term care services to certain low-income individuals.

Individuals with developmental disabilities often require long-term care services, such as personal care services and home health services. These services, commonly referred to as MA card services, are available to all MA recipients who are determined to need such services and are subject to certain limitations specified 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 more comprehensive programs. First, certain children may be eligible for MA under the Katie Beckett provision. Second, many MA-eligible individuals with developmental disabilities participate in MA waiver programs, which provide community-based services under waivers of federal law. The Katie Beckett provision and community-based MA-waiver programs are described below.

The Katie Beckett Provision

Historically, federal MA income and resource guidelines have presented eligibility barriers for disabled children who could be provided needed care in their homes. For a child under the age of 21 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, the case of Katie Beckett dramatized this situation. 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. As a result of this case, federal MA law was modified to incorporate the "Katie Beckett provision."

This provision permits states to extend MA coverage to disabled children under the age of 18 who: (1) are living at home and who 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 or nursing facility;

and (3) are determined to be appropriate to receive care outside of a facility. In addition, the cost of caring for the child at home can be no more than the estimated cost of institutional care for the child.

As of November, 2002, 4,713 children in Wisconsin qualified for MA under the Katie Beckett provision. In the 2001-02 fiscal year, MA expenditures for these children totaled approximately \$55 million (\$22.6 million GPR and \$32.5 million FED).

Medical Assistance Community-Based Waiver Programs

Federal law authorizes the U.S. Department of Health and Human Services, Center 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 six such programs that operate under four 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 program (COP-W); (5) the brain injury waiver (BIW); and (6) the community supported living arrangements waiver (CSLA). Four of these programs, CIP IA, CIP IB, CSLA, and BIW, provide services to persons with developmental disabilities.

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 three state centers for the developmentally disabled, whereas CIP IB supports services for persons who are diverted or relocated from nursing homes and intermediate care facilities for the mentally retarded (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 sheltered employment and home modifications, that are not otherwise reimbursed under the state's

MA program.

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 the program.

If permission is obtained, a county case manager is responsible for working with the parents or guardian, ICF-MR staff and service providers to develop an assessment of the individual's functional abilities, disabilities, strengths, weaknesses and unmet basic needs. One part of this process is determining that the person has an ICF-MR level of care need, which is done by completing a level of care form that is sent to the Division of Supportive Living and Bureau of Quality Assurance in DHFS for rating. Appendix III to this paper describes some of the criteria DHFS uses in assigning individuals to various levels of care. Another step in the process is a comprehensive assessment that identifies the capacities, interest and preferences of the person and the areas of need. County and center staff are then responsible for developing an individual service plan (ISP) for each waiver applicant. Each ISP 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.

Table 4 illustrates the growth in CIP IA and CIP IB expenditures and clients between calendar years 1989 and 2001. As of December, 31, 2002, there were 1,095 active CIP IA cases and an estimated 8,592 CIP IB cases. The CIP IB slots can be either state-supported (the state pays the 41% match under MA) or locally-supported from county COP or community aids funds or county property taxes.

Staff in the DHFS Bureau of Developmental Disabilities determine whether the individual's needs can be effectively met under the proposed

plan 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 all necessary services identified in the ISP are received.

DHFS reimburses counties for the actual costs of eligible services based on monthly cost reports submitted by counties. For the 2002-03 fiscal year, 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, and \$225 for persons placed on or after July 1, 2002. For CIP IA clients whose service costs exceed the fully funded rate, counties can be reimbursed for approximately 59% 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 fully 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 funds are available in the amount of 59% of the difference between \$48.33 (or the enhanced rate, if applicable) and actual expenditures (if below federal maximum) to reflect the counties' option of providing the matching funds required to receive federal MA funds.

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

Table 4: CIP IA and IB Funding and Participants

		Funding	Participants*
CIP IA	1989	\$10,349,900	404
	1990	12,675,700	449
	1991	14,861,700	475
	1992	17,947,600	544
	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	
CIP IB	1989	\$7,957,300	714
	1990	13,044,200	1,004
	1991	19,635,600	1,256
	1992	24,780,400	1,346
	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	

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

expenditure for participants does not exceed the overall allowable per diems. This mechanism provides counties flexibility in managing resources to maximize program participation.

In order to provide the services identified in an ISP, counties must use funding sources other than MA, because the MA reimbursement does not cover the full cost of services and some services are not eligible for MA reimbursement. For example, MA does not pay for a participant's room and board. Generally, supplemental security income (SSI) payments, which are available to all CIP participants, are used to support room and board

costs. Because MA cannot be used to cover the cost of developing assessments and case plans, these costs are frequently supported by funding made available to the county under the community options and community aids programs.

DHFS estimates that, in calendar year 2001, the average cost of providing care for persons with developmental disabilities in institutions was \$382.70 per day for the three state centers and \$147.27 per day in other ICFs-MR. By comparison, the average cost to serve a person under the CIP IA and the CIP IB programs was estimated to be \$250.17 per day and \$129.81 per day, respectively, when expenditures for MA card services are included.

