

Health Services

Public Health

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May, 2019

Joint Committee on Finance

Paper #390

Lead Exposure and Poisoning Prevention (Health Services -- Public Health)

[LFB 2019-21 Budget Summary: Page 173, #13 and Page 195, #1]

CURRENT LAW

Blood Lead Level Testing. All children enrolled in medical assistance (MA) and the children's health insurance program (CHIP) are required to receive blood lead level (BLL) screening tests at ages 12 months and 24 months. In addition, any child between the ages of 24 and 72 months with no record of previous blood lead screening tests must receive one.

Under MA's early and periodic screening, diagnostic and treatment (EPSDT) benefit, MA provides comprehensive coverage for any MA service listed in federal law that is medically necessary to correct or ameliorate defects in physical and mental illnesses and conditions identified by the screening services, whether or not the service is otherwise covered under the state's MA plan. For this reason, children who are found to have elevated BLLs are eligible for a wide range of treatment services, including environmental lead investigations (ELIs).

2017 Act 59 changed the statutory definition of lead poisoning or lead exposure from 10 mcg/dL of blood to a reduced threshold of five or more mcg/dL of blood. The new state standard is consistent with the current standard used by the Centers for Disease Control and Prevention (CDC).

Environmental Lead Investigations (ELIs). The MA program reimburses agencies that conduct lead investigations in the home or primary residence of a child found to have an elevated BLL. Under federal law, lead investigations must be conducted by a credentialed health practitioner who meets qualifications established by the state, and must be undertaken to identify the source of lead exposure to a child with an elevated BLL.

In the 2017-19 biennium, the Legislature and the Department of Health Services (DHS)

made several changes to the state's MA program to increase the number of ELIs conducted. First, as previously indicated, Act 59 broadened the definition of lead poisoning and lead exposure to the current five mcg/dL, a finding that triggers an ELI for a home occupied by child enrolled in MA. Second, Act 59 increased, from \$105.26 to \$800, MA reimbursement for ELIs. Third, effective for dates of service after March 1, 2018, the MA program no longer requires prior authorization for ELI services.

Current ELI covered services include: (a) an initial comprehensive lead investigation; (b) follow-up lead clearance investigations; and (c) nursing education visits related to lead poisoning performed by registered nurses. All persons conducting investigations must be DHS certified as a lead hazard investigator or risk assessor.

Lead Abatement. The state does not administer any programs that fund abatement of lead hazards.

BadgerCare Plus HMO Blood-Lead Testing Standards. DHS imposes a \$10,000 fine on BadgerCare Plus HMOs that fail to meet benchmarks standards for BLL testing for children. In 2019, the standard requires HMOs to test of 80.1% of enrolled children by age two.

GOVERNOR

Provide \$23,446,000 (\$5,282,400 GPR and \$18,163,600 FED) in 2019-20 and \$19,558,700 (\$6,467,200 GPR and \$13,091,500 FED) in 2020-21 and 2.14 GPR positions, beginning in 2019-20, to support lead exposure prevention activities, as described below.

CHIP Funding for Lead Abatement. Provide \$17,973,400 (\$2,136,200 GPR and \$15,837,200 FED) in 2019-20 and \$14,335,700 (\$3,321,500 GPR and \$11,014,200 FED) in 2020-21 for lead abatement to residential properties occupied by children and pregnant women eligible for MA or the children's health insurance program (CHIP).

Abatement for Properties Not Occupied by CHIP-Eligible Children. Provide \$1,000,000 GPR annually for lead abatement grants for properties not occupied by children enrolled in MA or CHIP.

Abatement Training Grants. Provide \$300,000 (\$50,900 GPR and \$249,100 FED) in 2019-20 to fund lead abatement training grants, with the intent of expanding the certified lead abatement workforce.

Public Health Outreach. Provide \$500,000 GPR annually for grants to physician groups to establish a peer-to-peer public health outreach program to increase lead testing among children at risk for lead poisoning.

State Staff. Provide \$172,500 GPR in 2019-20 and \$222,900 GPR in 2020-21 and 2.14 positions, beginning in 2019-20, to assist in the administration of an expanded lead exposure and poisoning prevention program.

HMO Incentives. Provide \$3,500,100 (\$1,422,800 GPR and \$2,077,300 FED) annually to increase pay-for-performance incentives to BadgerCare Plus HMOs to encourage HMOs to meet state and federal BLL testing standards.

Table 1 summarizes the funding that would be provided under these items.

TABLE 1

Summary of Proposed Lead Exposure and Poisoning Prevention Funding

	2019-20			2020-21		
	<u>GPR</u>	<u>FED</u>	<u>Total</u>	<u>GPR</u>	<u>FED</u>	<u>Total</u>
Lead Abatement Grants	\$2,136,200	\$15,837,200	\$17,973,400	\$3,321,500	\$11,014,200	\$14,335,700
Non-CHIP Abatement	1,000,000	0	1,000,000	1,000,000	0	1,000,000
Workforce Training	50,900	249,100	300,000	0	0	0
Public Health Outreach	500,000	0	500,000	500,000	0	500,000
State Positions	172,500	0	172,500	222,900	0	222,900
HMO Incentives	<u>1,422,800</u>	<u>2,077,300</u>	<u>3,500,100</u>	<u>1,422,800</u>	<u>2,077,300</u>	<u>3,500,100</u>
Total	\$5,282,400	\$18,163,600	\$23,446,000	\$6,467,200	\$13,091,500	\$19,558,700

In addition, the bill would modify the lead poisoning or lead exposure prevention grant program to specify that grants may be made for residential lead hazard abatement, residential lead hazard reduction, and lead abatement worker training.

DISCUSSION POINTS

Background

1. Exposure to lead can cause significant physical problems in children that can persist for a lifetime. Lead interferes with the normal development of a child's brain, and can lead to conditions such as reduced intellectual abilities, developmental disabilities, and behavioral problems. According to a 2010 report by the Wisconsin Childhood Lead Poisoning Elimination Plan Implementation and Oversight Committee, the average lifetime cost of lead poisoning is estimated to be approximately \$46,000 per child.

2. Young children are at the greatest risk of lead exposure because they often crawl on floors, have frequent hand-to-mouth activity, and eat nonfood items. Young children are more affected by lead exposure than older children and adults because of their smaller body size and weight.

3. The Department's 2016 Report on Childhood Lead Poisoning indicates that lead based paint found in older homes is the primary cause of lead exposure for children in Wisconsin. Ninety percent of children with lead poisoning in Wisconsin were first identified with lead exposure while living in housing built before 1950.

4. The number of children under the age of six tested for elevated BLLs generally increased

between 1996 and peaked in 2010, and declined until 2016, when it increased slightly. The percentage of children who are tested that have elevated BLLs continues to decrease, likely due to a gradual increase in the percentage of children who live in homes constructed after 1950. In 1978, the Consumer Product Safety Commission banned the consumer use of lead based paint and toys and furniture coated with lead based paint.

5. Table 2 presents information on the total number of Wisconsin children under the age of six who were tested for elevated BLLs, and the number and percentage of children who were tested who were found to have elevated BLLs for calendar years 2006 through 2016, the last year for which information is available. In 2016, 86,771 children under the age of six were tested, representing approximately 20% of the number of children under age statewide. In that year, 60% of all one-year olds, 48% of all two-year olds, and 14% of all children ages three through five who were not previously tested in the state received tests for elevated BBLs.

TABLE 2

**Blood Lead Level Testing -- Wisconsin Children under Age Six
Calendar Years 2006 through 2016**

<u>Year</u>	<u>Number of Children Tested</u>	<u>Tested Children with BLL > 5mcg/dL</u>	
		<u>Number</u>	<u>Percent</u>
2006	81,934	11,130	13.6%
2007	92,536	11,172	12.1
2008	97,043	9,059	9.3
2009	101,672	9,092	8.9
2010	106,590	7,630	7.2
2011	105,326	6,999	6.6
2012	98,582	6,175	6.3
2013	94,665	4,894	5.2
2014	89,258	3,981	4.5
2015	86,316	3,949	4.6
2016	86,771	4,348	5.0

6. Children enrolled in Medicaid and other children in families with low income are at greater risk of lead poisoning than other children, primarily because they tend to live in older homes. However, in 2016, only 32% of children enrolled in Medicaid received the required testing at both one and two years of age, even though states must ensure that children enrolled in Medicaid receive required screenings. DHS staff believe that many physicians follow a different testing standard established by the Healthcare Effectiveness Data Information Set (HEDIS), which only requires physicians to report one BLL test for a child by the time the child reaches age two. In addition, the current BadgerCare Plus HMO contracts penalize HMOs that fail to meet the HEDIS standard, rather than the federal Medicaid standard.

7. Higher rates of elevated BLLs are found in certain areas of the state, notably the cities of Milwaukee and Racine. For this reason, the 2016 DHS report recommends that universal testing of all children living in both cities, such that: (a) all children should have three BLL tests before they

reach the age of three; and (b) children ages three through five should be tested annually if they meet specified criteria, such as if they live in a house built before 1950, or have a sibling or playmate with lead poisoning. In other areas of the state, the report encourages health care provider to consider four factors to determine whether a child is at risk for lead poisoning and should be tested. These factors include whether: (a) the child lives in a home built before 1950; (b) the child lives in a house built before 1978 with recent or ongoing renovations; (c) the child has a sibling or playmate with lead poisoning; or (d) the child is enrolled in Medicaid or the supplemental food program for women, infants and children (WIC).

8. Generally, efforts to encourage BLL testing result in additional ELIs and lead hazard abatement efforts. However, several obstacles to abatement remain -- primarily the lack of workers who are certified to conduct lead hazard abatement activities, and the cost of lead hazard removal projects.

Lead Abatement -- Project Funding and Workforce

9. Lead abatement involves the removal of lead-based paint from homes of children who have been identified as having elevated BLLs or who are at risk of lead poisoning. Lead abatement services must be conducted by contractors who have been trained and certified by DHS to perform the work.

