Health Services

Elder and Disability Services

(LFB Budget Summary Document: Page 289)

LFB Summary Items for Which Issue Papers Have Been Prepared

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3 & 4	Aging and Disability Resource Centers -- Expanded Services and Dementia Care Specialists (Paper #361)
5	Alzheimer's Family and Caregiver Support Program (Paper #362)
8	Nursing Home Grant Program (Paper #363)

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11	Caregiver Designation for Hospital Releases
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13	Home Care Provider Registry Pilot Program
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LFB Summary Items Addressed in Sum Sufficient Estimates (Paper #102)

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10	SSI Supplements Reestimate

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June, 2021 Joint Committee on Finance Paper #360

Birth to 3 Program (Health Services -- Elder and Disability Services)

[LFB 2021-23 Budget Summary: Page 289, #1 and #2]

CURRENT LAW

Birth to 3 is an 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 (µg/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.

In calendar year 2019, the most recent year for which complete data is available, 12,725 children were served by the Birth to 3 program. The following table shows program expenditures for 2019, by fund source.

Birth to 3 Program Expenditures, by Source, 2019

Funding Type	Amount
Federal Part C Allocation	$5,836,046
State GPR Allocation	5,789,000
Medicaid (estimated)	6,961,636
Community Aids (BCA)	4,692,521
County Funding	14,781,466
Parental Cost Share	543,517
Private Insurance	2,414,776
Other	1,807,952
Total	$42,826,914

DISCUSSION POINTS

1. According to the Centers for Disease Control and Prevention (CDC), early intervention services, such as those provided through the Birth to 3 program in Wisconsin, are likely to be more effective when provided earlier in life rather than later. This is because 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. Over time, these connections become harder to change.

2. Further, the CDC notes that early intervention services can change a child's developmental path and improve outcomes for children, families, and their communities. In its 2020 report, the Early Childhood Technical Assistance Center, indicated that nationally for federal fiscal year 2018, 91% of families reported that early intervention services helped them know their rights and communicate their children's needs. Additionally, 93% reported that early intervention services helped their children learn and develop.

Federal Maintenance of Effort Requirement

3. Wisconsin's Birth to 3 program is funded from several sources, including federal IDEA Part C funds, parental cost sharing, state GPR, county funds, community aids, Medicaid, and private insurance reimbursement.

4. 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. Counties may not maintain waiting lists for the Birth to 3 program.

5. 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. Based on calendar year 2019 expenditures, counties cover approximately 46% of all current program costs through a combination of county levy and basic community aids (BCA) expenditures.

6. 2019 Act 9 increased state GPR funding for the Birth to 3 program by $1,125,000 in each year of the 2019-21 biennium, using one-time carry-over funding, so that GPR funding to support the program totaled $6,914,000 in 2019-20 and 2020-21.

7. DHS indicates that the additional $2,250,000 one-time funding from 2019 Act 9 was distributed across each of the county agencies based on a three-year evaluation of each agency's average percent of statewide Birth to 3 program enrollment and average percent of statewide population under age three. As a result of the one-time funding provided in Act 9, in the 2021-23 biennium, Wisconsin's maintenance of effort (MOE) funding obligation for the program is expected to increase by $1,125,000 annually.

8. Federal law requires that the total amount of state and local funds budgeted for expenditures in the current fiscal year for early intervention services must be at least equal to the total amount of state and local funds actually expended for early intervention services for eligible children and their families in the most recent preceding fiscal year for which the information is available. Meeting the MOE requirement is necessary in order to continue to receive federal IDEA funding.

9. Since the full annual amount allocated in the current biennium was expended on Birth to 3 program services, the Committee could increase funding for the Birth to 3 program in the 2021-23 biennium by $1,125,000 annually in order for the Department to meet its federal MOE requirement [Alternative A1].

10. In response to the COVID-19 pandemic, the American Rescue Plan Act (ARPA) provided additional funding for early intervention programs. According to the U.S. Department of Education, Wisconsin's Birth to 3 program is estimated to receive $3,387,129 in one-time funding. In addition to the individual state allocations, $37.5 million has been set aside nationally for state incentive grants. Guidance on allowable uses of the state allocated funding has not yet been issued and DHS indicates that the agency is still awaiting instructions from the federal Office of Special Education Programs (OSEP) regarding the permissible uses for this funding. However, DHS does not expect OSEP to allow states to use the additional ARPA funding to supplant other sources of funding.

11. If the Committee does not provide additional GPR to meet the federal MOE requirement, DHS must instead meet the requirement through increased county investment [Alternative A2].

Expanded Program Eligibility

12. In 2012, the federal Centers for Disease Control and Prevention (CDC) updated its recommendations regarding children's blood lead levels. Since the change, from the previous level of 10 micrograms per 100 milliliters (10 µg/dL), experts use a reference level of five µg/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 one to five years who are in the highest 2.5% of children when tested for lead in their blood.

13. The 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.

14. Based on the recommendations from the CDC, the Committee may wish to update eligibility for the Birth to 3 program as it relates to blood lead level. Currently, Wisconsin's eligibility standard for the program, as it pertains to lead exposure, is 10 µg/dL.

15. Under this alternative, as recommended by the administration, the Committee could expand eligibility for services provided under the Birth to 3 program by requiring DHS to ensure that any child with a level of lead in his or her blood that is five or more micrograms per 100 milliliters (5 µg/dL), as confirmed by one venous blood test, is eligible for services under the Birth to 3 program.

16. The Department indicates that based on a 2018 DHS report, there were 2,900 children aged 2 and under who had a blood lead level of five µg/dL or greater. Assuming approximately 75% of these children have a blood lead level under 10 µg/dL (based on 2014 data), approximately 2,175 children could be eligible under the administration's proposal.