Community Supported Living Arrangements. Beginning in April, 1992, Wisconsin was one of eight states authorized to provide an optional benefit, community supported living arrangements (CSLAs), under the state's MA plan. The program provides a variety of community-based services for persons with developmental disabilities, including supportive home care, respite care, housing modifications, specialized transportation, living skills training, counseling, therapy, personal emergency response assistance, communications aids and other adaptive services. Counties are responsible for providing the match to federal MA funds.

Eligible persons include individuals who qualify for MA and meet the federal definition of a developmental disability. Participants do not have to be at risk of institutionalization. Participants must reside in their own home, which may include:

- A dwelling (including an apartment, condominium, house or other rental unit) where the participant or the participant's guardian holds the lease and in which the participant and no more than two other persons with a developmental disability reside; or

- The home of the participant's parents or family.

The participant or guardian, through a people-centered planning process, is expected to identify and choose the supports and services that best meet the recipient's needs.

In calendar year 2001, \$1,354,700 (\$800,800 FED and \$553,900 in county funds) was expended under the program. As of December 31, 2002, there were 224 active participants in the program.

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 special 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 fiscal year 2002-03, the budgeted reimbursement rate is \$190.16 per day, and funding is budgeted to support a total of 212 participants in the program. In calendar year 2001, program expenditures totaled approximately \$13,679,600. As of December 31, 2002, 257 BIW individuals were enrolled.

MA Purchase Plan

The 1999-01 biennial budget act (1999 Act 9) created a new option provided under federal MA law to extend MA coverage to certain working, disabled persons. This program, which is referred to as the "MA purchase plan," was implemented on March 1, 2000.

An individual is eligible to participate in the MA purchase plan if he or she is engaged in gainful employment and meets certain financial and functional criteria.

The goal of this program is to remove financial disincentives to work. 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 to earn more without the risk of losing 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. Participants may pay a monthly premium, based on their income for receiving services. A more detailed description of the program can be found in Legislative Fiscal Bureau Informational Paper #42 "Medical Assistance and BadgerCare."

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 ("regular COP") and services that are funded with state and federal MA funds for services provided under an MA waiver ("COP-W"). Although COP-W 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. Persons seeking or about to be admitted to a nursing home may receive an assessment without regard to financial status, although individuals with adequate resources may have to contribute to the cost of the assessment. DHFS distributes COP funding to counties to support these assessments and services to persons who participate in the program. An individual must meet various financial standards to be eligible for COP-funded services.

In calendar year 2001, 129 individuals with developmental disabilities as their primary diagnosis were participating in COP, representing approximately 1.1% of the individuals who were participating in COP over the same time period (11,792). Physically disabled individuals represented 17.6% of all COP participants in 2001 (2,077 enrolled).

Family Care

The Family Care program is a long-term care pilot program that is intended to: (a) consolidate and replace current long-term care programs; (b) eliminate waiting lists for community-based care; (c) provide services tailored to the consumer; (d) improve the efficiency, cost effectiveness, and performance standards under a managed care system with state monitoring; (e) increase flexibility in the provision of services and provide better case management, and (f) assist with long-term planning by providing information and advice at resource centers. Currently, nine counties operate resource centers (Fond du Lac, Jackson, Kenosha, La Crosse, Marathon, Milwaukee, Portage, Richland, and Trempealeau), while five counties operate care management organizations (Fond du Lac, La Crosse, Milwaukee, Portage and Richland).

Family Care provides services to people who are elderly, physically disabled adults, and, to a limited degree, developmentally disabled adults. In general, FC enrollees must be at least 18 years of age and their primary disability must be something other than mental illness, substance abuse, or developmental disability. However persons with developmental disabilities may participate in counties (or tribes) where a CMO has operated before July 1, 2003.

The Family Care program consists of two major components. First, resource centers provide information, assessments, eligibility determinations and other preliminary services. Second, case 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.

As of August 31, 2002, there were 6,490 persons enrolled in Family Care, of which 943 were developmentally disabled. Most CMO enrollees (95.3%) were MA-eligible (6,341 of 6,490). This program and other programs that offer community-based long-term care services to persons with developmental disabilities are described in more detail in Legislative Fiscal Bureau Informational Paper #48, "Community-Based Long-Term Care Programs."

Institutional Services

State Centers for the Developmental Disabled

DHFS, Division of Care and Treatment Facilities (DCTF) operates three residential facilities for the care of persons with developmental disabilities. Northern Center, established in 1897, is in Chippewa Falls; Central Center, established in 1959, is in Madison; and Southern Center, established in 1919, is in Union Grove (Racine County). The centers 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 assigned the primary responsibility for the well-being, treatment and care of persons with developmental disabilities; however, the state functions as a back-up in providing these services.

In addition to providing education, training, habilitative and rehabilitative services for residents, the centers provide: (a) behavioral

evaluation of individuals at the request of county community program boards and county developmental disabilities boards; (b) short-term care as a supportive service to help prevent long-term institutionalization; (c) training and technical assistance to county boards to enable them to better meet the needs of developmentally disabled persons; and (d) research into the causes and treatment of developmental disabilities.