10. In August, 2018, there were 161 certified lead abatement companies in the state, and 474 certified abatement workers, about half of the number of certified abatement workers that there was in 2013. The Department attributes the decline in the number of certified lead abatement workers to an improving economy, which leads to more new construction projects, and therefore a strain on the supply of skilled workers who might otherwise pursue certification and work on lead abatement projects.

11. The Department estimates that with this additional funding, it could increase the total number of abatement workers and supervisors from 635 to 1,074. The administration argues that increasing the number of certified abatement workers is needed to quickly and effectively meet the increased demand for abatements that would result from the additional abatement funding in the bill.

12. Most of the additional funding that would be provided in the bill (approximately \$18 million in 2019-20 and \$14.3 million in 2020-21) to fund lead abatement projects for homes occupied by children enrolled in CHIP with elevated BLLs. The EPA estimates that lead paint abatement projects cost an average of \$8 to \$15 per square feet, and that the average abatement project costs approximately \$10,000. DHS estimates that the CHIP funding in the bill could support approximately 2,250 abatement projects in the 2019-21 biennium, at an average cost of \$14,360 per project. The actual number of abatement projects that could be funded with the amounts in the bill would depend on the scope of these projects.

Non-CHIP Lead Abatement

13. In addition to the CHIP funding, the bill also includes GPR funding for grants to conduct lead abatements in housing not occupied by properties not occupied by children enrolled in MA or CHIP. According to the Department's 2016 report, at least 650 children in the state were found to be

have lead poisoning, but were not eligible for MA. To meet the needs of these children, the administration argues that additional funding should be provided for abatement of non-CHIP occupied homes, and estimates that this funding could support 143 non-CHIP eligible properties in the 2019-21 biennium.

State Staff

14. The bill would provide \$172,500 GPR in 2019-20 and \$222,900 GPR in 2020-21 and 2.14 positions, beginning in 2019-20, for lead exposure and poisoning prevention activities. Of these positions, 1.0 would be a public health educator project position in the Division of Public Health, to administer the public health outreach initiative. The other 1.14 positions would be permanent positions to enhance the Department's lead poisoning prevention programs. The Department indicates that it would reallocate 2.86 existing federal positions to supplement the permanent 1.14 GPR positions, to provide a total of 4.0 positions for the program. These positions would replace 4.0 contract positions currently conducting program activities (a contract specialist, a public health nurse, a database specialist, and an epidemiologist).

Peer to Peer Outreach Efforts

15. The bill includes \$500,000 GPR annually for DHS to provide grants to physician groups to establish a peer-to-peer public health outreach program to increase lead testing for children most at risk of lead poisoning. The administration proposes to establish a peer-to-peer public health outreach program to encourage providers to exceed HEDIS BLL testing. The Department would allocate funding through a RFA process to a physician group. The awardee would be responsible for developing and conducting broad-based lead trainings for MA HMOs and develop partnerships between providers who have high lead testing rates with providers who have low BLL testing rates.

16. The administration indicates that peer-based outreach program could foster greater compliance and engagement among providers. Moreover, partnering high-performing providers with low-performing providers could cultivate a collaborative exchange of ideas to address gaps in testing, identify areas of unmet need, and develop innovative solutions designed to increase lead testing among children at risk for lead poisoning.

HMO Incentive Payments

17. Finally, the bill would provide \$3,500,100 (\$1,422,800 GPR and \$2,077,300 FED) annually to increase pay-for-performance incentives to BadgerCare Plus HMOs. This item would provide funding for incentive payments to increase the percentage of children tested. The amounts are based on approximately 0.25% of BadgerCare Plus HMO capitation payments.

18. Table 3 provides summary information on screening blood lead tests performed for MA-enrolled children in calendar years 2013 through 2017, the last year for which information is available.

19. Currently, DHS imposes a \$10,000 fine on HMOs for failure to meet the HEDIS standards for blood-lead testing for children, which, in 2019, is testing of 80.1% of enrolled children by age two. In 2017, HMOs were required to meet the BLL screening target of 79.5%, but two-thirds of the HMOs did not meet the target.

TABLE 3**Percent of Medicaid-Enrolled Children under Age Six Tested for Blood Lead Levels
Calendar Years 2013 through 2017**

<u>Year</u>	<u>Children Less Than Six Months Old</u>	<u>Children Six through 16 Months Old</u>	<u>Children Ages 17 Months through 29 Months Old</u>	<u>Children Ages 30 Months through 71 Months Old</u>	<u>Children Ages 30 Months through 71 Months that were Never Previously Tested</u>	<u>Percent of Total Children Tested under 72 Months</u>	<u>Percent of Children under 72 Months for Whom Testing was Required</u>
2013	0.2%	77.8%	59.8%	19.8%	14.4%	34.4%	52.9%
2014	0.2	71.9	54.9	19.1	13.3	32.3	49.0
2015	0.2	71.8	53.6	18.6	13.3	32.2	48.5
2016	0.3	70.6	53.2	18.7	13.9	32.1	47.6
2017	0.3	69.5	54.7	19.2	20.1	32.7	52.1

20. Although the table shows the percentage of MA-enrolled children, by age category, that received a BLL test in each year, it does not show the percentage of children that received all the BLL tests that a child would need to meet the federal BLL testing standard. For this reason, it is difficult to assess how successful HMOs would be in demonstrating that they meet the federal MA standard. DHS indicates that any funding budgeted for, but not paid under the incentive program would not be expended for other purposes, such as other HMO incentive payments.

21. There are likely many reasons why an HMO may not be able to meet the federal MA program standards for BLL testing. First, physicians may use discretion in determining if a BLL test is necessary, particularly if a child does not live in a home constructed before 1979 or had a recent BLL test. Second, compliance with the federal standard requires parents and other caregivers to schedule and keep appointments for EPSDT (HealthCheck) check-ups, factors not directly controlled by the HMO.

Use of CHIP Funding

22. The administration intends to maximize the use of federal funds to support these activities by expending federal CHIP allotments, which provide an enhanced match rate for CHIP eligible services, relative to the federal matching rate that applies to most MA expenditures (approximately 59% of eligible costs).

23. Federal CHIP funds are provided to states to increase healthcare coverage for children who would not otherwise be eligible under the standard Medicaid program. In Wisconsin, as with most states, federal CHIP funds are used, along with federal Medicaid funds, in a combined MA program. Generally, children covered under CHIP are children in households with income above 150% of the federal poverty line (FPL), but less than 300% of the FPL, although the CHIP thresholds vary by age of the child.

24. The state and federal share of the CHIP funding amounts in the bill are based on the CHIP federal matching rate applicable for the biennium (85.92% in 2019-20, and to 74.42% in 2020-21.) The reduction in the FMAP for CHIP reflects that the higher CHIP rate was established on a

temporary basis in the federal Affordable Care Act. No future decrease in the federal CHIP FMAP is anticipated.

25. Authorized under the federal CHIP program, health services initiatives (HSIs) allow states to use a portion of CHIP funding to provide preventative services and interventions that would not otherwise be eligible for federal matching funds. Examples of HSIs from other states include a Massachusetts initiative to prevent youth violence through after school programs aimed at mitigating the consequences of trauma and promoting healthy development, and a Missouri initiative to provide immunizations to low-income families that are less likely to receive the recommended immunizations.

26. As part of the CHIP program, HSIs are funded through a combination of state and federal funding, according to the CHIP FMAP. The federal portion is funded through a state's available CHIP allotment for a fiscal year. HSI expenditures (including administration of the HSI itself) are subject to a cap that also applies to administrative expenses. Under federal law, claims for HSIs and administrative expenses cannot exceed 10 percent of the total amount of CHIP funds claimed by the state each quarter. Within the 10 percent limit, states must first fund costs associated with administration of the CHIP plan, but any funds left over may be used for an HSI. In addition, states must assure in the CHIP plan that they will not supplant or match CHIP federal funds with other federal funds, nor allow other federal funds to supplant or match CHIP federal funds.

27. CMS has encouraged states to consider initiatives to increase blood lead level screening for young children, and has approved HSIs for lead abatement activities in Michigan, Indiana, Maryland, and Ohio. Similar to the approved initiatives in these states, DHS is proposing to implement a lead abatement HSI in Wisconsin.

28. The Department intended to begin funding lead abatement services in 2018-19, using CHIP funds and state matching funds from base resources. Accessing federal CHIP funds for this purpose requires an amendment to the state's federal CHIP plan, and, under provisions enacted in 2017 Wisconsin Act 370, such plan amendments must be approved by the Joint Committee on Finance prior to submittal to CMS. On February 14, 2019, the Department submitted a proposed plan amendment to the Committee under a 14-day passive review process. However, an objection to the plan amendment was registered. To date, no meeting had been scheduled to review the plan amendment. Consequently, DHS had not implemented this provision. This item would provide funding in the 2019-21 biennium. However, citing a recent court ruling that suspended enforcement of provisions in Act 370, DHS submitted the proposed amendment to the state's CHIP plan in March, 2019. CMS is currently reviewing the proposed amendment.

29. The Governor's budget recommendations reflect a comprehensive approach to addressing lead poisoning among children, as it includes initiatives to increase BLL testing among MA-eligible children (by funding MA HMO incentive payments and public health outreach efforts targeted to physicians), which would result in an increase in the number of environmental lead investigations (ELIs) conducted by local public health agencies. In addition, for the first time, state funding would be provided to support abatement projects for houses with lead hazards, and state funding would be provided to increase the number of workers who can safely eliminate lead hazards. Further, the proposal maximizes the use of enhanced federal matching rates available under CHIP.

30. In light of the importance of reducing the number of lead poisoned children in the state and the availability of significant federal CHIP and MA funding that is available to support efforts to reduce lead poisoning in the state, the Committee could adopt the Governor's recommendations (Alternative 1). Alternatively, the Committee could choose to delete one or more components from this item (Alternatives 2a, 2b, 2c, 2d, 2e, or 2f). Finally, the Committee could take no action on this item (Alternative 3).