17. As such, the Department estimates that expanding eligibility would result in an additional 2,000 children becoming eligible for Birth to 3 services annually, at an average cost per child of $3,300, based on the average annual cost of serving a child currently enrolled in the program.

18. Under this alternative, $3,300,000 could be provided in 2021-22 and $6,600,000 in 2022-23 to fully support the additional estimated costs of this program eligibility expansion, assuming the eligibility change would take effect on January 1, 2022 [Alternative B1]. By delaying the effective date to January 1, 2023, funding necessary would be $3,300,000 in 2022-23 [Alternative B2].

19. Alternatively, the Committee could choose to maintain current eligibility standards for the Birth to 3 program and take no action on this item [Alternative B3].

ALTERNATIVES

A. Maintenance of Effort

1. Provide $1,125,000 GPR annually to use state funding to cover the federal MOE requirement in the 2021-23 biennium.

ALT A1	Change to Base
GPR	$2,250,000

2. Take no action.

B. Expanded Program Eligibility

1. Expand eligibility for services provided under the Birth to 3 program, effective January 1, 2022, by requiring DHS to ensure that any child with a level of lead in his or her blood that is five or more micrograms per 100 milliliters, as confirmed by one venous blood test, is eligible for services under the Birth to 3 program. Provide $3,300,000 GPR in 2021-22 and $6,600,000 GPR in 2022-23 to fund services for newly eligible children.

ALT B1	Change to Base
GPR	$9,900,000

2. Expand eligibility for services provided under the Birth to 3 program, effective January 1, 2023, by requiring DHS to ensure that any child with a level of lead in his or her blood that is five or more micrograms per 100 milliliters, as confirmed by one venous blood test, is eligible for services under the Birth to 3 program. Provide $3,300,000 GPR in 2022-23 to fund services for newly eligible children.

ALT B2	Change to Base
GPR	$3,300,000

3. Take no action.

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June, 2021 Joint Committee on Finance Paper #361

Aging and Disability Resource Centers and Dementia Care Specialists (Health Services -- Elder and Disability Services)

[LFB 2021-23 Budget Summary: Page 290, #3 and #4]

CURRENT LAW

Aging and disability resource centers (ADRCs) provide information on a broad range of programs and services, serve as the access point for publicly funded long-term care programs, and assist people in understanding the various long-term care options available to them and how to apply for programs and benefits.

ADRCs may serve either a single county or a consortia of counties and tribes. There are currently 48 ADRCs and six tribal aging and disability resource specialists (ADRSs) serving residents statewide, including Milwaukee County, which has an aging resource center and a separate disability resource center. The ADRC program became available on a statewide basis in 2013.

GPR base funding for ADRC and tribal ADRS services is $42,127,500 annually, of which approximately $36 million is used to support ADRC base contracts. In addition, DHS claims federal Medicaid administrative matching funds based on estimates of the cost of services ADRCs provide to Medicaid recipients. Over the last three years, services eligible for federal match have resulted in additional funding of approximately $25.8 million annually. However, the actual amount of federal funding the state can claim depends on what portion of ADRC services are provided to Medicaid recipients. While ADRCs are mainly funded with GPR and corresponding federal matching funds, some ADRCs receive support by other revenue sources, including fee revenue, county levy funding, and other grants. The Department of Health Services (DHS) provides most of the funding for ADRCs through annual, sum certain allocations. However, counties are responsible for expenses that exceed these allocations.

Beyond the base funding available for core contract functions, ADRCs may receive additional funding for certain programs. For example, some ADRCs receive funding to support their dementia care specialist (DCS) programs. For these ADRCs, DHS provides $94,000 (all funds) annually to fund a DCS position to provide assistance to people with dementia and their caregivers.

DISCUSSION POINTS

1. According to the DHS *State of Wisconsin Aging Plan for Older People 2019-2021* report, "Wisconsin's population aged 65 and older is projected to increase from 780,000 residents in 2010 to over 1.5 million by 2040, a 30-year increase of more than 758,000 people or about 100 percent." Further the report notes that "those 65 and older currently comprise almost one in six individuals in Wisconsin and this ratio will rise to almost one in four by 2040. However, many counties in the northern tier of the state have already reached this threshold."

2. The report goes on to state that "large shares of the state's Native American population reside in a number of northern counties. Wisconsin is home to 11 tribes, with a total of more than 6,000 tribal members age 60 or older." Between 2000 and 2016, Wisconsin's Native American population ages 65 and older grew by 107%, while the statewide number of individuals over the age of 65 (all races and ethnicities) increased by 32%.

3. The 2021-23 budget bill would provide $2,425,800 ($2,395,000 GPR and $30,800 FED) in 2021-22 and $4,634,500 ($4,573,000 GPR and $61,500 FED) in 2022-23 to fund expanded services at the ADRCs and for the tribes.

4. While not specified in the bill, the Executive Budget Book indicates that the funding would be used to: (a) expand caregiver support services to address the needs of caregivers of adults with disabilities who are age 19 to 59; (b) require ADRCs to designate a caregiver coordinator and create a marketing plan to increase knowledge of available programs; (c) expand the tribal aging and disability resources specialist program, which provides liaison services between the tribes and ADRCs to ensure that tribal members receive culturally appropriate information and access long-term care programs and services; and (d) expand the tribal disability benefit specialist program, which is a contractual partnership between DHS and the Great Lakes Inter-Tribal Council to provide assistance and advocacy services to adult tribal members with disabilities.