People may be admitted to a center on a short-term basis. 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 Center Director 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.

As counties' ability to serve individuals in the community expands, there has been a movement from long-term extended care admissions to short-term admissions. In 1995, Central Wisconsin Center and Southern Wisconsin 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. Although Northern Wisconsin Center did not enter into such an agreement, DHFS applies the same extended-care admission standards to all three state centers.

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. In most instances, persons over 22 years of age are placed in the center that is closest to their county of residence.

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.

The population at the centers has steadily declined since 1970, when nearly 3,700 persons resided in the centers, 795 on December 31, 2002. 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. The resident population for each center, as of December 31, 2002, is shown in Table 5.

Table 5: State Centers Resident Population and Inpatient Rates as of December 31, 2002

	Rates	Population
Northern Center	\$522	174
Central Center	465	353
Southern Center	444	<u>268</u>
Total		795

The centers are certified as intermediate care facilities for the mentally retarded (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 6 identifies the total budget and the number of full-time equivalent (FTE) staff positions for each center for the 2002-03 fiscal year and identifies funding and position reductions resulting from CIP IA placements from the centers in the 2001-03 biennium. As a matter of practice, these funding and position reductions are made as part of the succeeding biennial budget.

The total amount of MA funds that will be claimed for the centers is greater than the MA amount budgeted for operation of the centers in that year. This is because DHFS can claim MA reimbursement for certain departmental administrative overhead costs, such as services provided by the Department's Bureau of Fiscal Services and the costs of interest paid on capital projects at the center, that are funded from state GPR. Further, MA provides reimbursement for capital expenses on a depreciated basis, rather than based on the full value of capital expenditures incurred in a given year. For this reason, DHFS may claim MA reimbursement, on a depreciated basis, for capital expenditures incurred in previous years. MA moneys claimed that exceed the MA funding budgeted for operating the centers are deposited to the state's general fund.

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, there are currently 37 ICFs-MR that operate in Wisconsin. The 37 ICFs-MR range in size from 14 to 260 staffed beds. Counties operate 19 of the 37 ICFs-MR, providing 797 licensed beds.

Table 6: State Centers for the Developmentally Disabled – Adjusted Base Budget and Authorized Positions – State Fiscal Year 2002-03

	Central Center	Northern Center	Southern Center	Total
I. Program Revenues—MA				
State Operations	\$50,700,300	\$27,535,100	\$34,481,600	\$112,717,000
Utilities and Fuel	1,453,900	832,700	1,012,900	3,299,500
Repair and Maintenance	258,300	325,400	350,400	934,100
Subtotal	\$52,412,500	\$28,693,200	\$35,844,900	\$116,950,600
II. Program Revenues—Other				
Alternative Services	\$192,600	\$66,200	\$28,100	\$286,900
Farm Operations	\$0	\$2,000	\$31,000	\$33,000
Activity Therapy	14,000	43,800	20,100	77,900
Gifts and Grants	35,000	70,000	30,000	135,000
Interagency and Intra-Agency Programs	248,300	84,900	147,000	480,200
Subtotal	\$489,900	\$266,900	\$256,200	\$1,013,000
Total Program Revenue Funding	\$52,902,400	\$28,960,100	\$36,101,100	\$117,963,600
III. GPR Funding				
General Program Operations	\$44,500	\$0	\$0	\$44,500
Total Funding (All Sources)*	\$52,946,900	\$28,960,100	\$36,101,100	\$118,008,100
Estimated CIP IA Reductions**				
Expenditures				
FY 02	-\$584,000	-\$730,000	-\$219,000	-\$1,533,000
FY 03	-410,600	-328,500	-246,300	-985,400
Net Funding After CIP IA Reductions	\$994,600	\$1,058,500	\$465,300	\$2,518,400
Total Authorized Positions (All Sources)	942.74	576.99	616.38	2,136.11
Estimated CIP IA Reductions**				
Positions				
FY 02	-11.64	-15.13	-4.56	-31.33
FY 03	-8.23	-6.87	-5.18	-20.28
Net Positions After CIP IA Reductions	922.87	554.99	606.64	2,084.50

*Actual expenditures will be somewhat less, since budget authority will be reduced according to the number of CIP IA placements.

**The estimated budget reductions for CIP IA placements in 2001-02 are based on the actual number of placements while for 2002-03, the number of placements represent estimates.

Table 7 provides information on these types of institutional services provided to persons with developmental disabilities in Wisconsin at the end of 1999, 2000, and 2001. As shown in Table 7, the number of developmentally disabled persons in institutions declined by 195 persons (6.7%) over this two-year period, from 2,932 on December 31, 1999, to 2,737 on December 31, 2001.