ALTERNATIVES

1. Adopt the Governor's recommendations.

ALT 1	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$11,749,600	2.14	\$0	0.00
FED	<u>31,255,100</u>	<u>0.00</u>	<u>0</u>	<u>0.00</u>
Total	\$43,004,700	2.14	\$0	0.00

2. Modify the bill by selecting one or more of the following options. [If the Committee selects more than one option, the fiscal change to the bill is cumulative. However, the change to base is not cumulative.]

- a. Delete funding for lead abatement grants funded from GPR and surplus FED administrative funding available under CHIP. Reduce funding in the bill by \$17,973,400 (-\$2,136,200 GPR and -\$15,837,200 FED) in 2019-20 and by \$14,335,700 (-\$3,321,500 GPR and -\$11,014,200 FED) in 2020-21.

ALT 2a	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$6,291,900	2.14	-\$5,457,700	0.00
FED	<u>4,403,700</u>	<u>0.00</u>	<u>- 26,851,400</u>	<u>0.00</u>
Total	\$10,695,600	2.14	-\$32,309,100	0.00

- b. Delete funding for abatement grants for non-CHIP properties. Reduce funding in the bill by \$1,000,000 GPR annually.

ALT 2b	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$9,749,600	2.14	-\$2,000,000	0.00
FED	<u>31,255,100</u>	<u>0.00</u>	<u>0</u>	<u>0.00</u>
Total	\$41,004,700	2.14	-\$2,000,000	0.00

- c. Delete funding for workforce training grants. Reduce funding in the bill by \$300,000 (-\$50,900 GPR and -\$249,100 FED) in 2019-20.

ALT 2c	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$11,698,700	2.14	- \$50,900	0.00
FED	<u>31,006,000</u>	<u>0.00</u>	<u>- 249,100</u>	<u>0.00</u>
Total	\$42,704,700	2.14	- \$300,000	0.00

d. Delete funding for public health outreach. Reduce funding in the bill by \$500,000 GPR annually.

ALT 2d	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$10,749,600	2.14	- \$1,000,000	0.00
FED	<u>31,255,100</u>	<u>0.00</u>	<u>0</u>	<u>0.00</u>
Total	\$42,004,700	2.14	- \$1,000,000	0.00

e. Delete 2.14 GPR positions for the Division of Public Health and \$172,500 GPR in 2019-20 and \$222,900 GPR in 2020-21.

ALT 2e	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$11,354,200	0.00	- \$395,400	- 2.14
FED	<u>31,255,100</u>	<u>0.00</u>	<u>0</u>	<u>0.00</u>
Total	\$42,609,300	0.00	- \$395,400	- 2.14

f. Delete funding for HMO incentive payments (-\$1,422,800 GPR and -\$2,077,300 FED annually).

ALT 2f	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$8,904,000	0.00	- \$2,845,600	0.00
FED	<u>27,100,500</u>	<u>0.00</u>	<u>- 4,154,600</u>	<u>0.00</u>
Total	\$36,004,500	0.00	- \$7,000,200	0.00

3. Take no action.

ALT 3	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$0	0.00	- \$11,749,600	- 2.14
FED	<u>0</u>	<u>0.00</u>	<u>- 31,255,100</u>	<u>0.00</u>
Total	\$0	0.00	- \$43,004,700	- 2.14

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Joint Committee on Finance

Paper #391

Birth to 3 Program Expansion (Health Services -- Public Health)

[LFB 2019-21 Budget Summary: Page 196, #2]

CURRENT LAW

Birth to 3 is a federally mandated early intervention program authorized under Part C of the Individuals with Disabilities Education Act (IDEA). The program offers early intervention services to children, ages birth to three, who are identified with, or determined to be at risk for developmental delays. The program's goals are to enhance the development of children with developmental disabilities, minimize the need for special education, and decrease rates of institutionalization.

Currently, a child is eligible for services if he or she: (a) has a developmental delay of at least 25% in one area of development; (b) has atypical development that adversely affects child development; or (c) is diagnosed by a physician as having a high probability of developmental delay. As it pertains to blood lead levels, at-risk children with lead exposure levels at or above 10 micrograms per deciliter (mg/dL) are currently eligible for Birth to 3 program services.

An early intervention team evaluates children referred to the program. Once a child's eligibility is determined, the team conducts an assessment to further identify the needs of the child and the family. The results of the assessment are used by a team of professionals, the service coordinator, the parents, other family members, and an advocate (if requested by the parent), to develop the individualized family service plan (IFSP).

The IFSP includes: (a) information about the child's developmental status; (b) a summary of the family's strengths, resources, concerns, and priorities related to enhancing the development of the child; (c) a statement of the expected outcomes; (d) early intervention services necessary to achieve the expected outcomes including how those outcomes will be achieved, a timeline for the provision of services, the manner in which services will be provided, and the sources of payment for the services; (e) the service coordinator who will be responsible for implementation of the IFSP; (f) a written plan for the steps to be taken to support the child and family through transitions, including the

transition upon reaching the age of 3 to a preschool program or other appropriate services; (g) provision for ongoing review, evaluation and, as necessary, revision of the plan; and (h) the projected dates for the periodic review and annual evaluation of the plan.

The services Birth to 3 participants frequently use include service coordination, communication services, special instruction, occupational therapy, and physical therapy. Children in the program may also receive audiology services, assistive technology services, family training, counseling and home visit services, nursing services, certain medical services, nutrition services, psychological services, sign language and cued language services, social work services, transportation, and vision services.

GOVERNOR

Provide \$1,550,000 GPR in 2019-20 and \$7,600,000 GPR in 2020-21 to increase funding for the Birth to 3 Program. Although not specified in the bill, DHS indicates that it would modify the program's current eligibility criteria to include all at-risk children with lead exposure levels at or above five mg/dL. As mentioned, Wisconsin's current eligibility standard for the Birth to 3 program, as it pertains to lead exposure, is 10 mg/dL.

This item would reduce GPR funding for the children's community options program (CCOP) by \$2,250,000 in 2018-19 but would replace this funding with the same amount of funding budgeted, but not expended, for CCOP that DHS will carry over from 2018-19 to 2019-20. Additionally, this item would increase funding for the Birth to 3 Program by \$3,800,000 GPR in 2019-20 and \$7,600,000 GPR in 2020-21. The following table summarizes the amounts that would be budgeted for both CCOP and the Birth to 3 Program in the 2019-21 biennium under the bill.

Birth to 3 and CCOP Funding (GPR)

	2019-20		2020-21	
	<u>CCOP</u>	<u>Birth to 3</u>	<u>CCOP</u>	<u>Birth to 3</u>
Base	\$11,200,000	\$5,789,000	\$11,200,000	\$5,789,000
Carryover from 2018-19	<u>2,250,000</u>	<u>0</u>	<u>0</u>	<u>0</u>
Total Available	\$13,450,000	\$5,789,000	\$11,200,000	\$5,789,000
Funding Change in This Item	<u>-2,250,000</u>	<u>3,800,000</u>	<u>0</u>	<u>7,600,000</u>
Total Available for Services (Governor's Bill)	\$11,200,000	\$9,589,000	\$11,200,000	\$13,389,000
Change in Available Funding	\$0	\$3,800,000	\$0	\$7,600,000

DISCUSSION POINTS

1. Early intervention programs are operated at the state level and program design differs considerably among states. States have flexibility in some areas, including the ability to define what constitutes a developmental delay and in establishing eligibility criteria.

2. Early intervention programs typically focus on children between birth and three years of age as the CDC reports that the connections in a baby's brain are most adaptable in the first three years of life. These connections, also called neural circuits, are the foundation for learning, behavior, and health, and over time become harder to change.

3. Early intervention programs have found to provide benefits to the participating child and family, as well as economic advantages for society. The National Early Childhood Technical Assistance Center (NECTAC) reports that, based on 2009-10 data, 71 to 76% of the children receiving early intervention services demonstrated greater than expected growth across the following domains: social relationships, use of knowledge and skills, and taking action to meet needs (for example dressing, feeding, and following rules related to health and safety). NECTAC further reports that between 54 and 62% of the children receiving early intervention services exited the program functioning within age expectations in these three domains.

4. Further, a clinical report from the American Academy of Pediatrics notes that children with low birth weight and preterm infants who received early intervention services showed improvements in verbal abilities, receptive language scores, and overall cognitive performance at the age of eight. By age 18, these children showed improvements in academic performance, and endorsement of less risky behaviors, fewer arrests, and a lower dropout rate.

5. NECTAC reports that additional benefits to society include reducing state and federal spending through a decreased need for special education and DHS reports that participation in early education programs improves child developmental outcomes, helping families avoid the need for long-term supports for their child later in life. Investment in early intervention services also benefits state Medicaid programs by reducing the need for expensive ongoing long-term support services among children who receive early intervention services.

6. The Center for Disease Control and Prevention (CDC) notes that exposure to lead can cause a child to suffer damage to the brain and nervous system; slowed growth and development; learning and behavioral problems; and hearing and speech problems.

7. In 2012, the CDC updated its recommendations on children's blood lead levels. Since the change, experts use a reference level of five mg/dL to identify children with blood lead levels that are much higher than most children's levels. This new level is based on the U.S. population of children ages 1-5 years who are in the highest 2.5% of children when tested for lead in their blood.

8. Until 2012, children were identified as having a blood lead level of concern if the test result is 10 or more micrograms per deciliter of lead in blood. The new lower value means that more children will likely be identified as having lead exposure allowing parents, doctors, public health officials, and communities to take action earlier to reduce the child's future exposure to lead and to mitigate the damage done by lead exposure.