5. Additionally, the bill would provide $1,175,000 ($1,000,000 GPR and $175,000 FED) in 2021-22 and $2,350,000 ($2,000,000 GPR and $350,000 FED) in 2022-23 to fund one full-time dementia care specialist for every ADRC and tribe.

Expanded ADRC Services

6. In response to the COVID-19 pandemic ADRCs received one-time funding through the federal Coronavirus Aid, Relief, and Economic Security (CARES) Act, in 2020. In total, DHS distributed $755,454 to the ADRCs and tribes using a population based allocation formula.

7. The Department allowed local discretion by each ADRC for the use of the funds within any or all of the following categories: (a) virtual management of ADRC access functions; (b) mitigating social isolation through proactive follow-up; or (c) developing or enhancing innovative services or service structures. Examples of these services include: providing home delivered meals to adults with disabilities between the ages of 18 and 59; purchasing personal protective equipment; recruitment and training of volunteers; travel vouchers; marketing and outreach activities for the ADRC; assistive technology for ADRC customer use; and support for and continuation of services as outlined in the 2020 ADRC scope of services.

8. In calendar year 2019, ADRCs reported 571,391 contacts, an increase of more than 17,900 contacts since calendar year 2017. Contacts do not represent the number of unique individuals served by the ADRC, since an individual may contact and receive services multiple times. Despite an increase in the number of contacts and individuals eligible for ADRC services, as a result of Wisconsin's aging population, GPR base funding for ADRC core contract purposes has not increased since ADRC services became available on a statewide basis in 2013.

9. In 2016, DHS published an analysis of the ADRCs, which found that 40.4% of people surveyed contacted the ADRC on behalf of a spouse or relative. DHS has not commissioned a more recent formal analysis of the ADRCs. However, a 2020 report, by the National Alliance for Caregivers and AARP, indicated that more than one in five Americans are caregivers, having provided care to an adult or child with special needs at some time in the past 12 months. This equals an estimated 53.0 million adults in the United States, up from an estimated 43.5 million caregivers in 2015. For purposes of the 2020 report "caregivers" were defined as unpaid family caregivers.

10. If the Committee wishes to expand services that ADRCs currently provide, as described in Discussion Point 4, in recognition of likely future increases in demand for ADRC services, the Committee could choose to provide $2,000,000 GPR in 2021-22 and $4,000,000 GPR in 2022-23 to increase funding available under the ADRC base contract [Alternative A1].

11. The Department indicates that, under the plan noted in the Executive Budget Book, funding would support both counties and tribes, although a distribution method has not been finalized. Further, additional funding would be predicated on contract amendments regarding expanded caregiver support services or through a separate caregiver support services contract for the ADRC.

12. Alternatively, in recognition of likely future increasing demand for ADRC services, the Committee could choose to increase base funding for ADRC contracts by an alternative amount. Depending on the amount of the increase, DHS would need to weigh the potential costs of adding requirements to the ADRC contracts with the additional base funding it could provide to each ADRC. For example, the Committee could provide $1,000,000 GPR in 2021-22 and $2,000,000 GPR in 2022-23 to increase funding available under the ADRC base contract [Alternative A2].

13. Finally, in light of competing budget priorities, the Committee could choose to take no action, thereby maintaining the current GPR funding level for ADRC base contracts [Alternative A3].

Tribal Aging and Disability Resource Specialists

14. Aging and disability services for the tribes are provide through an ADRC, which the tribe may join as a full partner, or by a tribal aging and disability resource specialist (TADRS) employed by the tribe. The Bad River Band of Lake Superior Tribe of Chippewa Indians, Ho Chunk Nation, Lac Courte Oreilles, Red Cliff, Oneida, and Menominee Tribes receive funding for TADRS positions, while Stockbridge-Munsee, St. Croix, Potawatomi, and Lac du Flambeau coordinate with county ADRCs.

15. Tribes currently receive annual allocations for TADRS services of between $40,000 and $68,000 GPR, plus any associated federal Medicaid administrative matching funds. The amount of GPR funding differs based upon the size of the tribe and when services were first expanded to the tribe. These allocations were established as part of the 2009-11 biennial budget and represent funding ranging from a 0.57 FTE to a 0.97 FTE. The 2009-11 budget increase for TADRS funding assumed a cost of $92,000 all funds per 1.0 FTE TADRS. Allocations have not been adjusted to account for wage inflation over time.

16. According to DHS, most recent estimates for costs associated with county and tribal aging and disability professionals, including salary, fringe, and indirect costs, total $94,000. Assuming that 30 percent of TADRS activities would be eligible for 50% Medicaid administrative federal match, fully funding 1.0 FTE TADRS is estimated to cost $80,000 GPR and $14,000 FED.

17. The Department indicates that historically, cost models for ADRC and TADRS allocations have assumed a constant cost to provide aging and disability services for every 1 percent of the Wisconsin population. However, this assumption is problematic as applied to the tribes for several reasons.

18. First, tribal populations may require additional support due to the population's higher rates of chronic illness. For example, according to the U.S. Department of Health and Human Services, in 2018, Native Americans were 50 percent more likely to have heart disease and be current cigarette smokers, 10 percent more likely to have high blood pressure, and were more likely to be obese, compared to their white counterparts nationwide. Further, according to federal Centers for Disease Control and Prevention, Native Americans were twice as likely to have diabetes compared to their white counterparts nationwide

19. Second, allocations proportioned by population size are often operationally insufficient for low-population jurisdictions, and the Department indicates that attempts to encourage collaboration and pooling of resources across counties or Tribal Nations have not proven sustainable.