Table 7: People with Developmental Disabilities in Institutions on December 31, in 1999, 2000, and 2001

Setting	No. of Residents 12/31/99	No. of Residents 12/31/00	No. of Residents 12/31/01	Change Over Two Years
State Centers	839	839	821	-2.1%
Other ICFs-MR	1,951	1,916	1,769	-9.3
Nursing Homes	142	141	147	3.5
Total	2,932	2,896	2,737	-6.7%

Summary

This paper has described the array of services available to persons with developmental

disabilities in Wisconsin. The state's policy has been to promote opportunities for individuals with developmental disabilities to live in the community by providing necessary support services and this policy has resulted in significant movement of persons with developmental disabilities to the community.

Because of the reductions of the populations at the three state centers, an issue that has been raised and will continue to be raised, is whether one or more of the state centers should be closed and residents moved to other ICFs-MR or receive community-based services.

This paper includes three appendices. Appendix I identifies 2001 community aids basic county allocation funds budgeted to counties for programs for persons with developmental disabilities. Appendix II identifies allocations of state and federal funds and local funds for the birth-to-three program by county for 2002. Appendix III describes the process by which persons with developmental disabilities are evaluated to determine the severity of their disability.

APPENDIX I

2001 County Community Aids Funds Budgeted for Programs for Persons With Developmental Disabilities

	Community Aids					Community Aids			
	Budgeted for Developmental Disabilities*	Family Support Allocation	County Matching Funds	County Overmatch		Budgeted for Developmental Disabilities*	Family Support Allocation	County Matching Funds	County Overmatch
Adams	\$53,838	\$14,710	\$8,413	\$246,747	Menominee	\$58,615	\$19,993	\$6,513	\$28,494
Ashland	200,000	24,652	15,000	85,000	Milwaukee	10,092,509	745,328	1,071,874	2,302,530
Barron	275,104	43,000	27,208	249,462	Monroe	351,480	41,564	35,148	865,540
Bayfield	24,591	27,695	8,000	319,193	Oconto	330,674	36,473	43,446	707,063
Brown	2,403,074	8,000	319,193	112,408	Outagamie	2,079,632	118,446	205,676	2,515,711
Buffalo	175,000	14,540	20,000	50,000	Ozaukee	518,484	51,931	51,279	1,709,692
Burnett	101,137	13,761	11,363	2,500	Pepin	126,367	12,409	12,498	0
Calumet	561,547	32,763	59,636	748,445	Pierce	153,379	27,000	17,840	24,098
Chippewa	500,000	48,812	50,000	75,000	Polk	250,000	36,278	28,313	21,687
Clark	371,923	35,115	63,849	559,778	Price	137,815	25,714	16,173	36,775
Columbia	280,000	39,753	35,000	200,000	Racine	1,190,566	147,218	132,308	133,159
Crawford	663,567	16,443	66,878	0	Rock	2,025,997	114,003	215,972	1,583,796
Dane	4,578,700	257,000	580,284	13,761,916	Rusk	225,000	16,262	23,357	47,000
Dodge	786,962	68,205	78,696	429,235	St. Croix	580,341	50,988	60,000	1,194,583
Door	362,579	39,714	35,860	576,223	Sauk	387,678	40,764	44,250	398,243
Douglas	585,880	42,110	62,109	592,186	Sawyer	169,228	32,583	19,959	15,041
Dunn	257,824	28,066	28,647	286,471	Shawano	575,812	34,149	57,581	88,180
Eau Claire	2,561,817	77,135	253,367	149,202	Sheboygan	760,301	86,361	76,030	1,648,294
Florence	36,790	11,940	4,820	1,680	Taylor	295,100	17,526	28,500	0
Forest/Oneida/Vilas	734,180	63,641	70,355	128,100	Trempealeau	374,964	22,164	37,084	38,208
Grant/Iowa	460,788	72,339	45,572	44,043	Vernon	550,808	22,006	13,868	63,746
Green	182,820	24,454	20,500	253,867	Walworth	513,243	58,527	65,150	670,000
Green Lake	115,341	18,035	13,841	174,376	Washburn	138,897	15,012	13,905	0
Iron	30,126	7,909	10,000	0	Washington	733,650	84,223	72,558	1,108,937
Jackson	518,355	29,715	51,266	350,283	Waukesha	2,414,403	223,153	309,600	2,553,195
Jefferson	557,429	60,717	60,696	820,941	Waupaca	963,292	46,038	301,927	172,530
Juneau	183,071	21,701	34,870	0	Waushara	266,864	36,382	29,290	313,862
Kenosha	1,239,334	97,783	122,572	142,567	Winnebago	2,707,872	110,203	243,541	1,566,977
Kewaunee	426,600	23,989	40,172	36,928	Wood	652,925	75,577	63,260	1,405,736
Lafayette	210,000	33,000	24,000	6,000	Total	\$52,680,612	\$3,939,005	\$5,880,396	\$43,673,169
Langlade/Marathon	1,667,960	133,500	166,796	1,405,909					
Lincoln	336,154	32,491	33,478	0					
Manitowoc	892,474	67,854	91,872	328,116					
Marinette	568,533	44,450	52,671	198,185					
Marquette	151,218	15,738	16,512	125,331					

Source: Wisconsin Council on Developmental Disabilities

*Amount of community aids basic county allocation budgeted for services for persons with developmental disabilities. The amounts do not include the categorical allocation for the family support program.