9. The administration indicates that it would modify the Birth to 3 program's current eligibility criteria to include all at-risk children with lead exposure levels at or above five micrograms per deciliter (mg/dL). Wisconsin's current eligibility standard for the Birth to 3 program, as it pertains to lead exposure, is 10 mg/dL.

10. The program is funded from several sources, including the federal IDEA grant, parental cost sharing, state GPR, county funds, community aids, Medicaid, and private insurance reimbursement. Counties are responsible for administering the program, based on state and federal guidelines and must establish a comprehensive system to identify, locate, and evaluate children who may be eligible for the program.

11. DHS provides counties with an annual fixed allocation for the Birth to 3 program. Counties are required to fund all Birth to 3 program costs over and above costs that can be supported by their annual Birth to 3 allocation, the Medicaid program, private insurance, or parental fees. Counties cover approximately 40% of all current program costs through a combination of county levy and Basic Community Aids (BCA) expenditures. Counties may not maintain waiting lists for the Birth to 3 program.

12. In 2017, the most recent year for which data is available, counties reported spending approximately \$32.9 million (all funds) for Birth to 3 services. In addition, the state's MA program funded approximately \$7.7 million in services, so that total program costs were approximately \$40.6 million in that year.

13. In calendar year 2018, the Birth to 3 program served 22,501 children, which included new and ongoing participants, children determined to be eligible but who did not enroll in the program, and children referred to the program who were determined to be ineligible to participate through the screening or assessment process. Total enrollment in 2018 was 12,864 children, of which 7,002 were new enrollments and 5,862 were ongoing. On average, children participated in the program for approximately 10 months.

14. The administration estimates that changing the eligibility criteria as it pertains to blood lead levels would result in an additional 2,000 children becoming eligible for Birth to 3 services. The average annual cost of serving a child enrolled in the Birth to 3 program is \$3,800 per year.

15. Funding for the Birth to 3 eligibility expansion would be partially offset by a one-time \$2,250,000 GPR reduction in funding that would be budgeted to support the children's community options program (CCOP) in 2019-20. However, DHS would use a corresponding amount of funding for the program carried over from the Community Options Program (COP), from the current biennium, to maintain funding for CCOP in each year of the 2019-21 biennium at its current budgeted level (\$11.2 million per year).

16. CCOP provides supports and services to children (under 22 years of age) living at home or in the community who have one or more of the following long-term disabilities: developmental disabilities, physical disabilities, or severe emotional disturbances. The child's disability is characterized by a substantial limitation on the ability to function in at least two of the following areas: (a) self-care, (b) receptive and expressive language, (c) learning, (d) mobility, and (e) self-direction.

Additionally, eligible children must require a level of care typically provided at an intermediate care facility for individuals with intellectual disabilities, a nursing home, or a hospital.

17. Available funding in the first year is half of the available funding in the second year, with the administration estimating that an additional 1,000 children would be eligible for and receive services in 2019-20, and an additional 2,000 in 2020-21.

18. The administration based the increased number of eligible children on a 2016 DHS report, which found that there were 3,125 children aged 2 and under who had a blood lead level of 5mg/dL or greater. Subsequently, the administration assumed that approximately 75% of these children have a blood lead level under 10mg/dL (as estimated based on 2014 data). As a result approximately 2,344 children could be eligible under the proposal, of which approximately 1,847 would be newly identified. This assumption regarding newly eligible and enrolled children seems reasonable.

19. Funding in the 2019-21 biennium is offset by one-time carryover funds. However, these funds would not be available in the future and so the ongoing annual GPR funding increase to the Birth to 3 program would be \$7,600,000 GPR.

20. In light of the health risks associated with heightened blood lead levels in young children and the recommendations from the CDC, the Committee could choose to approve the Governor's recommendation [Alternative 1].

21. Alternatively, the Committee may be concerned about the impact of the Birth to 3 program on counties since there is no limit on the amount of annual funding counties may be required to invest in the program beyond the funds provided by other payor sources. As such the Committee could choose to retain the current eligibility requirement for Birth to 3 as it pertains to blood lead levels. Additionally, the Committee could still require the one-time transfer of \$2,250,000 GPR that would otherwise be budgeted to support CCOP in 2019-20, and the subsequent transfer of carry over funding to maintain funding for CCOP in each year of the 2019-21 biennium at its current budgeted level (\$11.2 million per year). This would have the effect of creating a one-time funding increase for counties to help offset Birth to 3 program costs [Alternative 2].

22. Finally, in light of competing interests for state funding and the numerous other policy and funding changes made in the Governor's budget to address heightened lead levels in young children, the Committee could choose to delete the provision [Alternative 3].

ALTERNATIVES

1. Approve the Governor's recommendation.

ALT 1	Change to	
	Base	Bill
GPR	\$9,150,000	\$0

2. Delete the Governor's recommendation. However, require that DHS transfer \$2,250,000 on a one-time basis from CCOP in 2019-20 and subsequently transfer carry over funding from COP to maintain funding for CCOP in each year of the 2019-21 biennium at its current budgeted level (\$11.2 million per year).

ALT 2	Change to	
	Base	Bill
GPR	\$0	-\$9,150,000

3. Take no action.

ALT 3	Change to	
	Base	Bill
GPR	\$0	-\$9,150,000

Prepared by: Alexandra Bentzen



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May, 2019

Joint Committee on Finance

Paper #392

Tobacco Use Control (Health Services -- Public Health)

[LFB 2019-21 Budget Summary: Page 197, #3]

CURRENT LAW

The Division of Public Health in the Department of Health Services (DHS) administers the tobacco prevention and control program that awards grants to organizations throughout the state. The statutes require DHS to administer the program, establish criteria for grant recipients, provide a forum for public policy alternatives for smoking cessation and prevention, provide a clearinghouse of information on matters relating to tobacco, and continue implementation of a strategic plan for a statewide tobacco use control program.

The program may distribute grants to fund any of the following activities listed in s. 215.15 of the statutes: (a) community-based programs to reduce tobacco use or the burden of tobacco-related diseases; (b) school-based tobacco use cessation and prevention programs; (c) enforcement of local laws aimed at reducing exposure to secondhand smoke and restricting underage access to tobacco; (d) partnerships among statewide organizations and businesses that support activities related to tobacco use cessation and prevention; (e) marketing activities that promote tobacco use cessation and prevention; (f) projects designed to reduce tobacco use among minorities and pregnant women; (g) surveillance of indicators of tobacco use and evaluation of the activities funded by the tobacco control program; (h) development of policies that restrict access to tobacco products and reduce exposure to environmental tobacco smoke; and (i) other tobacco use cessation or prevention programs, including tobacco research and intervention.

Base funding for this program is \$5,315,000 GPR annually.

GOVERNOR

Increase funding for tobacco use control activities by \$3,300,000 annually, so that \$8,615,000 GPR would be budgeted each year for the program.

DISCUSSION POINTS

1. According to the Centers for Disease Control and Prevention (CDC), smoking is the leading cause of preventable disease and death in the United States, leading to approximately 480,000 deaths of people over 35 years old annually. A 2015 research paper published in the *American Journal of Preventive Medicine*, a peer-reviewed medical journal, estimated that, in 2010, approximately 8.7% of annual healthcare spending in the United States was attributable to cigarette smoking, amounting to as much as \$170 billion per year. More than 60% of this spending was paid by public programs, including Medicare and Medicaid.

2. Based on the most recent estimates of smoking attributable mortality, morbidity and economic costs, CDC estimates that an annual average of 7,900 people over 35 years old in Wisconsin die from smoking-related causes, not including deaths attributable to second hand smoke. The CDC estimates that, in 2014, the total medical cost of care resulting from smoking in Wisconsin was approximately \$2.7 billion.

3. According to a report from the University of Wisconsin-Milwaukee's Center for Urban Population Health, 16% of adults in Wisconsin currently smoke cigarettes, slightly below the national average of 16.4%. The estimated percentage of adults who smoke has decreased significantly over the past several years, from 21% in 2011 to the current rate of 16%.

4. There are significant differences in estimated smoking rates among demographic groups in Wisconsin. For example, it is estimated that 29% of adults with annual income up to \$25,000 smoke, while the smoking rate for adults with income between \$25,000 and \$50,000 is 17%. Similarly, 28% of adults with less than a high school education smoke, which is nearly double the smoking rate for individuals who have at some college courses (15%), and over four times the rate for college graduates (6%). Approximately 28% of adult MA residents smoke. For these reasons, the health care costs relating to smoking are disproportionately borne by public health programs.

5. In 2008-09, state funding for tobacco control and prevention grants totaled \$15,250,000. The 2009-11 budget act reduced this amount to \$6,850,000 in 2009-10 and 2010-11. The 2011 budget act reduced grant funding to the current base amount, \$5,315,000, beginning in 2011-12.

6. The CDC has developed several best practices for states to follow in the implementation of a tobacco control program, and a recommended funding level for the state program. The recommended funding amounts represent a level that the CDC claims could achieve a reduction of national tobacco use prevalence to 10% (if all states implemented the recommended levels). In its 2014 report, the CDC recommends that Wisconsin allocate \$57.5 million per year to the tobacco control program.

7. Funding for tobacco use control has remained constant at \$5.3 million over the past eight years. During that period cigarette smoking for adults in Wisconsin has declined from 21% to 16%. Additionally, excise taxes on cigarettes in the state have declined from \$604.8 million in 2011-12 to \$538.9 million in 2017-18, a reduction of \$65.9 million, or 10.9%.

8. However, even with the decline in cigarette smoking in the state, smoking continues to

be a major health risk and a significant driver of healthcare expenditures. Because of this, it could be argued that additional funding for tobacco use control is a necessary investment in the health of the state.

9. The bill provides an additional \$3,300,000 GPR annually for tobacco use control grants, an increase of 62% over the base level. Although the bill does not specify how that money will be allocated within the program, the administration has indicated its intent to use the additional funding for three purposes.