20. Consequently, tribes that receive a funding allocation for a TADRS position have had difficulty recruiting and retaining staff to fill these positions. Tribes that have chosen to integrate with ADRCs have access to more resources. However, the Department expresses some concern regarding the suitability of staff at ADRCs to serve the specialized needs of tribal members, especially as it pertains to cultural competency.

21. For these reasons, the Committee could adopt the Governor's recommendation to

provide $208,800 ($178,000 GPR and $30,800 FED) in 2021-22 and $417,500 ($356,000 GPR and $61,500 FED) in 2022-23 to expand the tribal aging and disability resources specialist program, which would fund a full time TADRS for each of the 11 tribes by increasing each tribe's allocation to $80,000 GPR per year. Funding under this provision is based on a January 1, 2022, implementation date [Alternative B1].

22. Under Alternative B1, total TADRS funding, across the 11 tribes, would be increased to $880,000 GPR and $154,000 FED per year, up from current annual funding of $524,000 GPR and $92,500 FED.

23. On the other hand, the Committee may want DHS to continue to encourage tribes to integrate with ADRCs and therefore choose not to provide additional funding for TADRS positions [Alternative B2].

Tribal Disability Specialists

24. The tribal disability benefit specialist (DBS) program is a contractual partnership between the Department and the Great Lakes Inter-Tribal Council (GLITC) under which GLITC provides assistance and advocacy services to adult tribal members with disabilities. Specialists are trained to help determine which benefits tribal members may be eligible for and assist in the application and appeal process. Current funding of approximately $260,400 per year supports three DBS positions that serve all tribal members statewide.

25. The Department indicates that GLITC DBS are extended past capacity, as demonstrated by some tribal members receiving DBS services from non-GLITC DBS. Tribal members may encounter delays that may cause some members to select receiving services through local ADRCs. In light of the unique benefits to which tribal members are entitled, the ADRCs are not necessarily equipped to serve tribal members, due to lack of expertise and experience.

26. In order to ensure timely access to DBS services for tribal members across the state, the Committee could increase the DHS contract with GLITC by $217,000 GPR annually in order to support an additional 2.5 FTE DBSs. Funding for an additional 2.5 FTEs would allow for .5 FTE per tribe [Alternative C1].

Dementia Care Specialists

27. 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 act 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.

28. The 2017-19 budget act 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 act, the Department received applications from 16 ADRCs. For 2019-21, 2019 Act 9 provided funding for eight additional DCS positions and one additional tribal DCS position. However, for the expansion funded under Act 9, DHS received 13 applications from 19 ADRCs and two applications from three Tribal Nations.

29. With the additional positions funded in Act 9, there are currently 29 dementia care specialists working in ADRCs covering 56 counties, as well as four tribal dementia care specialists employed by tribal agencies and covering five tribes. The appendix shows all counties and tribes currently served by a dementia care specialist.

30. 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. As with other ADRC costs, DHS claims federal Medicaid 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.

31. Dementia care specialists provide: cognitive screenings, programs that engage individuals with dementia in regular exercise and social activities, and promote independence for individuals with dementia; support for family caregivers, including assistance with care planning and connections to support groups; and community support, assisting in the development of dementia friendly communities through outreach events and professional consultations.

32. According to the Alzheimer's Association, it is estimated that nationally approximately 5.3% of people ages 65 through 74, 13.8% of individuals ages 75 through 84, and 34.6% of individuals 85 and older have Alzheimer's disease. The Alzheimer's Association estimates that in 2020, 120,000 Wisconsin residents age 65 and older have dementia, with that number anticipated to reach 130,000 in 2025. The number of people with Alzheimer's disease and other dementias is expected to increase as the population continues to age.

33. Further, the Alzheimer's Association indicates that nationally 48% of all unpaid caregivers who provide help to older adults do so for someone with Alzheimer’s or another dementia, which means that more than 11 million Americans provide unpaid care for people with Alzheimer's or other dementias.

34. In 2019, the most recent year for which data is available, DCSs documented 8,204 contacts with 2,830 consumers. According to DHS, in 2019, nearly 60% of contacts with DCSs were by telephone. In many cases, these calls were routed through the information and assistance specialists at the ADRC. DCSs also met with walk-in customers (2%) and customers at outreach events (10%). Additionally, DCSs provided information through email (16%) and home visits (9%). Nearly one-third of calls were initiated by a caregiver who was looking for information to support a person with dementia. Approximately 20% of the calls were either caregivers looking for help for themselves (for example, respite) or a person with dementia who was calling the ADRC on their own behalf.

35. In order to fund 18 dementia care specialist positions at ADRCs and seven tribal dementia care specialist positions, which would expand the dementia care specialist program to one full time position serving each tribe and ADRC in the state, ensuring equal access to the program, the

Committee could provide $1,175,000 ($1,000,000 GPR and $175,000 FED) in 2021-22 and $2,350,000 ($2,000,000 GPR and $350,000 FED) in 2022-23, as recommended by the Governor [Alternative D1].

36. 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 nine additional DCS positions and seven tribal positions. Under this alternative, DHS would allocate funding to all of the tribes and one-half of the remaining ADRCs that do not have DCS positions. The cost of funding for these 16 new positions would be $752,000 ($640,000 GPR and $112,000 FED) in 2021-22 and $1,504,000 ($1,280,000 GPR and $224,000 FED) in 2022-23 [Alternative D2].

37. Conversely, the Committee may determine that in light of the funding increases for the program in both the 2017-19 and 2019-21 budgets the program should not be expanded further at this time. For this reason, the Committee could choose to take no action. Under this alternative, funding for the current 29 DCSs and four tribal DCSs would continue in the 2021-23 biennium [Alternative D3].