Note: Fond du Lac, La Crosse, Portage, and Richland Counties provide services for persons with developmental disabilities through Family Care and therefore, are not reported in this table.

APPENDIX II

Birth-to-Three Allocations and Budgeted Local Funds
Calendar Year 2002

County	Maintenance of Effort (1999 Actual Expenditures)	2002 State Increase (Act 16)	Additional Federal Funds	2002 State/Fed Allocation	2002 Local Funds Budgeted	Total State/ Federal and Local Funds
Adams	\$29,297	\$7,377	\$0	\$30,784	\$29,297	\$60,081
Ashland	22,283	468	522	34,350	22,283	56,633
Barron	70,000	6,251	0	95,855	70,000	165,855
Bayfield	39,294	13,140	0	40,203	39,294	79,497
Brown	746,434	288,920	0	695,291	746,434	1,441,725
Buffalo	24,516	5,353	0	29,663	5,447	35,110
Burnett	25,592	4,057	0	32,339	33,777	66,116
Calumet	136,044	54,950	0	123,595	169,807	293,402
Chippewa	45,686	0	2,435	94,856	95,144	190,000
Clark	36,802	0	982	61,068	58,571	119,639
Columbia	114,781	35,484	0	121,472	117,570	239,042
Crawford	21,832	2,723	237	30,074	21,832	51,906
Dane	530,747	73,346	13,071	716,255	779,400	1,495,655
Dodge	148,178	44,306	0	157,763	148,178	305,941
Door	93,818	36,371	0	87,486	93,818	181,304
Douglas	66,865	4,569	1,631	98,178	82,400	180,578
Dunn	153,855	58,190	0	143,892	176,398	320,290
Eau Claire	164,405	20,828	4,015	228,016	164,405	392,421
Florence	500	0	0	16,273	500	16,773
Fond du Lac	211,284	60,490	0	231,633	247,472	479,105
Forest/Oneida/Vilas	151,916	47,865	0	158,877	188,116	346,993
Grant/Iowa	108,817	22,492	0	131,944	110,940	242,884
Green	22,338	0	795	57,965	22,338	80,303
Green Lake	31,688	6,488	0	38,842	38,919	77,761
Iron	360	0	0	18,634	360	18,634
Jackson	12,667	0	0	35,840	12,667	48,507
Jefferson	148,415	45,617	0	155,126	187,667	342,793
Juneau	29,124	0	640	49,912	39,504	89,416
Kenosha	127,995	0	6,981	288,429	127,995	416,424
Kewaunee	35,429	4,876	139	47,163	17,111	64,274
La Crosse	115,671	0	3,288	196,013	217,755	413,768
Lafayette	2,446	0	0	28,438	8,413	36,851
Langlade	203,339	102,530	0	152,534	203,375	355,909
Lincoln	70,611	24,296	0	71,130	101,623	172,753
Manitowoc	76,442	47,900	0	209,936	233,706	443,642
Marathon	381,338	145,764	0	356,862	529,187	886,049
Marquette	54,463	3,106	1,211	80,709	70,932	151,641
Marquette	27,018	6,992	0	30,803	63,035	93,838
Menominee	12,045	0	214	20,525	23,341	43,866
Milwaukee	2,190,392	363,788	59,067	2,876,372	2,190,392	5,066,764

APPENDIX II (continued)

County	Maintenance of Effort (1999 Actual Expenditures)	2002 State Increase (Act 16)	Additional Federal Funds	2002 State/Fed Allocation	2002 Local Funds Budgeted	Total State/ Federal and Local Funds
Monroe	\$50,134	\$3,290	\$0	\$71,357	\$67,989	\$139,346
Oconto	13,861	0	0	56,133	56,447	112,580
Outagamie	157,066	0	7,284	321,880	419,057	321,880
Ozaukee	256,396	116,477	0	213,634	256,396	470,030
Pepin	35,261	24,872	0	44,384	28,766	73,150
Pierce	23,860	0	0	67,680	26,889	94,569
Polk	78,745	17,610	0	91,890	104,452	196,342
Portage	173,154	59,388	0	172,955	138,636	311,591
Price	1,568	0	0	22,562	2,296	24,858
Racine	299,898	15,710	8,591	446,197	353,268	799,465
Richland	51,044	16,783	0	52,569	51,044	103,613
Rock	142,984	0	0	359,567	260,769	620,336
Rusk	26,110	2,330	0	35,661	26,110	61,771
St. Croix	117,392	34,844	0	125,395	153,073	278,468
Sauk	144,001	54,219	0	135,901	144,001	279,902
Sawyer	10,963	0	560	37,614	10,963	48,577
Shawano	53,881	9,790	1,394	69,319	54,295	123,614
Sheboygan	255,696	70,522	0	283,236	255,696	538,932
Taylor	4,863	0	0	32,535	15,040	47,575
Trempealeau	9,186	0	0	53,225	9,186	62,411
Vernon	33,815	1,962	645	50,169	41,991	92,160
Walworth	136,180	41,707	0	143,808	123,498	143,808
Washburn	24,000	2,082	0	32,832	24,000	56,832
Washington	100,920	0	3,549	169,041	124,411	293,452
Waukesha	277,602	5,440	14,043	434,159	277,602	711,761
Waupaca	151,886	50,190	0	152,956	157,726	310,682
Waushara	22,722	992	347	38,903	24,000	62,903
Winnebago	270,287	52,308	0	333,769	312,094	645,863
Wood	<u>17,228</u>	<u>0</u>	<u>0</u>	<u>124,874</u>	<u>51,106</u>	<u>175,980</u>
Total	\$9,425,430	\$2,119,053	\$131,641	\$12,249,305	\$11,060,204	\$22,766,594