10. First, \$2,300,000 annually would be provided to increase support for the University of Wisconsin Center for Tobacco Research and Intervention's (UW-CTRI) Wisconsin Tobacco Quit Line (WTQL). The WTQL is a free service to help people quit smoking, vaping, and using tobacco in other ways by providing free one-on-one phone counseling and information, local cessation program referrals, and starter packs of medications such as nicotine gum, patches, and lozenges. The program is funded through a combination of GPR and federal grants. In 2018-19, DHS provided approximately \$672,800 GPR for the program. Currently, the WTQL offers a one-call program, which allows Wisconsin residents to call in and receive counseling and recommendations for medication. It is up to the individual to follow-up on the recommendations of counsellors and to make any subsequent calls to the WTQL. The funding in the bill is intended to allow the program to implement a five-call program, in which state residents can call in for an initial appointment, and schedule four follow-up calls starting at the caller's chosen quit date. In these follow-up calls, counselors from the WTQL would call the person to offer additional counseling and motivation, as well as referrals for smoking cessation medication. Research from the UW Center for Tobacco Research and Intervention indicates that multi-call programs, such as the five-call program that would be funded under the bill, are more effective in helping individuals quit smoking than one-call programs. According to the research, one-call programs are associated with a quit-rate of approximately 25%, compared to a quit rate of 38% associated with a four-call program. The additional funding for the WTQL was chosen to reflect the estimated costs increased staffing resulting from a switch to a five-call program.

11. Second, \$500,000 of the additional annual funding would be provided to the Wisconsin Nicotine Treatment Integration Project (WiNTiP), which integrates evidence-based nicotine dependence treatment into behavioral health services. In 2018-19, this program received \$42,680 in GPR funding and an additional one-time \$112,000 FED from the community mental health services block grant distributed by the Department. The administration indicates that increased funding would be used to increase outreach attempts conducted through WiNTiP to the behavioral health workforce and increase the integration of tobacco cessation treatment among AODA mental health providers. A portion of funds would also be used for resource development.

12. Third, the administration intends to use \$500,000 in each year to improve outreach and cessation resources to individuals who have adverse childhood experiences (ACEs). This funding would be provided to the UW-CTRI to establish a grant program to increase the number of practitioners across the state who understand the impact of trauma and are able to identify ACE indicators among patients with tobacco use.

13. Several options are presented for the Committee's consideration. First, the Committee

could approve all of the Governor's recommendations (Alternative 1). Second, , the Committee could choose an alternative funding level for the program, enabling the Department to determine the highest priority projects that would be funded (Alternatives 2, 3, and 4). Finally, the Committee could maintain base funding for the program by deleting all of the additional funding that would be provided in the bill (Alternative 5).

ALTERNATIVES

1. Approve the Governor's proposal to increase funding for the program by \$3,300,000 GPR annually.

ALT 1	Change to	
	Base	Bill
GPR	\$6,600,000	\$0

2. Delete the Governor's recommendations to provide funding for specific projects identified by the administration (-\$3,300,000 GPR annually). Instead, increase funding for the tobacco control and prevention grants by \$5,000,000 GPR annually, enabling DHS to award grants to the highest priority projects, including the priority projects identified by the administration.

ALT 2	Change to	
	Base	Bill
GPR	\$10,000,000	\$3,400,000

3. Delete the Governor's recommendations to provide funding for specific projects identified by the administration (-\$3,300,000 GPR annually). Instead, increase funding for the tobacco control and prevention grants by \$2,000,000 GPR annually, enabling DHS to award grants to the highest priority projects, which may include some of the projects identified by the administration.

ALT 3	Change to	
	Base	Bill
GPR	\$4,000,000	-\$2,600,000

4. Delete the Governor's recommendations to provide funding for specific projects identified by the administration (-\$3,300,000 annually). Instead, increase base funding for the tobacco control and prevention grants by 10% in 2019-20 (\$531,500) and by an additional 10%

(\$1,063,000) in 2020-21, enabling DHS to award grants to the highest priority projects, which may include some of the priority projects identified by the administration.

ALT 4	Change to	
	Base	Bill
GPR	\$1,594,500	- \$5,005,500

5. Take no action.

ALT 5	Change to	
	Base	Bill
GPR	\$0	- \$6,600,000

Prepared by: Aaron Whitaker



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May, 2019

Joint Committee on Finance

Paper #393

Dementia Initiatives (Health Services -- Public Health)

[LFB 2019-21 Budget Summary: Page 198, #4]

CURRENT LAW

Dementia care specialists (DCSs) work at county aging and disability resource centers (ADRCs) or tribal agencies and provide cognitive screenings, programs that engage individuals with dementia in regular exercise and social activities, and promote independence for individuals with dementia. They also provide support for family caregivers, including assistance with care planning and connections to support groups. Finally, they provide community support, assisting in the development of dementia friendly communities through outreach events and professional consultations. Dementia care specialist positions are not state positions.

The Department of Health Services (DHS) contracts with ADRCs to support information and referral services for elderly and disabled individuals in the ADRC's service area. However, funding to support DCS positions is not part of the ADRC base contracts. Instead, DHS supports DCS positions by providing grants, each totaling \$94,000 (\$80,000 GPR and \$14,000 FED) annually. DHS claims federal medical assistance (MA) administrative matching funds to partially support these positions, to reflect that some DCS services are provided to MA-eligible individuals and therefore qualify as MA-eligible administrative expenses.

In 2019 contractual commitments for the ADRCs are estimated to be approximately \$70.3 million (\$42.2 million GPR and \$28.1 million FED), this amount includes the ADRC base funding as well as various other commitments, including the current dementia care specialist positions, various tribal specialists, adult protective services, and services provided by Disability Rights Wisconsin.

DHS currently funds 21 DCS and three tribal DCS positions, covering 34 counties and three tribes. The attachment identifies the ADRCs and tribes that currently have DCS positions.

GOVERNOR

Dementia Care Specialists. Provide \$2,822,000 (\$2,400,000 GPR and \$422,000 FED) in 2019-20 and \$2,822,000 (\$2,400,000 GPR and \$422,000 FED) in 2020-21 to support 27 additional DCS and three new tribal DCS positions, expanding the DCS program statewide.

Academic Detailing Program. Provide \$61,600 GPR in 2019-20 and \$78,200 GPR in 2020-21 on a one-time basis for DHS to implement a two-year academic detailing primary care clinic dementia training pilot program in ten primary care clinics through a contract with the Wisconsin Alzheimer's Institute.

Define "academic detailing" to mean a teaching model under which health care experts are taught techniques for engaging in interactional educational outreach to other health care providers and clinical staff to provide information on evidence-based practices and successful therapeutic interventions with the goal of improving patient care.

Require that DHS, as part of the training program, provide primary care providers with clinical training and access to educational resources on best practices for diagnosis and management of common cognitive disorders, and referral strategies to dementia specialists for complicated or rare cognitive and behavioral disorders.

Require that DHS ensure that the training program includes at least the following: (a) the most current research on effective clinical treatments and practices is systematically evaluated by the academic detailing team; (b) the information gathered and evaluated is packaged into an easily accessible format that is clinically relevant, rigorously sources, and compellingly formatted; and (c) training is provided for clinicians to serve as academic detailers that equips them with clinical expertise and proficiency in conducting an interactive educational exchange to facilitate individualized learning among participating primary care practitioners in the target clinics.

DISCUSSION POINTS

1. Dementia refers to a set of symptoms of cognitive decline resulting from brain cell death caused by disease and injury to the brain. Symptoms may include declines in memory, judgment, perception, and reasoning, as well as other cognitive abilities. There are several causes of dementia, the most prominent of which is Alzheimer's disease.

2. According to the Alzheimer's Association, it is estimated that approximately 3% of people ages 65 through 74, 17% of individuals ages 75 through 84, and 35% of individuals 85 and older have Alzheimer's disease. The Alzheimer's Association estimates that 110,000 Wisconsin residents age 65 and older have dementia. The number of people with Alzheimer's disease and other dementias is expected to increase as the population continues to age.

Dementia Care Specialists

3. The DCS program started as a pilot program in 2013, when DHS used one-time funds, resulting from unanticipated enhanced federal funding and unspent ADRC allocations, to support five

DCS positions. In 2014, DHS expanded the program to 16 DCS positions, also using one-time funding. The 2015-17 budget provided funding for 12 DCS positions. DHS supplemented the 2015-17 biennial budget allocation with surplus one-time ADRC funding to continue all 16 DCS positions through 2016-17. DHS also funded the three tribal DCS positions at that time, for a total of 19 positions. The 2017-19 budget provided additional funding for the DCS program, enabling DHS to fund a total of 21 DCSs and three tribal DCS positions on an ongoing basis. DHS indicates that for the additional five DCS positions funded in the 2017-19 budget, the Department received applications from 16 ADRCs.

4. DHS anticipates that there will be 48 ADRCs serving the state's 72 counties at the end of the 2017-19 biennium. The Governor's budget would enable DHS to fund one DCS for each ADRC, resulting in an additional 27 DCS positions.

5. However, based on the anticipated size of the population to be served, each tribe would not be allocated its own DCS. Instead, the Governor's budget allocates 1.0 DCS position for the Oneida tribe, and a 0.5 DCS position for each of the ten remaining tribes in the state. As such, the Governor's budget allocates funding for three additional tribal DCS positions. By providing an additional three DCS positions and allocating 0.5 DCS position to each tribe (other than Oneida), Menominee and St. Croix Chippewa would be allocated 0.5 fewer DCS positions than they are currently allocated.

6. Funding for the DCS positions is based on the assumption that approximately 30% of DCS activities are related to Medicaid and therefore qualify for a 50% federal Medicaid administrative match, which is estimated to equal \$14,000 FED per DCS positions annually. The remaining \$80,000 for each position is funded with GPR. Funding for the tribal DCS positions is budgeted using the same combination of GPR and FED.