ALTERNATIVES

A. Expanded ADRC Services

1. Provide $2,000,000 GPR in 2021-22 and $4,000,000 GPR in 2022-23 to increase funding available under the ADRC base contract to expand caregiver services.

ALT A1	Change to Base
GPR	$6,000,000

2. Provide $1,000,000 GPR in 2021-22 and $2,000,000 GPR in 2022-23 to increase funding available under the ADRC base contract.

ALT A2	Change to Base
GPR	$3,000,000

3. Take no action.

B. Tribal Aging and Disability Resource Specialists.

1. Provide $208,800 ($178,000 GPR and $30,800 FED) in 2021-22 and $417,500 ($356,000 GPR and $61,500 FED) in 2022-23 to fund a full time TADRS for each of the 11 tribes, starting on January 1, 2022.

ALT B1	Change to Base
GPR	$534,000
FED	92,300
Total	$626,300

2. Take no action.

C. Tribal Disability Benefit Specialists

1. Provide $217,000 GPR annually in order to support an additional 2.5 tribal DBS positions.

ALT C1	Change to Base
GPR	$434,000

2. Take no action.

D. Dementia Care Specialists

1. Provide $1,175,000 ($1,000,000 GPR and $175,000 FED) in 2021-22 and $2,350,000 ($2,000,000 GPR and $350,000 FED) in 2022-23 to fund 18 dementia care specialist positions at ADRCs and seven tribal dementia care specialist positions, for a statewide program.

ALT D1	Change to Base
GPR	$3,000,000
FED	525,000
Total	$3,525,000

2. Provide $752,000 ($640,000 GPR and $112,000 FED) in 2021-22 and $1,504,000 ($1,280,000 GPR and $224,000 FED) in 2022-23 to fund nine additional DCS positions at ADRCs and seven tribal positions.

ALT D2	Change to Base
GPR	$1,920,000
FED	336,000
Total	$2,256,000

3. Take no action.

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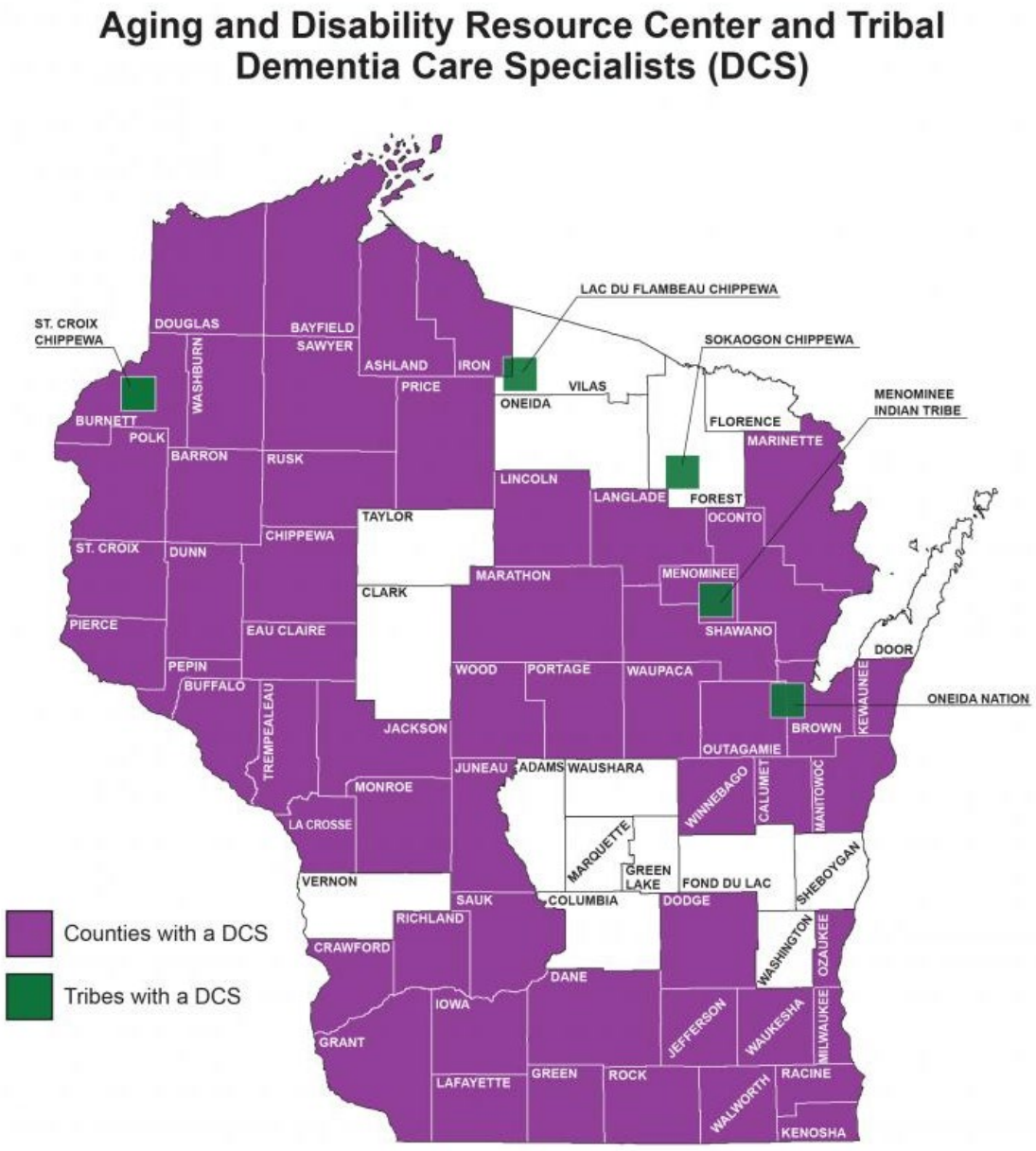
Appendix