Source: DHFS, Bureau of Developmental Disabilities

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 work, 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.



DIVISION OF CARE AND TREATMENT FACILITIES

Jim Doyle
Governor

1 WEST WILSON STREET
P O BOX 7851
MADISON WI 53707-7851

Helene Nelson
Secretary

State of Wisconsin
Department of Health and Family Services

Telephone: (608) 266-8740
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February 7, 2003

Rebecca Underwood
669 McCarthy Drive
Hartford, WI 53027

Dear Ms. Underwood:

In your letter dated January 30, 2003, you asked four questions. The questions and our responses are as follows:

(1) How are Social Security benefit payments utilized to offset the cost of care for residents of the State DD Centers?

As we have explained through previous correspondence, we bill all Medicaid eligible residents at the private pay rate. These bills are sent to the Wisconsin Medicaid fiscal agent, Electronic Data Systems (EDS), to be paid by Medicaid. The private pay rate that was billed is paid at the Medicaid rate, less any contributions from the resident, including Social Security benefits. Therefore, the Medicaid payment varies depending on the level of contribution from other sources.

(2) Where does the Social Security payments that the State Centers receive end up?

The payments from Social Security and other sources are deposited in the center's revenue accounts and are applied to the expenditures planned in the center's operating budget.

(3) Where can parents review written documentation illustrating how Social Security is used to offset the cost of care?

I have enclosed the Remittance and Status Report from Medicaid for the month of December 2002. It shows a Total Billed column (calculated using the daily private pay rate), the Total Allowed column (calculated using the daily Medicaid rate), the Other Deducted Charges column (contributions from the resident), and the Paid Amount column (difference between the Total Allowed column and the Other Deducted Charges column). The Social Security benefit amount applied to the charges would be under the Other Deducted Charges column. This column reduces the amount of the Medicaid payment/reimbursement to the Center. The report documents the Social Security benefits and other contributions applied to the cost of care. The resident names and any personal information are blocked out on the attached copy due to confidentiality reasons. This report is available from staff in the Department's Bureau of Fiscal Services billing and collections unit.

(4) Where do the Centers' budgets reflect the revenue from Social Security?

You will not see the revenue reflected in the budget. The budget and revenue are two completely separate items within the operating plans. The budgets are based on projected expenditures and estimated patient days for the fiscal year. Revenue accounts are used to collect the funds used to cover the expenditures planned in the operating budgets.

Sincerely,



Denise Webb
Deputy Administrator

Enclosure
Remittance and Status Report

cc: Senator Ted Kanavas
Representative Michael Lehman

**WE SUPPORT GOVERNOR DOYLE'S DECISION
TO END LONG TERM PLACEMENTS AT NORTHERN WISCONSIN
CENTER FOR THE DEVELOPMENTALLY DISABLED**

WHEREAS:

173 people with developmental disabilities currently reside at Northern Wisconsin Center (NWC) in Chippewa Falls, at an annual cost of \$29 million. The Governor proposes to enable the residents to return to their home communities via the Community Integration Program. The Governor's plan includes sufficient funding to provide quality community services for all current NWC residents.

Wisconsin has a higher proportion of people with disabilities in public and private institutions than all but a handful of other states. Wisconsin is one of only 12 states that have not closed a state institution for people with developmental disabilities. The Americans with Disabilities Act ensures the right of virtually every person in an institution to live in the community.

Wisconsin has successfully placed over 1,080 former Center residents via the Community Integration Program 1A (CIP 1A) since 1983. State and county governments have developed safeguards to assure the health and safety of individuals who move from the Centers into the community. 96% of the guardians of CIP1A participants report that they are satisfied with the services received.

It is not fiscally responsible to maintain three institutional campuses to serve the current combined census of under 800 residents; the excess administrative costs have led to an inflated cost per person of \$500/day at NWC. No longer using NWC as a long term residence will result in a savings of state and federal tax dollars in the 2003-05 biennium and in the future.

Ending long term placements at NWC will create an opportunity to capitalize on the skills of the Center staff and their relationships with residents by enabling them to develop and/or work in community programs which will serve former Center residents.