7. The main goals of the DCS program are to: (a) support individuals with dementia to remain active and able to stay in their own homes in the community; (b) support family caregivers so that they can continue to help family members with dementia remain in the least restrictive setting for as long as possible; (c) increase the dementia capability of the local ADRC as well as other county and tribal agencies; and (d) facilitate local efforts to build dementia-friendly communities

8. In 2017, DCSs documented 2,615 contacts with community members. Forty-four percent of these DCS contacts were people seeking help for themselves as caregivers. Of these 44%, almost half were between 60 and 79 years old, and were either the adult child or the spouse of a person with dementia.

9. DCS positions also refer individuals to community resources and programs. In 2017, DCSs made 5,881 referrals to other community partners such as caregiver support programs, county and tribal agencies, and long-term care and health care services. DCSs received over 2,600 referrals for DCS services from a variety of sources including: county and tribal agencies, friends and family, outreach events, and health care professionals.

10. DCSs are trained to perform free memory screens for individuals in the community. The exercises administered by the DCSs do not provide a reason for the memory issue, if one is indicated,

and do not constitute a medical diagnosis. However, these free screens indicate whether clinical follow-up with a primary physician or other health care professional is warranted, which may help reduce the need for an individual to seek further medical services. Beyond administering their own screens DCSs also train other ADRC and tribal staff to use the memory screen tools. In 2017, DCSs performed 494 memory screens, with ADRCs performing a total of 3,434 memory screens.

11. Additionally, DCS positions provide community education, mobilize community resources, and consult with law enforcement, adult protective services, crisis response teams, medical providers, and others who need information regarding dementia-related issues. In 2017, DCSs participated in 1,651 outreach events and reached approximately 29,600 attendees.

12. Based on the expectation of continuing growth in the demand for DCS services and to ensure equal access to DCS services throughout the state, the Committee could adopt the Governor's recommendation [Alternative A1]. Funding in the bill would be reduced by \$2,000 FED annually to reflect the administration's intent to provide \$14,000 FED for each additional position.

13. In light of other GPR funding commitments, the Committee could choose not to provide funding to expand the DCS program on a statewide basis, but instead provide funding for 14 additional DCS positions and three tribal positions. Under this alternative, DHS would allocate funding to one-half of the remaining ADRCs and all of the tribes that do not have DCS positions. The cost of funding for these 17 new positions would be \$1,598,000 (\$1,360,000 GPR and \$238,000 FED) annually [Alternative A2].

14. Alternatively, the Committee may determine that in light of the funding increases for the program in the 2017-19 budget the program should not be expanded further at this time. For this reason, the Committee could delete the Governor's funding increase for the DCS positions. Under this alternative, funding for the current 21 DCSs and three tribal DCSs would continue in the 2019-21 biennium [Alternative A3].

Academic Detailing Program

15. Early detection of dementia allows individuals to work with their doctors to determine what lifestyle changes they can make or what treatment options may be available to address the progression of the disease or ease symptoms; and participate in making health care and financial decisions and plans for the future, which may help avoid potentially costly, crisis situations.

16. The Governor's budget provides funding for DHS to contract with the Wisconsin Alzheimer's Institute (part of the University of Wisconsin School of Medicine and Public Health) to implement a "train-the-trainer" style training program designed to increase the timeliness and accuracy of dementia diagnosis in Wisconsin. The program would provide primary care providers with clinical training and access to educational resources on best practices for diagnosis and management of common cognitive disorders, and referral strategies to dementia specialists for complicated or rare cognitive and behavioral disorders, with the goal of improving patient care.

17. DHS indicates that the Wisconsin Alzheimer's Institute would recruit ten clinicians with expertise in dementia to be trained as academic detailers and implement the program in ten clinic sites

across the state. The ten clinicians selected would receive training at the National Resource Center for Academic Detailing. DHS estimates that one-time costs for the ten clinicians to attend this training is \$20,000 GPR.

18. Further, DHS anticipates that the Wisconsin Alzheimer's Institute would develop and print training materials for each of the ten clinicians to use when interacting with health care providers at participating clinics. DHS anticipates that the costs of developing and producing these training materials would be \$10,000 GPR annually.

19. Finally, the ten selected clinicians would provide ongoing training and mentoring to providers at one clinic for the duration of the initiative. The clinicians would make monthly four-hour visits, during which the clinicians would accompany providers as they conduct appointments, model best practices in dementia diagnosis and treatment, provide guidance, and respond to questions. DHS estimates the clinicians would make six clinic visits in 2019-20 and 12 clinic visits in 2020-21 and that reimbursement for the clinicians' time (based on an estimated annual salary of \$250,000) and mileage for these clinic visits would total \$31,600 GPR in 2019-20 and \$68,200 GPR in 2020-21.

20. In an effort to improve the timeliness and accuracy of dementia diagnosis in Wisconsin, the Committee may choose to fund the academic detailing program [Alternative B1].

21. Alternatively, the Committee could delete this item from the bill. Under this alternative, the University of Wisconsin School of Medicine and Public Health could choose to implement such a program if it determined that these activities were a priority use of base funding [Alternative B2].

ALTERNATIVES

The Committee should select one option from the alternatives under A and option from the alternatives under B. If the Committee selects A1 and B1, the Committee will approve the Governor's recommendation, as reestimated. If the Committee selects A3 and B2, the Committee will delete the provision.

A. Dementia Care Specialists in ADRCs

1. Approve the Governor's recommendation to fund 27 DCS and three tribal DCS positions. Reduce funding by \$2,000 FED annually to reflect the Governor's funding intent.

ALT A1	Change to	
	Base	Bill
GPR	\$4,800,000	\$0
FED	<u>840,000</u>	<u>- 4,000</u>
Total	\$5,640,000	- \$4,000

2. Reduce funding in the bill by \$1,224,000 (-\$1,040,000 GPR and -\$184,000 FED) annually to fund 14 DCS and three tribal DCS positions, beginning in 2019-20.

ALT A2	Change to	
	Base	Bill
GPR	\$2,720,000	- \$2,080,000
FED	<u>476,000</u>	<u>- 368,000</u>
Total	\$3,196,000	- \$2,448,000

3. Take no action with respect to additional DCS positions.

ALT A3	Change to	
	Base	Bill
GPR	\$0	- \$4,800,000
FED	<u>0</u>	<u>- 844,000</u>
Total	\$0	- \$5,640,000

B. Academic Detailing Program

1. Approve the Governor's recommendation to fund the academic detailing program.

ALT B1	Change to	
	Base	Bill
GPR	\$139,800	\$0
FED	<u>0</u>	<u>0</u>
Total	\$139,800	\$0

2. Take no action with respect to the academic detailing program.

ALT B2	Change to	
	Base	Bill
GPR	\$0	- \$139,800
FED	<u>0</u>	<u>0</u>
Total	\$0	- \$139,000

Prepared by: Alexandra Bentzen
Attachment

ATTACHMENT

Aging and Disability Resource Center and Tribal Dementia Care Specialists 2018

<u>ADRC of</u>	<u>Counties Served</u>
Barron, Rusk, and Washburn	Barron, Rusk, Washburn
Brown	Brown
Dane	Dane
Dodge	Dodge
Eagle Country	Crawford, Juneau, Richland, Sauk
Eau Claire	Eau Claire
Jefferson	Jefferson
Kenosha	Kenosha
the Lakeshore	Kewaunee, Manitowoc
La Crosse	La Crosse
Marinette	Marinette
Milwaukee (Aging Resource Center)	Milwaukee
the North	Ashland, Bayfield, Iron, Price, Sawyer
Ozaukee	Ozaukee
Pierce	Pierce
Portage	Portage
Rock	Rock
Southwest Wisconsin	Grant, Green, Iowa, Lafayette
St. Croix	St. Croix
Waukesha	Waukesha
Winnebago	Winnebago
<u>Tribe</u>	<u>Tribes Served</u>
Menominee	Menominee Tribe
Oneida	Oneida Nation
St. Croix	St. Croix Chippewa Tribe



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May, 2019

Joint Committee on Finance

Paper #394

Dental Services -- Public Health (Health Services -- Public Health)

[LFB 2019-21 Budget Summary: Page 199, #5]

CURRENT LAW

The oral health program in the Division of Public Health (DPH) administers several programs that are intended to improve access to dental care throughout the state. These programs are designed primarily to serve low-income individuals, Medicaid recipients, and individuals who lack dental insurance.

One such program is Wisconsin Seal-a-Smile, under which DHS awards annual grants, totaling \$170,000 annually, for fluoride supplements (\$25,000), a fluoride mouth-rinse program (\$25,000), and a school-based dental sealant program (\$120,000).

Additionally, the Department is required to distribute grants to at least nine nonprofit dental clinics in Wisconsin that are not federally qualified health centers (FQHCs) and that primarily serve low-income patients. Base funding for these grants is \$850,000 GPR annually.

GOVERNOR

Provide \$1,189,500 GPR in 2019-20 and \$1,789,500 GPR in 2020-21 and 4.60 positions, beginning in 2019-20, to support three dental health initiatives in the Division of Public Health.

Seal-a-Smile. Provide \$275,000 in 2019-20 and \$450,000 in 2020-21 to increase the scope and funding levels for grants DHS provides under the Seal-A-Smile program. Beginning in 2020-21, DHS would be required to award annual grants totaling no less than \$50,000 for fluoride varnish and other evidence-based oral health activities, \$700,000 for school-based preventive dental services, and \$100,000 for school-based restorative dental services. Notwithstanding the annual allocation amounts described above, in fiscal year 2019-20, DHS would be directed to

award \$525,000 for school-based preventive dental services, \$100,000 for school-based restorative dental services, and \$50,000 for fluoride varnish and other evidence based oral health activities.

The following table summarizes the funding changes for the Seal-a-Smile program in the bill.