APPENDIX


Aging and Disability Resource Center and Tribal Dementia Care Specialists (DCS)
LAC DU FLAMBEAU CHIPPEWA
SOKAOGON CHIPPEWA
MENOMINEE INDIAN TRIBE
ONEIDA NATION
ST. CROIX CHIPPEWA
DOUGLAS
BAYFIELD
SAWYER
WASHBURN
ASHLAND
IRON
PRICE
VILAS
ONEIDA
FLORENCE
MARINETTE
BURNETT
POLK
BARRON
RUSK
LINCOLN
LANGLADE
FOREST
OCONTO
TAYLOR
CHIPPEWA
ST. CROIX
DUNN
MARATHON
MENOMINEE
CLARK
PIERCE
EAU CLAIRE
SHAWANO
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June, 2021 Joint Committee on Finance Paper #362

Alzheimer's Family and Caregiver Support Program (Health Services -- Elder and Disability Services)

[LFB 2021-23 Budget Summary: Page 291, #5]

CURRENT LAW

Under the Alzheimer's family and caregiver support program (AFCSP), the Department of Health Services (DHS) allocates funding to counties, tribes, and area agencies on aging (AAAs) to assist individuals to purchase services and goods related to the care of someone with Alzheimer's disease. In any calendar year, up to $4,000 per person may be available, depending on the county's priorities and the person's need for services. In some instances, the funds are used within the county to expand or develop new services related to Alzheimer's disease, such as respite care, adult day care, or support groups.

To be eligible for the program, a person must have a diagnosis of Alzheimer's disease or a related disorder, and be financially eligible. The program is administered by the DHS Bureau of Aging and Disability Resources, and is available in every county and tribe throughout the state. Under current law, DHS may provide up to $2,558,900, of which at least $1,000,000 per year must be allocated for respite care under AFCSP.

DISCUSSION POINTS

1. The Alzheimer's family and caregiver support program was created by the Wisconsin Legislature in 1985, in response to the stress and service needs of families caring at home for someone with irreversible dementia.

2. 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.

3. According to the Alzheimer's Association, it is estimated that approximately 5.3% of people ages 65 through 74, 13.8% of individuals ages 75 through 84, and 34.6% of individuals 85 and older have Alzheimer's disease. The Alzheimer's Association estimates that in 2020, 120,000 Wisconsin residents age 65 and older have dementia, with that number anticipated to reach 130,000 in 2025. The number of people with Alzheimer's disease and other dementias is expected to increase as the population continues to age.

4. There are two main eligibility criteria for AFCSP. First, the individual must be diagnosed with Alzheimer's disease or any of the other irreversible dementias. Second, an individual or couple must have a joint annual income of $48,000 or less. However, if the individual or couple's income is more than $48,000, the costs related to Alzheimer's can be subtracted from the gross income. If, following this subtraction, the net income is then less than $48,000, the individual or couple would be eligible.

5. Annually, DHS may provide up to $2,558,900 for AFCSP to counties and tribes to assist individuals to purchase services and goods related to the care of someone with Alzheimer's disease. Up to $4,000 per person may be available, depending on the county's priorities and the person's need for services.

6. Generally, allowable services under the program are those that are necessary to maintain a person with Alzheimer's disease in the community. Typical services have included in-home help, respite care, adult day care, and transportation. Goods provided have included nutritional supplements, security systems, specialized clothing, home delivered meals, hobby equipment and chair lifts. However, counties may limit the types of services covered by this program. Counties may use money to start support groups, increase public awareness, purchase library books, start adult day care services, or to provide overnight or emergency respite.

7. In calendar year 2019, 1,242 families were served through AFCSP. The program does not currently maintain a waiting list for services at the state level, although some families may need to wait until funding becomes available in their county.

8. In calendar year 2019, a total of $2,526,634 was expended through AFCSP. The following table shows 2019 expenditures under the program by service category.

2019 AFCSP Expenditures, by Service Category

Respite Services	
Adult day services	$365,498
Caregiver self-care	14,016
Homemaker/chores	213,841
In-home general respite	666,839
In-home personal care	142,215
Overnight facility respite	176,713
Other respite	95,286
Subtotal respite services	$1,674,408
Other	
Other goods and services	$259,981
Development of new or expanded services	27,200
Outreach activities and public awareness	181,388
Support group development or assistance	88,450
Case management	166,671
Program administration	128,536
Total	$2,526,634

9. In calendar year 2021, DHS distributed the full $2,558,900 allowed by statute through this program. Of that total, DHS allocated $1,522,206 to 37 counties as an allocation under community aids, and $1,036,694 to tribes and area agencies on aging as non-community aids allocations. By law, area agencies on aging are generally not allowed to provide direct services. As such, when funding is provided to area agencies on aging the area agency on aging provides contract oversight and technical assistance but the program is still administered by the counties and tribes.

10. The amount each county or area agency on aging receives under this allocation is determined based on the state funding formula the Office on Aging uses for distributing federal Older Americans Act funds. Counties are not required to contribute additional funding to the program, however, may choose to do so if they determine that additional funding is needed on occasion.

11. 2015 Act 273 provided an additional $1,000,000 GPR and increased the funding DHS is authorized to distribute under AFCSP to the current maximum of $2,558,900, beginning in 2016-17. Further, 2015 Act 273 also established the current income eligibility limit of $48,000.