We believe that the state of Wisconsin has both the authority and the responsibility to downsize state-run facilities to achieve administrative and fiscal efficiencies.

CONSEQUENTLY, WE BELIEVE THAT FOR POLICY, FISCAL, LEGAL AND HUMANITARIAN REASONS, IT IS TIME FOR WISCONSIN TO END LONG TERM PLACEMENTS AT NORTHERN WISCONSIN CENTER AND ENABLE THE RESIDENTS TO RETURN TO THEIR HOME COMMUNITIES.

*ADAPT - WI
Arc Eau Claire
ARC - Milwaukee
Arc-Wisconsin
Access to Independence
Autism Society of WI
Barrier Busters
Brain Injury Association - WI
Coalition of Wisconsin Aging Groups
Community Alliance of Providers of WI
Community Living Alliance
Creative Community Living Services, Inc.
Dungarvin
Eisenhower Memorial Cerebral Palsy Work Center
Family Voices
Grassroots Empowerment Project
Hearthstone
Independence First
Independent Living Resources
Mental Health Association - Milwaukee
Midwest Community Services, Inc.
New Horizons North*

*North Country Independent Living
Options for Independent Living
People First of WI
REM
Rehabilitation for Wisconsin
Ranch Community Services
Respite Care Association of WI
State Independent Living Council
Survival Coalition of WI Disability Organizations
UCP - South East WI
UCP - West Central WI
UCP - WI
WI Association of Family & Children's Agencies
WI Board on Aging & Long Term Care
WI Coalition for Advocacy
WI Coalition of Independent Living Centers
WI Council on Developmental Disabilities
WI Council on Physical Disabilities
WI County Human Service Association
WI Disability Rights Coalition
WI Family Ties
WI Personal Services Association*

MAR 10 2003

Feb. 21, 2003

Dear Senator Roessler,

The people who live at Northern Center receive the best of care. They are like our own family. Please don't take our families away.

Northern Center can save the state some money, by eliminating some job positions. But start at the top. There is wasted money out here, but don't blame all of us, just because someone invented useless job positions. That is not our fault. I wrote to our politicians about ten years ago, telling them about the wasted dollars here, but they didn't listen. I hope you will listen.

I am a Resident Care Technician. I have worked at Northern Center for over twenty two years. I am fifty two years old. My husband passed away almost three years ago. I am alone. I do not have anyone to support me, or to lean on. I'm on my own. I have been working all of my life. I need my job at Northern Center. If you need to close a center, please consider central or southern. The jobs in our area are scarce.

Sincerely,

Donna J. Meinen

2556 126th Street
Chippewa Falls, Wi.

(715) 723-7727

I'm in the 23rd Senate District, 68th Assembly & 17th Congressional Di

Jermstad, Sara

From: Hess, Martha
Sent: Wednesday, February 26, 2003 2:04 PM
To: *Legislative Assembly Democrats; *Legislative Assembly Republicans; *Legislative Senate Democrats; *Legislative Senate Republicans
Subject: LRB 2115/1, relating to closing the Central Center for the Developmentally Disabled/deadline March 3rd

To: Legislative Colleagues

From: Sen. Dave Zien and Rep. Jeff Wood

RE: Draft to Close Central Center

Date: Feb. 26, 2003

Dear Colleagues:

Attached please find LRB 2115/1, relating to closing the Central Center for the Developmentally Disabled.

As you know, Gov. Doyle is proposing to downsize the Northern Wisconsin Center for Developmentally Disabled from 178 to 17 beds by 2004. While we applaud the Governor for his attempt at fixing the budget deficit, downsizing and eventually closing the Northern Center is not in the best interest of the majority of residents of this state, and especially not in the best interest of either the Center's residents, employees or the Chippewa Valley.

The Northern Center serves 52 of the 72 counties in Wisconsin. (Please see attached excel document if you would like to know how many residents are served in any of your counties.) The remaining two Centers -- both located in Southern Wisconsin -- serve the remaining 20 counties. Closing the Northern Center would force some families to drive hundreds of miles to visit loved ones in the Southern part of the state.

Further, closing the Northern Center would save \$4.6 million, which is a fraction of what would be saved by closing the Central Center. (A fiscal estimate will be available soon.)

The Northern Center employees have an excellent track record of caring for their residents, and the turnover rate is extremely low at Northern Center compared to Central Center. In addition, Northern Center employees have the best community placement record in the state, which was supposed to be a mandate on all three centers. Because Northern Center employees were so efficient and effective at their jobs, they are now being punished by the state.

Closing the Northern Center would have a devastating economic impact on the Chippewa Valley. Couple that with delaying the opening of Highview Prison, which is also proposed by the Governor, and the brundt of downsizing will be unfairly felt by our communities.

Closing the Central Center is a much better option. Not only does it make sense to have two centers located in different parts of the state, it makes fiscal sense because closing Central Center will save the state more money, and the job losses will be much better absorbed by a county with a 2.4 percent unemployment rate (Dane), compared to 6.5 percent unemployment rate (Chippewa).