Seal-A-Smile Funding Allocations

	2019-20			2020-21		
	<u>Base</u>	<u>Bill</u>	<u>Change</u>	<u>Current</u>	<u>Bill</u>	<u>Change</u>
Fluoride Supplements	\$25,000	\$0	-\$25,000	\$25,000	\$0	-\$25,000
Fluoride Mouth-Rinse Program	25,000	0	-25,000	25,000	0	-25,000
School-Based Dental Sealant Program	350,000	0	-350,000	350,000	0	-350,000
School-Based Preventive Dental Services	0	525,000	525,000	0	700,000	700,000
School Based Restorative Dental Services	0	100,000	100,000	0	100,000	100,000
Fluoride Varnish and Other Evidence-Based Oral Health Activities	<u>0</u>	<u>50,000</u>	<u>50,000</u>	<u>0</u>	<u>50,000</u>	<u>50,000</u>
Total	\$400,000	\$675,000	\$275,000	\$400,000	\$850,000	\$450,000

Dental Clinics. Provide \$425,000 in 2019-20 and \$850,000 in 2020-21 to increase funding for grants provided to dental clinics that serve low-income patients.

Oral Health Program Positions. Provide \$489,500 annually to support 4.60 positions, beginning in 2019-20, for the state's oral health program in the Division of Public Health

DISCUSSION POINTS

1. According to the U.S. Surgeon General, poor oral health is associated with a broad range of negative medical, social, and economic outcomes that adversely affect one's quality of life. Additionally, several academic studies have found that early detection and intervention of dental problems can reduce utilization and cost of dental and other medical services later in one's life.

2. The Department's state health plan identifies significant disparities in access to dental care and oral health outcomes based on an individual's income, ethnicity, and disability status. People of color are significantly more likely to have permanent teeth removed due to tooth decay or gum disease, and are less likely to have visited a dentist, dental hygienist, or dental clinic in the past year. Permanent tooth removal and lack of dental visits are significantly more common among people with low incomes and disabilities.

3. The oral health program in the Division of Public Health operates several programs aimed at providing dental services to underserved populations, including the Wisconsin Seal-a-Smile and the low-income dental clinic grant program.

Seal-a-Smile

4. The mission of Seal-a-Smile is to prevent dental decay and promote oral health as part of children's total health by increasing the number of dental sealants applied to their teeth. The sealants are applied to the chewing surfaces of a child's teeth, where they prevent cavities and the need for fillings. The sealants have been shown to effectively prevent tooth decay for several years.

5. The Seal-a-Smile program is funded from an appropriation for general dental services. This appropriation also funds contributions to Marquette University for the dental services provided by their students and faculty to underserved populations, for fluoride supplements and treatment efforts, and to technical colleges for oral health services. Base funding for all of these programs is \$2,974,300 GPR.

6. In practice, DHS has allocated approximately \$350,000 GPR per year for the school-based dental sealant program, which is matched by private funding from Delta Dental, and supplemented by MA reimbursement for eligible services provided to children enrolled in the MA program. The program is jointly administered by DHS and the Children's Health Alliance of Wisconsin (CHAW). Grant funding is awarded to approximately 40 local programs to provide services statewide. Each local program must follow statewide policies and protocols and use evidence-based strategies in providing care.

7. DHS anticipates that Delta Dental would contribute \$450,000 for the 18-month period from July 1, 2019, to December 30, 2020. Combined with GPR base funding for the program, approximately \$675,000 would be available to fund grants to local programs in 2019-20. Approximately \$150,000 that would be budgeted for the program would fund supplies, such as toothbrushes for children, travel, data management and CHAW staff salaries.

8. The additional funding in the bill is intended to increase, from approximately 700 to 1,400 the number of schools that could be served through the program. The Department indicates that the Seal-a-Smile program served approximately 720 schools in the 2016-17 school year, while approximately 1,400 schools qualified for the program. Preliminary information suggests that, during the 2017-18 school year, Seal-a-Smile funded programs served approximately 71,000 children, of which approximately 19,300 children (27%) had untreated decay and 29,400 (42%) received dental sealants. Of the children that received an oral screening, 8,300 (12%) had special health care needs.

Dental Clinics Serving Low-Income Families

9. The low-income dental clinic grant provides funding to non-profit entities, excluding FQHCs, which serve primarily MA recipients, low-income populations, children, elderly individuals, and persons with disabilities. Base funding for the program is \$850,000 annually.

10. In 2018-19, 19 clinics applied for state grants under the program, with funding requests totaling \$2.0 million. The following table lists the agencies that applied for grants in 2018-19, the amount each agency requested, and the grant funding DHS awarded to each agency.

**Dental Clinics Serving Low-Income Families
2018-19 Grant Applications**

<u>Agency</u>	<u>Public Health Region</u>	<u>Amount Requested</u>	<u>Award</u>
Funded Clinics			
Bread of Healing Clinic	Southeast	\$92,600	\$46,000
Brown County Oral Health	Northeast	100,000	51,000
CAP Services, Inc.	North	97,700	48,000
Chippewa Valley VTAE District	West	100,000	68,700
Door County Medical Center Foundation	Northeast	78,400	78,400
HealthNet of Rock County	South	65,100	65,100
Lake Area Free Clinic	Southeast	117,800	117,800
Open Arms Free Clinic	Southeast	125,000	125,000
Dr. James E. Albrecht Free Clinic	Southeast	68,000	68,000
Aspirus Riverview Dental Clinic	North	115,300	57,000
Madison Dental Initiative	South	<u>125,000</u>	<u>125,000</u>
Subtotal		\$1,084,900	\$850,000
Applications Submitted, Not Funded			
AIDS Resource Center of Wisconsin	South, Southeast, Northeast	\$125,000	
Children's Medical Group	Southeast	125,000	
Church Health Services, Inc.	South	125,000	
Columbia St. Mary's Foundation	Southeast	100,000	
Community Dental Clinic	Southeast	100,500	
St. Anne Center for Intergenerational Care	Southeast	125,000	
Tri-County Dental	Northeast	90,000	
Waukesha County Community Dental Clinic	Southeast	<u>125,000</u>	
Subtotal		\$915,500	
Grand Total		\$2,000,400	

The administration indicates that, by increasing the annual grant amount by \$425,000 in 2019-20 and \$850,000 in 2020-21, it would be able to address demonstrated unmet needs, while still maintaining a competitive grant program.

Oral Health Program Positions

11. Finally, the bill would provide \$489,500 GPR annually to replace federal grants from the Health Research Services Agency and the Centers for Disease Control that had previously funded 4.60 FTE positions. In the summer of 2018 the Department was informed that this federal funding would no longer be provided, with grant funding expiring August 31, 2018. DHS used carryover funds from the federal grants to maintain these positions through February, 2019. The Department currently has no other funding available to support these positions.

12. The 4.60 FTE positions for which grant funding expired included:

- 1.0 sealant program coordinator to manage the state school-based dental sealant

program and data collection system and assist with community water fluoridation and response efforts;

- 1.0 oral health epidemiologist to develop and maintain a statewide oral health surveillance plan, develop and implement statewide, regional, and local oral health surveys, coordinate evaluation activities with an evaluation contractor, and analyze, interpret, publish and communicate information on oral health;

- 1.0 fluoridation coordinator to plan, implement, and monitor water fluoridation activities, including documentation of public water systems that adjust fluoride, and provide education on the benefits, safety and effectiveness of community water fluoridation and promote quality control and management of fluoridated water systems;

- 1.0 an oral health workforce evaluation specialist to provide technical assistance on improving quality in dental health professional shortage areas (HPSAs) and developing metrics and identifying data sources for program evaluation; and

- 0.6 oral health workforce program coordinator to expand the capacity of the oral health program to address gaps in the oral health workforce, including access to dental services with substance use disorders.

13. Of these formerly federally-funded positions, 2.6 of these positions are currently filled, while 2.0 positions are vacant and cannot be filled due to a lack of funding. The administration indicates that the current incumbents would move into the newly created GPR positions were funding and position authority provided in the bill.

14. The Department states that these positions are necessary for the Department to carry out duties required of it in state statute, such as the operation of a school-based sealant program. The operation of the Seal-a-Smile program has depended on positions funded by federal grants since 2008.

15. The administration argues that the federal grants are awarded to states on a competitive basis, and that providing additional state funding for the oral health program would make it more likely that the state would receive similar federal grants in the future. Similarly, the administration contends that a lack of state funding for the oral health program could result in the Department being unable to meet best practice standards required by the CDC for the receipt of federal grant funding.

16. Several options are presented for the Committee's consideration. First, the Committee could approve all of the Governor's recommendations (Alternative 1). Second, the Committee could choose to delete funding or positions for one or more of the purposes recommended by the Governor (Alternatives 2a, 2b, or 2c). Third, the Committee could choose to offer some other amount of additional funding, and leave it up to the Department to determine how to distribute the funding. (Alternative 3). Finally, the Committee could maintain base funding for the program by deleting all of the additional funding that would be provided in the bill (Alternative 4).

ALTERNATIVES

1. *Governor's Recommendation.* Adopt the Governor's recommendation to provide \$1,189,500 in 2019-20 and \$1,789,500 in 2020-21 and 4.60 positions, beginning in 2019-20, to support dental health initiatives in the Division of Public Health. Adopt the statutory changes in the bill relating to Seal-a-Smile funding allocations.

ALT 1	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$2,979,000	4.60	\$0	0.00

2. Modify the Governor's proposal by choosing one or more of the following alternatives. [If the Committee chooses more than one of the alternatives, the change to bill is cumulative, but the change to base is not.]

a. *Reduce Funding Increase for Seal-A-Smile.* Reduce the funding increase that would be provided for the Seal-a-Smile program by \$75,000 GPR in 2019-20 and by \$150,000 GPR in 2020-21, so that an additional \$200,000 GPR in 2019-20 and \$300,000 GPR in 2020-21 would be provided for the program. Repeal the statutory allocations for specific types of services that would be funded under the program.