12. The Governor's budget would modify AFCSP in two ways. First, financial eligibility would be expanded to allow an individual or couple to have a joint income of up to $55,000, after any eligible deductions for Alzheimer's related care expenses, up from the current limit of $48,000. Second, to ensure that benefits are not reduced or limited as a result of expanding eligibility, an additional $500,000 would be provided annually for DHS to distribute to counties, tribes, and area agencies on aging under the program.

13. Based on ongoing demand for services, and the anticipated growth in the number of Wisconsinites aged 65 and older anticipated to live with Alzheimer's who could therefore benefit from

AFCSP services, the Committee may choose to provide an additional $500,000 GPR annually to expand eligibility for AFCSP, as recommended by the Governor [Alternative 1].

14. Alternatively, rather than expand the financial eligibility for the program, the Committee could instead provide $250,000 GPR annually and increase the funding DHS is authorized to distribute under AFCSP to $2,808,900.

15. While the Department does not collect data on individual benefit payments, 33 counties and tribes have set maximum benefit limits below the statutory maximum of $4,000 in order to serve more eligible individuals. By increasing the funding available, counties would be able to provide more aid to currently eligible individuals [Alternative 2].

16. Alternatively, the Committee could provide $250,000 GPR in 2022-23 and increase the funding DHS is authorized to distribute under AFCSP to $2,808,900 beginning in 2022-23 [Alternative 3].

17. Finally, the Committee may choose to take no action on this item [Alternative 4].

18. In addition to selecting one of the previous alternatives, the Committee may wish to repeal an obsolete statutory provision regarding cost-sharing requirements for the program, which the Department indicates does not reflect current practice [Alternative 5].

ALTERNATIVES

1. Provide $500,000 annually and increase the maximum amount of funding the Department may provide under the Alzheimer's family and caregiver support program from $2,558,900 to $3,058,900 annually. Increase the maximum income eligibility limit for the program to $55,000 per year.

ALT 1	Change to Base
GPR	$1,000,000

2. Provide $250,000 annually and increase the maximum amount of funding the Department may provide under the Alzheimer's family and caregiver support program from $2,558,900 to $2,808,900 annually.

ALT 2	Change to Base
GPR	$500,000

3. Provide $250,000 in 2022-23 and increase the maximum amount of funding the Department may provide under the Alzheimer's family and caregiver support program from $2,558,900 to $2,808,900 beginning in 2022-23.

ALT 3	Change to Base
GPR	$250,000

4. Take no action.

5. Delete obsolete statutory provision regarding cost-sharing requirements for the Alzheimer's family and caregiver support program.

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June, 2021 Joint Committee on Finance Paper #363

Nursing Home Grant Program Administrator (Health Services -- Elder and Disability Services)

[LFB 2021-23 Budget Summary: Page 293, #8]

CURRENT LAW

The federal Centers for Medicare and Medicaid Services (CMS) collects civil money penalties (CMP) from nursing facilities that have not maintained compliance with Medicare and Medicaid participation requirements and distributes a portion of this revenue to states to support projects to protect the health or property of residents of nursing facilities.

States are required to use their CMP allocations to support activities that benefit nursing home residents, and that protect or improve their quality of care or quality of life. CMS examples of allowable uses for CMP funds include, but are not limited to: (a) assistance to support and protect residents of a facility that closes or is decertified; (b) time-limited expenses incurred in the process of relocating residents to home and community-based settings or another facility when a facility is closed or downsized pursuant to an agreement with the state Medicaid agency; (c) projects that support resident and family councils and other consumer involvement in assuring quality care in facilities; and (d) facility improvement initiatives, such as joint training of facility staff and surveyors, or technical assistance for facilities implementing quality assurance and performance improvement programs.

Under the nursing home grant program, the Division of Quality Assurance (DQA) in the Department of Health Services (DHS) typically approves 15 to 20 applications per year. Due to the COVID-19 pandemic, the most recent and accurate program data is for 2019. In that year DQA managed 14 ongoing projects funded through the program, with total awards ranging from less than $5,000 to more than $1,500,000. DHS administers the program by assigning program management responsibilities to several staff in DQA.

DISCUSSION POINTS

1. Currently, to apply for a CMP grant, an eligible organization submits a project proposal to the Quality Assurance and Improvement (QAI) Committee, whose members are appointed by the DHS Secretary. The QAI Committee reviews project proposals during meetings in May or June and November or December each year. On average, the QAI Committee approves 15 to 20 proposals per year. Generally, any organization involved in the promotion of quality of care with licensed Wisconsin nursing homes are considered eligible to submit a project proposal for review.

2. Following approval for a project, DQA staff acquires CMS approval to use CMP funds for the project in question, develops grant agreements and purchase orders, and oversees the project throughout its life cycle, which is limited to a maximum of three years.

3. Examples of previous projects funded through the CMP nursing home grant program include a $611,000 grant to UW-Madison to design and implement a statewide training program to implement new federal infection control regulations; an $11,000 grant for a specific nursing home to develop a sensory and aromatherapy treatment program; and $42,000 to Music & Memory to help train and support new staff in how to provide personalized music to nursing home residents, which reduces agitation, enhances engagement with friends and family, and provides enjoyment to people with dementia.

4. In addition to programs for which specific organizations have applied, CMS launched two nationwide grants for eligible nursing home using the CMP funds during the COVID-19 pandemic. The first such funding opportunity allowed federally certified nursing homes to apply for up to $3,000 per facility to purchase tents for outdoor visitation and clear dividers (Plexiglas or a similar product) to create a physical barrier to reduce the risk of transmission during in-person visits. Subsequently, CMS expanded the allowable uses to include: outdoor furniture, heating units with appropriate venting; properly grounded lighting or electrical systems; and infrared temperature scanners, as long as such purchases were for the purposes of in-person visitation. In calendar year 2020, DQA issued $195,000 for these purposes.