Please contact our offices by Monday, March 3 to be a co-sponsor of this legislation. Please feel free to contact Senator Zien's office at 266-7511 or Representative Jeff Wood's office at 266-1194 either of us with questions. Thank you.

**NUMBER OF CLIENTS
BY COUNTY, BY CENTER**

02/26/2003

County	Center	NumClients	Total
ADAMS	CWC	2	
			2
ASHLAND	NWC	1	
			1
BARRON	CWC	1	
	NWC	4	
			5
BAYFIELD	NWC	1	
			1
BROWN	CWC	8	
	NWC	4	
	SWC	1	
			13
BUFFALO	NWC	5	
			5
BURNETT	NWC	1	
			1
CALUMET	CWC	1	
	NWC	1	
			2
CHIPPEWA	CWC	4	
	NWC	9	
			13
CLARK	CWC	1	
	NWC	2	
			3
COLUMBIA	CWC	3	
	SWC	1	
			4
DANE	CWC	34	
	NWC	1	
	SWC	16	
			51
DODGE	CWC	11	
	NWC	2	
	SWC	1	
			14
DOOR	CWC	1	
			1
DOUGLAS			

Center Totals
 CWC 353
 NWC 172
 SWC 264

**NUMBER OF CLIENTS
BY COUNTY, BY CENTER**

02/26/2003

	CWC	1	
	NWC	5	
DUNN			6
	NWC	5	
EAU CLAIRE			5
	CWC	2	
	NWC	9	
FOND DU LAC			11
	CWC	3	
	NWC	3	
	SWC	4	
GRANT			10
	CWC	6	
	NWC	2	
	SWC	2	
GREEN			10
	CWC	3	
	SWC	5	
GREEN LAKE			8
	CWC	2	
	NWC	4	
IOWA			6
	CWC	2	
IRON			2
	CWC	2	
JACKSON			2
	CWC	1	
JEFFERSON			1
	CWC	2	
	NWC	2	
	SWC	1	
JUNEAU			5
	CWC	5	
	NWC	3	
KENOSHA			8
	CWC	11	
	NWC	2	
	SWC	33	
KEWAUNEE			46
	CWC	1	
	SWC	1	
			2

**NUMBER OF CLIENTS
BY COUNTY, BY CENTER**

02/26/2003

LACROSSE	CWC	1	
	NWC	4	
	SWC	1	6
LAFAYETTE	CWC	2	2
LANGLADE	CWC	1	
	NWC	2	3
LINCOLN	CWC	1	
	NWC	6	7
MANITOWOC	CWC	4	
	NWC	1	
	SWC	3	8
MARATHON	CWC	5	
	NWC	9	14
MARINETTE	CWC	2	
	NWC	1	3
MARQUETTE	CWC	2	2
MENOMINEE	CWC	4	4
MILWAUKEE	CWC	98	
	NWC	5	
	SWC	106	209
MONROE	CWC	2	
	NWC	5	7
NONE	NWC	1	
	SWC	4	5
OCONTO	CWC	1	
	NWC	1	2
ONEIDA	NWC	2	2

**NUMBER OF CLIENTS
BY COUNTY, BY CENTER**

02/26/2003

OUTAGAMIE	CWC	18	
	NWC	14	
			32
OZAUKEE	CWC	5	
	SWC	6	
			11
PEPIN	NWC	1	
			1
PIERCE	NWC	3	
			3
POLK	CWC	1	
	NWC	4	
			5
PORTAGE	NWC	2	
			2
PRICE	CWC	2	
	NWC	2	
			4
RACINE	CWC	14	
	NWC	3	
	SWC	33	
			50
RICHLAND	CWC	3	
			3
ROCK	CWC	15	
	NWC	1	
	SWC	8	
			24
RUSK	CWC	1	
	NWC	1	
			2
SAUK	CWC	4	
	SWC	1	
			5
SAWYER	NWC	1	
			1
SHAWANO	CWC	1	
	NWC	5	
			6
SHEBOYGAN	CWC	5	

**NUMBER OF CLIENTS
BY COUNTY, BY CENTER**

02/26/2003

	NWC	4	
	SWC	3	
ST. CROIX			12
	CWC	2	
	NWC	8	
TAYLOR			10
	CWC	1	
	NWC	1	
TREMPEALEAU			2
	CWC	1	
	NWC	3	
VERNON			4
	CWC	3	
	NWC	1	
VILAS			4
	CWC	1	
	NWC	1	
WALWORTH			2
	CWC	8	
	SWC	9	
WASHINGTON			17
	CWC	2	
WAUKESHA			2
	CWC	17	
	NWC	1	
	SWC	20	
WAUPACA			38
	CWC	5	
	NWC	2	
WAUSHARA			7
	CWC	1	
	NWC	1	
WINNEBAGO			2
	CWC	7	
	NWC	5	
	SWC	3	
WOOD			15
	CWC	6	
	NWC	5	
	SWC	2	
			13
			Grand Total
			789