ALT 2a	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$2,754,000	4.60	- \$225,000	0.00

b. *Delete Funding Increase for Seal-a-Smile.* Delete the funding increase that would be provided for the Seal-a-Smile program (-\$275,000 GPR in 2019-20 and -\$450,000 GPR in 2020-21). Repeal the statutory allocations for specific types of services that would be funded under the program.

ALT 2b	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$2,254,000	4.60	- \$725,000	0.00

c. *Reduce Funding Increase for Clinics.* Reduce the funding increase that would be provided for low-income dental clinic grants by \$175,000 GPR in 2019-20 and \$350,000 GPR in 2020-21 so that an additional \$250,000 GPR in 2019-20 and \$500,000 GPR in 2020-21 would be provided for the grant program.

ALT 2c	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$2,229,000	4.60	- \$750,000	0.00

d. *Delete Funding Increase for Clinics.* Delete the funding increase that would be provided for grants to dental clinics that serve low-income patients (-\$425,000 GPR in 2019-20 and -\$850,000 GPR in 2020-21).

ALT 2d	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$1,704,000	4.60	-\$1,275,000	0.00

e. *State Positions.* Delete funding and position authority that would be provided to maintain funding and positions for the DHS oral health program (-\$489,500 GPR annually and -4.60 GPR positions, beginning in 2019-20).

ALT 2e	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$2,000,000	0.00	-\$979,000	- 4.60

3. Take no action.

ALT 3	Change to Base		Change to Bill	
	Funding	Positions	Funding	Positions
GPR	\$0	0.00	-\$2,979,000	- 4.60

Prepared by: Aaron Whitaker



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May, 2019

Joint Committee on Finance

Paper #395

Healthy Aging Grant (Health Services -- Public Health)

[LFB 2019-21 Budget Summary: Page 201, #8]

CURRENT LAW

The Department of Health Services (DHS) administers several programs that support services for elderly Wisconsin residents. However, DHS does not administer or provide grants for programs that support healthy aging. According to the U.S. Department of Health and Human Services (DHHS), "healthy aging" includes adopting healthy habits and behaviors, staying involved in community activities, using preventive services, managing health conditions, and understanding how medications can contribute to a productive and meaningful life.

2015 Wisconsin Act 55 provided one-time funding of \$200,000 GPR in each year of the 2015-17 biennium to support healthy aging programs. Since funding was not provided on an ongoing basis, the appropriation was time-limited and was repealed at the end of 2016-17, as directed by statute. DHS awarded this funding to the Wisconsin Institute on Healthy Aging (WIHA), which used it to develop and expand healthy aging programs across the state.

GOVERNOR

Provide \$250,000 GPR annually and require DHS to award a grant of \$250,000 GPR in each fiscal year to an entity that conducts programs in healthy aging. Create an appropriation in the Department's Division of Public Health for this purpose.

DISCUSSION POINTS

1. DHS estimates that between 2010 and 2040, the percentage of people in Wisconsin ages 65 and older will increase from 13.7% to 23.7% and the percentage of Wisconsin residents ages 85

and older will increase from 2.1% to 4.4% of the state's total population.

2. According to the federal Centers for Disease Control and Prevention, falls are the leading cause of fatal and nonfatal injuries among adults age 65 and older. CDC reports that nationwide, in 2017, approximately 31,400 adults over the age of 65 died as a result injuries from falls, and elderly individuals experienced 2,973,000 nonfatal injuries from falls. Injuries and deaths from falls are preventable. Health care providers can play a role in reducing injuries and deaths from falls by screening older adults for fall risks, reviewing and managing medications, and recommending vitamin D supplements to improve bone, muscle and nerve health. However, many elderly adults with access to primary care do not receive these services.

3. The Governor's budget would provide \$250,000 annually and require DHS to award a grant of \$250,000 in each fiscal year to an entity that conducts programs in healthy aging. The administration intends for the this funding to enable the selected entity to: maintain statewide program licenses; research, develop, and maintain the infrastructure for coordination of the state's healthy aging programs; provide data collection and analysis; and support county and tribal aging units, aging and disability resource centers, and other local partners in development and training leaders and recruiting participants.

4. In 2015, DHS was not required to solicit applications for a competitive process because WIHA was, and continues to be, the only organization in Wisconsin that serves as the statewide clearinghouse for healthy aging programs and maintains licensure for these programs. No other entity serves a similar purpose. DHS indicates that unless another organization becomes eligible to receive these funds, it is likely DHS will continue to pursue a sole source contract with WIHA.

5. WIHA is currently funded from a variety of sources including grants, registration fees for leader trainings; registration fees for the bi-annual Healthy Aging Summit; business sponsorships for the bi-annual Healthy Aging Summit; and sales of national Stepping On Falls Prevention licenses. In calendar years 2018 and 2019, approximately 70-75% of WIHA's budget is based on grant revenue, with approximately 60% of that grant revenue coming from the two federal grants, described below.

6. In 2017, WIHA was awarded two three-year federal grants from the DHHS Administration for Community Living to train program leaders and expand certain healthy aging programs. First, the chronic disease self-management expansion grant provided a total of \$845,850 FED to expand diabetes self-management programs. Second, WIHA was awarded a falls prevention grant, which provided a total of \$467,800 FED. As expansion grants, these projects contribute to long-term goals of bringing availability of the Healthy Living with Diabetes and Stepping On Falls Prevention programs to scale.

7. The Healthy Living with Diabetes program is intended to target individuals who have prediabetes or are at risk for developing type 2 diabetes. The program focuses on healthy eating, increasing physical activity, and weight loss. Participants attend 16 one-hour core classes during a six-month period and then another six one-hour post-core classes over the next six-month period.

8. The Stepping On program is an evidence-based falls prevention program targeting adults over age 60 who live in home and community based settings, and do not rely on a walker or wheelchair

while inside. The program is offered once a week in two hour sessions for seven weeks in small group settings in the community. The program focuses on strength and balance exercises, medication and vision review, and home modifications. After the seven weeks, follow-up is provided with a phone call or home visit as well as a booster session.

9. In 2016 and 2017, WIHA hosted 194 Healthy Living with Diabetes workshops in 46 counties and tribal communities, reaching 1,923 participants. During that same time, WIHA hosted 384 Stepping On workshops in 61 counties and tribal communities, reaching 4,384 participants. WIHA reports that Stepping On participants who completed the program had a 31% reduction in falls.

10. In addition, WIHA used approximately \$100,000 of the federal grant funding to support falls prevention mini-grants and another \$100,000 to fund chronic disease mini-grants. 40 organizations serving 36 different counties and two tribes received mini-grants during the three-year grant period. Grant recipients included: county aging units, Aging and Disability Resource Centers (ADRCs), county public health departments, YMCAs, federally qualified health centers, senior centers, independent living centers, and other community-based organizations.

11. However, the federal grants from the Administration for Community Living are program-specific, and therefore do not support the development of other health promotion program areas. Additionally, both grants are scheduled to end in July, 2020.

12. WIHA indicates that the funding provided in the Governor's budget would allow the agency to: continue expanding the Stepping On and Healthy Living with Diabetes programs; implement new programs focusing on physical activity for older sedentary adults, incontinence in older women, and pain self-management; expand culturally competent services and translate additional programs in to Spanish; and expand services to other underserved communities such as older adults with disabilities.

13. Additionally, WIHA would continue providing mini-grants to other organizations and also support a program through the YMCA Alliance of Wisconsin to develop and bring to scale a program called Tai Chi: Moving for Better Balance. This program is an evidence-based falls prevention program that aims to improve strength, balance, mobility and daily functioning, and prevent falls in older adults and individuals with balance disorders. The program is delivered in two one-hour sessions each week for 24 weeks. Each session consists of warm-up exercises; core practices, which include a mix of practice of forms, variations of forms, and mini-therapeutic movements; and brief cool-down exercises.

14. According to the administration, the \$250,000 annual grant amount included in the Governor's budget is based on funding that was provided in the 2015-17 biennium (\$200,000 per year), and increased to account for growth trends in the aging adult population.

15. If the Committee wishes to provide ongoing state support for healthy aging activities, it could approve the Governor's recommendation [Alternative 1]. Alternatively, if the Committee is convinced of the improved outcomes for participants in the WIHA healthy aging programs, it could choose to double the amount of funding in the bill, so that \$500,000 GPR would be budgeted annually for the program [Alternative 2].

16. On the other hand, the Committee could provide funding for the grant at the same level as provided in Act 55 (\$200,000 per year) by decreasing funding in the bill by \$50,000 GPR annually [Alternative 3]. Finally, the Committee may determine that, in light of other GPR funding priorities, the state should not commit GPR for the program, and delete the provision [Alternative 4].

ALTERNATIVES

1. Approve the Governor's recommendation.

ALT 1	Change to	
	Base	Bill
GPR	\$500,000	\$0

2. Increase funding in the bill by \$250,000 annually so that \$500,000 GPR would be budgeted annually for the program.

ALT 2	Change to	
	Base	Bill
GPR	\$1,000,000	\$500,000

3. Reduce funding in the bill by \$50,000 annually so that \$200,000 GPR would be budgeted annually for the program.

ALT 3	Change to	
	Base	Bill
GPR	\$400,000	- \$100,000

4. Take no action.

ALT 4	Change to	
	Base	Bill
GPR	\$0	- \$500,000

Prepared by: Alexandra Bentzen

HEALTH SERVICES

Public Health

LFB Summary Items for Which No Issue Paper Has Been Prepared

<u>Item #</u>	<u>Title</u>
7	Minority Health
9	Wisconsin Chronic Disease Program
10	Dispatcher Assisted Cardiopulmonary Resuscitation
11	Well Woman Program
12	Infant Mortality Prevention
13	Graduate Medical Education Support Grants
16	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)

LFB Summary Items Removed From Budget Consideration

<u>Item #</u>	<u>Title</u>
6	Dental Therapy Training
14	Family Planning and Women's Health Block Grant
15	Prescription Drug Importation Program