5. The second such funding opportunity allowed federally certified nursing homes to apply for up to $3,000 per facility to purchase electronic devices to enable residents to visit with family and friends in a virtual setting and participate in telehealth visits. CMP funds could be used by nursing homes to purchase tablets, iPads, and similar devices, as well as accessories including headphones and protective covers to help with cleaning between uses. This program was initiated in response to the restrictions placed on visitors in nursing homes to prevent the spread of COVID-19. In calendar year 2020, DQA issued $767,000 for these purposes.

6. Currently, the responsibility to administer the CMP grant program is divided between three employees within DQA, none of whom are assigned primary responsibility for the program. Instead, the time these employees spend administering the CMP grant reduces time these employees would otherwise have to perform their core responsibilities.

7. In February 2017, CMS started encouraging states to submit "administrative use" proposals, which are proposals to use CMP funding to fund permanent state positions relevant to the

administration of each state's CMP program. States must apply to CMS to receive approval for these proposals.

8. The Department indicates that CMS typically allows states to use between 1% and 3% of available funds for administrative use proposals. The following table shows revenues, expenditures, and balances for the appropriation which funds the program for state fiscal years 2018-19 and 2019-20.

Nursing Home Grant Program Revenues, Expenditures, and Balances
Fiscal Years 2018-19 and 2019-20

	2018-19	2019-20
Opening Balance	$11,506,500	$11,807,700
Revenues	1,827,500	1,409,200
Expenditures	1,526,300	1,371,000
Closing Balance	$11,807,700	$11,845,900

9. As recommended by the Governor, the Committee could provide $65,300 PR in 2021-22 and $83,700 PR in 2022-23, from the existing balance to fund 1.0 PR position, beginning in 2021-22, to manage the CMP grant program. The 2021-22 funding amount differs slightly from the amount recommended by the Governor, due to a reestimate of supplies and services costs for this position. Under this alternative, funding would fall below the CMS range for administrative use proposals, with the Department estimating the position would, when fully funded for 12 months in 2022-23, be funded using 0.76% of the appropriation cash balance at the end of 2019-20 minus funds already committed.

10. The administration indicates that, if authorized the position would, among other activities: (a) lead the QAI Committee to review nursing home grant program applications; (b) guide approved applications through the DHS and CMS approval processes; (c) develop and process grant agreements and purchase orders between approved applicants and DHS; (d) review, approve, and pay invoices related to approved programs; (e) report annual activity to CMS and maintain fiscal records of approved programs; (f) track progress of approved programs; (g) maintain contact with applicants, DHS bureau of fiscal services, and DHS bureau of procurement and contracting to assure accurate and timely processing of contracts, purchase orders, and payments; and (h) perform outreach and marketing to improve and expand the program.

11. Due to the federal limitations on how CMP funds can be used and the recommendation from CMS that states submit proposals to use CMP funding to secure permanent state positions to administer the state's CMP program, the Committee may wish to provide funding and position authority for a CMP grant administrator. Additionally, funding a designated position for this purpose would allow the staff currently administering the program to spend more time on their primary work duties, while allowing the administrator to focus solely on CMP grant administration and improvement activities [Alternative 1].

12. Under current law, DHS is authorized to expend all penalty revenues that are credited to

the appropriation for eligible projects and services. The base funding for these projects and services ($2,700,000) is intended to represent an estimate of annual expenditures that will be made from the appropriation, but does not limit the Department's expenditure authority. Based on the grant amounts that have been authorized during the past several years, as shown in the table in Discussion Point 8, the current (base) estimates of spending from the appropriation far exceeds actual expenditures from the appropriation. Consequently, it could be argued that it is unnecessary to increase estimated base expenditures from the appropriation in the 2021-23 biennium.

13. Instead, if the Committee wished to fund the position recommended by the Governor, it could: (a) reduce estimates of PR spending so that $2,000,000 PR would be budgeted as an estimate of program expenditures in each year; and (b) authorize 1.0 position, supported from the appropriation, and modify the appropriation language to reference the new position [Alternative 2]. If the Committee chooses not to fund or authorize the position recommended by the Governor, it could still reduce estimates of PR spending annually so that $2,000,000 PR would be budgeted as an estimate of program expenditures in each year [Alternative 3].

14. On the other hand, the Department indicates hesitancy to reduce the estimates of expenditures from the appropriation as DHS and Department of Administration staff would need to do additional work to increase expenditure authority for the appropriation in case DQA has a higher than normal grant cycle in the coming two years.

ALTERNATIVES

1. Provide $65,300 PR in 2021-22 and $83,700 PR in 2022-23, from the existing balance, to fund 1.0 PR position, beginning in 2021-22, to manage the CMP grant program.

ALT 1	Change to Base	
	Funding	Positions
PR	$149,000	1.00

2. Authorize 1.0 PR position to manage the CMP grant program and modify the current appropriation to reference the new position. In addition, reduce base estimates of PR spending for the program by $700,000 annually so that $2,000,000 PR would be budgeted as an estimate of program expenditures in each year.

ALT 2	Change to Base	
	Funding	Positions
PR	- $1,400,000	1.00

3. Reduce base estimates of PR spending for the program by $700,000 annually so that $2,000,000 PR would be budgeted as an estimate of program expenditures in each year.

ALT 3	Change to Base
PR	- $1,400,000

4. Take no action.

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Health Services -- Elder and Disability Services

LFB Summary Items for Which No Issue Paper Has Been Prepared

Item #	Title
9	Tailored Caregiver Assessment and Referral Pilot Program